Intercountry adoption Implications for adoption agencies and medical advisers

Cherry Harnott and Rosemary Robertson describe their findings during the surveillance of 35 children from overseas who entered Hampshire for the purpose of adoption between 1990 and 1995. This article emphasises the importance of screening the health and development of these children given the high number of unsuspected medical problems found, many of which were significant. It also identifies a number of key issues for adoption agencies to consider when preparing and assessing applicants for intercountry adoption, and the importance of a multi-disciplinary approach in helping to support the adopters in their task of caring for the child.

Introduction
The purpose of this article is to set out health and developmental issues in relation to 35 children who entered Hampshire from overseas for adoption between 1990 and 1995. As soon as possible after entry into the UK each child was examined by the intercountry adoption medical adviser, and was followed up at appropriate intervals for the first year. The medical adviser wrote to each child’s General Practitioner (GP) to explain her role, to give all available information about the health of the child and the results of physical and developmental examinations, and to ask the GP to update immunisations and carry out appropriate screening tests.

The main source of information was from the medical adviser’s direct observations of the child and applicants, and reports from other health and education professionals, as well as information given by the applicants to the Commissioning Officer (Adoption) and social workers responsible for adoption welfare supervision.

All the children came from ‘non-designated’ countries, as a result of which the adoptive parents were required to make applications to adopt through the English courts on their return to the UK. This process usually took between nine months and three years, at the end of which adoption orders were granted in the UK in respect of all the children in this study.

Many of these children were placed for adoption at a time of social or political crisis, or armed conflict; conditions could not have been worse for placing a child in an adoptive family. There was no formal matching process in respect of 24 children (68 per cent); the selection of each child was in the hands of either an intermediary or the adoptive parents themselves.

Eighty per cent of the children were placed with adoptive parents in the absence of a period of introduction. Almost all the children involved had suffered from emotional and social deprivation, and had restricted experiences and opportunities to develop speech well in their first language. Given the difficulties experienced by these children in their own countries of origin, they were not as well equipped as their peers in the UK to meet the challenges to be faced both inside and outside the classroom.

Profile of the children
Thirty-five children (46 per cent male and 54 per cent female), aged between five weeks and 16 years, were examined over a five-year period from September 1990 to September 1995. Fifteen (43 per cent) of the children originated from Romania; four (11 per cent) from India; three (8.5 per cent) from Russia; three (8.5 per cent) from Paraguay; and, of the remaining 29 per cent, one each from Bangladesh, Brazil, Indonesia, Iran, Jamaica, Latvia, Mexico, Poland, Yugoslavia and Thailand. There was one placement of three siblings, two of two siblings, the remainder being single placements.
Seven of the children (20 per cent) were adopted by applicants who originated from the same country as the child; the remaining 28 (80 per cent) were adopted by applicants who were ethnically different and shared neither the culture nor the language of the children.

In the majority of cases the quality of information recorded was very poor in respect of ethnic origin, medical history and social history of birth families. There was rarely any information on the pregnancy or birth history, and no information on feeding apart from the occasional use of the word ‘artificial’. Immunisation records were not always available and were often incomplete. The date of birth was sometimes uncertain, and in two cases was invented for the purpose of the adoption.

Fourteen girls (40 per cent) and ten boys (29 per cent) were known to have had medical treatment in their countries of origin, for conditions which included respiratory infections, asthma, gastrointestinal infections, failure to thrive, anaemia, rickets, recurrent ear infections, meningitis, threadworms, measles, chicken pox and scabies. Four children (11 per cent) had had surgery including repair of a hernia, incision of an abscess, eye surgery and following a head injury. Accurate information on the length of hospitalisation is scanty, but at least three children (nine per cent) were in hospital for between nine and 11 months and were abandoned there.

In four cases (11 per cent) diagnoses were not reliable: one child with severe untreated hemiplegia was diagnosed in his country of origin as having a ‘problem with one leg’; another child with mild hemiplegia had been classified as ‘normal’ in the country of origin; a third child, who was diagnosed in the country of origin as having rickets, in fact has severe congenital bowing of the tibiae; in a fourth child, the diagnosis of cerebral palsy in the country of origin was not upheld after examination here.

These findings are similar to those of Hostetter et al (1989) and Jenista and Chapman (1987), emphasising the need for a thorough screening evaluation for medical problems which may adversely affect their health and development.

Table 1

<table>
<thead>
<tr>
<th>Age range</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 10 years</td>
<td>2</td>
</tr>
<tr>
<td>Between 5 and 10 years</td>
<td>7</td>
</tr>
<tr>
<td>Between 2 and 5 years</td>
<td>6</td>
</tr>
<tr>
<td>Between 6 months and 2 years</td>
<td>12</td>
</tr>
<tr>
<td>Under 6 months</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>n = 35</strong></td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Duration</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 5 years</td>
<td>4</td>
</tr>
<tr>
<td>Between 1 and 5 years</td>
<td>12</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>n = 32</strong></td>
</tr>
</tbody>
</table>

Early care

Three children (nine per cent) went straight from the care of their birth mothers to their adoptive mothers. The remaining 32 (91 per cent) experienced some form of substitute care, the most common form of which was an institution, affecting 23 children (66 per cent).

Adoptive parents reported that children who had come from ‘orphanages’ had been kept in cots with no toys, stimulation or individual attention. They were described as suffering severe deprivation of food, warmth, clothing, hygiene, physical care and individual attention.

Medical information from countries of former residence

Intercountry adoption medical forms were only available for 22 children (63 per cent). In the majority of cases the quality of information recorded was very poor in respect of ethnic origin, medical history and social history of birth families. There was rarely any information on the pregnancy or birth history, and no information on feeding apart from the occasional use of the word ‘artificial’. Immunisation records were not always available and were often incomplete. The date of birth was sometimes uncertain, and in two cases was invented for the purpose of the adoption.

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These findings are similar to those of Hostetter et al (1989) and Jenista and Chapman (1987), emphasising the need for a thorough screening evaluation for medical problems which may adversely affect their health and development. Johnson et al (1992) concluded that Romanian adoptees were an extraordinarily high-risk paediatric group, having found that only ten per cent of children over 12 months were developmentally normal.
Four children were admitted to hospital, three of them for surgery, shortly after arrival in the UK. This was very traumatic for the children involved, who had to cope with a new country and language, as well as the results of their ill health. The sense of isolation and abandonment for those hospitalised was intensified, and was another major hurdle for them to face.

**Recording of medical information in the UK**

**Growth centiles**

All children had their weight and head circumference recorded by the same person, in order to maintain a consistent approach. Twenty-three per cent of the children were well grown on entry to the UK, height and weight being on the 75th centile or above. Six children (17 per cent) were particularly small on entry, with height and weight being less than third centile. One child was referred to a consultant paediatrician for failure to thrive. The remaining 60 per cent had their weight recorded as between third and 50th centile, and height, where recorded, as between tenth and 50th centile.

Most children improved in height and weight as would be expected, given better nutrition and an improvement in their general health (Winick et al, 1975; Colombo et al, 1992; Miller et al, 1995).

**Screening tests**

Screening tests carried out in the UK yielded abnormal results in respect of three children (8.57 per cent): one was hepatitis B+ve, one was a salmonella carrier and one had an abnormal haemoglobinopathy trait. These results, although small in number, are significant for the children’s long-term health and well-being.

**Immunisations**

No records existed for six children (17 per cent), and another six (17 per cent) had not been fully immunised. Twenty-two children (63 per cent) had received triple and polio; 21 children (60 per cent) had received BCG and two children (6 per cent) had received Hepatitis B. All children had their immunisation schedule checked and updated.

**Referrals to health professionals**

Thirty-one children (89 per cent) were referred to health professionals; 51 per cent required follow-up, 26 per cent in the short to medium term and 26 per cent in the long term.

**Attachment**

From the medical advisers’ observations during examination of the children, it was evident that six of the children (17 per cent) who had been placed with their adoptive parents before the age of six months were well attached to the adoptive parents by the time of the court hearing. Over the period of surveillance the remaining 29 children (83 per cent), who experienced difficulty attaching to their adoptive parents, interacted more effectively with them.

It was reported by the adoptive parents that, once settled into the family, several children tended to resent the intrusion of strangers, and it took a long time for them to accept other relatives such as grandparents.

Adoptive parents found it particularly challenging to manage children who would not accept emotional warmth, or rejected efforts to comfort them when distressed, especially during the early months of the placement.

**Behaviour difficulties**

Six children (17 per cent), who had been placed with their adoptive parents before

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**Table 3**

<table>
<thead>
<tr>
<th>Health problems experienced by the children</th>
<th>n = 35</th>
</tr>
</thead>
<tbody>
<tr>
<td>No health problems in country of origin or in the UK</td>
<td>7</td>
</tr>
<tr>
<td>Some health problems not requiring treatment in UK</td>
<td>3</td>
</tr>
<tr>
<td>Significant health problems in country of origin requiring treatment in the UK: for example, asthma, cleft palate, anaemia hepatitis, fits and failure to thrive</td>
<td>10</td>
</tr>
<tr>
<td>Significant health problems diagnosed by the agency medical adviser, of which the adopters were unaware: heart murmur, mild hemiplegia, chest and skin infections, conductive hearing loss and glandular hypospadius</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>n = 35</strong></td>
</tr>
</tbody>
</table>
the age of six months, showed no
behaviour problems at the first medical.
All the other children showed behaviour
problems of varying nature and degree
which altered over time, but generally
improved over the period of surveillance.
Many children displayed unusual
repetitive behaviours and body
movements which the adoptive parents
reported as being characteristic of
children living in the orphanages from
which they originated.

The majority of children had trouble
coping with the changes in sleeping,
bathing and eating arrangements. Some
children were distressed at having a
bedroom where they were expected to
sleep on their own, some were very
frightened of water and disliked bathing,
and others would hide and eat voraci-
ously, especially unfamiliar foods.

Similar findings were identified by
Hostetter and Johnson (1989), Saetersdal
and Dalen (1991) and Triseliotis et al
(1997).

Common difficulties were aggressive-
ness to adults and children, including
family members, destructiveness of their
own belongings and those of others,
hyperactivity, no sense of danger, and
attention-seeking behaviour which was
deeply annoying to other children and
adults alike.

Development
Developmental assessment of these
children proved to be problematic as it
was not possible to use standardised
developmental tests because of language
problems, poor concentration, behaviour
difficulties, and a high level of distracti-
bility due to a marked fascination with
toys and equipment in the clinic
surroundings. Their development was
screened using the Stycar sequences
(Sheridan, 1973) and Developmental
Screening (Egan et al, 1969). School
reports were obtained in respect of older
children.

Speech and language
Thirty-three children (94 per cent) were
learning English as a second language,
and two children (six per cent) as a third
language.

Adoptive parents reported that many of
these children soon learned to speak
English. However, on closer observation
much of the speech and language was
composed of learned sentences and
delayed echolalia, and it was apparent
that their comprehension was limited.
This point was also emphasised by
Saetersdal and Dalen (1991) who state
that:

... even though the children had a good
command of the spoken language, they
still lacked a deeper understanding of
many everyday words and expressions.
(p 95)

With regard to language development,
adoptive parents reported that many of
these children tended to plateau about
nine months after entry into the UK.

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Table 4
Referrals to health professionals

<table>
<thead>
<tr>
<th>Type of referral</th>
<th>No. of children</th>
<th>Reason for referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>25</td>
<td>Screening and treatment of caries</td>
</tr>
<tr>
<td>Consultant paediatrician</td>
<td>14</td>
<td>Failure to thrive, anaemia, asthma, fits, heart murmur and cerebral palsy</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>10</td>
<td>Assessment of speech and language</td>
</tr>
<tr>
<td>Ophthalmic surgeon</td>
<td>8</td>
<td>Squint, hemiplegia, ptosis, amblyopia</td>
</tr>
<tr>
<td>Audiologist</td>
<td>8</td>
<td>Failed hearing screen</td>
</tr>
<tr>
<td>Orthopaedic surgeon</td>
<td>4</td>
<td>Congenital bowing of tibiae, untreated hemiplegia and deformity of toes</td>
</tr>
<tr>
<td>Paediatric surgeon</td>
<td>3</td>
<td>Hypospadius</td>
</tr>
<tr>
<td>ENT surgeon</td>
<td>3</td>
<td>Conductive hearing loss</td>
</tr>
<tr>
<td>Health visitor</td>
<td>3</td>
<td>Behaviour management and routine screening</td>
</tr>
<tr>
<td>Plastic surgeon</td>
<td>2</td>
<td>Untreated cleft palate and ptosis</td>
</tr>
<tr>
<td>Paediatric cardiologist</td>
<td>2</td>
<td>Heart murmur</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>2</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>Adult physician</td>
<td>1</td>
<td>Hepatitis B+ve</td>
</tr>
<tr>
<td>Consultant dermatologist</td>
<td>1</td>
<td>Mastcell naevi</td>
</tr>
</tbody>
</table>

Total number of children referred to health professionals = 31
Fourteen children (40 per cent) showed some gross motor delay, largely thought to be due to the restrictions imposed on them in the institutions from which they came. Sixteen children (46 per cent) showed fine motor delay. These children improved over the period of surveillance, although fine motor development took longer to improve in older children. Two children had cerebral palsy.

Education

Eleven children (31 per cent) were of or just under school age on entry into the UK. Of these, nine children aged five to 13 years attended mainstream schools, and two children aged five and 15 years attended independent schools. Half of the remaining children attended pre-school groups.

Two children (six per cent) had a Statement of Special Educational Needs; this compares with 2.87 per cent of children between two and 16 years of age resident in Hampshire. Fifty-five per cent of the children in mainstream education were having special provision in accordance with the Special Education Provision Code of Practice. A similarly high number of children receiving special education provision was found by Saetersdal and Dalen (1991).

Adoptive parents reported that the children were very happy to go to school since, having come from institutions, they were accustomed to being with large numbers of children. Teachers consistently reported that typical difficulties experienced by these children inside school were low concentration, poor social skills, inability to operate as part of a group, inability to take turns, an overwhelming desire to be first, being excessively noisy, a lack of respect for other children’s belongings, having no sense of danger, few boundaries and a lack of trust in adults. Despite these problems, the adopted children were popular with other children and were accepted by their local communities. Kaler and Freeman (1994), in their study of children living in an orphanage in Timisoara, found that ‘the children’s greatest strengths were in their peer interaction’ (p 777).

When small Hampshire rural schools were approached about accepting a child, the head teachers were particularly enthusiastic about helping the children, but the school staff were unprepared for the extent of the difficulties they would face. This led in some cases to an over-optimistic belief of what could be achieved by the school staff, and over time a more realistic approach became necessary. This issue is also raised by Saetersdal and Dalen (1991) who found that:

> To begin with everyone was taken in by the rapid language learning of these children. Both parents and teachers were blinded by the facade of language . . . in everyday situations. (p 93)

Children in mainstream education in Hampshire received considerable assistance from the Bilingual Learners Support Service, a facility not available to the two children in independent education.

In order to maximise the effectiveness of agencies involved in the provision of services for the children with special needs, a network meeting was routinely arranged, shortly after the child’s arrival in Hampshire. This included the GP, agency medical adviser, head teacher, social work manager, adoption adviser and any other relevant therapeutic support staff.

Ethnicity and cultural heritage

It must be acknowledged that precise information about the ethnic origins of
the birth mothers of these children was rarely available while, in most cases, no information at all was known about the background of the birth fathers. Nevertheless, the majority of applicants in this study shared neither the culture nor the language of origin of the children. This reinforced the need for the adoptive parents to develop a deep understanding of the social, political and cultural context in which the intercountry adoption was to take place.

It was equally important for the applicants to develop links with other adopted children and adults from the same country living in the UK. The issues of identity and discrimination were placed high on the agenda of preparation and training programmes. Due emphasis was also placed on the need for applicants to develop and maintain strong links with communities and networks which reflected the child’s culture, language, religion and ethnicity.

Several applicants retained an abiding commitment to participating in humanitarian aid programmes aimed at helping to improve the lives of children in residential institutions overseas. Many have maintained close links with the child’s country of origin, some have learned to speak her or his first language and several have already taken the child back to visit the country concerned.

In terms of placement breakdown, to date none of these placements has disrupted, as far as we are aware.

**General conclusions: children**

- There were no differences apparent between male and female children in terms of health or development, or in relation to specific countries of origin. The most significant factors affecting outcome were the type and duration of early care, their general health care and nutrition, and the age of the child on placement. Similar findings are reported by Carstens and Juliá (1995) who concluded that the child’s age on placement was the most significant factor affecting outcomes. Rutter et al (1998) concluded that the strongest predictor of level of cognitive functioning at four years was the children’s age at entry into the UK.

- There was a general lack of medical and social information about these children, many of whom had health problems undiagnosed or untreated in their countries of origin and of which the prospective adoptive parents were unaware.

- Most children’s general health improved over time, as would be expected with better nutrition and access to health facilities.

- Although most children learned to speak English fairly easily, it was apparent that many had limited comprehension. Children from overseas are greatly advantaged by adoptive parents who familiarise themselves with the child’s first language.

- The majority of children experienced difficulties in attaching to their adoptive families and needed frequent and sustained stimulation in order to assist the bonding process. Given the lack of attachment evident in some children, even after several months in the UK, it is apparent that adoptive parents need to be available to invest time in this process, especially for the first year after placement, if a reciprocal emotional bond is to be established with the child.

- It is essential that all children entering the UK from overseas (whether or not they originate from a ‘designated’ country) receive medical surveillance so that they can receive appropriate help. The agency adoption medical adviser can play a significant part in this process and is well placed to report to the adoption court on the child’s progress. Jenista and Chapman (1997) emphasise the need to develop a simple protocol to screen foreign-born children, ‘allowing rapid identification of treatable problems at the least cost and inconvenience to the family’ (p 298).

- Admissions to hospital of these children soon after their arrival into the UK should be delayed until such times as they are settled and secure in placement, unless their condition is life threatening.

- Education authorities need to be informed as early as possible of the entry
of children into the UK for the purpose of adoption so that plans can be made to try to meet their needs. A multi-disciplinary meeting should be held as soon as possible in respect of all children of school age with special education/health needs, to co-ordinate the services involved and to support the adopters in their task of caring for the child.

Profile of the adoptive parents
The source of information about adoptive parents was obtained from home study reports, information given direct to the medical adviser and the commissioning officer (adoption).

There were 62 applicants associated with the 35 children concerned in this study. The age of applicants, all of whom were married, ranged from 32 to 61 years. One couple had previously applied to adopt. Twenty-three per cent of the applicants adopted children from their own countries of origin, and 26 per cent had previous parenting experience.

Thirteen per cent of the applicants were black, as were 37 per cent of the children, therefore the majority of applicants were seeking to adopt an ethnically different child, who shared neither their culture nor their language. Thirty-one per cent of the applicants had lived or worked in the child’s country of origin and had a positive regard for the culture, people and communities involved. Many adopters made efforts to learn some of the child’s first language.

Most applicants were motivated by a mixture of infertility and altruism, prompted by watching television programmes on children in residential institutions for whom there was little prospect of experiencing family life. Several applicants met a particular child with whom they felt a special bond while they were participating in humanitarian aid programmes overseas, and subsequently sought to adopt the child concerned.

There were only two examples of extended introductions. Eleven per cent of the children were not adopted in their own countries of origin, and 34 per cent were brought into the UK without advanced entry clearance.

For the majority of applicants, the responsibility for collecting background information about the child was entirely in their own hands – a task which was undertaken with enthusiasm. Some applicants went to extraordinary lengths, at considerable risk to themselves, by travelling to remote villages in their quest for information about the child’s background.

All the adoptive parents reported that they experienced the very high stress levels associated with intercountry adoption, and most stated that they felt a sense of isolation and intense frustration with the bureaucratic processes, especially in the child’s country of origin. These feelings were intensified in those applicants who were not familiar with the local language.

Those applicants who had achieved close links with the child’s country of origin prior to the adoption were much better placed than their counterparts in preparing the ground for the adoption process. This also provided a better foundation upon which to build for the child a sympathetic understanding of the circumstances which led to the adoption, and made it more likely that established links would be sustained over time.

It was of critical importance to the new parents that there was a reciprocal emotional bond with the child. Where there was no evidence of reciprocity, the children’s behaviour tended to extremes. Nevertheless, most adoptive parents reported a high level of satisfaction with their children, and were neither upset nor embarrassed by behaviours which would usually be considered as unacceptable to many parents in the UK. The motivation of these adoptive parents remained undiminished and was a very powerful force in sustaining them in their challenging role. Groothues et al (1998/99), in their study of outcomes from adoptions from Romania, found similarly high levels of parental satisfaction. It was interesting to note that 29 per cent of the applicants had either adopted a second child from overseas, or were subsequently approved by this adoption agency to do so.
Implications for adoption agencies

There can be no substitute for the thorough preparation of applicants to ensure that they are equal to the life-long responsibilities they seek to take on through intercountry adoption. Adoptive applicants need the fullest possible information, from the first enquiry made, right through the intercountry adoption process.

In preparation and training programmes, adoption agencies need to ensure that intercountry adoption applicants have a clear understanding of the following:

- the lack of information likely to be available in respect of the birth family, including the history of the pregnancy, the birth history, the child’s health and development, immunisation history and medical treatment given in her or his country of origin;
- the potential risks of the unknown, especially medical risks, and the fact that some medical problems may be neither diagnosed nor treated until after the child enters the UK;
- the effects of institutionalisation and/or severe deprivation on children and how this may impact on their capacity to form close emotional relationships;
- the difficulties likely to be experienced by children in bonding with adoptive parents;
- the need to be conversant with techniques for promoting attachment, especially eye-to-eye contact, to enable children to develop an awareness of social communication and cues;
- an understanding of the types of behaviours that children are likely to exhibit and how to manage them;
- the importance of gradually getting to know the child before placement;
- the importance of maintaining realistic expectations of what children can achieve, especially during the early stages of placement;
- the health and education support services which exist in their area and how to access them;
- the process of children learning a second language in association with all the life changes to which they must adapt;
- the relevance of attempting to learn some of the child’s first language and of making contacts with people in their own locality who are able to speak that language;
- discrimination likely to be encountered as the child grows up and techniques for dealing with this sensitively;
- the adoption task in general, as well as the stresses and complexities related to intercountry adoption in particular.

Conclusions

An intercountry adoption service with effective arrangements for the medical surveillance of these children can be set up at minimal cost to adoption agencies once the ground has been prepared.

It is helpful for the agency medical adviser to be involved in the early stages of applicants’ preparation and training so that applicants develop an understanding of the medical adviser’s role throughout the intercountry adoption process.

Applicants need to be supported in their task of caring for the child by a variety of professionals who understand the difficulties faced by these children, in addition to the families’ own kinship and social support systems.

Adoption agencies have an important role to play in helping GPs to understand the issues involved in intercountry adoption. Without it they are unlikely to be able to secure the co-operation and commitment of GPs to carrying out the intercountry adoption screening battery required, or their support to individual families and children. The role of the health visitor is also important in the provision of support services to adoptive families, especially during the early stages of placement.

Education authorities need to be informed as early as possible of the entry into the UK of all children from overseas with special health and education needs.

A multi-disciplinary meeting should be
held very soon so that plans can be made to meet the child’s needs, and to support the adopters in their task of caring for the child.

In preparing applicants for inter-country adoption, agencies will also need to focus on specific areas in addition to those relevant to domestic adoption – in particular, health, development, education and attachment issues should be highlighted for these children. There may also be an increased need for post-placement and post-adoption support; it is essential, therefore, that applicants are aware of support programmes available so they can make an informed choice about participation.

In summary, the crucial principle in intercountry adoption is thorough and specific preparation, both in terms of the applicants seeking to adopt a child from overseas, and of the agencies setting up co-operative systems with health and education colleagues which will help to ensure that the experience is rewarding and successful for all those involved. Most important of all, it will help to ensure that the children concerned grow up in an environment which promotes their physical and emotional health and development.

References


