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The quality of medical information given to prospective intercountry adopters in England

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Abstract

Poor quality medical information adds to the risks associated with intercountry adoption. Other receiving countries acknowledge this more readily than the UK. All have to tackle the problems posed by inadequate reports and most insist on further assessment of the child on arrival. This article comprises a retrospective review of 120 medical reports from 23 countries written about children matched with adopters from IAC-the Centre for Adoption (registered as the Intercountry Adoption Centre) between April 2010 and November 2014. The quality and quantity of medical information varied widely but was generally inadequate. Most reports consisted of an isolated, single physical examination. There was incomplete screening for important medical conditions, inadequate medical histories and virtually no assessment of development. The reports for special needs children and adolescents were particularly concerning. In almost all cases, there was a lack of the essential information needed by adopters in order to make an informed decision about the suitability of the match.

All intercountry adopted children, regardless of their country of origin, need the involvement of an experienced medical adviser in the matching process and should have a comprehensive paediatric health assessment after placement. This should be carried out on the NHS and be free to parents, as it is in Northern Ireland. The number of children concerned is small but their needs are important, particularly as they are disadvantaged compared to domestic adoptees.

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Introduction

Intercountry adopters in the UK undergo the same assessment and approval process as those engaged in domestic adoption (Department for Education, 2013). After approval, a Hague Article 5 Certificate of Eligibility is issued by the central authorities and the prospective adopters' names are placed on a waiting list in the state of origin. However, the matching process is very different. Unless it is a kinship arrangement or a placement through a special programme run by IAC-the Centre for Adoption (henceforth referred to as IAC), it is usual for the child to be initially identified by overseas establishments without the involvement of either the adopters or the adoption agency.

In 2003, the UK signed the Hague Convention Protection of Children and Co-operation in Respect of Intercountry Adoption (HCCH, 1993a) and it is one of 97 countries that have ratified or acceded to it. There are differences between matches from Convention countries and those outside. The guidance Adoptions with a Foreign Element Regulations (Department for Education and Skills, 2005; Scottish Government, 2009) also governs how matches from overseas should be managed.

In Convention countries, the central authority or accredited overseas agency identifies the child to be matched. An Article 16 report, which includes medical and social information, is then sent to the relevant central authority in the UK and to the UK adoption agency which approved the applicants. The Convention states that these reports should include information about the child's identity, adoptability, background, family history, medical history (including the birth family) and special needs.

In non-Convention cases, matching information may be sent directly to either the agency or the prospective adopters, after which the relevant central authority is informed. In both cases, an agency matching meeting should take place within 10 working days of the information being received.

Method

Adoptions covered by the Foreign Element Regulations do not require ascertaining the view of a medical adviser on the health information received from overseas. However, the Adoption Statutory Guidance (Department for Education, 2013) is also relevant to intercountry adoption and clearly states that this should occur. The majority of adoption agencies will try to provide the prospective adopters with a doctor's opinion on the child's medical needs and ensure that this information forms a key part of the matching meeting.

In 2014, IAC assessed and approved intercountry adopters from 29 local authorities in London and the south of England and currently oversees about 85% of all UK intercountry adoptions. At the Centre, it is standard practice for all the medical information received from abroad to be sent to the agency's medical adviser who prepares a report. This informs adopters about the implications of the medical information received and highlights areas where important facts are missing or incomplete. The matching meeting is only held after the report has been shared with the adopters and their questions answered. The task of completing this within 10 working days is challenging but was met in every case studied.

Between April 2010 and November 2014, 120 medical reports received from abroad at the time of the proposed match were reviewed retrospectively. They all concerned children matched with adopters from IAC. The following analysis is divided into two sections: (1) the characteristics of the children and (2) the information in the medical reports. Brief references will be made to UK domestic adoption practice for comparison.

Characteristics of the children

Country of origin

In the early days of the study, the majority of the children came from Russia but this stopped in July 2013 when the UK Parliament legalised same-sex marriage. There followed a marked shift to Ethiopia. The countries of origin and the numbers of children involved are shown in Table 1. At the time of matching, there were 37 children from Convention countries, marked with a 'C'.

The reasons for choosing the country of origin varied. For example, 34 of the 120 applications were for children already identified by prospective adopters and who had a pre-existing relationship with the child. These adopters had often started the process of securing permanence overseas before realising that to comply with UK legislation they had to undergo an assessment of suitability before the child could be brought to the UK. The adopters fell into three groups:

(1) Fourteen applications sought to adopt children related to them, usually members of their extended family. These often featured a precipitating family crisis, such as frail elderly carers or seriously ill birth parents, and the adoption was undertaken with the permission and co-operation of the birth family.
(2) Eighteen concerned a child being adopted by families returning to their countries of heritage, mainly India and Pakistan. The adopters were of the same race and religion as their identified child.

Table 1. Countries of origin.

Russia		29	USA	C	1
Ethiopia		20	Canada	C	1
Pakistan		12	Algeria		1
India	C	12	Morocco		1
China	C	11	Cameroon		1
Nigeria		9	Serbia		1
Philippines	C	4	Guyana		1
Jamaica		3	Mali	C	1
Ghana		3	St Lucia		1
Thailand	C	2	Sri Lanka	C	1
Turkey	C	2	Tanzania		1
Macedonia	C	2	Total		120

(3) Two children were adopted transracially by adopters who had already identified the child during previous visits to the country.

Previous knowledge of the child did not mean that the medical information provided was of a higher quality. However, these adopters were generally less anxious about this as they already knew the child and the social demographics of the country. Within this group, only one family withdrew because of the complexity of the child's health needs.

The 86 remaining children were non-identified in the sense of being unknown to the adopters. Twenty-five of them were being adopted by adults from the same country of origin while 61 were transracial or transcultural placements. In this group, six families withdrew as a result of the medical information provided to the matching meeting, five of whom had been planning to adopt children matched through the China Special Needs programme.

Age and gender

Of the 120 children studied, 78 (65%) were girls and 42 (35 %) boys. The ages of the children at the time of the reports are shown in Table 2.

Five cases involved siblings being adopted together, including three sets of twins. There was one pair of related siblings and one pair of unrelated social siblings, i.e. two children living in the same orphanage being adopted by the same family.

Date of birth

A child's identity starts with knowledge of his or her family name, given name, date of birth, gender and nationality. By registering a child's birth, the state officially recognises the existence of the child and formalises his or her status in the eyes of the law. Without it, a child may be unable to receive health care, education, employment, voting rights or a passport. Worldwide, 230 million children under five years old have not had their births registered; 59% of these live in Asia and 37% in sub-Saharan Africa (Unicef, 2013).

Many children in the cohort did not have an accurate date of birth. There were nine abandoned babies under the age of one month with some only days old – most of them from Pakistan. Their abandonment was stated in the information supplied and the children had been given an estimated date of birth based on the day on which they had been found.

Table 2. Age of children at the time of the reports.

Age range	*No.*
Under one month	8
1–6 months	14
7–12 months	24
13–24 months	34
25–60 months	22
5–11 years	6
Over 11 years	6
Age not given	6
Total	120

The more concerning group comprised the 23 children, aged one to 12 months and usually living in orphanages, who had estimated ages and no accurate birth dates. Of these, 17 were from Ethiopia, three from India, two from Pakistan and one from Nigeria.

The absence of an accurate date of birth limits medical advice because, without it, weight measurements and developmental milestones cannot be accurately assessed. For instance, a single weight measurement of 2.5 kg in a baby without a recorded date of birth can represent a variety of situations: full-term small normal infant, an infant with intrauterine growth retardation, a premature infant with a normal weight for gestation or a malnourished infant aged three months.

Fifteen children aged one to six years had an estimated age. The oldest was a special needs Chinese girl estimated to be 5 years and 9 months. She had been abandoned at about the age of one year and had been in an institution ever since. One abandoned child had had his age estimated as three years by the police and another was estimated to be three months old by the examining doctor but older – seven to eight months – by the orphanage. One child had two medical forms with different dates of birth. The birth date was not entered on the forms of 10 children.

The ages of two children were estimated by x-ray but radiological bone age measures skeletal maturity rather than chronological age. There are wide discrepancies in this type of assessment because bone age is affected by ethnicity, socio-economic factors and nutrition. Paediatricians across Europe are agreed that dental and skeletal maturity can only assess age within a margin of two to three years (Council of Europe Commissioner for Human Rights, 2011; Royal College of Paediatrics and Child Health, 2007; Smith and Brownlees, 2011).

Analysis of the medical information

The medical forms

It is accepted in the UK that using a standardised form to capture the health information of a child coming into care improves the quality of the information and promotes consistency of practice. Currently there are two recommended forms for intercountry use.

Form ICA. This was produced in 2004, with minor revisions in 2012, by the British Association for Adoption and Fostering (BAAF) which, in 2015, became the CoramBAAF Adoption and Fostering Academy. It is recommended for use in the UK but is not available online and must be purchased from CoramBAAF. It was the only form used for non-Convention countries and was sent by IAC for completion by a doctor in the state of origin. Of the 120 reports reviewed, 85 were completed using this form and of these, 36 had supplementary reports attached.

The form covers most of the important areas related to health but does not encourage the collection of detailed information. Many questions elicited single word answers, usually ‘normal’. Other unhelpful examples included:

- immunisations: ‘on progress’
- development: ‘not walking as expected’
- vision: ‘blinks to clapping’
- birth history: ‘extreme prematurity, birth weight 850 grams with no other details.

Hague medical forms. These are recommended for use by Convention countries and are free and easy to access via the Hague website (HCCH, 1993b). They have more detailed medical questions and include social areas that can help with the interpretation of medical information. An annex sheet contains a checklist of developmental milestones that allow for a more accurate picture of a child's progress. However, neither form is completely comprehensive. Both are more appropriate for young children and inadequate for those of school age, young people with special needs or for older adolescents.

No Hague forms were used by any of the countries in this study. Personal communication with colleagues in Sweden, Finland, France, Germany, Austria and Spain confirmed that they are not in general use in Europe. Elsewhere, India's new guidelines (Central Adoption Resource Authority, 2015) require that medical information be provided on the Hague form, whichever receiving state is involved, and China's current documentation form is very similar.

The remaining 35 reports in the study were ad hoc medical summaries which did not use a standard form.

Qualification of examining doctor

Less than one-quarter (28) of the forms were completed by a paediatrician identified either by qualifications or job title. In 90/120 reports, the qualifications and experience of the examining doctor were unclear.

Family history

The majority (93/120) of reports contained no information about the child's extended family. The remaining 27 gave minimal detail, e.g. 'mother 22, second child', 'mother died in childbirth', 'mother mental retardation'. Only four reports included details about the child's father and siblings were not mentioned, even when comments like 'third pregnancy' or 'fifth child' indicated that they clearly existed. One adopter found that her child's younger brother was living in the same orphanage through a chance remark made by a staff member.

All adopted children need information about their family's medical history and, without this, are seriously disadvantaged. Most adopters expressed concerns about the probability of inherited mental health problems and learning disability in their child; without any knowledge of the birth family reassurance is impossible. Although very few genetic conditions have significant morbidity in childhood, many common ones, such as dementia, high cholesterol, heart disease, diabetes, stroke, hypertension, depression and some cancers, have a familial genetic risk. Knowing this allows an individual to modify other factors, especially smoking and obesity, and can encourage early screening.

Pregnancy, delivery and neonatal progress

Globally, many women receive an inadequate level of antenatal care. Although the World Health Organization (WHO) recommends a minimum of four antenatal visits, between 2007 and 2014 only 64% of pregnant women received even this minimum (WHO, 2016).

In 93/120 reports, there was no information about the pregnancy or antenatal progress; 74/120 contained no details about the delivery; 71/120 had no recorded birth weight; and 91/120 had nothing about the neonatal period. This lack of information is understandable when a child has been abandoned but in other reports the reasons were uncertain. Comments like 'antibiotics for syphilis in pregnancy', 'mother HIV positive: given antibiotics', 'parents students: baby voluntarily relinquished', 'given iron drops', 'mild rickets' suggested that more information was available but not passed on. Assessing the significance of these brief statements and suggesting further testing, either abroad or in the UK, posed challenges for the agency, its medical advisers and the adopters.

Over the last 40 years, it has been conclusively established that exposure to alcohol before birth is the most important preventable cause of brain damage in children. The effects range from devastating physical and learning disabilities to subtle damage causing impulsive behaviour, violence and criminality. The vast majority (over 85%) of children damaged from prenatal alcohol exposure have no physical birth defects (Mather, 2015). Despite this knowledge, exposure to alcohol and drugs in pregnancy was largely ignored in the reports scrutinised. Out of the 29 children being adopted from Russia, who are at high risk of prenatal alcohol exposure, only one report mentioned 'mild FAS features'.

Immunisations

Infectious diseases cause death, serious illness and disability, and immunisation prevents an estimated two to three million deaths annually. Globally, childhood immunisation programmes have improved but schedules in developing countries are still impaired by limited resources, competing health priorities and inadequate monitoring. In 2014, 86% (115 million) of infants worldwide received three doses of diphtheria, tetanus and pertussis vaccine and 129 countries had at least 90% coverage. However, an estimated 18.7 million infants are still not reached with routine immunisation (WHO, 2015).

Only 40/120 of the cohort children appeared to be fully immunised for their age and in another 40 cases there was a complete absence of immunisation data. For a further 21 children the data was incomplete and for 16 more, immunisation was said to have been given but without any details of what for and when.

Childhood immunisation schedules vary across the world. Current government guidance (Department of Health, 2014, 2015) specifies that if a child's record has no or incomplete immunisation data, it should be assumed that they have not been immunised and a full course of the UK recommended schedule should be given as soon as possible. All the adopters were concerned about this recommendation and needed considerable reassurance that repeat immunisations were safe. Intercountry adopted children also miss several important vaccines routinely given to British children. No child in the study had been given protection against haemophilus influenza B, rotavirus, meningitis B, meningitis C, pneumococcus or influenza.

Medical examination

The majority of the 120 children were reported to have 'normal' physical examinations. This statement was based on a single examination by a doctor examining the child for the first time, with no access to previous medical history or social information. Additional comments about the child's physical status were made in 30 cases but there was frustratingly little information about severity, investigations, treatment and follow-up. Brief entries, such as 'heart murmur', 'treated for scabies with residual rash', 'motor delay', 'legs tight', 'deformity left arm due to accident', 'dwarfism' and 'failing to thrive' were worrying for adopters and challenging for IAC medical advisers. The onus was invariably on the adopters to obtain more information when they travelled overseas.

The examinations were also several months out of date in a number of cases, even for children known to have significant medical conditions. Examinations from some countries had to be translated, carrying a risk of misinterpretation. Unusual medical terms like ‘mixed specific changes of psychological development’ and ‘hyper-excitability syndrome’ were difficult to interpret and often did not appear to relate to the later developmental description of the child.

After meeting the child, some adopters emailed photographs or medical queries that were then dealt with by professionals who had never seen the child. Others commissioned expensive independent medical examinations. In one case, an adopter spent a thousand US dollars on a private assessment during which a doctor spoke only in English to a Russian-speaking toddler who understandably could not carry out any of his instructions.

Regular vision and hearing are essential for normal child development. In the UK, all children are examined at birth for congenital eye defects and have a hearing test within days. Routine hearing and vision screening is then repeated at regular intervals throughout childhood. Again, the majority (103/120) of the children in the study did not appear to have had either tested. In only nine cases were comments made about vision, with one child described as ‘very myopic’ (short-sighted). Similarly, only nine children had had some form of hearing assessment. Institutionalised children often have recurrent, untreated, upper respiratory tract infections that damage the middle ear and impair hearing, and it is important not to miss any hearing loss that might be contributing to speech delay. All adopters were strongly advised to get their child’s hearing tested in the UK, together with an accurate vision test as soon as the child was old enough to co-operate.

Dental health was not mentioned in any form. Anecdotal reports from adopters indicate that many children adopted from overseas have very poor teeth due to early malnutrition and neglect.

Development

For 20 of the 120 children, descriptions of development were not expected because the child was very young and 31 reports had no information on this. Most of the other reports had limited or outdated details of developmental skills. There was little documentation of motor milestones; the phrase ‘normal motor skills’ does not indicate whether a child is sitting, crawling or walking. There was no documentation related to self-care skills and toilet training was not mentioned at all. Speech development was particularly poorly documented and there was no record of the language or local dialect that was spoken to the child. Any delay noted at examination was usually attributed to institutionalisation, with the assumption that the child would catch up when moved to a more stimulating and caring environment.

The most useful information about development was usually provided in supplementary reports, more often than not completed by an orphanage worker or by the adopters themselves following their meeting with the child.

Although poor health is worrying for parents, in most cases physical illness can be effectively diagnosed, monitored and treated. Delayed development, however, has lifelong implications. Although institutional care has a negative impact on development, adopters need to be aware of other unknown factors such as pre-birth exposure to drugs or alcohol (referred to above), extreme prematurity, prolonged labour and genetic conditions, all of which can cause long-term developmental problems.

A large study of children adopted from China into the US reveals the true picture of developmental problems among intercountry adoptees: 55% had delayed gross motor skills; 49% delayed fine motor skills; 32% cognitive delays; 43% language delays; 28% social emotional delays; 30% delays in activities of daily living; and 44% global delays (Miller and Hendrie, 2000). Moreover, 44% had delays in three or more of these areas. Interviews with international adoption doctors and researchers revealed that developmental delays were common for children who resided in orphanages in other countries as well (Albers, et al., 1997).

Growth

A child's growth depends upon ethnicity, genes, parental height, health in pregnancy, the absence of serious illnesses and adequate nutrition and nurture. It is also affected by institutionalisation: the accepted rule of thumb is that a child will lose one month of linear growth for every three months in an institution. In a study comparing Guatemalan children in foster and orphanage care, the children who had resided in an orphanage before adoption were significantly smaller in height, weight and head circumference (Miller, et al., 2005). Similar growth delays were also found in Chinese and Russian orphans adopted from institutions (Albers, et al., 1997; Miller and Hendrie, 2000).

The information on growth was more extensive in the reports than for other areas: 94/120 children had their height, weight and head circumference recorded; 12 had their height and weight noted; and seven had only a weight measurement. However, single recordings make growth trends impossible to establish and no recordings had been plotted on local centile charts. Overseas measurements could only be replotted on standard UK growth charts, which might not be relevant to countries with different ethnic populations.

In addition, some recorded measurements were clearly wrong. The head circumference measurement in several children indicated microcephaly, a condition that can have serious implications for development. These measurements were later found to be incorrect when repeated in the UK. Training on how to accurately measure a child's head is now given to all IAC adopters.

Blood tests and screening investigations

Every adopted child with an unknown medical or family history needs screening, not only to protect his or her health but also to protect the adoptive family from the transmission of infections. Of particular importance are the blood-borne viruses, hepatitis B, hepatitis C and HIV.

Most children in the cohort had had some level of screening in this respect, with 68/120 tested for hepatitis B and/or C, HIV and syphilis. In 27 cases, additional investigations had been undertaken: usually a full blood count, thyroid function test, and stool and urine culture. Twelve reports had no such screening mentioned. A number of children, mainly from one country, had had multiple normal radiological investigations, including radiographs of the chest and abdomen and ultrasound scans of the brain, heart, kidneys, hips and abdomen. But these were apparently done without an obvious medical indication. This means that the reliability of overseas test results cannot be assumed, as there was usually no laboratory report or reference number but only a date or a tick or 'negative' written in the appropriate box.

Research in the US has shown that 81% of the underlying medical conditions affecting intercountry adopted children are not detected by physical examination alone and that there is a need for additional screening, such as blood, urine or stool tests (Hostetter, et al., 1991). For example, out of 452 Chinese children adopted into the US, 28% had hepatitis B, 9% intestinal parasites and 3.5% tested positive for tuberculosis (Miller and Hendrie, 2000). In the US, where specialised intercountry adoption clinics have existed for over a decade, there is a nationally recommended schedule of tests, including screening for anaemia, haemoglobinopathies, HIV, syphilis, hepatitis B and C, tuberculosis, intestinal parasites, hypothyroidism, rickets and lead poisoning (American Academy of Pediatrics, 2000).

In the UK, with the exception of tuberculosis, screening for infectious diseases is not mandatory at the point of entry. Although BAAF issued guidance in 2004, adapted from the US recommendations, comprehensive screening of intercountry adopted children is rare; only 17/120 children had undergone the full range of tests advised by BAAF.

Particularly worrying in this respect is hepatitis B, which is highly infectious and poses a risk of transmission to the adoptive family. All IAC adopters and their immediate families are now strongly advised to have hepatitis B immunisation before travelling abroad and to repeat all screening investigations on their child when they return home. They are also told that if they are paying for testing abroad, they should accompany the child to the examination and ensure that an unopened sterile needle and syringe are used to reduce the risk of the child contracting infection from the test itself. They must also request a copy of the laboratory report to discuss with their general practitioner. However, placing the total responsibility for protecting health upon adopters in this way is unacceptable and potentially leaves a family at risk of serious problems.

Children with special needs

A small number of adopters were looking to adopt children with significant medical or developmental disabilities. One child was previously known to the adopters and in 12 cases the child was identified by IAC following an online search. The families then had several days to 'reserve' a child, after which further, limited, medical information could be sought.

Thirteen such reports were analysed on children, ranging in age from 13 months to 5 years 9 months. These had more detailed information than those covering the other areas. Eight children were reported to have some degree of developmental delay and most had some description of the child's skills at more than one point in time. However, two reports were more than six months out of date. The accuracy of these assessments was also questionable as one child did not have any apparent medical problems when examined in the UK.

Despite the detail provided, the original medical information on all the special needs children was inadequate and insufficient for adopters to make an informed decision about matching. Indeed, in five cases the prospective adopters did not proceed to matching following the receipt of updated medical information and social work counselling that indicated that the child's needs were greater than they could manage.

School-aged children and adolescents

The majority of the forms reviewed were for children aged under five years. However, there were six children aged 5 – 11 and six over 11. Most of these were being adopted by their extended families and were usually living abroad with another family member or a foster carer. These forms were generally of extremely poor quality.

The problems of adjustment raised by the experience of intercountry adoption are especially severe for older children. In addition to the loss of their birth family and native country, they have to cope with all the pressures of a British adolescent culture. In this respect, the reports were noticeably deficient. There was no information about the child's wishes and feelings, no additional family medical information – even where birth parents had died or had limited life expectancies – and no mention of any emotional or behavioural issues. Although the children will be moving to very different school environments and taught in English, there was no information about the child's current performance in school. Neither was the language spoken in the home and school documented. The child's pubertal status and the examination of the genitalia were not recorded.

Discussion

Current UK knowledge about intercountry adoption

Compared to the growing body of findings from the US, Scandinavia and The Netherlands, intercountry adoption is a neglected area of research in the UK. There has been only one longitudinal study, the English and Romanian Adoptee Study (ERA), which looked at the outcomes for 165 children adopted in the early 1990s (Rutter, et al., 2009). Two retrospective studies have looked at the adjustment of British intercountry adopted children, the first at those adopted from Vietnam (Bagley, Young and Scully, 1993) and the second, the British Chinese Adoption Study, which examined the experiences and outcomes for 100 women between the ages of 40 and 50 who were adopted from orphanages in Hong Kong in the 1960s (Feast, et al., 2012). Although the cohorts of children in these studies were adopted from the same country at about the same time, all three groups had unique characteristics. For example, the Romanian children had suffered severe institutional deprivation and the Hong Kong group was all female.

One small British study of 35 children adopted into Hampshire in the 1990s found medical reports were available for 63% of them, but most were poorly completed and contained little information (Harnott and Robertson, 1999). As many as 69% had required treatment abroad for infectious diseases, failure to thrive, anaemia or rickets. Screening tests found hepatitis B, abnormal haemoglobin and a chronic salmonella carrier and one child had an untreated hemiplegia diagnosed as a 'problem with one leg'. Two further small-scale reviews of UK adopters from a range of countries did not specifically focus on medical issues but noted that adopters found their child to be in poor or very poor health at first meeting (Mason, 1999; International Bar Association, 1991).

As far as we are aware, this is the first UK study to look specifically at the medical information given to adopters at the time of matching and comprise a large sample (120) of children of differing ages, with a variety of needs and adopted from 23 countries.

Failure to recognise the vulnerabilities of the intercountry adopted child

Regardless of their country of origin, numerous studies across the world have shown that intercountry adopted children have a myriad of special health care needs and an increased incidence of physical, developmental and mental health concerns (American Academy of Pediatrics, 2000; Bolton and Day, 2007; Juffer and van IJzendoorn, 2005). Although some of these may be addressed before adoption, many problems persist, continue to be significant or do not become apparent until after placement in an adoptive home. Dana Johnson from the University of Minnesota International Adoption Clinic has said that the chances of an institutionalised orphanage child having normal growth, health and development are 'essentially zero', and the situation in the child's birth country marked by limited resources, poor information technology and storage facilities adds to the difficulties of providing good quality medical information (Johnson, 2010).

Other receiving states acknowledge these issues more readily than the UK. All have to tackle inadequate reports and most see further assessment on arrival of both the child and the report as essential. This issue has detailed coverage on the US State Department's website (undated), which explains that all children new to the country must have an immigration medical, ideally carried out by a specialist, within two weeks of arrival. This includes not only a physical examination but also a developmental assessment, vision and hearing testing and screening procedures depending upon the child's age and country of origin. US adopters are advised that medicals carried out in the country of origin are not reliable and all immunisations should be repeated (US Center for Disease Control and Prevention, 2016). Similar advice is given in Canada. In Northern Ireland, the adoption regulations (BAAF, 2010) state that every intercountry child coming into the province should be seen by a social worker, a general practitioner and a health visitor within seven days of arrival, and by a paediatrician within 21 days. Elsewhere in the UK there is no statutory requirement for the child to have any health assessment.

Recommendations

This study was by its nature limited, looking retrospectively at the medical information given at the time of matching to prospective intercountry adopters living in London and the southeast of England between 2010 and 2014. Apart from two North American adoptions (one Canadian and one US) where comprehensive health information was provided, all the other adopters had little more than an isolated, poor quality physical examination to inform their matching process.

This is an ideal cohort for further research and in particular it would be useful to know more about the adopters' initial knowledge of the health conditions unique to intercountry adoptees and their perceptions of the usefulness of medical reports. There is virtually no medical follow-up of individual children after adoption. It would therefore be helpful to know what the future holds for them and their families and whether any health and development problems could have been better predicted from the initial information.

Intercountry adoption is a specialised process that needs experienced practitioners. The medical and social work tasks are challenging. Matching a child with an adoptive family is crucial to the success of any placement. For the intercountry adopter, the process is totally dependent upon information sent from abroad and the status of the country under the Hague Convention. Information is very limited and outside the control of either the adopters or the agency. Some countries, including Hague signatory countries, are utilising online processes to match children. There are sometimes time constraints at the pre-matching stage, when prospective adopters have a limited number of hours or days to decide if there is sufficient information to 'reserve' a child's file, and to understand the implications of the medical information provided by the state of origin. Helping the adopters to make an informed choice in the absence of clear information, working with time constraints and helping them to understand that uncertainty is a key part of the process is not an easy task.

Specialised preparation is essential for all intercountry adopters. The three-day preparation course for adopters at IAC involves two hours with an experienced medical adviser, concentrating on the limitations of a physical examination, the long-term implications of exposure to malnutrition, alcohol and drugs before birth and the impact on health and development of institutionalisation.

The current medical form does not encourage the sharing of detailed information. Consideration should be given to the development of a revised form, commissioned by the Department for Education, for national use and available free online. This should be based on the Hague format, a physical examination form and a developmental annex.

The developmental section must be completed by a person who knows the child well, such as an orphanage worker or foster carer. It should contain a detailed account of the child's current health and developmental milestones, including questions about life skills, self-care, diet, language, behaviour, learning and puberty. As the spectrum of children involved ranges from abandoned babies to adolescents, more specific age-appropriate questions are needed. The physical examination record should be completed by a doctor with paediatric training and experience who has access to everything that is currently known about the child. Growth should be plotted on local growth charts. The form must be completed within three months of the proposed match. For the increasing numbers of adopted children with complex special needs, very specific information about their current difficulties and past treatment is essential.

All intercountry adopted children, irrespective of their country of origin, deserve a comprehensive health assessment and screening after placement. This should be carried out in the NHS by a paediatrician and free to parents as it is in Northern Ireland. The number of children concerned is small but their needs are important and they are disadvantaged compared to domestic adoptees. Many families struggle unfairly with prejudice and even professional hostility. General practitioners and general paediatricians see few intercountry adopted children. We are aware of a general reluctance to comprehensively assess children, to give hepatitis B immunisation or to refer for further specialist advice. There are no specialist intercountry adoption clinics in the UK and for many families, other adopters and the IAC advice line are their main sources of advice and information. In short, British paediatricians and child psychiatrists need to become more knowledgeable about the unique health and psychological problems of intercountry adoption.

Conclusions

British intercountry adopters are usually articulate and well educated. Despite the difficulties they face, they are undoubtedly resilient and committed. At the time of writing (2016), there have been no placement disruptions in any of the 120 cases in this study. It is time for the unspoken prejudice that exists in the British social and health care systems around intercountry adoption to be challenged. These adopters and their children deserve better treatment than they currently receive from both health and social care, and should not be left alone to secure the future health of their child.

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