Health Promotion International, 2016;31:459–469
doi: 10.1093/heapro/dav010
Advance Access Publication Date: 3 March 2015

OXFORD

Building healthcare workers' confidence to work with same-sex parented families

Henry von Doussa[1,*], Jennifer Power[1], Ruth McNair[2], Rhonda Brown[3], Margot Schofield[4], Amaryll Perlesz[1], Marian Pitts[5], and Andrew Bickerdike[6]

[1]The Bouverie Centre, La Trobe University, Melbourne, VIC, Australia, [2]Department of General Practice, University of Melbourne, Melbourne, VIC, Australia, [3]School of Nursing and Midwifery, Deakin University, Melbourne, VIC, Australia, [4]Counselling and Psychological Health, School of Public Health and Human Biosciences, La Trobe University, Melbourne, VIC, Australia, [5]La Trobe University, Melbourne, VIC, Australia, and [6]Relationships Australia Victoria, Melbourne, VIC, Australia

*Corresponding author. E-mail: h.vondoussa@latrobe.edu.au

Summary

This article reports on a qualitative study of barriers and access to healthcare for same-sex attracted parents and their children. Focus groups were held with same-sex attracted parents to explore their experiences with healthcare providers and identify barriers and facilitators to access. Parents reported experiencing uncomfortable or anxiety-provoking encounters with healthcare workers who struggled to adopt inclusive or appropriate language to engage their family. Parents valued healthcare workers who were able to be open and honest and comfortably ask questions about their relationships and family. A separate set of focus groups were held with mainstream healthcare workers to identity their experiences and concerns about delivering equitable and quality care for same-sex parented families. Healthcare workers reported lacking confidence to actively engage with same-sex attracted parents and their children. This lack of confidence related to workers' unfamiliarity with same-sex parents, or lesbian, gay and bisexual culture, and limited opportunities to gain information or training in this area. Workers were seeking training and resources that offered information about appropriate language and terminology as well as concrete strategies for engaging with same-sex parented families. For instance, workers suggested they would find it useful to have a set of 'door opening' questions they could utilize to ask clients about their sexuality, relationship status or family make-up. This article outlines a set of guidelines for healthcare providers for working with same-sex parented families which was a key outcome of this study.

Key words: lesbian and gay parenting, cultural sensitivity training, lesbian and gay health, cultural competency

INTRODUCTION

Individuals and groups who are socially or culturally marginalized may face greater barriers to healthcare than others due to discrimination, difficulties with language or anxiety about accessing services (Gulliford, 2013). While many services have equity policies in place, less tangible barriers may remain, particularly those related to cultural bias or lack of familiarity among staff with particular groups or cultures (Celik *et al.*, 2012).

There is evidence that many same-sex attracted people experience marginalization within mainstream health services (McNair *et al.*, 2012). While this may not take the form of overt discrimination or refusal of service, many same-sex attracted people encounter service providers who are uncomfortable or avoidant when it comes to asking questions or discussing sexual identity or relationships (Hutchinson *et al.*, 2006; Bjorkman and Malterud, 2009). Same-sex attracted people also report heterosexist attitudes among healthcare providers. Usually this means a provider assumes consumers are heterosexual, unless explicitly told otherwise, and ask questions or make treatment decisions on that basis (Hutchinson *et al.*, 2006; Spidsberg, 2007; Hayman *et al.*, 2013). On one level it may seem simple for a consumer to be upfront with healthcare providers about their sexuality. However, many same-sex attracted people report that they find this stressful and they fear discomfort or discrimination from the provider (Hinchliff *et al.*, 2005; McNair and Hegarty, 2010). This may mean same-sex attracted people find healthcare encounters anxiety-provoking and difficult to manage which may lead them to delay health seeking and/or choosing not to disclose their sexual identity (Hinchliff *et al.*, 2005; Leonard *et al.*, 2012).

Increasing numbers of lesbian, gay and bisexual (LGB) identified people are the parents of dependent children, although exact estimates vary. In the USA, it is estimated that up to 37% of LGB adults have had a child at some point in their lives (including biological, non-biological, adopted, foster or step children; Gates, 2013). In Australia, the most recent census data indicate that ~3% of gay male couples and 22% of lesbian couples have dependent children living with them (Australian Bureau of Statistics, 2012). However, findings from a major survey of same-sex attracted Australians, published the same year, indicated that 32% of lesbian or bisexual women had children or step children and 11% of men (Leonard *et al.*, 2012).

There is a small body of research which has identified barriers to healthcare access for same-sex parented families. At an administrative level, intake or medical history forms often do not accommodate same-sex couples. This means providers may not have appropriate information about a child's family circumstances and one parent may not be afforded decision-making power with respect to the child's medical care (Hayman *et al.*, 2013). When it comes to same-sex parented families, heterosexist assumptions on behalf of healthcare providers may take the form of not recognizing a family as a family—assuming one parent is a friend or other relative (Hayman *et al.*, 2013). Providers may also insist on collecting information about a child's genetic parentage even where it is not relevant to the consultation. Same-sex attracted parents often experience this as lacking respect for their family make-up by not recognizing the parental role of non-biological parents (Chapman *et al.*, 2012). Many same-sex attracted parents have also encountered providers who engage with only one parent during healthcare consultations, usually excluding the non-biological parent (Goldberg and Allen, 2012). Non-biological parents may feel reluctant to clarify their role in the family for fear of being inappropriately deemed ineligible to make health decisions (McNair *et al.*, 2008).

Some studies have shown that many healthcare providers do not consider it important for same-sex parents to disclose their sexuality in a healthcare consultation as they feel it has no bearing on the quality of care they deliver (Chapman *et al.*, 2012; Heyes and Thachuck, 2014). However, for parents who wish to disclose their sexuality, this attitude places the onus on them to raise the topic, rather than on providers to ensure people feel safe to do this. Further, the attitudes of healthcare providers can affect the quality of care due to a provider's lack of knowledge of health issues for same-sex parented families or if a provider's discomfort with same-sex attracted populations leads to awkward or difficult interactions in a consultation (Hutchinson *et al.*, 2006).

Training in cultural sensitivity and inclusive practice can make a difference. Healthcare providers and students from the health and helping professions who have access to training and information about same-sex attracted populations are more likely to perform more comprehensive patients histories, have more positive attitudes towards sexuality and a greater awareness and knowledge about health needs and outcomes for same-sex attracted people (Kelley *et al.*, 2008; Krehely, 2009). Comprehensive patient histories, for instance, are important in providing clients with the space to speak safely about sexuality and/or gender, and about the relationships they have with partners and/or children.

This study explored experiences and perceived barriers for same-sex attracted parents engaging with health and welfare services from the perspective of both parents and service providers. The study aimed to identify key themes to inform the development of an evidence-based set of guidelines and training program for healthcare service providers who may work with same-sex parented families.

METHODS

This project was part of a broader piece of research into the experiences of same-sex parented families. Full details of the study methods have been published elsewhere (Power *et al.*, 2010a) as have study findings (Perlesz *et al.*, 2010; Power *et al.*, 2010b; Power *et al.*, 2012a;

Power *et al.*, 2012b; Power *et al.*, 2010a). The project received ethics approval from the La Trobe University Human Ethics Committee.

Recruitment

In this qualitative study, data were collected through focus groups with same-sex attracted parents and health and welfare service providers. A small number of telephone interviews were conducted with same-sex attracted parents who were unable to attend focus groups. All groups and interviews were conducted in 2012.

Focus groups with parents

Two focus groups were held with same-sex attracted parents, one in metropolitan Melbourne, Australia, the other in a small regional town, North-East of Melbourne. The Melbourne focus group was advertised through relevant community email lists. The regional focus group was co-hosted with a local support agency and advertised through their local networks.

Focus groups with service providers

Three focus groups were held with mainstream service providers and one with a group of students studying a Masters course in family therapy. For the purposes of this project, 'mainstream' service providers were considered those who were part of the general health services sector (including mental health) and did not specifically cater to the needs of same-sex attracted populations. The mainstream service providers who were invited to participate were purposively selected to reflect services likely to be used by parents during early parenting. This included Women's Hospitals, midwifery services, breastfeeding education and support services, antenatal classes, maternal and child health centres, fertility clinics, relationship mediation services and counselling services across the public and private sectors. Separate focus groups were run with service providers from the health and hospital sectors and from the counselling and mental health sectors. Childcare services were excluded from this list given the nature of this service sits outside our definition of 'health and welfare services'. However, the findings of this research may still have relevance to childcare settings.

To recruit service providers, a database of healthcare services likely to be used by parents during early parenting was compiled from Internet searches for organizations and services in the Australian state of Victoria. On completion of an extensive list of the types of services we wished to represent in focus groups (those listed above), organizations were contacted by telephone, provided with an explanation and rationale for the study, and then personally invited to participate. Focus groups were conducted on site at The Bouverie Centre, La Trobe University, Australia.

Interviews

Interviews were offered to same-sex attracted parents who expressed interest in attending a focus group but who were unable to attend due to inconvenient scheduling of the groups. In total, three interviews were conducted over the telephone. Each interview lasted ~30–45 min. Informed consent was provided by all focus group and interview participants.

Focus group and interview schedule

The focus groups were conducted using a semi-structured schedule. Each group lasted for ~2 h. A similar set of issues were covered with both parents and service providers, albeit with reference to their different perspectives. Discussion topics included barriers for same-sex parents accessing mainstream health services and strategies to improve access and enhance quality of service delivery for same-sex attracted parents and their families. Parents were asked to comment on their experience of the healthcare sector, while service providers commented on their experience working with same-sex attracted parents or their concerns about this if they had little experience with same-sex attracted parents. Finally, participants were invited to view and provide feedback on a draft set of 'Practice Guidelines for Healthcare Providers Working with Same-sex Parented Families' that had been prepared by the researchers.

The schedule for telephone interviews was similar to that of focus groups, although it accommodated for the one-to-one format through adjustment of language. Participants were emailed a copy of the draft Guidelines prior to the interview.

Data analysis

Focus groups and interviews were recorded and data were analysed using thematic analysis. One researcher reviewed the recordings to identify themes related to barriers and challenges for services and parents as well as solutions or strategies for inclusive practice. The researcher used an open, inductive coding technique to explore emergent themes in these areas, writing detailed notes and analytic memos throughout the process (Bryant and Charmaz, 2007). The notes and memos were then reviewed by a second researcher who was present and had taken independent notes, at each of the focus groups. As themes were further refined and developed through discussions between the two researchers, the researchers returned to the recordings and notes to review the data.

Participants

Parents

Ten parents participated in focus groups and three in a telephone interview. This included seven parents who lived in metropolitan Melbourne and six who lived in a regional town or its surrounds. Of the 13 parents, 9 identified as female and 4 as male. All of the female participants were currently in same-sex relationship as were three male participants; one participant described himself as a single bisexual dad. The 13 participants had 26 children between them, whose ages ranged from 3 months to 25 years. The parents had come to parenting through a range of circumstances including a previous heterosexual relationship, utilizing international surrogacy services or being a foster parent. Table 1 shows characteristics of parents who participated in focus groups and interviews. Pseudonyms are used in this table and throughout the findings section.

Service providers

In total, 32 service providers (workers) participated in four focus groups. Participants represented government and non-government organizations and currently held professional roles including: community-based maternal and child health nurses; hospital-based midwives; family therapists; counsellors or psychologists across a range of sectors including disability services, alcohol or other drugs services, dispute resolution services and private counselling/psychology practice; educators from health and welfare services and occupational therapists. Participants included people currently working in executive/director roles, project/team coordinators and direct care workers.

As the service provider focus groups were larger than those with parents (both parents' groups having <10 participants) we were unable to identify each individual in the audio recordings of service provider groups. As such, quotations utilized in the findings section are not attributed to an individual, except where the occupation of the speaker is known.

FINDINGS

Barriers to inclusive practice

The service providers who participated in focus groups expressed a desire to support same-sex parented families. Most participants indicated they had attended the focus group because they hoped it would provide some information about ways to improve their work with same-sex attracted clients. This initially seemed problematic to us as researchers. We were concerned that we would only be 'speaking to the converted' rather than developing understanding of what it might take to change attitudes among those who were less accepting of same-sex attracted clients. In hindsight, we realized we had been working from the assumption that we would find ignorant, negative or homophobic attitudes among service providers to be one of the major barriers to equitable service provision. However, it quickly became evident that despite their positive attitudes towards same-sex attracted people, the service providers in our focus groups lacked confidence in working with them and felt they did not have the skills or knowledge to deliver appropriate and meaningful service. The service providers felt that this was of greater concern to ensuring equitable and quality healthcare for same-sex parents than overt discrimination or homophobia in the service system. This became the over-riding theme to emerge from these focus groups. These workers lacked confidence, knowledge and skills in how to be inclusive of same-sex parents and their children. This theme then contained a number of sub-themes including fear of offending, uncertainty regarding language to use, silence or lack of inquiry and assumptions. These themes were echoed in the focus groups with parents. No parents in our study felt they had experienced direct discrimination or homophobia in the healthcare sector. Rather, they were more likely to have encountered service providers who, despite having an interest in offering an inclusive service, asked inappropriate questions or no questions at all, or who did not offer proper acknowledgement of their family.

'Fear of mucking up'—uncertainty about language

In focus groups, service providers spoke about being unfamiliar with same-sex couples and LGB culture. This led to a lack of confidence in asking questions or engaging with same-sex couples about their family make-up. In part this was related to a sense that they had limited knowledge about health issues for same-sex attracted populations and lacked familiarity with same-sex parented families in general. But it was also that service providers were not sure how to translate what knowledge they had into appropriate and inclusive practice because they were unsure of what questions to ask or what topics they should or should not focus on. The lack of confidence was described by service providers as a simple fear of 'mucking up', of getting things wrong. One service provider explained this succinctly, 'I don't think we should underestimate the anxieties and the nervousness around offending or saying the wrong thing'.

In particular, many service providers lacked confidence to ask questions of clients related to sexual identity or same-sex relationships. They were fearful of using inappropriate or offensive language or terminology to refer to people's relationships or their families. One service provider said, what they lacked was, 'just knowing what

Table 1: Characteristics of parent participants

Name	Number of children	Children's age (range)	Conception and care context	Relationship and/or sexual identity	Location of residence
Rachel	3	4–8	Non-biological mother, primary carer	Lesbian relationship	Inner city
Sally	1	3	Biological mother, primary carer	Lesbian relationship	Inner city
Tom	2 (twins)	Infant	Surrogacy, care status unknown	Gay relationship	Inner city
Stacey	2	Unstated	Non-biological mother and biological mother, care context unknown	Lesbian relationship	Inner city
Will	1	1	Surrogacy, primary carer	Gay relationship	Regional
Elizabeth	1	11	Biological mother, primary carer	Lesbian relationship	Outer suburbs
Marg	2	Infant—1	Biological mother, primary carer	Lesbian relationship	Inner city
Peter	3	9–20	From previous heterosexual relationship (including one foster child), shared care	Gay relationship	Regional
Deb	2	17–22	From previous heterosexual relationship, primary carer	Lesbian, does not live with partner	Regional
Tania	2	13–18	From previous heterosexual relationship, primary carer	Lesbian, does not live with partner	Regional
Carl	3	Unstated	1 child via surrogacy, 2 children as donor dad	Gay relationship	Inner city
Harry	2	Unstated (primary–secondary school age)	From previous heterosexual relationship, shared care	Single bisexual man	Regional
Doris and Alison (couple)	5	Unstated	Two children from Doris's previous relationship, one child from Doris and Alison's relationship (Alison bio mum), also shared care for two children of their donor	Lesbian relationship	Regional

words to use'. Another said, 'just knowing how not to make a mess of things'. For instance, service providers were unsure how to ask questions of same-sex attracted mothers regarding their family make-up and children's biology. One Maternal Child Health Nurse offered the following example,

> People will often say this is my partner. But if I walked into a room and couldn't obviously tell which one was breastfeeding or who was pregnant, I'm wondering is there a way to say (*hesitation*) which one of you is physically carrying the baby and planning to breastfeed? What terminology is best to use?

These service providers knew enough to understand that these issues may be sensitive for same-sex couples and that acknowledging both women as mothers was important. But they were unsure how best to do this.

In our focus groups with parents we heard similar concerns to that of service providers. Parents had all encountered providers who were awkward or uncomfortable speaking or asking about sexuality, same-sex relationships or family make-up. In some cases parents felt that service providers did 'muck up' because they were unsure how to ask or how to listen for cues from families about appropriate language. One father, for instance, had experienced frustration explaining the language his family used around surrogacy.

> Often they [the service provider] don't know how to describe the surrogate. I had an occasion where [a healthcare worker] was describing her as the mother. In the end, I had to say, 'Look, mother has connotations of a maternal role and this is a woman who already has a family and has no interest in this child'. At that point she described her as the natural mother, which really pissed me off, then she described her as the birth mother, which in the end I thought this is as far as this person can go. (Will)

In the above scenario, Will did not expect the service provider to be familiar with the specific language used in his family to describe their child's surrogate. Families use different terms and for some families use of the term 'mother' to refer to the surrogate would be appropriate. But Will felt frustrated that the service provider did not know to ask about which language was best for his family and did not listen to, and reflect back, the language being used by the family.

Silence—failure to inquire

The above scenario highlights the concerns and anxieties service providers we spoke to worried about. They understood that they could offend clients due to naivety, but were not sure what questions were appropriate, or how to ask questions about relationships or family make-up. This apprehension often meant providers avoided asking these questions altogether. Those who had little prior experience working with same-sex families feared they would not be able to gather information they needed and that consultations would be awkward and interspersed with silence.

From parents' perspective, if providers do not ask about family or relationships they often feel their family is not acknowledged or respected. One parent, Rachel, told us, 'Asking questions is one of the best things they [service providers] can do.' Another recalled the awkwardness of service providers staying silent

> Silence is always bad because it always makes you feel uncomfortable. Silence is worse than a muck up question because no one knows where to go with silence. (Stacey)

One same-sex attracted father spoke of the importance of service providers acknowledging his relationship, not necessarily because he wants to speak about being gay, but simply because it is core to his family make-up. This father also spoke of his frustration with a service provider who clearly avoided referring to him and his partner in terms that acknowledged them as a couple

> How do we show respect for gay relationships without being gushy or ignoring them? As gay parents, sexuality is secondary (*to parenting*) but fundamentally important . . . our status as gay dads needs to be acknowledged, a 'nod' to it by service providers is essential. (Carl)

Making assumptions

While service providers worried about how to ask questions about relationships or family, parents explained that 'coming out' to service providers was often uncomfortable and something they worried about prior to a consultation. Parents found coming out particularly difficult in cases where they had to correct service providers who had assumed they were heterosexual, something which had happened to most parents we spoke to. It was less common for parents to have encountered service providers who simply asked them if they were a couple, as one same-sex attracted mother explained;

> It would be so much easier and so much nicer and so much better for my son if I didn't have to explain; 'So we're from a same-sex family and we . . .'. There shouldn't be an automatic assumption that you are from a heterosexual family. (Elizabeth)

Service providers explained that they sometimes felt that being upfront in asking about sexuality or relationship status was inappropriate or invasive and was not something they found easy. In some cases this was because they felt asking about sexuality risked offending people, including heterosexual people if they wrongly assumed a client was

same-sex attracted. This meant that seemingly simple questions such as 'are you a couple?' did not come easily to service providers.

Solutions for inclusive practice

Both workers and parents had a number of suggestions for ensuring practice was more sensitive and inclusive of same-sex families. Workers suggested that they needed specific information and strategies regarding how to ask questions about sexuality, relationships or family make-up. Similarly, parents discussed the need for service providers to have skills in facilitating disclosure of sexuality and knowing how to set up welcoming environments.

Disclosure skills—invitation to disclose

Parents wanted service providers to take a lead in conversations with them about their relationships or sexuality. This would help parents overcome their anxieties about coming out and offer a definite, positive indication that the provider is welcoming of same-sex parented families. However, service providers were seeking specific strategies to do this as it also provoked anxiety and confusion in them to lead conversations about sexuality or relationships when they were unfamiliar with clients.

Parents had a number of ideas about how service providers could facilitate 'coming out'. Some suggested that ensuring intake forms enabled them to explicitly state they were a same-sex parented family would offer a comfortable way to disclose their sexuality. Clearly stating family make-up on intake forms and in patient records also assists in making this information available to all relevant staff in a practice. Parents told us this would offer relief from continually having to come out to each provider or reception staff.

Service providers suggested that a list of questions which they could have 'at the ready' to ask couples and families about their relationship and family make-up would be useful. These questions could be as simple as: 'What is your partner's gender?'; or, if both partners were attending a consultation, asking clarifying questions like 'What is your relationship? Are you partners, friends, relatives?'

'Opening doors'

Similar to the above, service providers were interested in resources which offered strategies to encourage clients to talk about their family. Service providers were particularly interested in how to ask questions to facilitate greater understanding of family make-up and familiarity with the language families use to describe each parent or significant others in their family life such as grandparents or donors. With respect to these questions, one participant was looking for a resource that would illustrate 'a nice way of putting it [so] you can incorporate that into your practice knowing that's going to be a nice way of phrasing what you're wanting to ask but not sure how to put.' Another service provider spoke of seeking 'door opening questions'. Questions or encouraging statements such as 'tell me a bit about your family' provide a simple and inclusive way of opening up dialogue.

Information, skills and strategies

Many service providers told us they attended the focus group because they were looking for information and training about working with same-sex parented families. In part, providers were seeking 'factual' information about same-sex parented families such as how most same-sex female couples conceive children, surrogacy processes or issues confronting same-sex parents and/or their children. But, as has been discussed, these providers were also seeking specific information about ways to engage same-sex parents and their children. Knowledge in itself did not necessarily help to build confidence in working with same-sex parented families. It was important that this information was accompanied by practical strategies for asking questions, opening discussions and acknowledging families.

Self-reflection

A number of service providers noted that self-reflection can be an important part of developing sensitivity and confidence in working with any people or groups with whom one is unfamiliar. Creating space to think about how assumptions about homosexuality can impact upon practice or areas where providers may feel uncertain or uncomfortable was likely to be an important part of any resources or training in inclusive practice. One provider described the importance of this process, saying:

> When you're naive or don't have the experience or come from a fairly conservative background or whatever, those things can be very new and to not be informed can have huge implications without you even knowing it. So I think that experience counts for a lot but having access to resources and training where [workers] can really have some good knowledge and reflect on their own perspectives is vital . . . and even the notion of gay and lesbian people having internalised homophobia, it took me a long time to wrestle with that one.

DISCUSSION

For healthcare providers, achieving cultural sensitivity in working with same-sex parented families requires the

skills and confidence to appropriately acknowledge a client's family make-up and engage sensitively around issues related to sexuality. This acknowledgment also needs to be balanced with a focus on clients' healthcare needs. Sexuality is one layer of a client's story, but it is not the whole story. Same-sex attracted parents in this study indicated a likeliness to find too much attention (even positive attention) on their sexuality to be uncomfortable, as much as they may find no attention to be inappropriate. Holman and Oswald succinctly articulate the tension at the heart of this complex negotiation though posing the question, 'how do you strengthen community infrastructure for a stigmatised minority group when members of that group do not always feel stigmatised or always want their sexuality to be at the forefront?' [(Holman and Oswald, 2011), p. 145]. The way forward might be a focus on understanding that while same-sex attracted parents want equitable access to health services, they also want affirming and supportive acknowledgement of their unique family structure. Service providers may help to put same-sex attracted parents at ease by treating them as other families while at the same time understanding that there are unique aspects and potential challenges to being a same-sex attracted parent or child of a same-sex attracted parent that need to be listened for in a consultation.

Previous research has identified the need for increased training of healthcare workers to improve their capacity to provide culturally appropriate services for same-sex attracted clients, including those who are parents (Hinchliff *et al.*, 2005; Fell *et al.*, 2008; McNair *et al.*, 2008; McNair and Hegarty, 2010; Victorian Department of Health, 2011). For both service providers and parents who participated in this study, the most salient barriers to equitable healthcare delivery were subtle and informal, relating largely to healthcare providers' lack of confidence or familiarity with same-sex parented families. Service providers lacked confidence in opening up conversations or asking seemingly simple questions about partners or relationships. Service providers had some awareness of issues that may be important for same-sex attracted clients and their families—and were concerned to provide these families with an appropriate and meaningful service encounter—but their limited exposure to the same-sex attracted communities or same-sex attracted clients meant they felt nervous about how best to engage clients. The type of education or training being sought by these service providers was therefore not only knowledge-based information about the issues for same-sex attracted populations. Service providers were also seeking strategies to become more comfortable opening up conversations with same-sex attracted clients in ways that appropriately acknowledge their sexuality and relationships. They were interested in learning more about language used by same-sex attracted clients to describe their families and wanted to develop greater sensitivity to questions or topics that may be difficult for some clients.

These findings support the previously documented importance of an 'whole-of-service' approach to inclusive practice for same-sex parented families (Barrett *et al.*, 2013), which may include a review of intake forms and processes and training of all staff, including reception and administrative staff, in inclusive and sensitive practice (Mikhailovich *et al.*, 2001; Chapman *et al.*, 2012; Barrett *et al.*, 2013). In particular, this approach may help ease the anxiety experienced by many same-sex parents in coming out to service providers by indicating that the service is same-sex-friendly, while also providing options for clients to note their sexual identity on intake forms if they chose. Following this, these findings suggest that professional development training should incorporate the following:

1. Raising awareness and challenging attitudes among workers who currently hold negative attitudes towards same-sex parented families.
2. Providing information about issues regarding same-sex parents and their children and the opportunity to safely ask questions. This may include 'role-plays' which will allow providers to practice questions and help them develop language to have 'at the ready' in consultations.
3. Encouragement of self-reflection on attitudes and assumptions and the implications for practice.
4. Skill-based training in areas such as asking about sexuality or family make-up and opening discussions.

Practice guidelines

A whole-of-service approach to inclusive practice and professional development training allows for a comprehensive professional and service development strategy. However, an aim of this project was to develop a set of Practice Guidelines for healthcare providers working with same-sex parented families. Following these focus groups we were initially concerned that a brief set of guidelines would have little impact on the confidence or practice of healthcare workers. However, on reflection, we felt we could develop a set of guidelines to be responsive to the findings of this study. In particular, we aimed to produce guidelines that assisted with language and provided some specific questions workers could use to ask about sexual identity or family make-up—'door opening questions'. We also felt that the guidelines could play a role in workplaces as a conversation starter, which may encourage workers to think and ask questions about their current attitudes, assumptions or practice (Table 2).

Table 2: Brief guidelines for working with same-sex parented families in healthcare settings

Section	Details
What same-sex parented families value when using healthcare services	Accepting and affirming attitudes from service providers, with a welcoming and friendly approach
	Understanding from service providers that it is important that the role of both parents is openly acknowledged in consultations
	Inclusive language from service providers to indicate it is safe to 'come out'. This may include service providers asking directly if a client identifies as LGB or same-sex attracted and/or the gender of their partner (see door opening questions)
	Appropriate questions being asked about family make-up. Some questions about a child's biological heritage or conception can be intrusive and alienating (see door opening questions)
	Knowledgeable service providers. Same-sex parents can become frustrated at having to educate service providers about their families, especially as useful information and resources are increasing available online
	Trusted referrals. When referring same-sex parents to other providers, these should be to LGB sensitive services where possible
Tips for creating a welcoming environment	Display LGB inclusive signs, posters and books in waiting room
	Intake forms send a message about the inclusivity of the service as well as collecting important information. Review forms to ensure they use inclusive language and accommodate same-sex couples. Provide an opportunity for people disclose their sexual orientation and gender of their partner if relevant, or if the form is for a child ask about the gender of each parent
	Make a habit of explicitly telling new clients that the service is welcoming of all types of families including same-sex families. Communicate an inclusive message on all information and resources from the service
	Reflect on your own values and practices. Pay attention to times when you assume or take for granted that a client is heterosexual
Door opening questions	Door opening questions are designed to put clients at ease and invite them to talk about their family structure in a safe way. A simple and useful question is: 'Tell me about your family'. If a client is alone: .Tell me about yourself? Do you have a partner? How does your partner describe their gender? If two clients present: Tell me about yourselves, what is your relationship?" or, if there is a child, 'Tell me about your family? Are you the parents?' Take care to acknowledge both adults when asking questions about children
	Pay attention to the language people use when they describe their family. Remember all same-sex families are not the same. When seeing a family in a counselling setting for example, always ask about the language the family uses. You could ask, 'So I can get a picture of your family, can you tell me what your kids call you at home? Is this different when you are away from home?' 'Are there other people who play an important role in your family life?'
	Respect that the parent or parents who are caring for their child are that child's parents. Asking questions about biology or conception out of curiosity can be alienating so avoid this unless you know clients well and are confident this will be okay for them. When information about a child's birth or biological parent is needed, ask sensitively. For instance, in a maternal/child health nurse visit where the nurse needs to check the health of the birth mother he or she could ask, 'How are you both adjusting to parenthood? We like to check in on the mental well-being on both parents and the physical health of the birth mother. Who is the birth mother?'

Limitations

One limitation of this study is the sample size of the parents' focus group. We advertised the study through same-sex attracted parent networks but the response rate was low despite repeated emails and 'e-flyers' being circulated. Further, there were no General Practitioners (GPs) involved in this study. While this was deliberate, as other studies have focused on research with GPs (McNair and Hegarty, 2010), GPs are an important part of the primary care pathway of many prospective or new parents. As such, future research with GPs exploring their confidence in engaging with same-sex attracted parents would be useful. Parents who participated in this study were confident and assertive in accessing healthcare. As such, the views of those who are less capable in negotiations with service providers may not be adequately represented. There were also no parents who identified as transgender in this study, a population group that receives little attention and is therefore an area for future research.

CONCLUSION

Cultural sensitivity and awareness training for healthcare providers have been shown to make a positive difference for same-sex attracted people who access mainstream services. Findings from this study suggest that cultural sensitivity and awareness training needs to do more than familiarize service providers with issues related to marginalization and the barriers to care faced by same-sex attracted parents. Training needs to include skills development for providers to build confidence to actively and appropriately implement sensitive and inclusive practice. To provide the most appropriate and meaningful service encounter for same-sex parented families and their children, and prospective same-sex parents, skills and competencies need to assist providers to open the door for people to tell their story and 'come out' in safe and easy ways. Providing parents and families with a space to tell their story and articulate their needs will not be possible if service providers are silenced or inert from a fear of getting it wrong or offending.

ACKNOWLEDGEMENTS

We would like to thank the service providers and same-sex parents who participated in the focus groups and the LGBT organisations that supported us to recruit for the parents' focus groups. For co-hosting the regional parents' focus group we would particularly like to thank GV Pride Shepparton. This study is funded by an Australian Research Council Linkage Grant with financial support from VicHealth (the Victorian Health Promotion Foundation), Relationships Australia (National and Victoria) and ACON (formerly the AIDS Council of NSW) and in-kind support from Gay and Lesbian Health Victoria and the Queensland Association for Healthy Communities.

CONFLICTOF INTEREST

None declared.

REFERENCES

Australian Bureau of Statistics. (2012). *Reflecting a Nation: Stories from the 2011 Census, 2012–2013, 'Same-Sex Couple Relationships'*. Canberra: ABS.

Barrett C., Turner L., Leonard L. (2013). Beyond a Rainbow Sticker: A Report on How2 Create a Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Inclusive Service. Gay and Lesbian Health Victoria, La Trobe University, Melbourne, Australia.

Bjorkman M., Malterud K. (2009) Lesbian women's experiences with health care: A qualitative study. *Scandinavian Journal of Primary Health Care*, **27**, 238–243.

Bryant A., Charmaz K. (2007) The coding process and its challenges. In Bryant A., Charmaz K. (eds), *The SAGE Handbook of Grounded Theory*. SAGE Publications Ltd, London.

Celik H., Abma T. A., Klinge I., Widdershoven G. A. M. (2012) Process evaluation of a diversity training program: The value of a mixed method strategy. *Evaluation and Program Planning*, **35**, 54–65.

Chapman R., Wardrop J., Freeman P., Zappia T., Watkins R., Shields L. (2012) A descriptive study of the experiences of lesbian, gay and transgender parents accessing health services for their children. *Journal of Clinical Nursing*, **21**, 1128–1135.

Fell G. R., Mattiske J. K., Riggs D. W. (2008) Challenging heteronormativity in psychological practice with lesbian, gay and bisexual clients. *Gay and Lesbian Issues and Psychology Review*, **4**, 127–140.

Gates G. J. (2013) *LGBT Parenting in the United States*. The Williams Institute, The University of California School of Law, Los Angeles.

Goldberg A. E., Allen K. R. (2012) *LGBT-Parent Families: Innovations in Research and Implications for Practice*. Springer, Dordrecht.

Gulliford M. (2013) Equity and access to health care. In Gulliford M., Morgan M. (eds), *Access to Health Care*. Routledge, London.

Hayman B., Wilkes L., Halcomb E. J., Jackson D. (2013) Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse*, **44**, 120–127.

Heyes C. J., Thachuck A. (2014) Queering know-how: clinical skill acquisition as ethical practice. *Journal of Biomedical Inquiry*, **11**, 1–11.

Hinchliff S., Gott M., Galena E. (2005) 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health and Social Care in the Community*, **13**, 345–353.

Holman E. G., Oswald R. F. (2011) Nonmetropolitan GLBTQ parents: when and where does their sexuality matter? *Journal of GLBT Family Studies*, **7**, 436–456.

Hutchinson M. K., Thompson A. C., Cederbaum J. A. (2006) Multisystem factors contributing to disparities in preventive health care among lesbian women. *JOGNN—Journal of Obstetric Gynecologic and Neonatal Nursing*, **35**, 393–402.

Kelley L., Chou C. L., Dibble S. L., Robertson P. A. (2008) A critical intervention in lesbian, gay, bisexual, and transgender health: knowledge and attitude outcomes among second-year medical students. *Teaching and Learning in Medicine*, **20**, 248–253.

Krehely J. (2009) *How to Close the LGBT Health Disparities Gap*. The Centre for American Progress, Washington, DC.

Leonard W., Pitts M., Mitchell A., Lyons A., Smith A., Patel S. (2012) *Private Lives 2: The Second National Survey of the Health and Wellbeing of gay, Lesbian, Bisexual and Transgender (GLBT) Australians*, Vol. 86. Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

McNair R., Hegarty K. (2010) Guidelines for the primary care of lesbian, gay and bisexual people: a systemic review. *Annals of Family Medicine*, **8**, 533–541.

McNair R., Brown R., Perlesz A., Lindsay J., De Vaus D., Pitts M. (2008) Lesbian parents negotiating the health care system in Australia. *Health Care for Women International*, **29**, 91–114.

McNair R., Hegarty K., Taft A. (2012) From silence to sensitivity: a new identity disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations. *Social Science and Medicine*, **75**, 208–216.

Mikhailovich K., Martin S., Lawton S. (2001) Lesbian and gay parents: their experiences of children's health care in Australia. *International Journal of Sexuality and Gender Studies*, **6**, 181–191.

Perlesz A., Power J., Brown R., McNair R., Schofield M., Pitts M., et al. (2010) Organising work and home in same-sex parented families: findings from the work love play study. *Australian and New Zealand Journal of Family Therapy*, **31**, 374–391.

Power J., Perlesz A., Schofield M. J., Pitts M. K., Brown R., McNair R., et al. (2010a) Understanding resilience in same-sex parented families: the work, love, play study. *BMC Public Health*, **10**, 115.

Power J., Perlesz A., Brown R., Schofield M., Pitts M. K., McNair R., et al. (2010b) Diversity, tradition and family: Australian same-sex attracted parents and their families. *Gay and Lesbian Issues and Psychology Review*, **6**, 66.

Power J., Perlesz A., Brown R., Schofield M., Pitts M. K., McNair R., et al. (2012a) Bisexual parents and family diversity: findings from the work, love, play study. *Journal of Bisexuality*, **12**, 519.

Power J., Perlesz A., McNair R., Schofield M., Pitts M., Brown R., et al. (2012b) Gay and bisexual dads and diversity: fathers in the work, love, play study. *Journal of Family Studies*, **18**, 143–154.

Spidsberg B. D. (2007) Vulnerable and strong–lesbian women encountering maternity care. *Journal of Advanced Nursing*, **60**, 478–486.

Victorian Department of Health. (2011) *Well Proud: A Guide to Gay, Lesbian, Bisexual, Transgender and Intersex Inclusive Practice for Health and Human Services*. Department of Health, Melbourne.