DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

Submissions on the Child and Youth Wellbeing Strategy

August 2019

The Department of the Prime Minister and Cabinet has released the following submission received during its public consultation on the child and youth wellbeing strategy.

Some of the information contained within this release is considered to not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act).

- Where this is the case, the information has been withheld, and the relevant section of the Act that would apply, has been identified.
- Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes and their reference to sections of the Act:

- **9(2)a** – Section 9(2)(a): to protect the privacy of natural persons, including deceased people.

child & youth wellbeing

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Child and Youth Wellbeing Strategy – Submission Template

This document is intended for individuals or groups who wish to make a formal submission on the child and youth wellbeing strategy.

Please complete this template and email it to: childandyouthwellbeing@dpmc.govt.nz

A guide to making a submission is available on the DPMC website https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Submissions will close on **Wednesday 5 December**.

Please provide details for a contact person in case we have some follow up questions.

Contact Name:	9(2) (a)
Email Address:	
Phone Number:	
Organisation Name:	[Please include if you are submitting on behalf of an organisation]
Organisation description: (tell us about your organisation – i.e. who do you represent? How many members do you have? Are you a local or national organisation?)	We are senior lecturers 9(2) (a) 9(2) (a) with expertise in the health and wellbeing of sexual and gender minority young people in Aotearoa New Zealand (NZ).
Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	The proposed framework and outcomes cover key child and youth health and wellbeing areas, however the strategy needs to explicitly name sexual and gender minority children and young people as a population requiring specific care and attention. Sexual and gender minority individuals make up at least 6% of the child and youth population, however they can be made 'invisible' in policy, practice, and evaluation, when they are not explicitly recognised. Currently, these young people are underserved in relation to their health and wellbeing, and are 'at risk' (e.g., in terms of depression and suicide attempts). Recent research indicates that the negative effects of deprivation may be amplified for this group, making it more critical that they are explicilty recognised in this strategy. The strategy will also need to carefully consider how to use and collect data to ensure that it is responsive to this traditionally neglected group, especially those within the group who may experience particular hardship (e.g., those experiencing poverty and deprivation). We endorse some proposed outcomes, and call for consideration of an

	additional specific strategy and office to address sexual and gender minority children and young people's enduring, and increased, health and wellbeing needs.

Submission Content
We strongly endorse the construction of a dedicated strategy to support the health and wellbeing of children and young people in Aotearoa New Zealand (NZ). The proposed framework includes a broad array of features and outcomes that offer important opportunities to promote health and wellbeing. For us, the importance of this kaupapa is reflected in the *potential* it offers to redress the increased, and disproportionate, negative social, educational, health and wellbeing outcomes reported by sexual and gender minority children and young people in NZ. The *Youth 2000* survey series, conducted in 2001, 2007 and 2012, have provided a valuable overview of the health and wellbeing issues of sexual and gender minority youth in NZ (e.g., Lucassen et al. 2015; Clark et al. 2014). These nationally representative surveys have highlighted that 6% of secondary school students (Years 9 to 13) are sexual minority youth (based on data from 2001, 2007 and 2012), and 1.2% are transgender (based on data from 2012). The *Youth 2000* data highlighted that these youth experience compromised health and wellbeing relative to their cisgender (i.e., not transgender) and exclusively opposite-sex-attracted peers. This is especially so in relation to depressive symptoms (2 to 6 times the odds of their peers), suicide attempts (2 to 5 times the odds of their peers) and bullying (3 to 5 times the odds of their peers). Representative data from sexual and gender minority children (versus secondary school aged young people) in NZ are not currently available. Unfortunately, sexual and gender minority youth are often 'problematised', placing the issues they experience as internal to the actual young person, rather than reflecting the impact of the challenging environments they face in NZ. In light of these findings we strongly support the recognition on page 15 of the May 2018 cabinet briefing paper that "transgender children and young people, and other children and young people with diverse gender identities, can have particular wellbeing needs, and face poor outcomes in certain areas, such as mental wellbeing and bullying. The focus of the child wellbeing strategy on improving the wellbeing of children with greater needs will help to address the disparities experienced by transgender and other gender-diverse young people". Additionally, the findings above indicate that sexual minority children and young people also have particular wellbeing needs and face poor outcomes in these areas as well. As such, ensuring that sexual and gender minority young people are explicitly mentioned in the strategy is critical to ensure that their needs

are not unintentionally or accidentally neglected by stakeholders of the strategy. We welcome the explicit recognition of the additional equity needs facing children and young people with disabilities. We argue that a similar requirement is required for sexual and gender minority children and young people in NZ. Unlike children and young people with disabilities in NZ, sexual and gender minority young people do not have a national strategy (i.e., The NZ Disability Strategy) or an office (i.e., the Office for Disability Issues) that is able to advocate for them in policy and chart a path for better health and wellbeing outcomes independent of the proposed strategy upon which we here comment. The present lack of a national strategy and overarching organisational structure to advocate for such children and young people, makes their *explicit* recognition, and inclusion, in this strategy even more critical. Unfortunately, without explicit recognition, we fear that their health disparities, that have persisted for decades, due in part to inadequate policy responses (e.g., Fenaughty, 2004; Fenaughty & Pega, 2016), will continue if such young people are not explicitly mentioned in the strategy as a group requiring specific and additional care and recognition.

One of the key and enduring barriers to the poor health and wellbeing outcomes for this group is the lack of a national strategy supporting sexual and gender minority children and young people's health and wellbeing, as well as a relative lack of data addressing their health, educational, and social outcomes. Other than occasional opportunistic studies, and the three survey waves from the Youth2000 (on average one every six years), there is a staggering lack of data about the health and wellbeing of this key group of children and young people. While recent activity by Statistics New Zealand regarding the collection of sexual orientation and gender identity data in the census is heartening in this regard, such discussion (and potential options) are orientated towards people aged 15 years and above. The focus for this consultation is on appropriate ways to identify and measure adult and young people who are sexual and gender minorities. Such necessary blanket approaches are likely unsuited for young people, who given the particularities of sexuality identity formation at this age (where attraction, rather than identity, is the more sensitive factor in identifying sexual minorities), are likely to be significantly underrepresented in such statistics. Sexual and gender minority children under the age of 15 will of course remain invisible in such statistics given the age range of the census. Of course that census, even were it able to be sensitive to these issues for children and young people, is only able to offer limited data on health and wellbeing outcomes.

Thus, there is an opportunity for the government to address the lack of data now, and in the future, by convening a group to consider how best to collect such data for children and young people, and where data would be best collected (e.g., the School Wellbeing Surveys run in conjunction with NZCER and the MOE offer a critical opportunity to collect anonymous information). Other options no doubt exist, notwithstanding situations where the state apparatus intersects with sexual and gender minority children and young people. Of course, much further work is required to address ways of safely doing collecting such national administrative data, especially where the findings anonymity cannot be achieved for children and young people (i.e., the IDI).

The reason for the need for quality and regular data collection reflects the desire of the strategy to make a difference for *all* children and young people's health and wellbeing. Currently there is little evidence that can be recruited to ascertain the success of the proposed outcomes for sexual and gender minority young people. To ensure that the strategy is delivering for sexual and gender minority children and young people means that it will need robust and sensitive baseline indicators. As this population is geographically distributed throughout NZ, and of relatively low prevalence (i.e. less than 10% of the population), the type of research that can address such data needs will need high numbers of participants from across a range of social and demographic areas to produce findings that have enough statistical power to support the strategy to determine whether it has been effective for this unique group of children and young people.

Convenience samples and qualitative evidence may be able to offer some evidence for the success of the strategy, however in order to assess the intersectional outcomes of interest in the strategy (e.g., the effects of poverty and deprivation), large samples and regular reporting of sexual and gender minority children and young people's outcomes are required. Furthermore, to ensure that such data can be aggregated and triangulated to investigate intersectional outcomes and validity, there is a need to develop structures by which such data can be safely and appropriately accessed, shared, and analysed in line with the strategy's priorities.

The need for intersectional analyses on the experiences of sexual and gender minority children and young people in NZ reflects work conducted to date that demonstrates that significant within-group differences exist for these children and young people. For instance, recent work (Fenaughty, Lucassen, Denny & Clark, in preparation) shows that on average sexual and gender minority secondary school students report

significantly lower educational achievement and aspiration than other young people, even controlling for social economic status. In fact, the large and randomised sample set of the Youth‘12 survey enabled the analysis of the relationship of child poverty and deprivation for this group of young people in relation to academic achievement. The findings show that the effects of deprivation and low SES on this group of young people are significantly more serious than for other young people. For instance, even when controlling for experiences of victimisation at school, prioritised ethnicity, whether they were male or female, teacher expectations of their success, and reports of school belonging, and supportive school structures for lesbian, gay and bisexual students, sexual and gender minority young people experiencing deprivation have nearly twice the odds of reporting below average achievement than other young people experiencing deprivation. Such findings indicate that the effects of child poverty and deprivation are amplified for this group of young people and as such require the proposed strategy to specifically recognise and address these disparities. It is worth noting that the ability for such an analysis to be conducted (especially in the case of gender minority children and young people) was only possible given the high numbers of participants that the Youth2000 series was able to include in 2012 (i.e. 8,500 secondary school students), again reiterating the need for the strategy to ensure that appropriate research around child health and wellbeing will include large samples and appropriate and universal questions on sexual and gender minority children and young people’s experiences where ever possible and appropriate.

In summary, the disproportionate negative social, educational, health and wellbeing outcomes reported in the few studies that are able to assess such issues in NZ, demonstrate that sexual and gender minority children and young people are a group who needs have not been met nor equitably addressed in relation to other children and young people. The reasons for such high needs relative to other children and young people may include a relative, and seemingly stubborn, invisibility of sexual and gender minority children and young people’s needs in policy and practice. The genesis of the lack of such policy and practice engagement may stem from the lack of an overall national strategy and organisational structure to produce and advocate for sexual and gender minority children and young people’s needs and experiences. Additionally, there is a ‘data-void’ around sexual and gender minority children and young people’s experiences in NZ. Whereas ethnicity and disability demographic information is routinely collected and reported on in relation to children and young people’s health and wellbeing (including educational outcomes), the same is not the case for sexual and gender minority children and young people. In the absence of robust and

sensitive data and analysis, the strategy risks failing this key group of young people, if it is not able to identify and be responsiven to the unique needs the group presents. In addition to naming sexual and gender minority people as a priority group in the strategy, we urge further consideration and work around establishing appropriate, sensitive and sustainable research practices to assess the performance of the strategy for this priority group.

In the absence of (or indeed in addition to) any explicit outcomes recognising sexual and gender minority young people's improved access, we endorse the prioritisation of three of the initial prioritised focus areas (27.4, 27.5, and 27.6) mentioned on page 19 of the May 2018 Cabinet briefing paper (i.e., 27.4: Children are safe and nurtured, in their whānau and their homes; 27.5 Children's mental wellbeing is supported; 27.6 Children are free from racism, discrimination and stigma). Such outcomes seem to offer a stronger opportunity to encourage dedicated focus on the experiences of sexual and gender minority children and young people (including by schools and health services), than some of the other priorities. For instance, as many issues facing sexual minority children and young people do not emerge until adolescence, a sole focus in the strategy on early years would be limited in its effectiveness to redress stigma-related sexual minority youth challenges.

Given the links between educational outcomes and future health and wellbeing (Link & Phelan, 1995; Zajacova & Lawrence, 2018), and the role schools play in sexual and gender minority children and young people's experiences, we also endorse the following outcome indicator: "children and young people are positively engaged with and achieving in education, and building skills and knowledge for life and learning". Furthermore, the recent findings from the 2018 ERO review of sexuality education in NZ schools highlighting the lack of effective sexuality education, and the deficits facing sexual and gender minority children and young people's sexuality education experiences, we also strongly endorse the proposed outcome indicator that "young people take a positive approach to relationships, sexual health and reproductive choices".

We also note that many of the other indicators are particularly relevant to sexual and gender minority children and young people (e.g., children and young people are free from victimisation at school and in the community, they have positive connection to others, etc.), however some of these outcomes would seem to be preconditions of other indicators (e.g., to be positively engaged in education requires safety at school, freedom from victimisation, and positive connection with others, etc.). Thus while we

have endorsed some outcomes in particular this is not to say that others are irrelevant, simply that some seem to be more encompassing of positive actions and others more focussed on particular outcomes that are precursors to other outcomes.

References

Clark, T.C., Lucassen, M.F., Bullen, P., Denny, S.J., Fleming, T.M., Robinson, E.M. and Rossen, F.V., 2014. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). *Journal of Adolescent Health*, 55(1), pp.93-99.

Education Review Office. (2018). *Promoting Wellbeing through Sexuality Education*. New Zealand Government: Wellington. URL: https://www.ero.govt.nz/assets/Uploads/Promoting-wellbeing-through-sexuality-education.pdf

Fenaughty, J. (2004). The end of queer: Heteronormativity and suicide. In L. Alice & L. Star (Eds.), *Queer in Aotearoa New Zealand* (pp. 71-85). Palmerston North: Dunmore Press

Fenaughty, J. J., & Pega, F. (2016). Why marriage equality is not enough: Enduring social policy concerns for gender and sexually diverse New Zealanders. In L. Beddoe, J. Maidment (Eds.) *Social policy for social work and human services in Aotearoa New Zealand: Diverse perspectives* (pp. 223-236). Christchurch, NZ: Canterbury University Press. URL: http://hdl.handle.net/2292/33072

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 35, 80–94. https://doi.org/10.2307/2626958

Lucassen, M.F., Clark, T.C., Denny, S.J., Fleming, T.M., Rossen, F.V., Sheridan, J., Bullen, P. and Robinson, E.M., 2015. What has changed from 2001 to 2012 for sexual minority youth in New Zealand?. *Journal of paediatrics and child health*, 51(4), pp.410-418.

Zajacova, A., & Lawrence, E. M. (2018). The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. *Annual Review of Public Health*, 39(1), 273–289. https://doi.org/10.1146/annurev-publhealth-031816-044628

information contained in your submission in response to a request under the Official Information Act 1982.

The Department of the Prime Minister and Cabinet may withhold all or parts of your submission if it is necessary to protect your privacy or if it has been supplied subject to an obligation of confidence.

Please tell us if you don't want all or specific parts of your submission released, and the reasons why. Your views will be taken into account in deciding whether to withhold or release any information requested under the Official Information Act and in deciding if, and how, to refer to your submission in any possible subsequent paper prepared by the Department.