LGBTQ+ young people's experiences of residential social care in England

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Contents

Acronyms and abbreviations

BAME	Black, Asian and minority ethnic
CAMHS	Child and Adolescent Mental Health Services
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
SEN	Special Educational Needs
SOGIE	Sexual Orientation, Gender Identity and Expression
TGD	Transgender and Gender Diverse

Content warning

This report includes references to self harm, suicide and suicidal thoughts, mental health problems, homophobia, biphobia and transphobia, which some readers might find distressing. The report also includes strong language.

It is important that we report the experiences of young people clearly accurately and in their own words. We have used verbatim anonymised quotations from the interviewees and the language is their own. This does mean that the report includes examples and some detail about specific (positive and negative) experiences, which some readers might find distressing.

Executive summary

Introduction

This study provides the first in-depth exploration of LGBTQ+ young people's experiences in residential social care placements in England. The resulting analysis explored the specific service needs of this group and their experiences of cultural matching among those from minoritised racial backgrounds. Overall, the study examined their experiences of what works and what needs to change to improve the experiences of LGBTQ+ young people in social care placements.

In preparation for this study, we conducted a PRISMA-compliant systematic scoping review of the international research literature (Schaub, Stander & Montgomery, 2022), and found that LGBTQ+ young people in out-of-home social care are a largely invisible population who face considerable challenges. To summarise, LGBTQ+ young people in care are twice as likely to be placed in restrictive residential care or group homes, and face more significant physical health, mental health and wellbeing inequalities than their care-experienced non-LGBTQ+ peers. They also experience significant discrimination and victimisation related to their sexual orientation or gender identity/expression before, during and after being in care, which often results in multiple unstable placements as a result of rejection or placement breakdown. However, much of the current evidence comes from studies conducted in the United States with a focus on foster care settings. Very little is known about the residential care experiences or needs of a diverse range of LGBTQ+ young people with no published research of their experiences in the United Kingdom to date.

Research questions

This study sought to answer the following research questions:

1. What are the experiences of LGBTQ+ young people in residential care?

2. Do LGBTQ+ young people in residential care have particular needs and, if so, what are those needs?

3. What are the implications of cultural matching for LGBTQ+ young people in residential care who are from minoritised racial or ethnic groups?

Methods

The study employed qualitative and collaborative research practices to explore how LGBTQ+ young people experienced residential care. Given the lack of previous research, exploratory methods were required. In-depth, semi-structured online interviews were conducted to provide rich, nuanced accounts of participant experiences. The study recruited 20 LGBTQ+ young people (aged 16 to 24) in England who were either currently or previously placed in residential care for three months or longer. The young people were diverse in terms of sexual orientation, gender identity/expression and race/ethnicity, with a large portion of the sample identifying as trans or nonbinary (7) and as racial or ethnic minorities (10). A range of stakeholders contributed to shaping the study design. The stakeholder group included people who support LGBTQ+ young people, such as social workers and representative organisations, and also

a group of LGBTQ+ young people with lived experiences of social care. Data was analysed using reflexive thematic analysis.

Key findings

LGBTQ+ young people who participated described residential care experiences filled with specific and heightened challenges connected to their sexual orientation, gender identity and/or expression, and other intersecting minority statuses (e.g. race/ethnicity, disability, neurodevelopmental disorders). This was especially true for transgender and gender diverse young people. Key findings indicate high rates of instability and multiple placements or disruptions throughout their care journey; persistent institutional and interpersonal discrimination connected their LGBTQ+ identities; intense regulation of gender norms; and significant mental health struggles. Our findings also reveal formidable educational barriers and the need for LGBTQ+ inclusive sex and relationship education for young people in care. A few participants spoke about the importance of positive individual relationships with professionals that affirmed their identities and provided support. Participants also described how a range of factors combined to affect their resilience. In terms of cultural matching, only one participant in our sample reported that they experienced cultural matching in placement, suggesting that this practice remains rare among LGBTQ+ young people from minoritised racial backgrounds.

Discussion

To our knowledge, this is the first study to exclusively focus on LGBTQ+ young people's residential care experiences and needs in England. Although participants' experiences varied, there was evidence of frequent homophobia, biphobia and transphobia and care environments that did not support their sexual orientation and/or gender identity/expression. These challenges were particularly true for transgender and gender diverse young people who described poor social care experiences and felt that they encountered worse treatment than their cisgender or heterosexual peers due to non-gender affirming interactions and policies.

Even in a small sample of 20, there was a strong prevalence of participants describing mental health problems being exacerbated by their time and treatment in care; these issues are closely linked to multiple marginalisations (e.g. sexual and/or gender identity or expression; care status; race/ethnicity; physical or neurodevelopmental impairments). Furthermore, we found few examples of cultural matching practices and culturally sensitive services for LGBTQ+ young people from minoritised racial backgrounds remain scarce. These young people face particular challenges based on their intersectional identities which require acknowledgment and development. Our findings also show strong support for holistic, SOGIE-affirming and person-centred care which accounts for intersectional identities with LGBTQ+ young people in residential care.

Conclusion and recommendations

LGBTQ+ young people in residential social care face unique and heightened challenges. The following recommendations, drawn from this small-scale but in-depth study, could be beneficial to addressing these challenges. There is an important need for policies that are LGBTQ+ specific, culturally affirming training, and mental health programmes within social care settings. First, policies specific to LGBTQ+ identities are strongly encouraged to better support LGBTQ+ young people as they navigate placements given the general absence of such policies in England. Second, mandatory and comprehensive LGBTQ+ knowledge training for all social care professionals is needed. This training should include ongoing

reflective supervision to address implicit bias particularly as it relates to transgender and gender diverse young people, and those from diverse racial and religious backgrounds. It is important that policy and practice consider the intersecting identities for this group of young people to create safe and affirming environments. Care systems therefore need to address these intersecting identities in comprehensive ways to meet their needs without exposing them to settings that support one identity but are discriminatory towards another. Additionally, mental health awareness training is also needed for residential staff and social care professionals as they encounter specific challenges and barriers to mental healthcare. Local authorities should ensure that their residential home environments support educational engagement and provide detailed and universally available sex and relationship education that is LGBTQ+ specific.

Future studies should include longitudinal data to provide a robust understanding of LGBTQ+ young people's experiences in residential care. More rigorous methods are needed to evaluate the effectiveness of available training to better support LGBTQ+ young people. There is also an urgent need to investigate the mental health help-seeking behaviours and treatment efficacy for these groups to ensure they can achieve equitable health and wellbeing, as well as further exploratory research about the availability and experiences of cultural matching practices with LGBTQ+ young people.

1. Introduction

Little attention has been paid to experiences of lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) young people[2] in out-of-home social care placements in the areas of research, practice and policy (McCormick, Schmidt & Terrazas, 2017). Though the evidence is scarce, recent reviews of the literature, most often from the United States, indicate that LGBTQ+ young people are more likely to end up in foster and residential care and report significant health, mental health and wellbeing inequalities when compared to their cisgender (non-transgender) and heterosexual peers in care (Kaasbøll, Pedersen & Paulsen, 2021; Schaub, Stander & Montgomery, 2022). Despite social advances, LGBTQ+ young people experience higher rates of family mistreatment and rejection related to their sexual orientation, gender identity or expression (SOGIE) (McGeough & Sterzing, 2018); issues with SOGIE are often identified as reasons for them coming into care (Mallon, 2011; McCormick, Schmidt & Terrazas, 2017). It is important to note that rejection, abuse and discrimination continue to affect LGBTQ+ young people while they are in care, from social workers, foster parents, residential facility staff, and peers according to US- and UK-based evidence (Cossar et al., 2017; Kaasbøll, Pedersen & Paulsen, 2021; Schaub, Stander & Montgomery, 2022). It is therefore unsurprising that LGBTQ+ young people report that they are less satisfied with their social care experience (Wilson & Kastanis, 2015). Although there is an emerging research base on the experiences and outcomes of LGBTQ+ young people in foster and residential care from the US since the 1990s, there has been limited international research with none from the United Kingdom focusing specifically on their residential care experiences (Schaub, Stander & Montgomery, 2022).

Much of the existing research understandably focuses on experiences of LGBTQ+ young people in foster care (Schaub, Stander & Montgomery, 2022), given that these placements are preferred (Berridge et al., 2011). For this study, residential care is defined as living in a setting organised by a local authority in a group home or alternative, and not in foster or extended family care. Although residential care placements may be better suited to some young people and can achieve positive outcomes (Cameron-Mathiassen et al., 2022; Steels & Simpson, 2017), these placements are often viewed in the UK as a "last resort" or the "end of the line" for young people with severe behavioural and emotional needs assessed as incapable of living in a family home (Holmes et al., 2018). Historically, residential care has been particularly problematic for LGBTQ+ young people because of the adverse impacts these placements have on wellbeing and achieving permanency. Early evidence from the US found that bias, harassment and violence that was anti-LGBTQ+ related was commonplace in group homes and the placements rarely met their needs (Freundlich & Avery, 2004; Mallon, 2001, 2011; Mallon, Aledort & Ferrera, 2002). The knowledge base describes several consistent elements for this population: family and caregiver rejection, multiple unstable placements and placement breakdown related to their SOGIE and unmet mental health needs (McCormick, Schmidt & Terrazas, 2017; Wilson & Kastanis, 2015). More recent findings from the US continue to demonstrate a range of challenges for LGBTQ+ young people including: higher rates of residential placement, greater emotional distress, and more homelessness (Wilson & Kastanis, 2015), with one report concluding that as many as one out of four LGBTQ+ young people in group homes exit care without permanency (Martin, Down & Erney, 2016).

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[2] The term "young people" will be used throughout this report when referring to persons under the age of 25.

It is important to note that some groups of LGBTQ+ young people have more challenges than others. The evidence is increasingly clear that trans and gender diverse[3] (TGD) young people and LGBTQ+ young people with other intersecting minoritised statuses, such as race/ethnicity and disability, experience specific and greater difficulties in residential care; but there is little research exploring their experiences (Schaub, Stander & Montgomery, 2022). One study from the US found that trans and nonbinary young people experienced worse mistreatment within care environments; some describe more placement disruptions compared to cisgender lesbian, gay or bisexual young people. They also described a lack of competency about understanding and affirming their identities from their social workers, foster parents and other caregivers (Mountz, Capous-Desyllas & Pourciau, 2018). There are some rare positive examples, however. A UK study found that some foster trans young people felt residential homes were a safer setting for exploring their gender identity than their birth families; however, this exploration included a context of multiple care placements and the less intrusive practice of leaving care (Cossar et al., 2017). Racial or ethnic minority LGBTQ+ young people also experience greater challenges according to US-based evidence. In comparison to their White peers, they are more likely to be placed in residential than foster care (Dettlaff et al., 2018; Wilson & Kastanis, 2015) and face multiple forms of oppression related to their intersecting minority identities (e.g. in terms of race/ethnicity, SOGIE and being care-experienced young person) (Erney & Weber, 2018). Intersectional identities mean that these young people experience compounding barriers related to multiple minority identities which present in unique ways for each individual. Given these challenges, the practice of cultural matching, where young people are placed with carers that match their cultural or ethnic background, may be beneficial given that cultural dissimilarity has been found to have a negative influence on young people in care's mental health and wellbeing and conduct in the home (Anderson & Linares, 2012). Unfortunately, no published evidence is available about this practice, and cultural matching for LGBTQ+ young people requires more exploration to understand whether it is helpful in these situations.

As adults, LGBTQ+ individuals continue to report significant challenges. Findings from the National LGBT Survey, the largest UK survey on the experiences of LGBTQ+ people, demonstrate high rates of homo/bi/trans-phobic incidents, alongside significant concerns of direct and indirect discrimination across a range of life spheres including healthcare, employment and education (Government Equalities Office, 2018). Although limited, longitudinal investigations from the US have shown that the accumulation of these specific stressors and repeated marginalisation lead to poorer mental health outcomes among LGBTQ+ young people in the general population (Mustanski, Andrews & Puckett, 2016), and care-experienced LGBTQ+ young people especially when compared to their non-LGBTQ+ peers (Dettlaff et al., 2018). Taken together, these findings demonstrate a need for greater understanding of this group's needs and services should include early and targeted intervention strategies to improve their wellbeing and reduce risk across the life course.

To fill these gaps in the literature, this study provides the first in-depth, qualitative data about LGBTQ+ young people's experiences of residential care in England. To our knowledge, this is the first study to exclusively focus on this group's residential care experiences and unique needs in the United Kingdom. Additionally, this study also sought to examine the cultural matching practices for LGBTQ+ young people in care. The study is part of the wider Lgbtq+ Young People in Social cAre (LYPSA) project and includes several research studies seeking to improve the social care experiences of sexual and gender minority young people in England. Led by Dr Jason Schaub (Department of Social Work and Social Care), these studies include: a PRISMA-compliant systematic scoping review concerning the health and wellbeing

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[3] Gender diversity refers to the extent to which a young person's gender identity, role or expression differs from cultural norms prescribed for people of a particular sex.

experiences of LGBTQ+ young people in out-of-home care (Schaub, Stander & Montgomery, 2022); the first qualitative study exploring the residential social care experiences of LGBTQ+ young people in England; and a randomised controlled trial testing the effectiveness of an "LGBT young people knowledge" e-learning training package for social workers in England. The project includes substantive collaboration and co-production with a young advisors' group who have lived experiences of social care and identify as LGBTQ+, and stakeholder groups that are connected to LGBTQ+ young people in out-of-home care (the names of which can be found in the study design section).

2. Methods

Study design

The study employed a qualitative, semi-structured interview design that collected data from 20 LGBTQ+ young people from across England. Qualitative methods permit participants to describe their experiences in their own terms, providing a holistic view to address the richness and complexity of these experiences in their own terms; however, this limits the generalisability of the findings (Ormston et al., 2014). The emphasis on LGBTQ+ young people's voices aimed to give weight and raise awareness of their experiences and needs in residential care, to serve as a foundation for future research and make practice and policy recommendations within a neglected area.

Two advisory committees guided and co-produced the study. The first group included LGBTQ+ young people (aged 16 to 25) with lived experiences of social care who we recruited through our networks. The second group comprised organisational stakeholders who have either a clear interest in children's social care (e.g. Principal Children and Families Social Worker Network), provide specific support to LGBTQ+ young people in care (e.g. LGBTQ+ young people in care network), or general social work engagement or institutions. Members of the young advisor and stakeholder committees helped recruit participants across a diverse range of geographic locations, ages, gender identities, sexual orientations and race and/or ethnicities. These committees met regularly throughout the study and provided feedback on data collection tools, data interpretation and dissemination activities. The study followed a published protocol (Schaub, Montgomery & Stander, 2021) and received approval from the University of Birmingham's Humanities and Social Sciences Ethical Review Committee in August 2021 (registration number: ERN_21-0809).

Research questions

The research questions we sought to answer are:

1. What are the experiences of LGBTQ+ young people in residential care?

2. Do LGBTQ+ young people in residential care have particular needs and, if so, what are those needs?

3. What are the implications of cultural matching for LGBTQ+ young people in residential care who are from minoritised racial or ethnic groups?

Sample

The participants in this study were recruited through community connections at various social service organisations and via social media. The study inclusion criteria was that participants:

- Self-identify as LGBTQ+

- Were aged 16 to 25 years

- Were either currently or previously in residential care in England for at least three months during their care experiences.

Our study inclusion criteria and approach to recruitment was informed by our scoping review of the existing literature (Schaub, Stander & Montgomery, 2022) and stakeholder and young advisors' input.

Twenty LGBTQ+ young people (aged 16 to 24, mean age 19) participated in the study. They presented a broad range of sexual orientations, gender identities, ethnicities, and a few had physical or neurodevelopmental impairments (see Table 1, for a more detailed overview of participant characteristics see Appendix A). The duration in care ranged from nine months to over seven years among the sample.

Table 2.1. Participant demographics

Characteristic	Participants
Sexual orientation	7 bisexual 5 lesbian 5 gay man 2 asexual or asexual panromantic[4] 1 heterosexual
Gender identity	7 transgender and/or nonbinary 7 cisgender male 6 cisgender female
Ethnicity	10 White British 7 Black British or Black African 2 Dual or multiple heritage 1 British South Asian
Physical or neurodevelopmental impairments	16 no impairments stated 3 autism 1 deaf/hearing impaired

When considering the range of gender identities, it is helpful to note that findings from the national LGBTQ+ survey conducted by the UK Government Equalities Office (2018) found younger people are

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[4]Panromantic is a romantic attraction to people regardless of gender. This is not to be confused with pansexual which refers to both romantic and sexual attraction.

more likely to identify as TGD when compared to LGBTQ+ people older than 35 years old, and this proportion appears to be increasing. The participant group includes a larger proportion from ethnic minority backgrounds when compared to an analysis of individual-level, national data about children in residential care (Schoenwald et al., 2022) (White 78%; Mixed or Multiple ethnic groups 10%; Black, African, Caribbean or Black British 7%; Asian or Asian British 3%; other ethnicities 2%). We purposely built intersectionality and diversity into our sampling strategy to pay close attention to intersectional differences within our sample. In the past, researchers in this area have often treated LGBTQ+ populations as a homogeneous group, focusing on sexual identity at the expense of other intersecting minority identities such as race/ethnicity and gender identities or expression (Fish, 2012; Schaub, Stander & Montgomery, 2022).

Data collection

Twenty one-to-one semi-structured interviews were conducted online via Zoom between September 2021 and January 2022. The COVID-19 pandemic required social distancing, meaning that online interviews were required and enabled the study to reach a larger geographic spread of participants. Data collected through online interviewing can be as rich and valuable as that generated during in-person or face-to-face interviews (Deakin & Wakefield, 2014; O'Connor & Madge, 2017). Aware of challenges associated with conducting qualitative research online more generally (Archibald et al., 2019; Tremblay et al., 2021), we employed several strategies to build rapport prior to data collection. These included researcher transparency and disclosure about study purposes and participant rights, "chatting" or informal impromptu interactions to promote familiarisation of the Zoom platform and generate a sense of familiarity or connection between researchers and participants (Creswell, 2018). Additionally, we sent interview transcripts to participants for member checking (a validation technique to check the authenticity of transcripts by sending transcripts to participants) and discussed our data analysis with the young advisor committee to improve validity of findings. If participants wished, they were able to have a supportive adult attend their interview, such as a social worker or key worker, to help them feel more comfortable or assist those with additional needs during the interview. Two participants requested this.

Written informed consent was obtained from each participant. Interviews were conducted by two authors and a programme manager from What Works for Children's Social Care and ranged between 28 and 67 minutes in length (mean 47 minutes). Interviewers used a semi-structured interview guide developed by the research team to serve as the scaffolding of the interview which allowed for probing and follow-up questions. This approach encouraged participants to provide depth, details, thoughts and emotions, and generated rich data that further explored their experiences (see Appendix B). The initial interview guide was developed based on findings from our systematic scoping review concerning LGBTQ+ young people's experiences of out-of-home care (Schaub et al., 2022), conducted in accordance with the PRISMA extension guidance for scoping reviews (Tricco et al., 2018). We then refined the interview schedule in consultation with our advisory committees and held a workshop with our young advisors' group to ensure the questions were age-appropriate and reflected their experiences of social care. The interview explored experiences and needs in residential care, participant relationships with residential staff and social workers, support received, and difficulties encountered. It was discussed with participants that any safeguarding concerns would be disclosed to relevant parties, and the research team held discussions to explore if any concerns should be followed up. The need for safeguarding processes were discussed both before and during interviews with each participant. There were no allegations made during interviews that required breaching participant confidentiality. A post-interview debrief was offered to ensure that participants had additional support if they wished. While no participant asked for a separate debrief, a list of support organisations was shared electronically after each interview

to help them connect to relevant services at a later stage if they wished with an offer to discuss these with them.

All interviews were digitally recorded and transcribed verbatim. To ensure confidentiality, all identifying information was removed from the transcripts and replaced with related but not-identifiable information as well as pseudonyms. Participants received a £25 e-gift voucher as remuneration for their time.

Data analysis

The data was analysed using a reflexive thematic analysis to identify relevant patterns and themes and extracts were used illustratively (Braun & Clarke, 2006, 2021). Reflexive thematic analysis involves critical interrogation and reflection on the researchers' practice throughout the research process (Braun & Clarke, 2021), and provides   an appropriate method to centre participants' lived experiences in the analysis and also the social processes that shape their experiences, meanings and assumptions. This was achieved through reflective practice and group discussions among the research team, as well as a discussion of nascent themes and recommendations with our young advisors and other stakeholders on the project.

Reflexive thematic analysis involves six – recursive – phases including *familiarisation; coding; generating initial themes; refining, defining and naming themes;* and *writing up*. Once all interview data was transcribed, data familiarisation was achieved through active and immersive readings of the entire data set to obtain a broader understanding of the data and generate initial ideas (phase 1). Following this, an initial list of codes was generated and NVivo 12 (QSR International) was used to code the dataset according to this initial code list and also codes generated during subsequent readings (phase 2). The "One Sheet of Paper" (OSOP) method developed by the University of Oxford for interpreting qualitative data (Ziebland & McPherson, 2006) was employed in data analysis for clarity and to reduce the number of emerging themes (phase 3). Co-authors then grouped codes, developing a provisional thematic map, separating codes unrelated to the research questions, and further reviewing and organising the themes and the codes within them (phase 4). Workshops were also held during this stage with our young advisors and stakeholder committee to discuss and reflect on the nascent themes. Lastly, the final themes were defined and named (phase 5) and written up (phase 6).

3. Findings

During their qualitative interviews, LGBTQ+ young people described care experiences filled with specific and heightened challenges. Although not universal, they spoke of poor overall experiences and discrimination and shared that their SOGIE and other intersecting minority statuses (e.g. race/ethnicity, physical and neurodevelopmental impairments) caused issues within social and residential care settings. This was especially true for TGD young people. Our analysis developed five main themes showing multiple unstable disruptions throughout their care journey:

- Pervasive discrimination

- Intense regulation of gender norms

- Mental health burden

- The importance of individual affirming relationships with professionals

- Resilience strategies.

Each theme is presented in turn and similarities and differences within themes are explored. We use pseudonyms throughout to disguise participants' identities.

With respect to our reporting style, we'd like to inform the reader that, while this is a socially constructed study drawing on young people's experiences, we believe it is helpful to indicate how many participants reported these experiences. This is a partial indication of the strength of the theme across our data set. However, this "quantitative sensibility" needs to be treated with caution in a qualitative study and is not meant to indicate a quantitative strength.

Multiple unstable placements

Most participants in this study experienced multiple unstable placements while in out-of-home care. Recent evidence suggests that young people with experience of residential care in England had an average of 6.7 placements during their time in care (Schoenwald et al., 2022), and international findings suggest that LGBTQ+ had a higher number of placements compared to their non-LGBTQ+ peers (Wilson & Kastanis, 2015). In our study, the majority (14) felt placement instability was the norm throughout LGBTQ+ young people's care journey when compared to peers, which resulted in numerous emergency or temporary foster and residential care placements. Almost all TGD young people in this study reported high rates of placement instability (6 of 7 TGD participants).

During interviews, participants described feeling that their SOGIE increased the number and instability of placements. Young people's SOGIE is a significant factor for the reasons that LGBTQ+ young people come into contact with care and experience placement instability (Schaub, Stander & Montgomery, 2022). Their SOGIE was the most common reason they were placed in care (e.g. explicit rejection or other non-affirming environments) (12); followed by neglect and abuse (8) and behavioural and mental health issues (7). Reasons for placement breakdown often included mental health issues and substance abuse as the most common reason (6); with participants often describing these as responses to

discriminatory environments. Other common reasons included abuse and neglect (5) and explicit rejection of participant's SOGIE (4) by caregivers.

Like all young people that come into care, for our participants, becoming a looked-after child resulted in additional challenges such as changes in support systems (e.g. family, friends), new school placements and disruption to their education, social stigma and isolation:

> *"Before I was put into the residential unit, there were four families. I isolated myself a lot after [after I was placed in residential care]. I wasn't happy about going to another school, because even though if I was getting bullied in the school, I was kind of used to it. And then entering a new school and then getting bullied all over again by new people and then having to relive the experience … It was kind of like Stockholm Syndrome in a way with my school. I was so used to being discriminated against, but I also had a safe space within that school because I had some friends."* (Orion)

> *"Moving from [south-east England] to [east Midlands] was not great, because – obviously, I couldn't go to schools down there. I wasn't at any schools down there at the time anyway. But obviously, when I was doing emergency placements I would go to a place for the night, then my social worker or one of their colleagues would pick me up in the morning, and then I would spend the day at my social worker's office, and they'd try and get me a bed by 8pm that night. That went on for six weeks, every single night. Apart from some weekends, I'd got to be there a couple of days. But literally, every day a different care home or foster home. I was going from one side of the country to the other every day. I spent extreme amounts of time out of school."* (Sparrow)

More than half of the participants reported delaying disclosure of their SOGIE while in care due to concerns about discrimination, with several participants reporting that it was easier to come out about sexual orientation than gender identities in placements. Their decision-making included careful consideration about whether they were physically and emotionally safe to disclose their SOGIE to different foster parents, social care professionals, group home staff and their peers during each move:

> *"It's just easier not to bring stuff like that up, because you never know how people are going to react to it. Like, I wouldn't want to bring it up and then realise that the people I'm living with, or the staff aren't very comfortable with it … You might mention it and then you find out they're homophobic or something. So, I just never bothered."* (Vesper)

In many cases, young people were looking for signs that would show whether the care environment was affirming or discriminatory towards LGBTQ+ individuals. They looked for examples of inclusive language, displaying signs or posters, talking about their connection to the LGBTQ+ community or other markers; participants felt that these signs meant it was safe for them to discuss SOGIE issues.

The participants described clear concerns for homophobia, biphobia and transphobia, and felt that this affected their transition following care   ; the lack of acceptance by family and strained dynamics related to participants' SOGIE identities was a frequent topic in interviews. Most participants reported either strained relationships or little to no connection with their birth families, meaning family support after leaving care was limited or unlikely.

Persistent discrimination & marginalisation

Participants described frequent institutional and interpersonal homophobia, biphobia and transphobia. They also described social and care environments as cisgenderist and/or heteronormative. In addition to this, participants with additional minority identities (e.g. race/ethnicity, disability, etc.) experienced magnified social challenges that resulted in greater marginalisation and isolation.

The majority of participants reported frequent verbal and physical harassment, intimidation, bullying, isolation and threats from peers, both in care and at new school placements; they described these experiences severely impacting their mental health, wellbeing and educational attainment:

"There were three girls … all started creating their own gang within the household, and I became a victim of verbal bullying … They were all making threats saying that they were going to try and kill me and my family, they called me gay twat, and they were always trying to remind me that I was gay all the time. It was quite a lot of bullying in the house from most of the children. There was one child who got a slip of paper saying, 'If you stop being gay, I won't cut you.' That happened a few times. I don't think I ever [reported or talked] about that… my experience of the whole of high school was just terrible. I was never the smartest kid and I got really bad grades when I did leave. But I never really talked to most of the students … everyone used to say that I was going to try and rape them. It was a weird form of bullying I went through, it was always the guys." (Clarke)

Several racial and/or ethnic minority participants experienced racist remarks from peers. Most TGD young people encountered intense bullying, often from early childhood:

"It was hard for me as a Black kid [in the care home]. Most of the kids there were White, and there was that stigma. Then they realised I was gay, so there was even more stigma. You don't have friends; you don't have people you can speak to. Yeah, it was challenging." (Parker)

"I would say other kids who were quite senior and who had lived in the place. They had this kind of bullying aspect that was entrenched in both racial discrimination and abuse and also my gender queerness. So, the fact that my identity was quite unique brought some ridicule from kids who were in the care home." (Carter)

In addition to peers, participants reported an overall lack of acceptance and competence from social care professionals about their LGBTQ+ identities; the majority of participants described that professionals assumed they were heterosexual/cisgender. Some participants shared they were concerned that a professional's religion or faith might affect how they would support them. They also suggested that professionals minimised their identities, describing unhelpful and harmful interactions with foster carers, social workers and residential staff who suggested their SOGIE identity was a phase, that they were too young/confused to know they were LGBTQ+ or attributing their SOGIE to the trauma they had experienced. Some young people reported characterisations or stereotypes of LGBTQ+ identities by some residential staff and social workers as pathological, predatory or circumstantial that, when reported, were often minimised or ignored:

"It was ridiculous when I came out. They tried to keep it boys on one side, girls on the other. I was 17 and on the same side of the corridor as a 13-year-old girl, one staff member went, 'Well, we don't really know whether or not to keep you there now, because you might try and

*sleep with her.' I was like, first of all, 'I'm 17, she's 13. Do you know how illegal that is?'
Second of all, 'Are you trying to make out that I'm a slag, just because I'm bisexual?' Like,
what the hell? There are so many layers of wrong with that."* (Rebel)

Participants felt that even well-intentioned practitioners trying to protect LGBTQ+ young people in care
from discrimination reinforced cultural norms of heterosexuality and elided the possibility of LGBTQ+
identities:

*"When I first came out to my carers, they didn't want me to tell the kids because we had three
boys who were all gang affiliated, so quite a lot of them have shown racism and homophobia
in the past. But I told my carers that I wasn't going to hide who I was no matter if I got bullied
or hurt physically or mentally. So, I did come out to them, it went quite positively surprisingly
because I told them and instead of them being, like, cruel or criticising me, they just made
jokes. And jokes never seem to hurt me only because I knew they were meant for humour."*
(Tommie)

Analysis of participant narratives found young people wanted providers to be more knowledgeable about
their sexual health needs, including offering them SOGIE-inclusive sex and relationships education,
information and resources. Participants reported receiving some sexual education in schools, but the
content was almost exclusively heteronormative and cisnormative and disregarded LGBTQ+ young
people's needs – transgender young people in particular – and lacking the information they needed to
make informed sexual health decisions. Some participants mentioned that although they eventually
received some of these services, they would have benefited from earlier access:

*"I had sex education three times. All of it was fairly generic heterosexual sex education. We
never had any education based on how it would work with same sex or even with
transgender people. There is something now which covers everything … I wish that I was
[younger] because I'd be able to do that lesson. I felt like I didn't have the experience that I
needed when it came to having my first time, and it was scary. Quite a lot of it I found …
online, and it was mainly based on gay sex. I looked at porn, I know that's not really
something that I should have been looking at because I'm under 18, but I felt like it was more
educational."* (Clarke)

A scoping review (Schaub, Stander & Montgomery, 2022) found that there was a lack of understanding
about cultural matching, and so this study asked about participant cultural matching experiences. There
was very little evidence of cultural matching – only one participant reported having been culturally
matched with foster carers. The philosophy behind cultural matching suggests this approach can assist
children's sense of security and wellbeing when separated from their birth families (Anderson & Linares,
2012; Brown et al., 2009). It is important to note that cultural matching in foster and adoption placements
may require careful consideration for LGBTQ+ young people. A participant described the culturally
matched placement as helping his racial and/or ethnic minority identity development, he also described
being kicked out of his home by his foster parents upon discovering that he was bisexual. A few
participants desired cultural similarity with their professionals which they cited would be helpful in
navigating cultural hybridity, finding pride in their cultural heritage, or nurturing a connection and stronger
understanding of their histories and family of origin:

*"My dad is still very annoyed we keep having White female social workers. He goes on rags
about it all the time. But I don't remember being matched, I don't think it would have been
problematic. I think definitely when I was younger it would have made a big difference. I have*

a lot of issues coming to terms with my racial identity, and I think that would have definitely helped me be more comfortable with myself. I don't think I've ever had a social worker who wasn't White. And I don't think that was on purpose, I just think that there are just, I guess, more White social workers." (Arrow)

"[My therapist was] African Caribbean. So, you could speak to him, he could understand what your needs were, he could relate to you, he could talk to you on a level. And he could dig deep into what the problems were … coming from a BAME community, because I'm from a BAME community, I could understand what he was explaining, like how he could relate, how he could talk on a level. So, it just made me feel comfortable." (Zane)

Regulation of gender binary norms

The TGD young people we spoke to described experiencing particular challenges within residential care. TGD participants described frequent encounters of structural and interpersonal transphobia. They felt intense gender regulation from the placement and professionals; feeling they were pressured to conform to rigid binary cisgender norms:

"When I was coming to terms with my gender [and not out], I was eating dinner with [residential staff members]. We started talking about trans issues and my keyworker mentioned that her son had a friend that was trans. They then started talking about how you know if someone's trans or not. My keyworker brought up a group photo of her son and his trans friend and they played a game where they tried to figure out who the trans person was ... I was kind of trying to ignore it … [one of the workers] pointed out who she thought was trans, and my keyworker was like, 'No, that's my son.' The other worker made a joke, like, 'Ha, ha, is your son trans?' And my keyworker said, 'I would kill him if he was trans.' I wrote a really long email detailing the entire event; I sent it to the manager of the home. For days, I heard nothing of this complaint. At one point, I spoke to the care manager, and was like, 'Did you see the email I sent you?' and she was like, 'yeah, yeah' – completely dismissed it." (Sparrow)

The above account is an example where the participant suggests that this happened because the placement workers were unaware that they were trans but, ultimately, such conversations could be seen as harmful to any young person present due it being transphobic. Exploring and understanding gender and sexual identities is a complicated process for most LGBTQ+ young people. As a result, these young people may not be "out", either to themselves or to those around them throughout their young adulthood (Rosario et al., 2001), and their "outness" will change over time, and be dependent on the situation and their perceived safety in relation to divulging their minority identity.

Almost all TGD young people in this study described that social care professionals and services lacked competency and appeared uncomfortable when discussing or engaging with their gender identities or expressions. Participants often spoke about caregivers and other professionals misgendering them and not acknowledging or affirming their gender identity or expression. Participants described a range of examples including: that some professionals would forget or refuse to use correct gender pronouns or to address them by their asserted name; forcing young people to wear clothing that corresponded with their sex assigned at birth; sex-segregated housing options that did not allow for their gender identity; and a lack of emotional or financial support in accessing gender-affirming healthcare, services and goods:

"I never came out a nonbinary while I was in care, not while I was in residential care. There were quite a lot of issues around gender expression, because I was more comfortable wearing masculine clothes. When you're in care, you get a clothing allowance and my support worker was like, 'You're not wearing boys' clothes, you are not buying boys' clothes, you are not going to the boys' section at all.' So, I ended up buying a couple of sets of boxers. She found out and went ballistic. She was like, 'You need to return these right now … You don't need to buy these right now. You're not a boy, you're not a boy, you're not a boy.'" (Rebel)

"I've had the same four binders for five years … You need to buy binders or things that help [trans children] express their identity positively that maybe other children in care would not need. It's something that someone should bring to whoever's attention … a quality chest binder can range anywhere from £30 to £70. There are [cheaper] ones on eBay but they're not safe. And when you're not financially supported to buy safe binders, trans masculine or trans people with a chest will be more inclined to buy the unsafe binders and then that will lead to a lot of problems down the line, like actual physical medical problems like ribs breaking and everything." (River)

Transgender participants described exploring their gender identity during unstable care placements and leaving care. This instability impacted upon their access to mental healthcare services and gender identity clinics.

"I'm on the gender identity clinic wait list. I need to just fill in my paperwork and send it to them with my address, but I don't know where I'm going to be living, so I've been putting that off. I can't do that till I know where I'm going to be living. It's the same with adult mental health services … it is the one problem that stems into everything else. It impacts my actual mental health and my trans healthcare services … Most 18-year-olds are looking forward to their 18th birthday, because they are going to plan their drink, or whatever [laughs], and I'm here, like, 'oh, my God, where am I going to live?'" (Sparrow)

One participant also described that the impact of these challenges meant they considered criminal or transactional sexual activities to fund gender-affirming treatment and clothing:

"I did consider committing crime or sexually exploiting myself at some point, because – and I was very young at this time as well – being in care you're given quite restricted finances, and I had this idea that I was somehow going to illegally obtain hormones, because [gender identity clinic appointments] were taking way too long, and putting me on blockers, and then you have to be on that for a year, and then you'll be put on hormones, but I wanted it now … I was tired of saving up £10 a week to try and find someone that could get me illegal anabolic steroids. Also, you know, stuff for validating my own identity, I suppose. I wanted to buy tracksuits that lots of the boys around me would wear, or I wanted to buy new Nike shoes and stuff like that to kind of feel more secure in how I saw myself and stuff like that … Because I felt like if I emulated what other guys had to the best degree possible, I would feel more confident and content. So, I did consider, oh, maybe I should steal things or find a way to sell drugs or sexually exploit myself to try to get money to do these things. But I never actually got through to doing it." (Orion)

Importantly, participants describe the profound and positive impact of encounters with affirming professionals, caregivers and organisations. Participants described these relationships as rare across

their out-of-home care experiences and under constant threat given placement instability and high staff turnover. Participant narratives suggest some good practice examples affirming young people's gender identity or expression through supporting clothing and hairstyle choices; not pathologising their gender identity or expression; modelling respectful and consistent use of chosen names and personal pronouns; advocating on behalf of their needs; and avoiding unnecessarily segregating activities by gender:

> "[The residential home staff] were really good. They were always respectful, and they navigated my gender issues with a lot of consideration … There was never any predicaments that occurred, like me being referred to with my legal name, out loud – and this was before the name-change – or like me being referred to as 'Miss' or whatever. So, they made sure that that didn't happen – which was very considerate." (Orion)

For some trans young people, the gender of their social worker was particularly important for their identity development:

> "It was amazing. It felt liberating. And I know that sounds dramatic, but it felt a lot different than being with a female social worker, especially when I myself am a man. I don't even remember if I'd come out at that point, but I distinctly remember always getting along better with male authority figures. Not like I had a problem with female authority figures, but I clicked with male authority figures. And I'm not really sure why that is but it did feel very – it just felt good to have someone else like me, even though he was straight. He was a guy and I was a guy, and it was kind of like the same, that kind of thing." (Arrow)

Coping with mental health problems

Unsurprisingly, given these challenges, a substantial majority of participants (14) struggled with mental health issues while living in residential care. Common mental health problems they described included anxiety, depression, suicidality (i.e. suicidal thoughts or suicidal ideation), self-harming and bipolar disorder. Participants often related their mental health challenges to traumatic experiences with their birth family and care experiences. These experiences included sexual abuse, harassment and exploitation; intergenerational mental health and substance abuse struggles; isolation; and oppressive or unsupportive environments about their intersecting identities (e.g. SOGIE, race and/or ethnicity, ability, neurodevelopmental disorders).

During the interviews, young people generally recounted poor experiences with Child and Adolescent Mental Health Services (CAMHS) and difficulties accessing gender identity clinics or specialist trans consultants. Many of these participants reported unmet mental health needs or receiving little mental health support and some recounted being hospitalised for acute crises while in care due to homo/bi/trans-phobia experienced within residential care:

> "When I was younger, when I was about ten, I went through quite a traumatic assault, and the staff kind of associated the assault with me being bi. I was like, 'That's not how it works.' Then [one of the residents] made a joke about the assault and said, 'If something like that can make you bi, I can do it again and make you straight.' And then he went, 'I'm on your side of the corridor tonight.' He'd basically just threatened to do something to me … I had a full-blown mental breakdown and had a CAMHS appointment a few weeks after that, and I told them about it. I had another full-blown panic attack, and he was like, 'Right, I'm not letting

> *you go home. You're being put on a 136,' so the psychiatrist could evaluate me. So, I was in A&E waiting for an assessment and then hospitalised."* (Rebel)

Some reports suggest that residential care is the most appropriate setting for children experiencing mental health issues because the trained staff can help the child in a controlled professional environment, often with 24-hour care to monitor and safeguard them from harm (Whittaker, del Valle & Holmes, 2014). But it is important to note that our participants reported that residential staff often suggested their SOGIE identities were pathological and requiring intervention. When asked whether they had sufficient mental health support while in care, one participant responded:

> *"From CAMHS, yes. From residential staff, no. They never explicitly said it, but was almost a case of 'well, you deserve to have [mental health problems] because of your [bisexuality and nonbinary] situation'. It was never explicitly stated but it was almost like something that people weren't quite willing to say but everyone was thinking it … It happens quite a lot within the children's social care, if someone comes out, it's treated as a safeguarding issue. It's like not a case of 'Is there any help that you want?' It's a case of, 'Right, we've got to treat this as a safeguarding issue.' And I've known young people be kicked out of meetings because they've come out in a meeting, so they've kicked them out so they can talk about whether or not it's appropriate to keep them in the meeting."* (Rebel)

Furthermore, several participants reported that social care professionals and residential staff minimised their emotional and mental distress, only engaging when a crisis happened (e.g. suicidal behaviour, nervous breakdown):

> *"I was going with this person that I don't know was a sex offender and I didn't know he was HIV-positive. I didn't know what that was, I wasn't educated on it. So, I went with him a couple of times, and then this thing happened, and I went to my social worker to get support, told him everything that happened, and he just sort of left me to it. He said, 'Oh, OK,' that's it. And my mum was like 'He's telling you that he's literally having problems with this person, he didn't know until the first time that he was a sex offender, he didn't know anything about AIDS or HIV.' And unfortunately, I was raped, but I didn't get help with that from him. They sort of skirt around the issue, push it under the carpet, that type of thing … they're not there for you, I always feel with social services you have to fucking scream because if you don't scream you won't get anything, and that's not how it should be."* (Roux)

Some participants reported using substances (e.g. alcohol, cocaine, ecstasy, etc.) to cope with multiple compounding challenges: mental health difficulties, family or caretaker SOGIE-rejection, homo/bi/trans-phobia; and to temporarily "escape" a restrictive and isolating group home:

> *"It was a good way to cope, like it made me feel good. I used drugs quite regularly … I was going through quite a bad time because I'd just moved out of my parents' house with all that [traumatic] stuff. I was coming out as gay and I was quite depressed as well. I was dealing with a lot. Plus, I didn't like being in the [group home], and it gave me reason to get out of the house and be outside and be with people, and just deal with everything."* (Vesper)

Only a few participants reported their care met their mental health needs. Regular affirming counselling or residential therapeutic input were both described as being particularly helpful:

"And as part of being in this residential care, because it's a therapeutic home, we also have therapy and stuff, and inside those weekly sessions that we have, we'll speak about health and relationships and stuff and how that relationship would make us feel." (Rio)

Importance of individual relationships with professionals

Throughout their accounts, participants explained that affirming and competent professionals, carers and workers were essential for them to develop positive SOGIE identities and supporting their capacity for resilience to withstand adversities. They talked about the importance of having knowledgeable practitioners that: accepted and affirmed their SOGIE or multiple minority identities; validated them as individuals; and advocated for relevant help and support. Often these professionals were LGBTQ+ themselves or were connected to the LGBTQ+ community, although a few were described as younger than other professionals with links made between age and more liberal worldviews – it is important to note, however, that these key supportive relationships were experienced by half of the participant sample but often short-lived due to high staff turnover. Thus, for some young people residential care offered safer spaces to explore their SOGIE in environments than with their birth family:

"My support worker, she's also queer herself, and we do have conversations about me progressing with my transition … my support worker and one of the members of staff sometimes take me to [gender identity] appointments at [a gender identity clinic] … They were very helpful, very supportive. It was a really good environment for me with the staff in regards to my queer-ness." (Arrow)

"There is one person that I am more comfortable with [in the care home]. She happens to be one of the youngest members of staff, and just like the younger the person, there tends to be a larger number of people that are more tolerant … in a care home you have a unique position [compared to your] parents, or a family home, if they are homophobic, that is it; they are homophobic. And it's going to be a dangerous living situation for that young person. But in a care home, with the right people, you have this opportunity to make things the most tolerant, the most accepting environment possible." (Vesper)

In contrast with these positive and nurturing relationships, more than half of the participants described struggling to establish trusting or sustainable relationships with an ever-changing roster of professionals involved in their lives; a challenge that is partially due to high staff and case/social worker turnover. Connecting with an affirming professional was described as a lottery and was often short-lived because of the rapidly changing and overburdened care system. As reported elsewhere, rising numbers of children's social workers are leaving the sector due to deteriorating working conditions (DfE, 2022). One of the most consistent concerns expressed by participants was that the frequent staff changes created uncertainty and made it harder to develop positive emotional attachment to their caregivers:

"I have had a lot of social workers. They all seem to quit their job … they're overworked and underpaid ... a lot of them either moved sectors or just straight up moved jobs. I think a couple got fired … the issue you generally have with social workers is asking them, 'where have you been? I've been trying to contact you for three weeks' [and the social worker responding] 'oh, sorry, I have a lot of kids.' That's generally the experience. If you're not causing problems, you're not being given attention." (Morgan)

"There is a very, very quick turnover of staff. There are literally staff that come and then they leave within a couple of months. There are no staff that are here from when I joined. Not one … and I can't build relationships with staff when they're only here for a couple of months. The quick turnover of staff makes things so unstable … say you're at five residential homes over ten years, two years in each, you meet hundreds of different staff, rather than if you were in a foster home for years, you know, at least you have consistency." (Rio)

Resilience and resourcefulness

During their interviews, many of the participants described examples of extraordinary resilience and resourcefulness that they developed and exhibited throughout their arduous care journeys. Resilience, defined here as the ability to regain, sustain or improve their wellbeing in contexts of significant adversity by drawing on a range of resources (e.g. individual, relational, sociocultural and ecological) (González Álvarez et al., 2022), was described at various levels. Individually, some participants worked hard to create a positive SOGIE identity. Some described using various mechanisms, like creative processes such as art, or drawing on spirituality and religious belief (despite their experiences of discrimination within religious contexts). Several participants employed strategies of self-reliance to overcome challenges experienced within care. Several young people described expending significant effort to carefully and strategically manage their care journey; an impressive feat for a young person in care and with multiple challenges. In this example, one participant explains how they planned what they needed to do to get the qualifications they wanted:

"When I first moved here, they couldn't find me a school. They wanted to find me a [Special Educational Needs (SEN)] school. They found me a school that I knew wouldn't suit my needs. I applied for college, and I did a one-year – and I got in. My social worker didn't want me to go, so I had to fight against my social worker to go to college and do my GCSEs. I did the one-year course, did my GCSEs; then I managed to get onto the A Level course … she thought it wasn't right for me. Proved her wrong … I did my GCSEs, which I wouldn't have if I had gone to the SEN place that she had found, after a year. I'd been out of school before she found even one place. And then I did it in a couple of months." (Sparrow)

At the community level, participants stated the importance of access to LGBTQ+ and/or young people's organisations; they described some provided more accepting environments, important for their confidence and identity development:

"It seems a cliché, but you feel so powerless as a kid sometimes, and especially as a kid in the care system. You're just kind of being thrown around by all these different parties, and you feel as though you cannot change things. So being a part of movements or groups where you are aware that these are actively changing things … was actually helpful to me, and I got to know, if this happens, this is what I'm supposed to do." (Quinn)

These resources did have challenges, with some participants reporting them as too far away, or that the range of attendees did not include enough TGD young people, and that there was a stigma related to being care experienced. Participants described feeling isolated because of these "lost" connections and felt the lack of community groups had a negative impact on their health and wellbeing.

4. Discussion

Discussion of findings

The experiences and needs of LGBTQ+ young people in social care have been overlooked in the UK, in policy, research and social work education (Inch, 2017; Schofield et al., 2019). To our knowledge, this is the first study to exclusively focus on LGBTQ+ young people's experiences and needs living in residential care placements in England. Although participants' experiences varied, there was persistent experience of homo/bi/trans-phobia and navigating environments that did not support their SOGIE. Furthermore, the findings highlight a series of interlocking issues that for many participants created significant challenges. These issues include:

- Multiple unstable placements

- Pervasive structural and interpersonal discrimination and intersecting oppressions

- Significant mental health challenges

- The positive influences of important individual relationships with professionals

- The resilience and resourcefulness of this population.

Furthermore, our findings suggest that young people who identify as TGD young people are largely underserved by the social care system and encounter unique challenges in residential care settings. Although based on a small sample and not generalisable, there were strong resonances between the findings within this study and existing research in this area (see Kaasbøll, Pedersen & Paulsen, 2021; Schaub, Stander & Montgomery, 2022). Taken together, these findings suggest that much progress still needs to be made to ensure that care systems, and residential settings in particular, are doing everything possible to acknowledge and support the wellbeing and resilience of LGBTQ+ young people in their care.

The mental health challenges experienced by LGBTQ+ young people in residential care is often exacerbated by their time and treatment in care. The significance of these findings is supported by previous studies, young people in out-of-home care have high rates of mental health problems, educational difficulties and neurodevelopmental disorders (Ford et al., 2007); with greater difficulties for those in residential care and LGBTQ+ young people in particular when compared to their non-LGBTQ+ peers (Baams, Wilson & Russell, 2019; Dettlaff et al., 2018). The most commonly cited cause of these disparities is "minority stress", where experiences of stigma-related prejudice compound over time to provide significant and negative effects (Meyer, 2003; Testa et al., 2015). We found participants experienced a unique set of these stresses because of multiple marginalisations: sexual and/or gender minority; care status; other intersectional identities. Importantly, LGBTQ+ identities are not symptoms of trauma or problems to be solved. Rather, the discrimination and abuse that LGBTQ+ young people experience prior to and during care are the actual problems. Targeted interventions must identify and address those social inequalities early on especially given that longitudinal data demonstrates that LGBTQ+ young people in general, and LGBTQ+ young people care in particular, are at substantially higher risk of mental health concerns that tend to persist over time (Dettlaff et al., 2018; Mustanski, Andrews & Puckett, 2016). Thus, this is an area in which this group could use additional support and intervention especially as it relates to placement instability, feeling abandoned or isolated, struggling to

establish new relationships, educational barriers and suffering deteriorating mental health. Mental health awareness training for children's social services teams to allow for earlier recognition of mental distress, ill-health, continuity of mental health and gender identity clinic service provision are key.

Our findings provide notable evidence to support holistic, SOGIE-affirming and person-centred care, with participants singling out the significant value of individual supportive and affirming relationships with professionals. It is difficult to provide this type of care when professionals have limited knowledge and skills about LGBTQ+ young people's unique challenges and needs. In order to provide affirming care, the sector needs adequate skills and knowledge for the workforce, policies that are LGBTQ+ specific, culturally affirming training and mental health programmes within the social care settings. The sector currently does not have consistently supportive policies; in a previous study, while 38% of local authorities in England had a care policy that mentioned LGBTQ+ young people, only 5% had a specific policy for this group and almost none of the authorities recorded service user SOGIE identities (Cossar et al., 2017). Furthermore, the reviewed evidence demonstrates a lack of LGBTQ+ specific competence and knowledge among the social work workforce (Schaub, Stander & Montgomery, 2022) with English social work qualifying programmes containing very little content about gender variance (Hudson-Sharp & NIESR, 2018; Inch, 2017). It seems likely that this omission contributes to the challenges that currently exist for LGBTQ+ young people in care, and more affirming policies and practices are needed to improve their lives and outcomes.

We were also interested in cultural matching practices, and whether this was experienced or welcomed by LGBTQ+ young people in care. Understanding the cultural factors associated with young people's experiences in care is important because cultural dissimilarity contributes to poorer mental health and wellbeing outcomes. For example, Anderson & Linares (2012) found that a cultural mismatch between foster children and their caregivers can contribute to depression and loneliness symptoms and conduct problems in the home. Our interviews reported limited cultural matching practices with ethnic minority LGBTQ+ young people. One participant expressed mixed opinions as to whether this approach was helpful. Others did wish for culturally similar professionals to help them navigate complex cultural hybridity, such as nurturing a stronger connection to their cultural background – but it is important to note that this is within a desire for a SOGIE-affirming context. These findings suggest that cultural matching practices and culturally sensitive services for ethnic minority LGBTQ+ young people remain scarce. As such, this question about the cultural matching experiences of LGBTQ+ young people in residential care is one that, currently, is unanswerable within this study and an area for future research as argued elsewhere (Schaub, Stander & Montgomery, 2022).

Limitations and contributions

Our data makes original and important contributions. To our knowledge, this is the first UK study to provide a detailed exploration of LGBTQ+ young people's experiences in residential social care placements. Key strengths of the study include sampling diversity in terms of sexuality and gender identities and the type of data. Our participants included groups that are often understudied, namely bisexual and/or TGD-identifying young people (Kaasbøll, Pedersen & Paulsen, 2021; Schaub, Stander & Montgomery, 2022). Additionally, our sample mainly consisted of White (British or other White background) participants (10), followed by Black (British and African) participants (7) and those with mixed or multiple ethnicities (2) and Asian British (1); this range broadly reflects the general characteristics of looked-after children in residential care in England according to a recent report (Schoenwald et al., 2022). Furthermore, while many of the studies examining the experiences of LGBTQ+ young people with social care systems are retrospective and done with young adults (Kaasbøll,

Pedersen & Paulsen, 2021), this study included some participants that were currently in residential care placements. It is unsurprising that many studies use retrospective methods, because the topic area can be difficult to address and recruitment can be challenging; but retrospective reporting does not include participant's immediate experiences. Because this study included some participants currently placed in residential care, a strong feature of the data was the "raw" immediacy of vivid descriptions of current experiences. Finally, the contribution of the young researchers/advisors group enhanced every stage of the project. Their contributions were notable when creating the interview schedule and developing the nascent themes during data analysis.

The primary limitations of the study include general challenges associated with a small qualitative sample, and so it may be that findings of the study are not generalisable. Due to COVID-19 disruption and large geographic spread of participants, all interviews were conducted online via Zoom. We encountered common challenges associated with conducting qualitative research online including technical difficulties and occasional difficulties building rapport (see for example Tremblay et al., 2021); for instance, some participants lacked privacy in an intrusive or disruptive residential care home and were unable to access video conferencing software or reliable internet connection in private settings. Consequently, these more public interviews may have limited disclosure compared to more private interviews (Jenner & Myers, 2019). However, these instances were rare and the benefits of using Zoom for data collection (recruitment and ease of participation) significantly outweighed the challenges encountered in this study. We sought to mitigate these limitations by spending significant time developing substantial rapport with participants prior to and through the interviews. Finally, given our focus on young people's lived experiences, we did not include the views and perspectives of professionals supporting LGBTQ+ young people. More in-depth understanding of the various groups of social care professionals, and their differing needs and abilities working with this population will be important moving forward.

Conclusions and recommendations

Looked after LGBTQ+ young people face an array of unique challenges while in residential social care. As the first UK study to exclusively focus on LGBTQ+ young people's experiences of residential care placements, our analysis, while not generalisable, provides an important foundation for future studies to build on. Specifically, our findings suggest multiple unstable placements; frequent SOGIE discrimination; and significant mental health challenges for LGBTQ+ young people in residential care placements. These challenges can congregate for some individuals to create significant barriers, and may, for some, interact with other minority identities to generate even greater hurdles. The narratives also described the central importance of affirming relationships with professionals and the resilience and resourcefulness of this group. It would appear that their emotional, psychological and social wellbeing depends on how they manage, and are supported in managing, both the difficult histories shared with care leavers and experiences shaped by multiple intersecting minority identities.

These findings suggest several key practice and policy recommendations to be explored further:

- **Policies specifically related to SOGIE are needed across the sector to better support LGBTQ+ youth as they navigate placements.** Local authorities and residential care homes are encouraged to adopt targeted and affirming policies and standards of practice. Policies should include practical recommendations and be clearly conveyed to caregivers, staff and other professionals that will come into direct contact with young people in care (this study's outputs include a practice briefing). Other young people's services such as runaway, homeless and youth

work programmes have made significant strides in their capacity to create practice and policy standards addressing the needs of LGBTQ+ young people and can provide valuable lessons in this regard (McCormick, Schmidt & Terrazas, 2017). Care providers must go beyond simply prohibiting discrimination, and actively embrace and advocate on behalf of LGBTQ young people. It is important to create welcoming, affirming settings before having any "out" LGBTQ+ young people in residence. Social workers and residential staff can provide a safe space for LGBTQ+ young people by using inclusive language and ensuring they do not assume residents are heterosexual or cisgender.

- Because of the intersecting and specific challenges for this population, and the knowledge that they are more likely to come into care, **we recommend mandatory and comprehensive LGBTQ+ knowledge and mental health awareness training for all social care professionals, in both qualifying and post-qualifying programmes**. Our participants described deep and long-standing mental health challenges related to the frequent SOGIE-related discrimination they experience. Having a deeper and broader understanding of the issues affecting LGBTQ+ young people can allow professionals to better support these young people and more effectively liaise with outside services. Such training should be rigorously evaluated to determine its effectiveness and also include ongoing reflective supervision to address implicit bias – particularly as it relates to TGD young people and those who come from minoritised racial or religious backgrounds to improve understanding and reduce biases about the LGBTQ+ community. Recent research found training combined with ongoing coaching or supervision helps enhance children social workers' knowledge and real-world application of content (Triggs, 2020).

- **To reduce direct discrimination, it is important to assess staff attitudes about LGBTQ+ young people in the placement and recruit more affirming foster families and group home staff.** This could be enacted through employment/assessment activities but will also need to form part of an ongoing reflective supervision process for professionals.

- **Local authorities should be aware of the educational needs of LGBTQ+ young people in care and ensure that their residential home environments support educational engagement.** LGBTQ+ young people are significantly more likely to be bullied, and this has a significant impact on their educational experience (Aragon et al., 2014; Henderson, 2016); secondly, their more frequent placement disruption also affects their educational engagement. As a result, interdisciplinary collaboration between schools, residential care and local authorities is critical to improve educational policies to ensure that LGBTQ+ young people's academic, social, emotional, and employment needs are met.

- **Detailed and universally available sex and relationship education that is LGBTQ+ specific is needed to support LGBTQ+ young people to understand their choices and responsibilities, as well as the potential risks.** This has been highlighted in statutory guidance for relationship and sex education in schools (see DfE, 2021). However, such provision also extends beyond the classroom, and it is vital that social workers and carers can provide information or support needed. Most notably, young people's projects and workers often undertake sex and relationship education with marginalised groups and there may be scope for closer collaboration here.

- **A greater proportion of LGBTQ+ young people should be placed with families.** Evidence from other studies shows that children fare better when placed with families than in group care settings (Berridge et al., 2011), and participants from this study described a desire to live with

families that were supportive and affirming of their identities; this could be instrumental in establishing stability and permanence for LGBTQ+ young people.

- **Early and targeted family reunification or family acceptance efforts to address the rejection experiences that many LGBTQ+ young people have experienced from their birth families or previous foster families are needed.** However, further research and rigorous evaluation is needed to determine what types of intervention are the most effective.

Directions for future research

Although the data provides us with the first picture of LGBTQ+ young people's experiences in residential care in England, there are additional gaps in our knowledge base that would benefit from future research. Because of the significant omissions in UK evidence, it is important that future studies include longitudinal research designs (both quantitative and qualitative) to provide a robust account and understanding of LGBTQ+ young people's experiences in residential care. Additionally, as evidenced in this study, LGBTQ+ training for social care professionals is clearly essential, in both qualifying and post-qualifying settings. However, what is not known, is whether existing training is adequate or based on evidence-based approaches (Hunt et al., 2019). More research and rigorous methods are needed to evaluate the effectiveness of available training to better support LGBTQ+ young people.

Due to the prominence of mental health problems among our participants, there is an urgent need to investigate the mental health help-seeking behaviours and treatment efficacy for these groups to ensure they can achieve equitable health and wellbeing. In-depth exploratory research about the availability and experiences of cultural matching practices for LGBTQ+ young people in out-of-home care placements is also needed given the paucity of data within this study.

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Appendices

Appendix A. Participant Characteristics

Pseudonym	Age	Gender Identity	Sexual Orientation	Ethnicity	Dis/ability
Carter	24	Trans & nonbinary	Bisexual	Black African	No disability stated
Vesper	18	Cisgender woman	Lesbian	White British	No disability stated
Rebel	18	Nonbinary	Bisexual	White British	No disability stated
Zane	24	Cisgender man	Gay	British South Asian	No disability stated
Sparrow	17	Trans man	Bisexual	White British	Autism
Morgan	24	Cisgender woman	Lesbian	White British	No disability stated
Finley	16	Cisgender man	Bisexual	White British	Autism
Roux	21	Cisgender man	Gay	White British	Autism, deaf/hearing impaired
Arrow	18	Trans man	Asexual Panromantic	Dual or multiple heritage	No disability stated
Clarke	17	Cisgender man	Gay	White British	No disability stated
Rio	16	Nonbinary	Bisexual	White British	No disability stated
Orion	20	Trans man	Heterosexual	White European	No disability stated
Reef	17	Cisgender woman	Bisexual	Dual or multiple heritage	No disability stated

River	16	Trans man	Asexual	White British	No disability stated
Robbie	19	Cisgender man	Bisexual	Black British	No disability stated
Quinn	18	Cisgender woman	Lesbian	Black African	No disability stated
Harley	19	Cisgender woman	Lesbian	Black British	No disability stated
Peyton	19	Cisgender woman	Lesbian	Black British	No disability stated
Parker	19	Cisgender man	Gay	Black British	No disability stated
Tommie	21	Cisgender man	Gay	**Black African**	No disability stated

Appendix B. Interview schedule

Participant Number:

Demographic information:

- Ethnicity (if relevant, ask about their immigration status, e.g. first-generation, second-generation or migrants themselves)

- Religion

- Age

- Location

- Can you please describe your gender identity and sexuality?

Could you broadly outline your experience of residential social care?

Prompts: How long have you (or did you) live in residential care?

How many different residential homes did you live in? Were you in other types of care (such as foster care)? If so, how did residential care compare?

What are some events that have impacted on your experience of being in care?

Can you describe how you came to be in residential care?

Prompts: What were the reasons you entered residential care?

Have you retained a connection with your parents/biological family? Can you describe it briefly?

What is your relationship like with your parents/family?

Can you describe your relationship with staff at the residential home(s)?

Prompts: Were there any residential staff that make you feel that they are easy to talk to?

Can you explain why this was the case?

Did you feel supported/unsupported within your residential homes to express your gender identity or sexuality? How did this feel?

What was your experience of coming out whilst in residential care?

Prompts: What were the reasons why you decided this approach?

What were your experiences of how residential staff and other young people in the

home responded to your gender identity or sexuality/orientation?

What sorts of support did you receive or support about your LGBTQ+ identity or coming out while in residential care?

Prompts: Who and where did you look for support? When did you look for that support?

What were your experiences like receiving that support?

Were any services more/less helpful? Why?

What sorts of support do you think would have been helpful?

Did you have any particular needs that you felt weren't being met while in residential care?

Prompts: How did you communicate these needs to the different services/adults/friends around you?

Was there anything that made it particularly difficult for you to get the help that you needed?

Were you "matched" to a social/residential worker, etc. from a similar background? (cultural matching question)

Prompts: How did that go? What was that experience like?

In what ways was it helpful (or less helpful)?

Can you outline your experience of having a social worker?

Prompts: What support services were helpful (and why)?

Which were not helpful (and why)?

Can you think of any services or support that may have been helpful that weren't available or offered to you?

If you had a magic wand, what sort of changes would you make to improve residential care LGBTQ+ young people? Why these changes?

Topics:

These topics are to be considered throughout the above questions. They are overarching considerations for young people in care, and particularly prominent for LGBTQ+ young people. Follow up on these when raised in the above responses. If there are no descriptions of any of these, ask about them in turn.

Substance/alcohol misuse	Exploitation
Professionals' responses	Family relationships

Friends	Employment/education
Mental health	Partners