Coming Out in the Care System: Participatory Research with Care Experienced LGBTQ+ young people in England

This chapter focuses on the experience of the care system and of leaving care services in England of a marginalised group of young people, those who identify as LGBTQ+. There is an emerging literature about this group, predominantly US based, with the occasional mention of sexual orientation and gender identity in UK studies of care leavers' experiences (see, for example, Duncalf, 2010). The chapter outlines the international research literature before discussing the SpeakOut study, which was a multistrand research study in England looking at the experience of LGBTQ+ young people growing up in the care system in England, and the support services they receive. Two theories underpin the study: minority stress theory, and intersectionality. The findings of this interview study with young people will be explored in the context of UK policy and practice, with a particular focus on coming out in the care system. Implications for practice are discussed.

A note on terminology: The LGBTQ+ category is constantly being contested and reinvented, reflected in the multiple and multiplying acronyms used in different contexts. Cronin and King (2010) for example, cite LGBT, LGBTQ, LGBTQQ, LGBTQQU and LBGTQQUI (lesbian, gay, bisexual, trans/transgender, queer, questioning, unsure, intersex) as a variety of acronyms to signify the community within the UK. Since 2010 additional terms have been added. Throughout this chapter we use the term LGBTQ+, when referring to the SpeakOut study. Where the literature or policy reviewed refers to a specific population the most appropriate abbreviation will be used. The term SOGIE is used as a collective term for sexual orientation, gender identity and expression. The term cisgender is used to refer to people whose gender identity corresponds to the sex assigned to them at birth. The term trans is used to refer to people whose gender identity does not correspond to the sex assigned to them at birth. All names used are pseudonyms.

Overview of research literature

Several key themes emerge in the literature including: a lack of certainty about how many LGBTQ+ young people are in care; predominantly negative experiences of LGBTQ+ young people in the care system; professional lack of knowledge about LGBTQ+ young people's needs and appropriate support, and intersectionality – LGBTQ+ young people experiencing care differently depending on factors such as gender and ethnicity.

Identifying LGBTQ+ young people in care

The number of young people in the care system who are LGBTQ in the US as well as the UK is hard to identify due to a lack of systematic data gathering on sexual

orientation and gender identity (Dworsky, 2013; Gallegos et al, 2011; Berberet, 2006; Freundlich and Avery, 2004). However, a growing body of evidence from the US suggests that LGBTQ young people may be overrepresented within the care system. For example, recent large-scale studies from the U.S. have shown sexual minority young people are more likely to be living in foster care (Fish et al 2019, Baams et al 2019, Wilson and Kastanis 2015) or in the child welfare system (Dettlaff et al 2018) than heterosexual youth. Grooms (2020) suggests reasonable estimates of the LGBTQ foster youth population to be from 10-30% of the young people in care nationwide in the US and suggest that collecting data on this population is imperative for planning appropriate provision.

The higher estimated percentages of LGBT young people in care have been partly attributed to birth family rejection in the US literature (Woronoff et al, 2006; Berberet, 2006; Maccio and Ferguson 2016, McCormick et al., 2017). Additionally, some young people who are categorised as entering care due to their difficult behaviour may in fact have experienced conflict in the home due to sexual orientation/gender issues (Sullivan et al, 2001). More recent studies in the US have suggested a further cohort of LGBT young people who come into the care system because of difficulties in the family and community not related to their SOGIE (Mountz & Capous-Desyllas, 2020).

LGBTQ+ young people's experiences in residential and foster care

US research has raised concerns that while some young people reported having positive experiences as LGBTQ young people in care, a number faced abuse, rejection and discrimination from peers and staff and experienced placement instability (Sullivan *et al*., 2001; Woronoff *et al*., 2006; McCormick *et al*., 2017; Poirier *et al*., 2018, Grooms, 2020, Shpiegel and Simmel 2016). A study by Clements *et al* (2008) involving 25 foster carers found that some foster carers had on previous occasions asked for placements to be terminated when a young person in their care 'came out' as LGBTQ+. Several qualitative studies suggest that foster carers were concerned that they would sexually assault other young people in the home (Clements et al, 2008; Woronoff et al, 2006; Mallon, 2001).

There is also evidence that LGBT+ young people may be discriminated against in residential placements, through being separated from cisgender heterosexual peers, (either for their own safety or due to misplaced fears that the other young people might be at risk) (Woronoff et al, 2006: Mallon, 2001, Weeks et al 2018). Trans young people's experiences, although less documented, appear to be equally poor but with additional challenges, such as young people's decisions about gender expression, names and pronouns not being respected and staff making insensitive decisions about how to handle changing rooms, bathrooms, and dormitory set-ups (Woronoff et al, 2006). These studies suggest that being out in care, or even being suspected of being LGBT, have led to serious risks involving young people's emotional, physical and sexual health (Duncalf, 2010; Woronoff et al, 2006; Mallon, 2001).

It is unsurprising then, that LGBTQ+ young people may be vigilant about whether it is safe to come out to carers, peers, or schools when they enter the care system as they may encounter new or renewed discrimination in their new environment (Gallegos et al 2011, McCormick 2018).

Discrimination, rejection, and lack of support can contribute to adverse outcomes for LGBTQ young people in care, including homelessness after care (Robinson, 2018; Forge *et al*, 2018, Shpiegel and Simmel, 2016). A qualitative study of young people exiting care in the US identified several unmet needs, including safety and protection, lack of access to affirming health care and appropriate housing, lack of connection to LGBTQ community resources and lack of support with LGBTQ identity development (Paul 2018).

Intersectionality

Since LGBTQ+ comprises diverse identities, it is not surprising that the literature points out that not all LGBTQ+ young people experience care similarly and that gender and ethnicity, for example, will interact with LGBT experiences in complicated ways (Mountz, 2020).

In a study of foster care, carers described a reluctance to have young gay men in their homes due to fears around potential sexual violence directed toward other young people in their care. Their attitudes toward lesbian or bisexual women were more relaxed, however, with foster carers describing functioning care arrangements even when a lesbian or bisexual young woman was out (Clements et al, 2008).

The intersection between race and sexual orientation is also complex, with one study suggesting that LGBTQ black youth may be treated as older than they are and vulnerable to assumptions of criminality (Erney and Weber, 2018). They suggest that restorative approaches rather than zero tolerance responses to challenging behaviour in school may be helpful.Restorative approaches could also be used in out of home care settings.

Recommendations for LGBTQ+ young people in care

Research indicates that there is a need for improved record~~ing~~ keeping of young people's sexual orientations and gender identities in order to better track outcomes and plan service provision (Detlaff 2018, Fish et al 2019, Washburn et al 2018).

Professionals working directly with LGBT young people in the care system should also understand the effects on the young people of the risks they face. These include risk of homophobic or transphobic bullying or abuse, as well as rejection by carers, staff, and birth family members, because of their SOGIE. This may lead to depression, anxiety and suicidal ideation (Morrow, 2004; Sullivan et al, 2001; Mallon, 1997). Young people may in turn be at greater risk of going missing and ending up homeless, in which situation they may encounter additional victimisation such as sexual exploitation and sexual assaults, or may become involved in sex work and

experience associated risks such as HIV/AIDS and drug and alcohol abuse (Mountz, 2011; Craig-Oldsen et al, 2006; Woronoff et al, 2006).

Qualitative studies in the Netherlands (Gonzales-Alvarez et al, 2021) and Australia (Gatwiri et al, 2022) suggest the importance of warm, caring relationships with adults, positive affirmation of SOGIE, and acknowledgment of and challenge to social inequalities and injustice. An adaptation of the 'secure base' model has been utilised to outline how LGBT young people's needs can be met by foster carers. This model underlines the importance of acceptance of the young person's SOGIE, communicating openly about LGBTQ issues, protecting young people from stigma and victimisation, providing emotional and practical support and offering opportunities to develop a sense of belonging to the LGBTQ community (Schofield et al, 2019).

More specific recommendations include measures to ensure safety in residential, foster, and other settings (Morrow, 2004, Berberet, 2006). These include:

- providing a generally LGBT-friendly environment in all services working with young people by displaying LGBT posters and images of LGBT role models (Wilber et al, 2006);
- using gender-neutral language when speaking to young people about sex and sexuality (Morrow, 2004);
- supporting young people in their coming out process or in their process of questioning their sexual orientation/gender identity and helping to normalise it (Morrow, 2004; Sullivan et al, 2001);
- liaising with voluntary agencies that offer support to LGBT young people and their carers (Wilber et al, 2006; Mallon, 1997);
- LGBT foster carers and staff as well as LGBT-friendly foster carers and staff should be specifically recruited to work with and look after young people, creating natural opportunities for mentoring and support (Woronoff et al, 2006; Sullivan et al, 2001).

Policy in the UK context

The needs of lesbian and gay young people in the care system have been acknowledged in law in the UK through the Children Act, 1989 and its accompanying standards and guidance from the earliest versions of that Guidance. The 1991 family placement guidance contained the first mention of 'gay young men and women' in public care by the British government regarding their specific needs being acknowledged and protected. 'The needs and concerns of young gay men and women must … be recognised and approached sympathetically' (Department of Health, 1991: 98).

The Fostering Services National Minimum Standards (Department of Health, 2002) stated that fostering agencies had to ensure that: '… each child and his/her family have access to foster care services which recognise and address her/his needs in terms of gender, religion, ethnic origin, language, culture, disability and sexuality' (Department of Health, 2002:11).

This guidance was published at a time when LGB people could not have their partnerships formally recognised in law (which changed only with the Civil Partnership Act 2004), or adopt children as a couple. Indeed Section 28 of the Local Government Act 1988 prohibited teaching in schools about the acceptability of homosexuality, describing it as a ‘pretended family relationship’. It is contradictory that one area of government guidance encouraged recognition of the needs of gay youth, whilst another law discouraged educators from talking about their needs. The existence of Section 28 led to a climate of fear in education and self-censorship regarding support for young LGBT people in schools. It was eventually repealed in 2003 (in 2000 in Scotland). The Adoption and Children Act 2002 (implemented 2005) made it legal for same sex couples to adopt children.

The main anti-discrimination legislation in the UK is the Equality Act 2010 which replaced previous anti-discrimination legislation with a single legal framework, including ‘sexual orientation’ and ‘gender reassignment’ amongst nine protected characteristics. It is important to note that the gender reassignment protected characteristic does not include other trans identities such as non-binary. The Act also created the Public Sector Equality Duty (PSED), which (among other effects) places duties on local authorities in fulfilling their responsibilities towards children in public care. The PSED requires local authorities to give due regard to eliminating unlawful discrimination, advance equality of opportunity between different groups, and foster good relations between different groups.

Whilst it is possible to trace increasing recognition of LGB needs in government guidance from 1991 onwards, including changes in language, more mentions of sexual orientation as an identity need, and acknowledgement of specific challenges faced by LGB youth, there is hardly any mention of the needs of trans young people. More recently, the National Institute for Clinical Excellence (NICE 2015) guidelines for looked after young people make recommendations around diversity, and include ‘lesbian, gay, bisexual or transgender’ amongst other aspects of diversity. Recommendations include: promoting an organisational approach to diversity; contacting relevant community support groups; consulting young people about their experiences; appointing a local diversity champion; producing a diversity profile to ensure services are relevant; and ensuring a diverse range of placements.

Whilst the needs of trans youth are barely mentioned in guidance, there have been changes in relation to the law relating to transgender adults. The Gender Recognition Act 2004 gives certain legal rights and protections to transgender men and women, including the ability to apply for a Gender Recognition Certificate. The application process requires that they meet certain criteria which include a diagnosis of gender dysphoria. This legal recognition does not cover children and young people, nor those who identify as non-binary or other trans identities. There has been debate in England about changing regulations to allow trans people to self-declare their gender identity but no change in legislation has been put forward. In Scotland however a Gender Recognition Reform Bill has been published (2022) proposing to make it possible to get a gender recognition certificate without need for medical reports.

For children and young people, access to medical treatment relating to gender variance (specifically puberty blockers) usually requires parental consent, although in

some cases this is not necessary if the young person is deemed competent to make their own decision. This was subject to legal challenge between 2019-2022. Cross sex hormones can be prescribed according to National Health Service guidance from age 16 and surgery from 18.

In many ways the UK has been progressive since 2000 in advancing legislation that protects LGBT rights. The national census in 2021 included voluntary questions on sexual orientation and gender identity for the first time. However, there is increasing public debate over trans rights and the debate has become increasingly polarised. In 2021, the UK government aimed to introduce a ban on conversion therapies – therapies which aim to change someone's sexual orientation or gender identity, to stop them from identifying as LGBT+. However, the plan to introduce this legislation was shelved. It was later resurrected, but as a proposal to ban conversion therapies relating to sexual orientation only. A conversion therapy bill was listed in the Queen's Speech in 2022 to prohibit sexual orientation conversion therapies, but not gender identity conversion therapies. In the future there may be increasing divergence across the UK, as Scotland and Northern Island exercise their devolved powers in relation to legislation affecting LGBTQ+ people.

The SpeakOut study

The SpeakOut study (Cossar et al 2017) was the first national study in England of the experiences of LGBTQ young people growing up in the care system. The study's objectives were to investigate how LGBT young people experience growing up in care and how they negotiate their identities. The research questions also included a consideration of how LGBT young people in care experience the support they receive from foster carers, residential workers and social workers and other professionals.

Two theoretical frameworks informed the study. Minority stress theory (Meyer, 2003, Hendricks and Testa, 2012) was originally developed in relation to sexual minorities and adapted to apply to trans communities. It proposed that the higher rates of mental health problems in the sexual minority community (which has had a history of being pathologised) could be attributed to the stress encountered in living with a stigmatised and marginalised identity. Minority stress is defined as 'excess stress to which individuals from stigmatised social categories are exposed as a result of their social, often minority, position (Meyer 2003). The theory posits that the experience of growing up and living in a homophobic or transphobic environment leads to stress. This can lead to a negative self-perception (shame), vigilance about one's safety, and concealment of identity as a way to keep safe. This latter strategy however, may lead to additional stress due to the cognitive effort of hiding – for example self-monitoring of speech, body language and gender expression. Minority status can also be associated with resources that can aid coping and be protective: family support and acceptance, as well as group solidarity within the LGBT community.

The second theory informing the study is intersectionality theory. Since Crenshaw's (1989) use of the term in her paper concerning the unique position of black women in

society, in which she wrote: '…the intersectional experience is greater than the sum of racism and sexism,' (Crenshaw, 1989:140) intersectionality has been used to critically engage with questions of identity. The theory suggests that multiple aspects of identity come together in unique ways which cannot be adequately understood by viewing them separately, in an additive model. Intersectionality draws attention to the fact that no social identity category occurs in isolation from others. Instead we are all positioned within a framework of identities including gender, racialisation, class, sexual orientation and others. Multiple factors combine uniquely to define an individual's experience. The aspects of identity that were central to the aims of the study were about being LGBTQ and care experienced.

The LGBTQ+ community is diverse, comprising multiple gender identities and sexual orientations. Whilst 'growing up in care' may not be seen as a social identity category in the way that gender and sexual orientation are, it can be argued to be so (Fieller and Loughlin 2022, Rogers 2017). In a qualitative study of young people in foster care Rogers (2017) found that they experienced stigma. The young people managed this by being very careful about disclosure of their 'in care identity', seeking support from peer groups, particularly other care experienced young people who engendered a sense of belonging. Such findings suggest that young people growing up in care are part of a minoritised group. In the UK a government-commissioned independent review of children's social care goes so far as to recommend that care experience should be recognised as a protected characteristic (McCallister 2022).

Design

Throughout the research the academic research team worked with a team of young researchers, who were actively involved in the research process in project design, analysing data and dissemination of findings. At the conclusion of the project they worked to coproduce an animated film to assist in dissemination of findings (available at SpeakOut - LGBTQ Young People in Care Matter - Groups and Centres (uea.ac.uk).

The young researcher team comprised six young people who were involved throughout the project, and two who were involved for part of the duration. The project design anticipated that young people might need to step away from the research at times or not wish to commit to the whole research period. Recruitment of the young researchers was aided by a national voluntary agency working with young people in care and care leavers. This was done on the basis of interest, aiming initially for a group of six or seven young people. Although it was not part of the recruitment strategy, the mix of ethnicities in the group was beneficial to the research as all the academic researchers were white. Five of the eight young researchers were of black and minority ethnicity. Their insights enriched the consideration of ethnicity, culture and religious affiliation across the findings. It was also important to include the perspectives of different genders and sexual orientations and there was some diversity within the group, which included lesbian, gay, bisexual and trans young people.

It was considered important to tailor the research tasks in a way that was accessible to the group, rather than seek young people with particular research skills (Cossar and Neil 2015). The group met every six weeks throughout the research. They were involved in research design, recruitment, analysis and dissemination. Follow on

funding was secured for a participatory film making project resulting in an animation to disseminate the findings of the research.

Life history interviews were conducted with 46 LGBTQ young people aged 11- 26 with more than six months care experience. They included 18 cisgender male, 7 trans male, 13 cisgender female, 6 trans female, 1 agender young person and one currently identifying as a cis male but with a clear plan for future gender transition. In terms of sexual orientation, there were 13 gay male, 8 lesbian, 5 bisexual female, 6 bisexual male, 2 pansexual, 4 questioning and 6 heterosexual (five of these identified as trans heterosexual and one was a cisgender young man who identified as heterosexual but who had sex with males and wanted to take part in the research). The research was successful in recruiting diverse young people from the LGBTQ community. Thirty-three of the sample were white British, two black British, three black African, one Asian British, two white European, four dual or mixed heritage and one from the travelling community.

Most of the young people first came into care as adolescents and had experienced abuse or neglect. Three came into the care system after rejection by birth family due to SOGIE. A further six described difficult relationships with parents that led to them coming into care, where either their SOGIE was a factor, or the young person developed behavioural or mental health difficulties related to suppressing their SOGIE. Twenty-five of the young people entered care as adolescents with the other nineteen entering care under the age of twelve.

The interviews were recorded, transcribed and anonymised. Thematic analysis was used. Codes were developed inductively working from the data (Braun & Clarke 2006). However, inevitably researchers drew upon background knowledge of existing theory. Researchers read through the entire set of transcripts noting down initial ideas and developing codes. The entire set of interviews were then coded using NVivo software. A case summary was also constructed for each interview and each of these was discussed by two academic researchers. This approach allowed the data to be analysed in terms of cross-cutting themes, whilst also maintaining the complexity and integrity of each individual's situation. Key themes were elicited from the data with representative quotes. These were discussed with the young researcher group who added further insight to the analysis. The involvement of young researchers in data analysis helped address concerns about power imbalances in the construction of knowledge about marginalised groups (Doucet and Mauthner, 2002).

The discussion that follows will focus on themes related to coming out in the care system. The quotations are all taken from the transcripts of the young people's interview conversations with the researchers.

Findings

Stigma in relation to sexual orientation

Many of the young people experienced stigma and bullying in relation to their sexual orientation. They encountered homophobia and biphobia from family and peers, in the community and in school and church. Some young people found it hard to accept their sexual orientation themselves as well as ~~then~~ having to face negative reactions from

others. This could make them vigilant about how they managed this aspect of their identity and how open they could be. After a struggle to acknowledge her sexuality to herself, one young person felt overwhelmed with the prospect of others knowing:

> *I know I'm gay. I'm going to accept it now. But actually is anyone else going to accept it kind of thing – I was like oh my gosh, my whole world is over now.*

Non-conforming gender expression in particular could make a young person a target for bullying. Faced with such difficulties some young people developed strategies for concealing their sexual orientation:

> *[I dated girls] just like a little barrier so people never knew kind of thing.*

Stigma in relation to gender identity

The descriptions of stigmatisation in relation to trans identities had a different quality to those relating to sexual orientation. The young people described a sense that non-LGBTQ people were very threatened by gender expression which did not fit with cisgender norms. Trans young people felt that they became an object of curiosity, almost perceived not to be fully human:

> *…when people can't identify your gender, like you lose your hold on humanity because there is no point of reference….. they don't actually like know how to interact with you at all and then they get scared or they 'other' you….or like you become demonised.*

Gender expression could attract both homophobic and transphobic attack,

> *…every day I could get beaten up, I could get beaten up and it wasn't even just from like kids it was from adults, homophobic adults at the time because as I said they could see me as just a gay boy. At first they thought I was a girl and this guy would flirt with me and I would ignore him and then he would realise that I am a boy and then he would like become either sexually aggressive or try to attack me…. I would get beaten up at school and then I would probably get beaten up as I go home from school and I would come home like to have people just totally ignore me and like literally I don't exist.*

This young person's quote underlines the difficulty young people faced in expressing their gender identity without being drawn into a web of negative reactions and associations making them vulnerable to sexual predation and physical attack. This trans young person was negotiating homophobia as well as transphobia and this was occurring across all contexts of their life – at school and in the community, with no source of safety at home. In fact home was neglectful and abusive.

Stigma about being in care

A third source of stigma was that related to growing up in the care system. Young people were vigilant about how they managed their care identity and many had experienced bullying, both verbal and physical at school and in the community.

I got kicked, I then got punched, your parents don't love you, they didn't love you, they don't care about you, ..

I felt like it was a bad thing. My parents didn't want me… I still felt like it was bad so yeah, I didn't want people coming round and seeing all of these other people living in the household.

Both in relation to their SOGIE and their being in care young people had internalised a negative self image, and then were vigilant about others' responses and took action to protect themselves (for example by dating heterosexually, or not inviting other people to their foster home). The SOGIE and care aspects of their identities could also intersect so that a negative experience in relation to one aspect of their identity could lead to greater concealment of another:

I got bullied because of my accent, because of the way that I looked… and because I was looked after. …so I didn't want to say to my friends, 'oh I am gay' for them to go tell other school kids I was gay … for me to get bullied. [This young person had been moved across the country as part of his care placement hence the accent difference]

Oh, "…you don't have a mum and dad and that"…that's why I just made sure no one knew at school [about being trans], 'cause yeah. It's like it'd be a bomb going off…

Some young people suggested it was easier to be open about their SOGIE than it was about being in care.

Being in care is my own business like I don't need to tell people, why should people know and then they might look at me different, whereas if I am gay if you look at me different then that is your own issue.

This quote suggests that the young person has developed more resilience around his sexual orientation than the fact that he is in care. The young researcher group felt that this was understandable. They pointed out that whereas there is a counter to the feelings of shame/stigma around being gay through belonging to the LGBT+ community and the public visibility of Pride movements, there is not an equivalent source of pride or validation for young people with respect to being in care.

Vigilance about rejection in a long term placement

The case studies created from the individual interview transcripts give an insight into the complexity of the intersection between being LGBT and being in the care system.

For those in a stable placement their early experience of separation from birth family meant that they felt concern about potential loss of stability, as one of the young researcher team put it, 'You don't want to lose a family again' (SpeakOut film 2018). One of the interview case studies illustrates this well. Lisa had been in a long term

foster placement since the age of 4. She felt she was part of the family. Lisa had a close and secure relationship with her foster carers but still feared rejection if she came out.

> *Obviously my friends are fine with it because they don't really care. But my foster family, I didn't really know. So yeah… I wanted them to know, but I couldn't really tell them. … I was just scared that ….something would go wrong and I end up leaving here, but I didn't, thank God.*

Lisa's foster carer discovered her sexual orientation via Facebook and talked to Lisa about it. She was accepting, and took Lisa to a local LGBT group. Whilst Lisa's experience was generally positive her experience of coming into care meant that she was cautious about risking her stability by coming out.

Concealment of sexual orientation in care

Not only the attitudes of carers, but also of local communities could be an issue. Gemma, a white British young person, was placed close to home in a close knit community. Although this is often viewed to be protective as it involves greater stability for the young person, perhaps avoiding a change of school, for Gemma this caused difficulties. She had come out at school, but not in care and she experienced bullying at school. She "went out causing trouble", challenging carers to reject her:

> *It wasn't too far from where I actually got brought up to be honest. So then I was still around people that I knew. But obviously with coming out gay and all that stuff. I didn't want to be there. So I used to go out and cause loads of trouble. Get arrested off police.*

Gemma engineered a move, as she was uncomfortable being out in her local community. She was bullied at school and accused of 'turning others'. However, the change of placement meant she had to come out again in a new school, with people she didn't know. She went missing from care to explore the LGBTQ+ scene in a nearby city. As she was not out in her residential placement she did not tell them where she was going, putting herself at risk. Although Gemma's struggles were apparent to carers and professionals over a long period, the underlying reason for her behaviours was not known as she had not felt comfortable to be out in the care system. At the time of interview she was receiving support from a specialist housing provider where she felt that LGBTQ+ issues were understood, unquestioned and supported.

Trans young people's experience of coming out in care

Some of the trans young people had started to explore their gender identity whilst in foster placement but they and their carers had struggled. One young person had yet to articulate his gender identity to himself. His foster carer came across a list of boys' names in his pocket. The young person kept thinking of these names, but wasn't sure why and tried unsuccessfully to push away his thoughts. The foster carer's response was not attuned to the young person's thoughts and feelings at the time:

…foster carer [was] saying 'so you want to be a boy? what about kids?'…. And she was like, 'Fine, fine. But you know ….. bearing in mind it is not a normal relationship you will be in'. And I'm like 'Well, I'll be in a straight relationship'. She was like, 'Well you will never be straight. You change gender you will never be straight.' I can get where she is coming from. And it didn't bother me. And I was like, 'Okay, um, but…' and she was like, 'Do you realise the impact it is going to have, people aren't going to be as open to it'. And she is trying to help me and give me advice and I was like.. I think I was like, well, 'We will deal with that when I come to it.'

In this situation both the young person and the carer independently needed information and support to ensure that the young person could explore their gender identity at his own pace. The carer's response was potentially overwhelming for the young person.

For the trans young people interviewed it was notable that several did not feel psychologically safe enough to explore their gender identity until the point of leaving care. This quote is from a young person who at the time of interview identified as male, but had a clear plan to transition:

Transitioning for me, I want to go through it. It is very… with me and what I've been through in my life… it just makes me not want to do it. If I did it at the moment, I think it would be a cop-out of who I am, again. Like I said to you before. I know that I want to be (female name) and I want it to happen, but it's just like I need time to be in the right frame of mind to start again. Does that make sense?

Another young person felt finally able to explore their gender identity when they had secured stable housing.

I was in a space that I was comfortable to be myself and kind of have my own flat, there was stability and I was finally kind of safe away from things that I thought had always been like a priority: of making sure that I was safe rather than thinking about who I actually was.

Care as an opportunity to explore

It is important to acknowledge being LGBTQ and in care could also intersect in positive ways. One case example illustrates this. Sol, a black African young man, was physically abused in his family for being gay. It was not acceptable in his community or his church. The police repeatedly intervened in arguments between him and his mother. Social workers worked to reunify him with his mother, and Sol felt that the risk to him from his family and community was underplayed, and that his social worker, who was the same ethnicity and culture as his family, possibly shared his mother's attitudes. Notably Sol did not know what his social worker's attitudes actually were, however, and he was vigilant about the likelihood of further rejection. The fact that efforts were made to reunify him with his family confirmed his feeling that he wasn't being heard. However, once he was in care he had the opportunity to explore his sexual orientation for the first time. He said,

> *My mum is really religious and the culture that I was brought up with is really harsh. It's really hard for me because I have the religious side of me saying like gay people should be banned, should be killed and everything.*

> *When I was in care I was really happy in care because I was myself. Because when I was with her [mum] I was never myself.*

Sol was relatively unusual in the sample as he had come into care because of family rejection of his sexual orientation. He was out at the point of coming into care and efforts were made to place him in an appropriate placement which he experienced as supportive.

The responses of carers and professionals

Coming out is not a one off event, but an ongoing process (Guittar and Rayburn 2017, Toft 2020) and within the literature there is an emerging interest in coming out as a way of strategically managing identity, rather than being viewed as a linear psychological process of self-acceptance with an endpoint of living authentically (Toft 2020, Orne 2011). Coming out conversations have to be negotiated (Manning 2015) in different contexts and situations. Intersectional identity is important in how an individual manages such negotiations (Toft 2020). Young people in care have additional concerns about their own safety and stability and may make strategic decisions with these in mind. It is therefore of crucial importance how carers and professionals interact, respond or react to LGBT+ young people in their care.

In the study young people experienced a range of reactions from foster carers and professionals (see also Schofield et al 2019). These ranged from rejection to acceptance. In a minority of cases it led to the termination of a placement:

> *My first placement after I'd identified as bisexual, they actually threw me out. They gave me a matter of days' notice. Because she had a daughter around the same age as me and she goes 'it's not safe for you to be at the same house'*

Other responses, although not involving outright rejection, were not experienced as helpful. These included being told it was 'just' a phase; that it was normal to be 'confused' (where the young person did not consider themselves to be confused), and that they were 'too young' to think about it.

There were also examples of heteronormativity which created a barrier to young people coming out:

> *My social worker came to my house and asked me ... 'Do you have a boyfriend? Are you having safe sex?' .... You're in a situation where you feel like now you've put me in a place where I can't talk about if I like girls or not.*

Some professionals were able to raise the topic, but the conversation was awkward and uncomfortable for the young person:

It was just a case of like, we need to check in with you…. 'You are gay and do you need any help with that?' It is like, 'Yeah I would love some help with my gayness, please provide it to me: like, what does that mean?' and {sighs} yes, just not good.

The most helpful responses were those that were attuned to the young person in terms of pacing and where the carer or social worker offered acceptance and an openness to exploration:

Those are the ones that basically said whatever you are, that's ok, so made me feel accepted before I even knew if that makes sense.

Discussion

Minority stress theory was a useful framework for understanding these young people's experiences. The findings confirm the value and validity of this approach and demonstrate its applicability in different cultural contexts: care experienced young people who identify as LGBTQ+.

A number of the young people had difficulties accepting their own SOGIE and were vigilant about rejection, and/or chose strategies of concealment. Importantly, they also managed aspects of their identity strategically, in different ways in different contexts. It was notable that having multiple stigmatised identities could consolidate both vigilance and concealment, so where there was a negative response to LGBTQ identity, this could affect the young person's openness about being in care, and vice versa. Practitioners need to be aware of both the benefits and risks of coming out in different contexts, and able to advise and prepare young people for this (McCormick 2018). In order for this to be possible the young people first need to feel comfortable to come out to the practitioners.

A common recommendation for practice in the international literature is that young people can find a sense of validation and belonging through connections to the LGBTQ+ community and this was also true in the present study. However, there was some suggestion that the LGBTQ+ youth services also need to change to ensure that they are accessible for young people growing up in the care system. Some young people suggested that they felt like outsiders in youth groups because their experience in care was so different from that of other young people. As well as professionals working in the care system having a raised awareness of issues affecting the LGBTQ+ community, youth workers in the LGBTQ+ services need an awareness of issues affecting young people in care so that they can best support and integrate them into services.

It was notable that trans young people in the study often were exploring their gender identity at the point of leaving care, and at times struggled with accommodation offers that did not fit with their gender identity. They also viewed services as concentrating unduly on independent living skills at a time when many were extremely vulnerable in terms of their gender identity and mental health. These young people may need

extra support leaving care, with services that are appropriate and include support for gender identity.

These findings add further evidence to the international literature base, but more research still needs to be done in different cultural contexts and in different populations within countries. The experiences of LGBTQ+ young people are also likely to change as culture evolves. The young researcher group (aged 17-23) considered that the younger participants in the interview study, aged only five years younger than them, were a different generation and had a very different experience to them as mobile phone technology and social media had evolved so fast.

The importance of the political and social context in which a person is situated is integral to both minority stress theory and intersectionality. In the English context the findings suggest that, despite liberalisation of the laws and guidance over the past twenty years, LGBTQ+ young people in care remain stigmatised and are vulnerable in their communities. There is no reliable data about how many LGBTQ+ young people there are growing up in the care system in the UK. Asking about SOGIE needs to be a precursor to planning appropriate provision and monitoring outcomes. Many practice recommendations from the US literature are relevant to the UK context, and LGBTQ+ awareness should be embedded in the social work qualifying curriculum and in post-qualifying training. More research is needed about this group's experiences over time in different sociopolitical and cultural contexts in order to ensure that social workers in different contexts can meet the needs of their communities.

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