

Interprofessional working: adoption assessments for people living with HIV

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Introduction

In 2013, approximately 107,800 people were living with HIV infection in the UK. Of these, 3,710 had CD4 count levels above 500 cells/mm³; they adhered to antiretroviral treatment and were living steadily (Public Health England, 2014). Those with suppressed viral loads may not require treatment and may live normal lives. The prevalence of HIV falls within the reproductive age range of 15–59 years. It is likely that men and women in this group will consider parenthood, be it naturally or through surrogacy or adoption (Gerrand, 2012). More recent work by Townsend *et al.* (2014) has found the risks of mother-to-child transmission in the UK to be significantly lowered to 0.46. Their study reports the continued desire to be biological parents within this group. Nevertheless, in some cases, child adoption becomes a preferred choice, often after other options have been explored (Paiva *et al.*, 2003). Official UK adoption statistics do not publish information about the numbers of potential adopters who are HIV+ and there no existing studies that help to quantify the issue. Therefore, it is difficult to assess the number of potential adopters who are HIV positive. Nonetheless, adoption is one of the options for HIV positive individuals who wish to be parents.

Opportunities for early treatment have reduced HIV-related illnesses, the progression to AIDS or AIDS- and non-AIDS-related chronic illnesses, and have increased life expectancy (Sherr *et al.*, 2010). This approach requires consistent and sustained delivery of health, treatment and social care interventions in line with clinical treatment guidelines (British HIV Association, 2013). Public Health England and other organisations such as the British HIV Association (BHIVA) and Social Care Institution for Excellence (SCIE) rely on clinical, community and outreach services in monitoring and improving long-term successful outcomes for PLWHIV (people living with HIV) (BHIVA, 2013; Public Health England, 2014). Alongside these, adoption protocols and action plans encourage adoption pathways that use efficient collaborative models for information-sharing and accurate recording to ensure that

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3 the needs of prospective adoptive children and adopters are accurately represented (Selwyn
4 *et al.*, 2008; Department for Education, 2012a).

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9 While interprofessional partnerships are seen as the preferred method of working in adoption
10 (Selwyn *et al.* 2008), there is little evidence to show the effectiveness of collaborative
11 working for PLWHIV. Selwyn *et al.* (2008) found improvements in adoption interagency
12 working practices; the study also found assessment documents, relied upon for information-
13 sharing such as core assessment, the Adoption Medical, and Child Permanency Report, are
14 often poorly written with poor articulation and missing information. This creates barriers,
15 tensions and power struggles in decision-making (Atkinson *et al.*, 2005). This is important in
16 the PLWHIV adoption process because the literature around adoption and HIV identifies a
17 'stack of stigmas' associated with HIV-related infertility, HIV itself and adoption (Goldberg *et*
18 *al.*, 2011; Gibson and Fair, 2015).

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31 Fear of HIV testing within adoption processes has led to PLWHIV withdrawing their intent.
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33 While confidentiality and stigma issues pose concerns for effective collaboration, the need to
34 share information sensitively remains central, offering best outcomes for PLWHIV and
35 adoptive children arising from shared language and meaning (Atkinson *et al.*, 2005).
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37 Newmeyer *et al.* (2011) provided a snapshot of potential barriers in a study of 14 Canadian
38 sero-discordant couples, finding in some cases HIV couples were prevented from accessing
39 both fertility treatment and adoption processes. Other couples perceived resistance from
40 adoption agencies who denied equal access to adoption because they were HIV positive.
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42 There were also reports that adoption opportunities were confined to disabled or HIV-
43 positive children. Newmeyer *et al.* (2011) concluded that PLWHIV adoption-related medical
44 examinations would lead to stigma and disqualification from the adoption process. On the
45 other hand, however, it is important to understand how HIV intersects with other layers of
46 stigma that compromise social justice (see Diagram 1). Logie *et al.* (2011), identify that the
47 intersection between HIV and various stigmas such as gender, sexuality, sexual orientation,

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3 race and class negatively impact on the healthcare and social care outcomes amongst
4 PLWHIV. They propose that, illuminating these stigmas at micro, meso, and macro levels
5 would enable professionals to challenge the stigma. For PLWHIV, considering ecological
6 factors and taking a holistic picture of prospective adopters' circumstances will allow social
7 workers to address the complexity associated with the lives of those seeking to adopt.
8 Although social work adoption assessments should be broadened to incorporate biological,
9 health, social and wider issues that influence the experiences of PLWHIV, the primary focus
10 should be that of determining overall suitability, readiness and capability to offer good
11 parenthood, and this comes from a good analysis of holistic information collated about the
12 applicant (Lind and Lindgren, 2017).
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25 As good interprofessional working is well documented in areas such as occupational
26 therapy, mentorship and rehabilitation programmes that foster lifestyle changes, stability,
27 cognitive support and home management (Tunncliffe *et al.*, 2013), it makes sense to examine
28 the potential for a similar approach in HIV-related adoption. Research indicates this may
29 increase efficiency within health and social care systems, allowing holistic provision of
30 services for those with a broad spectrum of needs, coordinated by different service
31 providers/professionals (Atkinson *et al.*, 2005; McColl and Dickenson, 2009). Forward
32 planning of health services for PLWHIV can facilitate the management of sensitive issues
33 disclosed during adoption processes, as well as consider the long-term management of the
34 condition (Tran *et al.*, 2010). This planning also allows consideration of HIV strategies for
35 both child and potential adoptive parent. To work this requires interprofessional partnership.
36 Generally, partnership working in adoption is improving (Selwyn *et al.*, 2009).
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52 Moreover the British Association for Sexual Health (BASH), National Institute for Health and
53 Care Excellence (NICE) and other healthcare institutions are interested in ensuring that
54 interprofessional working is at the heart of preventative care and its delivery for PLWHIV
55 (BHIVA, 2013). Despite this, there is some evidence of barriers, particularly with the sharing
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3 of sensitive information. For example, Underhill *et al.* (2016) found sharing specific health
4 information can create room for stigma and discrimination. The study advocated for health
5 records of prospective adoption parents to remain confidential from those without expert
6 knowledge or formal qualifications in managing regulations around specific health conditions
7 such as HIV. Further, Underhill *et al.* (2016) argue that, PLWHIV should be warned and
8 counselled about disclosure and potential discrimination.
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17 Cameron *et al.*'s (2012) description of “discrete joint working models” offers a potential
18 model for the adoption process. In this model, collaboration between professionals takes
19 place with agencies that operate independently. Partnership working takes a “targeted
20 approach”, focusing on sharing information between professionals working with PLWHIV to
21 inform assessments and provide guidance on how adoption services and adoption plans
22 should be delivered and managed. Studies looking at joint-working generally report service-
23 user satisfaction, better social well-being and improvements in the quality of life and
24 lifestyles of service users at the centre of joint working initiatives (Cameron *et al.*, 2012).
25 However, existing studies looking at HIV and child adoption suggest that many PLWHIV
26 going through the adoption process experience substantial dissatisfaction due to the stigma
27 and discrimination around HIV that prevents their applications from being considered within
28 adoption systems (Gerrand, 2012).
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43 Drawing on an Interpretative Phenomenological Analysis (IPA) study, looking at the lived
44 experiences of PLWHIV going through fertility treatment and the adoption process, this
45 paper will present themes around interprofessional working in respect of HIV-related
46 adoption. The views and perceptions of five participants (both couples and single potential
47 adopters) who went through various stages of the adoption process will be analysed. The
48 paper argues that professionals from all agencies involved in the health and social care of
49 PLWHIV, including charitable organisations, should be embedded within models of
50 interprofessional working within adoption. Collaborating with all relevant professionals will
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3 provide a range of perspectives, inclusive adoption strategies for PLWHIV and holistic
4 considerations of applications made by PLWHIV (Atkinson *et al.*, 2005). This approach aims
5 to address the theme of HIV as a long-term condition in those seeking to adopt and any
6 gaps in HIV knowledge which may enhance the understanding of normalcy principles for
7 PLWHIV who are stable in their health and lifestyles.
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15 Empirically, however, it is unclear what interprofessional models are in place for PLWHIV
16 who are applying to become adoptive parents, and whether these are consistent and
17 integrated within adoption teams. In advocating such services there is a need for
18 interprofessional working that is distanced from tokenistic non-HIV-related practices. As
19 there is scant literature on interprofessional working strategies for PLWHIV seeking to adopt,
20 the rationale for this paper lies in the need to understand and explore the value of
21 interprofessional working between professionals. It also explores the impact of this model
22 on PLWHIV going through the adoption process.
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31 *****insert diagram 1 about here*****
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33 **Methodology**

34 *Participant Recruitment*

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36 The study received ethical approval from the University of Surrey Ethics Committee and was
37 supported by the Terrance Higgins Trust (THT). Recruitment was led by HIV charitable
38 organisations who promoted this study. In addition, other charitable organisations and
39 adoption agencies also promoted the study. The research was advertised through the THT
40 my HIV confidential web forum, leaflets, adoption agencies and through HIV-related radio
41 shows. THT awarded the lead researcher with honorary researcher status, giving an official
42 connection to the organisation. Eligible participants contacted the researcher directly through
43 a nominated telephone number and were given full information about the study. Study
44 information was also shared through a preliminary screening telephone call. Written consent
45 was given by participants prior to the interview commencing. Participants were interviewed
46 either at THT or at the venue of their choice. Incentives were offered to cover expenses. At
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3 every point, potential participants were offered an option to opt out. All potential participants
4 who contacted the researcher agreed to take part in the study.
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8 9 **Characteristics of Participants**

10 This study is part of a larger study which explored the lived experiences of PLWHIV who had
11 undertaken either fertility treatment and/or adoption. The main study recruited eleven
12 respondents (seven individuals and four couples). See Table 1 for the ethnic description of
13 the larger sample. Three of the individual prospective adopters in the original sample were
14 from a white background, a further three were black and one was Asian. Of the couples,
15 three were white and one was black.
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23 *****Insert Table 1 about here*****
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27 As the purpose of the study described in this paper was to explore the UK adoption
28 experiences of PLWHIV, it focused only on those who were currently engaged in the
29 adoption process at the time of the study. One of the original participants was in the process
30 of international adoption and therefore excluded from this study. A further five of the original
31 participants were exploring or had accessed fertility treatment and were thus excluded from
32 this study. The study thus examines five in-depth, semi-structured interviews involving two
33 single interviewees and three couples who had accessed adoption services while receiving
34 support through HIV-related charitable organisations in England, but were not accessing
35 fertility treatment at the time of the study.
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46 Table 2 describes all of the participants in the original study. The final column in the table
47 indicates whether they were included in this study or not. The sample for this study included
48 two single homosexual men and three heterosexual couples. All of the participants were
49 white. It is unclear whether or not this suggests that formal adoption is not common among
50 Black and Ethnic Minorities although earlier studies identify that culturally and gender-
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3 specific expectations may force PLWHIV to have children biologically (Newmeyer *et al.*,
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5 2011).
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7 ***Insert Table 2 about here***
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11 This study's participants' experiences range from the adoption consultation stage to the
12 assessment stage and post-adoption. Participants in the early stages of adoption
13 applications were involved with child adoption services for a period of at least three months.
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15 This ensured that participants' experiences were considerable. Successful adopters were
16 either waiting to have their children placed in their care or already had their children living
17 with them. Therefore, individual narratives will reflect varied experiences within the adoption
18 system. Their experiences are interpreted and understood within their contexts, although
19 common experiences are underlined from an interpretative engagement with the data.
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29 **Data Collection**

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31 Semi-structured in-depth interviews lasted 60 to 120 minutes. Interpretative
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33 Phenomenological Analysis (IPA) methodologies were used to draw on experiences and to
34
35 make meaning (Smith, 2004). Participants were interviewed as individuals or couples. All
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37 interviews were conducted by the researcher and were recorded and transcribed verbatim.
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39 An interview guide was used to conduct the interviews.
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43 **Data Analysis**

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45 The researcher used the IPA framework for analysis (Smith, 2004) to understand and make
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47 sense of the participants' narratives. Initially, recorded interviews were transcribed and
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49 inputted into NVivo software for qualitative data analysis. Data coding and cluttering of
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51 themes was achieved through cross-case analysis. A staged and cyclical IPA procedure for
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53 analysis was used to provide a robust analysis. Due to the sensitive nature of HIV and
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55 adoption, the researcher offered sensitivity to the context of experiences when engaging
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57 with, and becoming submerged in, the analysis.
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4 Rigorous attention was given to the data through case-by-case and cross-case analysis
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6 allowing the researcher to become immersed in the data during analysis. Through
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8 embracing inter-categorical intersectionality approaches (McCall, 2005), the analysis looked
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10 at how participants made sense of how HIV-related stigma and discrimination were not
11
12 always in isolation from other contextual factors such as race, gender and sexual orientation.
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14 Participants interpreted their experiences at the individual level (e.g. being male or female,
15
16 their sexual orientation, or social class) and they interlocked them with what they considered
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18 to be discriminatory or oppressive practices they observed at the macro level of society) to
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20 make sense of what they perceived as social injustices that prevented them from
21
22 successfully accessing adoption.
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26 The accuracy and validity of data was checked with participants during data collection to
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28 avoid participants revisiting distressing narratives after their interview. Direct quotations were
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30 used to ensure illustrative accuracy. The lead researcher met with two other researchers for
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32 briefing, to discuss and refine the analysis. This ensured the construction of meaning
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34 through understanding participants' perceptions, feelings and experiences endured during
35
36 the adoption process. A thematic analysis of recurring themes was followed within the
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38 stages of IPA to provide structure to the concepts and issues raised by participants.
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42 43 **Limitations of the Study**

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46 This study consists of only five interviews. The advantage of a small sample size is that it
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48 enabled the researcher to explore deeper into individuals' personal experiences and
49
50 perceptions using an interpretative approach (Smith and Osborne, 2007; Flowers *et al.*,
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52 2011). This is in line with IPA analysis (Smith, 2008). It is also not unusual in a hard-to-
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54 reach population to have smaller sample sizes (van Eeden-Moorefield *et al.*, 2008).
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3 The sample for this study consisted of only couples and individuals from a white background
4 despite the original sample including a more diverse group of individual and couple
5 prospective adopters. This may be because the original sample included both those
6 seeking, or those already engaged in, fertility treatment and adoption. As mentioned above,
7 there can be cultural reasons why certain groups prefer not to adopt (Gerrand, 2012). In this
8 case, this may mean that the results of this study are not generalizable to a wider population.
9 Nonetheless the study does produce findings that are of value to the debate and the future
10 development of services.
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20 21 **Results**

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25 This part of the paper will focus on the main aspects of interprofessional working that
26 emerged from the IPA analysis. The extracts were chosen from many themes that emerged
27 in the analysis of the main study because they relate most closely to the concept of
28 interprofessional working. The extracts from the interviews depict issues such as sensitivity
29 in information-gathering, communication between participant/s and professionals, and the
30 potential reluctance of professionals to accept expert advice. These extracts portray features
31 that form part of the day-to-day operation of a social worker. In the case of PLWHIV, where
32 the issues being dealt with are complex in terms of people's health but also in terms of the
33 social and cultural context, interprofessional working becomes an even more important
34 framework to explore.
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48 ***Recording and sharing factual information: "I did not want to be misrepresented"***

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50 Social workers cannot be experts in all areas of their practice. When working with service
51 users presenting uncommon health issues such as HIV, how issues are approached is very
52 important. In the case of Alan who was a single, white homosexual adopter, how information
53 was collated and recorded had potential long term-repercussions:
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3 *I did not want to be misrepresented. At the end of the day my child may read my file*
4 *when he is older, other professionals will read it and make judgements about me. I*
5 *just didn't want that. Well, she (the social worker) was brilliant. [Alan, single adopter,*
6 *white, homosexual]*
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9 The importance of accurate representation was echoed by another couple Hillary and Marius
10 who went through the adoption process as a serodiscordant heterosexual couple. For Alan,
11 his anxieties were reduced because he viewed the social worker's capabilities positively.
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13 There is a real sense of worry that misrepresentation will have an impact on the adoptive
14 child and how others may interpret that information. In that same vein, some participants felt
15 that preparing for adoption panels in order to answer a diverse range of questions would
16 provide an opportunity to demonstrate their capability of adopting.
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25 For example, Hillary and Marius' experience depicts how they prepared for an adoption
26 panel and how they were ready to respond to questions that related to dual diagnosis.
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28 Although Hillary was HIV negative, Marius was HIV positive with haemophilia. The couple
29 were worried that this dual diagnosis was likely to affect their chances to adopt. The fact that
30 the social worker's report contained sufficient relevant health information appears to have
31 made such a line of inquiry unnecessary.
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37 *We went to the panel quite geared up to be asked about mixed illnesses. We were*
38 *surprised that the panel did not have to go through HIV all over again. The panel got*
39 *factual information they needed from the social worker's report in terms of, what is*
40 *your prognosis, what is your CD4 count. That's all they were interested in. Thinking*
41 *about it, they did not ask us about what we will do if you (Marius) had got ill. I was*
42 *expecting them to ask. Maybe they were worried about being accused of stigma and*
43 *discrimination. That would have been a fair question to me. [Hillary and Marius, a*
44 *couple affected by HIV and haemophilia, attending an adoption panel]*
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47 Hillary and Marius recognised the relevance of questions pertaining to contingency planning
48 in the event of illness. In this instance, exploratory interview questions in an adoption panel
49 were seen as reasonable by the potential adopters opposed to stigmatising. In this case
50 factual reporting supported the concept of discrete joint working and collaboration where
51 sharing sensitive information increased the panel's knowledge and at the same time reduced
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3 the need to revisit HIV, thus showing the importance of the social workers' communication
4 and reporting skills.
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7 **Openness to information sharing: "Call them, be my guest"**
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9 Generally, all participants were open to the idea of practitioners collaborating with other
10 professionals in order to gather information that informs their assessment. For instance,
11 Gary was a single homosexual man who had experienced poor mental health after
12 contracting HIV and was open to social workers contacting mental health services for further
13 information:
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19 *The first social worker had not assessed someone with HIV before. She wanted more*
20 *information about my mental health and my HIV. I said call them, be my guest. Within*
21 *a week they had rung and said yes, we want to assess you. [Gary, white,*
22 *homosexual male]*
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24 This suggests that information-sharing can yield positive results for PLWHIV. This excerpt
25 also portrays willingness by potential adopters to cooperate with an assessment process that
26 requires collaborating with other professionals.
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32 **Professional reluctance to accept expert advice: "You might not live long enough to**
33 **have a child"**
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37 When it comes to decision-making and consideration of medical advice, two couples in this
38 study indicated that some social workers and adoption panels were reluctant to accept the
39 advice they were given by HIV consultants. For example, Gabriella and Brad report their
40 observation:
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46 *Social services refused to accept expert advice from my HIV treating consultant. The*
47 *consultant wrote a letter about my HIV status and lifestyle but the social worker did*
48 *not put these through. [Gabriella and Brad, HIV+ heterosexual couple (both +)]*
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51 Another example relates to Alan's case, it appears that a decision was made without the
52 necessary consultation with relevant health professionals. Alan reported that this distressed
53 him:
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3 *The social worker wrote, you might not live long enough to have a child. I said, how*
4 *can you say that? You have not contacted my HIV consultant or my GP. I was*
5 *absolutely angry. [Alan, single adopter, white, homosexual]*
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7 Alan demonstrates the importance of social workers communicating with HIV consultants
8 and other professionals to avoid making negative judgements that are not supported by
9 expert opinion. All participants presented in this paper support the need for professionals to
10 use sensitive language. It is important to consider using sensitive language rather than
11 communicating to a service user that they will not live long enough, especially without
12 medical evidence.
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21 Alan relayed how his experience led him to query decision-making by adoption panels after
22 they analysed health information provided by medical specialists. He demonstrated a sense
23 of ambiguity around why his application was rejected. Others with similar experiences
24 demonstrated feelings of upset, powerlessness and unfair treatment.
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29 *Social Services rang me up and they said based on their medical advisor, we are not*
30 *clear on what your life prognosis is and therefore we are finding it very difficult to*
31 *decide whether we should go forward or not. I could not accept that the medical*
32 *advisor for the panel could not make the decision one way or the other. What I was*
33 *told was that they sat on the fence. They would not advise one way or the other. I*
34 *think this is generally true for doctors but maybe I'm wrong. They are very risk*
35 *averse. They will not put anything in black and white unless they are sure they can*
36 *back it up. [Alan, single adopter, white, homosexual]*
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39 This could be seen as indirect discrimination associated with fear of making wrong
40 decisions. This concern was expressed across the board. On the other hand, opportunities
41 for collaboration are noted by Marius (HIV+male who subsequently successfully adopted two
42 children) but he felt these were not fully utilised because he felt the professionals were over-
43 cautiousness:
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49 *They refused to accept my application based on HIV. They were just over-cautious.*
50 *That is the problem and this leads to many people feeling prejudiced against,*
51 *especially when they are not clear of ins and outs of HIV. They could have sought*
52 *clarification from my haemophilia consultant and my HIV consultant; I gave them all*
53 *the information. [Marius, HIV+ male]*
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56 The above account indicates the importance of exploring and seeking further information in
57 order to gain a rounded understanding of the prospective adopters' circumstances. Without
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3 this, it appears that PLWHIV may feel and indeed be marginalised and prejudiced against, in
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5 that, lack of clarity increases concerns by PLWHIV that their chances to adopt are prevented
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7 by HIV itself, as suggested:

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10 *They did not give us the reason for refusing. They said, this has nothing to do with*
11 *HIV (laugh!). Obviously, it is. It is a concern that adoption consultancy does not share*
12 *a common ground; there is still a disparity from health professionals on what is a*
13 *healthy person [versus] an unhealthy person. You are relying on a consultant who is*
14 *going to support you. Our consultant knew the facts not the adoption consultant.*
15 *[Hillary HIV-female adopting with her HIV+ partner]*
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18 Hillary is clearly dissatisfied about the misunderstanding and disparities between health
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20 professionals and adoption social workers regarding what constitutes a healthy person living
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22 with HIV. Reductionism in the sense of over-simplifying the complexities between HIV and its
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24 impact on adoption appears connected with how decisions were separated from HIV even
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26 though HIV was connected or embodied to the PLWHIV seeking to adopt. Hillary's excerpt
27
28 suggests that PLWHIV may rely on medical expertise possessed by HIV consultants who
29
30 obtain medical facts that will be useful to other professionals, as they may contribute towards
31
32 decision-making.
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34 35 36 **Discussion**

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38 The findings in this paper demonstrate a lack of collaboration between those assessing
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40 PLWHIV through the adoption system with HIV experts. This has been reported in other
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42 studies (Hekkink *et al.*, 2005 and Wilson *et al.*, 2005) that suggest HIV expertise and quality
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44 of care are better provided by HIV experts than non-HIV clinical experts. Thus, there needs
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46 to be transparent processes around how HIV-related expert contributions are welcomed by
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48 social workers, including useful contributions by HIV charitable organisations. On the other
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50 hand, collaboration should be seen as a routine part of assessment to include experts rather
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52 than as an option. Specifically, those with expert knowledge about HIV, such as HIV
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54 consultants and HIV counsellors, must be consulted fully prior to any adoption decisions
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56 being made.
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5 Findings corroborate with Paiva et al. (2003) and Schofield and Ward (2011) highlighting that
6 reluctance in joint working results in feelings of powerlessness. Unsupportive systems, HIV
7 discrimination and stigma raise the potential that PLWHIV will be refused opportunities for
8 adoptive parenthood (Newmeyer *et al.*, 2011). It still remains uncertain about the extent to
9 which PLWHIV are fairly considered within the system, given the small sample in this study.
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11 Nevertheless, it is clear from participants in this study that good communication and
12 accurate representation of PLWHIV going through adoption is important. It is vital that social
13 workers do not lose sight of the long-term consequences that misrepresentation may have
14 on adoptive parents and their adopted children.
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25 Thus, this paper adds to the evidence base that supports the UK policy of cross-agency
26 partnerships to facilitate best practice (BHIVA, 2013). Working in isolation can leave any
27 potential adopter feeling that the adoption process is unfair. However, efforts to improve joint
28 working for PLWHIV are evident in healthcare settings (Tunnicliff *et al.*, 2013). It is
29 recognised that confidentiality around HIV positive adopters can make collaboration
30 challenging, given the sensitive nature of HIV, secrecy and stigma attached to the illness.
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37 One way to manage this would be to apply social work values and ethical practices and to
38 use social work approaches such as cultural competence, HIV-culturally-sensitive language
39 (that is non-offensive or non-derogatory), and relationship-based and strength-based
40 models. Being HIV inclusive in adoption social work would require drawing on the expertise
41 of those in the HIV voluntary sectors who are the main providers of support to PLWHIV.
42 Also, existing adoption procedures should include an additional section to elaborate the
43 need for joint working for PLWHIV potential adopters. This could include structures that
44 further facilitate censored and consensual information sharing within existing protocols. From
45 this, PLWHIV may be reassured about the transparency and consistency of decision-
46 making. Integrated adoption practices can increase knowledge and expertise through joint
47 learning and understanding of what it means to live healthily with HIV. This will help to
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3 reduce disparities around 'HIV today' and will lessen the repetition of preconceived
4 judgements linked to HIV.
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9 **Conclusion**

10 This paper identified gaps perceived by PLWHIV around interprofessional working in
11 adoption. There is a need to develop additional guidance about interprofessional working for
12 PLWHIV to develop social workers' core skills that call for collaborative working between
13 professionals, HIV experts and their contributions to the adoption process.
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21 The study suggests that without improved communication and interprofessional working
22 between adoption social workers and HIV consultants, it may lessen the chances of PLWHIV
23 being considered positively within the adoption. Hence, interprofessional working should
24 include coordinating with not just HIV consultants or support workers in HIV voluntary
25 sectors but also with other professionals, thus representing a holistic picture of those
26 PLWHIV when going through the adoption process. To conclude, HIV stigma and
27 discrimination cannot be seen in isolation. It is important for social workers to understand
28 PLWHIV as unique individuals by recognizing the importance of intersectionality and
29 structural and individual-level influences that create barriers for PLWHIV coming through the
30 adoption system. Decisions about whether PLWHIV are suitable to adopt should be based
31 on good partnership working and whether or not PLWHIV will be suitable to offer good
32 parenthood (see Diagram 1 for a visual framework explaining this depiction). Ultimately,
33 integrative partnership approaches to supporting PLWHIV seeking to adopt will bring the
34 health and social care worlds together to become more holistic, as opposed to taking a
35 reductionist approach.
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54 **Cautionary note:**

55 Establishing the views of social workers is a recommendation for future research. This paper
56 opens a dialogue for discussing issues around the adoption for PLWHIV and informing
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3 professionals about increasing opportunities for PLWHIV to adopt children where there is a
4 high demand for adoptive parents. The views of participants in this study need to be placed
5 within the body of knowledge.
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13 charitable organisations supporting PLWHIV who helped promote this study.
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20 **Declaration of interest**

21 There are no conflicts of interest. This paper is drawn from a doctoral thesis and some
22 concepts may be linked to other papers to be published in due course. The doctoral thesis
23 was subject to peer review by way of a supervisory support and internal and external
24 examinations. The author alone is responsible for this particular paper.
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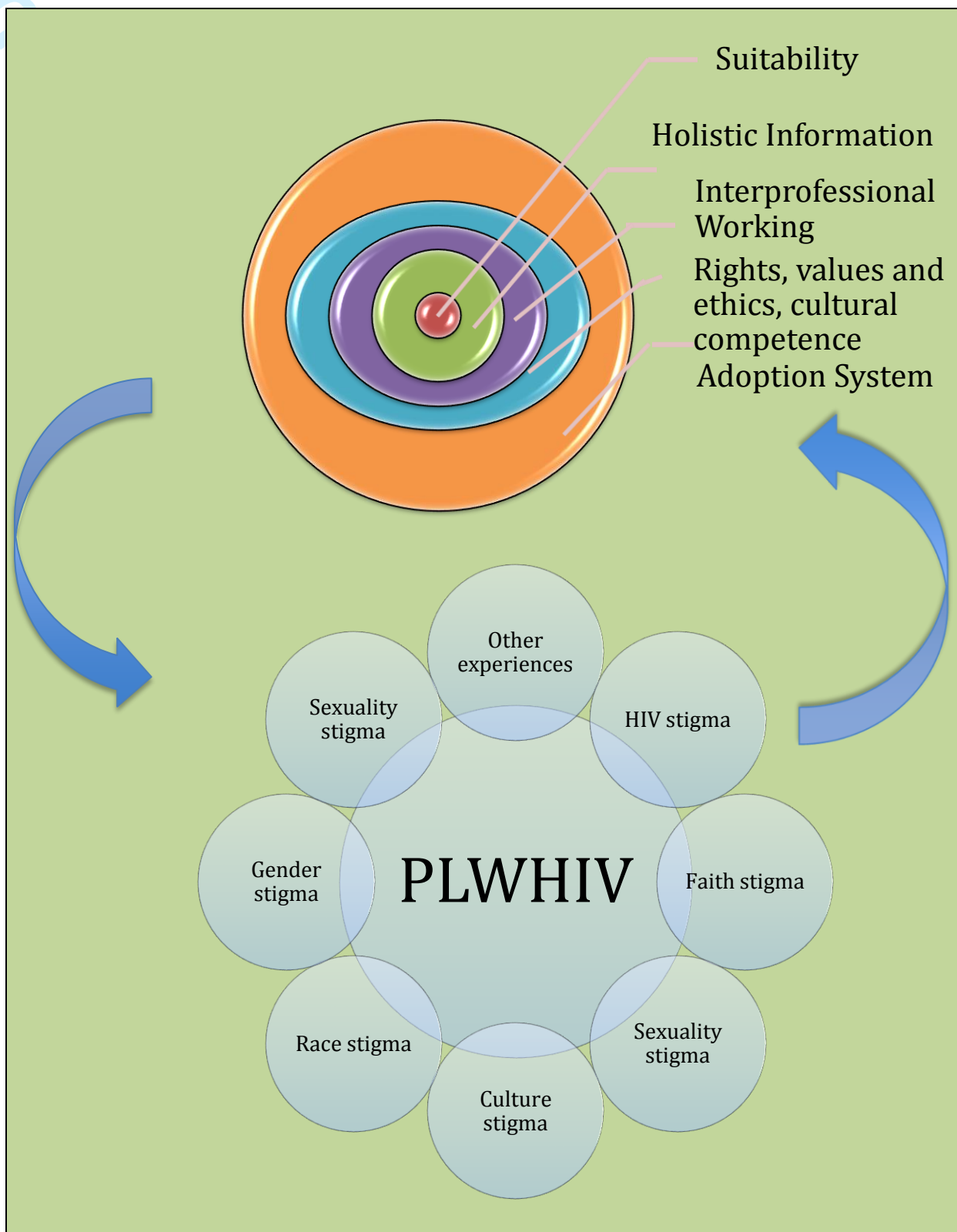
Table 1: Ethnic profile of original study sample

<u>Ethnicity</u>	<u>White</u>	<u>Black</u>	<u>Asian</u>	<u>Total</u>
Individual Prospective Adopters	3	3	1	7
Couple Prospective Adopters	3	1	0	4

Table 2: Summary of participants and outcome of parenting option sought

<u>Participant</u>	<u>Pseudonyms</u>	<u>Demographic</u>	<u>Option</u>	<u>Outcome</u>	<u>Included</u>
Interviewee 1	Gary (White)	Single homosexual man	Adoption only	Unsuccessful	Included
Interviewee 2	Hillary (White) Marius (White)	Heterosexual couple (male +)	Fertility treatment then adoption	Successful	Included
Interviewee 3	Alan (White)	Single homosexual man	Adoption only	Successful	Included
Interviewee 4	Jenny (White) Dean (White)	Heterosexual couple (male +)	Adoption only	Successful	Included
Interviewee 5	Angie (42 yr old Black African + White)	Heterosexual female	Fertility treatment	Unsuccessful	Excluded
Interviewee 6	Kelsea (Black African) Trev (Black African)	Heterosexual couple (male +)	Fertility treatment	Successful	Excluded
Interviewee 7	Malvern (Black African)	Heterosexual Male (both +)	Fertility treatment	Unsuccessful	Excluded
Interviewee 8	Rean (Black African)	Heterosexual male (female +)	Fertility treatment	Unsuccessful	Excluded
Interviewee 9	Leanne (Asian)	Heterosexual female (male +)	Fertility treatment	Unsuccessful	Excluded
Interviewee 10	Gabriella (White) Brad (White)	Heterosexual couple (both +)	Adoption only	Successful, international adoption.	Included
Interviewee 11	Trisha (Black African) 30yrs old	Heterosexual female (both +)	Fertility treatment	Successful	Excluded

Diagram 1: Visual framework for the intersectional stigmas associated with PLWHIV seeking adoption and how they interact with the process of assessing prospective adopters.



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