Post Placement Inter-country Adoption:

A survey of Irish General Practitioners

February 2016

Marié T O'Shea, Claire Collins and John Bourke

Post Placement Inter-country Adoption: A Survey of Irish General Practitioners

The Authority is very pleased to launch the results of this survey of Irish General Practitioners in relation to children adopted from abroad. The Authority launched its new website in September 2016 and the Survey Results are now available on that forum, in line with the objectives of our Corporate and Business Plans www.aai.gov.ie.

The Irish Council of General Practitioners collaborated with the Authority to complete the survey. The research is heartening in significant respects, showing that adoptive families can and do provide an environment where children can recover from very serious developmental delay, disadvantage and emotional deprivation. More than two thirds of children seen in general practice are not considered by their GPs to have emotional social or mental health issues requiring specialist intervention.

The study indicates that for a small number of children, usually those adopted at an older age, specialist mental health services are required to assist them to meet their potential and to recover from adversity in early life. The survey results corroborated what has been described anecdotally by parents in the past, that some children adopted from abroad have increased risks and need for post adoption services. This view is consistent with international research also.

The Authority began this initiative by collaborating with the International Adoption Association and the parents support groups that it represents, Tusla Child and Family Agency Adoption services and accredited bodies working in intercountry adoption. We thank these service providers for sharing their expertise with us. We appreciate the support we receive from the Minister for Children and Youth Affairs and her Department in carrying out our role. Our aim together with all our stakeholders, is to provide the highest possible standards in adoption and adoption related services. This is in line with our legal and policy obligations and consistent with the limitations on our resources.

As a direct result of this survey, the Authority subsequently compiled the Post Adoption Services Directory, see www.aai.gov.ie.

The Authority seeks to ensure that the needs of children are adequately addressed by our national health and social services, and we believe that both this Survey and the resulting Post Adoption Services Directory are valuable supports for adoptive families. The Authority continues to highlight the rights and best interests of children, and hears the voice of the child in all adoption matters.

Dr Geoffrey Shannon *Patricia Carey*

Dr Geoffrey Shannon
Chairman

Ms Patricia Carey
CEO

Foreword

This study begins to determine the level of post adoption services required by families on behalf of their children adopted from abroad. It is an exploratory study following on from the last significant research undertaken by the Adoption Board with Trinity College Dublin in 2007, on intercountry adoption. The first study highlighted the fact that General Practitioners are a focal point for adoptive parents to access health services for their children. Adoptive parents have long known that services are necessary to support their children in dealing with challenges faced by them following their intercountry adoption. This research study evidences the need for adequately resourced and specialist post-adoption services.

The Irish College of General Practitioners collaborated with the Adoption Authority of Ireland to complete this study. The methodology used was a review of international literature and a quantitative survey of General Practitioners working in Ireland. The response rate is relatively low. However, the numbers of children referred to in the study and the fact that the data is consistent with other research, indicates that the sample is representative and allows general inferences to be made about the need for specialist post adoption services.

Findings from the research are heartening in significant respects: Adoptive families can and do provide an environment where children can recover from very serious developmental delay, disadvantage and emotional deprivation, and more than two thirds of children seen in general practice are not considered by their GPs to have emotional, social or mental health issues requiring specialist intervention. Other findings are more challenging such as, when a child is aged six months or more before adoption, they can have mid- to long-term difficulties requiring specialist services. The highest referral rates to specialist mental health services were made on behalf of children who were older than two years of age at the time of adoption, and in the study sample, that was less than 80 children.

The study outlines GPs' views on the extent that the services are effective for children, the need for more specialised services for children with complex needs, the lack of services in some areas and the delays that can be encountered when accessing services.

The study is valuable for the evidence it provides in support of the need to provide adequately resourced specialist services tailored to meet the unique needs of children adopted into Ireland from abroad. It is the intention of the AAI to further build on this research in collaboration with parents and service providers to ensure that appropriate post adoption services are provided for within the Irish national health services system.

This study is an important first step in reviewing supports required for adopted children and the Authority welcomes its findings and looks forward to further research in this area.

Dr Geoffrey Shannon
Chairman
Adoption Authority of Ireland
November 2015

Authors' Biographies

Ms. Marié T. O'Shea is the Research Officer in the ICGP. Marié has an MSc in Applied Social Research; she joined the ICGP in 2014 after holding a number of research positions in Trinity College Dublin and Dublin City University.

Dr. Claire Collins (PhD) is the Director of Research in the ICGP. Claire has over twenty years' research experience. She has held the post of Director of Research in the Irish College of General Practitioners since 2004 with responsibility for the development and implementation of research within the College.

Dr. John Bourke is a full time GP with a special interest in medical issues relating to adoption. He is CME Tutor for North Cork Faculty ICGP and works as Medical Advisor to the Adoption Authority of Ireland.

Acknowledgements

We would like to express our gratitude to the GPs who took the time to complete the survey and inform this topic. Sincere appreciation is also extended to the Advisory Committee who oversaw the research and contributed to the questionnaire design and piloting

Advisory Committee Members

Dr. Geoffrey Shannon, Chairman, AAI.

Ms. Patricia Carey, CEO, AAI.

Dr. Imelda Ryan, Board member, AAI.

Dr. John Bourke, Medical Advisor, AAI.

Ms. Celia Loftus, Principal Social Worker, AAI.

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Summary

Aims and objectives of study

The aim of this study was to explore Irish General Practitioners' experiences of treating children adopted from abroad in order to establish the possible supports needed in Irish general practice.

Specifically, the objectives of this study were:

- To investigate the types of referral made by GPs for early intervention assessment for children adopted from abroad.
- To determine whether GPs are treating any children from abroad with behavioural, psychological or attachment issues.
- To investigate GPs' views on the outcomes of these referrals for early intervention assessment for children adopted from abroad.
- To investigate the average waiting times from referral to assessment for children adopted from abroad.
- To determine the services currently available and services which GPs require to meet the needs to children adopted from abroad.

Methods

The study employed a quantitative design to meet the objectives. Ethical approval was granted by the Irish College of General Practitioners' Research Ethics Committee in February 2015. A data processing and protection procedure was devised for the purpose of this study. A pilot survey of small cohort of GPs was undertaken in advance to test the questionnaire and to gain information to improve its efficiency and appropriateness for the GP population. Data collection was achieved through the use of postal questionnaires which were sent to ICGP members in the Republic of Ireland, excluding retired GPs and Trainees. The survey was sent in March 2015. A postal reminder was sent two weeks following the initial posting. Overall, 426 completed questionnaires were returned, a response rate of 15.2% of all individual members and 27% of all practices. The study demographics are consistent with the overall ICGP membership population (ICGP, 2015).

Summary of findings

- Of the 426 GP respondents, 243 indicated that they had 461 children adopted from abroad attending their practice.
- Comparison between age at adoption and age first seen in practice shows an overall average of a six month delay in time from adopted to being seen by a GP, however, over 73% of children adopted from abroad were seen immediately in their GP practice.

- Just over 66% (n=262) of children included by GPs were adopted between the years 2002 and 2010.
- Twenty-nine countries were represented in the sample; with nearly one third of children adopted from Russia. Post 2012 the number of children adopted from Russia and Romania dropped.
- A little over one quarter (26%) of children were identified as having some form of emotional, social or mental health related issues with a non-significant increase as age at adoption increases.
- Just over 18% of children had been referred for HSE/Child and Family Agency (CFA) early behavioural intervention assessment or for Child and Adolescent Mental health Services (CAMHS) assessment. Referral for assessment was significantly related to age at adoption with referral rates higher for children adopted aged two or older.
- Less than one third (31.7%) of GPs considered the level of specialist services available to their intercountry adopted patients as 'adequate'. There was no observed statistically significant relationship between Dublin and non-Dublin based GPs in their assessment of such services.
- Almost half of GPs (47%, n=39) indicated their experience of average waiting times to be 1-<6 months for HSE/CFA assessment.
- Just over half of GPs (54.1%, n=41) who requested a patient referral for assessment via private services reported an average wait of less than one month.
- The majority of GPs consider 'paediatric assessments', 'development assessments', 'post assessment intervention services', 'roadmap of services for GPs', 'roadmap of services for parents' and 'relevant training for GPs and practice nurses' to be required or necessary services. However high percentages of respondents indicated that these services were either unavailable in their area or they were unsure if they were available.

Conclusion

The results of this survey are consistent with findings from elsewhere and provide corroborating evidence that this group of patients attending Irish general practice have increased risks and hence need for services; that there are service gaps and that GPs consider themselves in need of guidance and training.

While both the response rate and the existence of recall bias are limitations, the profile of GPs who did reply is consistent with national GP data and the data on adopted children in terms of age at adoption and countries or origin is in line with Irish evidence. Furthermore, our findings are supported by international literature.

Introduction

In 2015, the Adoption Authority of Ireland (AAI) and Irish College of General Practitioners (ICGP) collaborated in a study to gain an insight into general practitioners' experience of treating children adopted from abroad. The aim of the study was to establish the impact, challenges and possible supports general practitioners require for this patient population in Irish general practice. Knowledge in this area could assist general practitioners (GPs) in identifying and accessing the appropriate services for children adopted from abroad, of which there have been circa 5,700 since 1991. This would further ensure these children have access to support services pertaining to their potential behavioural, emotional, psychological, psychiatric and attachment needs. Research to dates underlines a dearth in literature regarding general practitioner experiences in treating and referring children adopted from abroad with complex care needs.

Background to intercountry adoption

Intercountry adoption refers to the movement of children of all ages, for whom a family cannot be found in their country of origin, across international borders for the purpose of adoption (Kane, 1993; UNICEF, 1999). In the fifty years to 2000, the incidence of intercountry adoption dramatically increased. Intercountry adoption is thought to account for 15% of the total number of adoptions worldwide (www.UN.org). In the vast majority of cases of intercountry adoption this related to disadvantaged children of poor, under-developed sending nations, to families situated in developed countries in the western world. Since 2004 global trends indicate that the numbers of children adopted intercountry has been decreasing and that more older children with special needs have been available for intercountry adoption. In Ireland, such adoptions have occurred since the 1980's with approximately 5,700 children adopted into Ireland from multiple countries, including; Romania, China, Belarus, India and Vietnam (Health Service Executive, 2010). In many of these underdeveloped countries a wide range of social and political factors led to an increased incidence of sending children abroad for adoption. Reasons for sending children abroad can be multifaceted; factors include restrictive political policies on the number of children per family, war, chronic poverty or other forms of socio-economic deprivation, illness and addiction (www.UN.org). Such factors have led to the creation and development of institutions, orphanages and care homes in which abandoned, ill or impoverished children were placed for adoption (UNICEF, 1997; Johnson et al, 1996).

Ireland had one of the highest rates of intercountry adoption in Europe with assessment applications for the purpose of adoption increasing throughout the 2000s (Greene et al, 2007). Figures from the Adoption Authority since 2010 show a decline in the numbers of assessments, with 35 applicants receiving authorisation to adopt intercountry, in the first six months of 2015 (www.aai.gov.ie). In 1993, the Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption established international standards of practices to regulate intercountry adoption. Since November 2010, any persons in receipt of a declaration enabling them to adopt into Ireland can only adopt from countries compliant with the Hague Convention No 3; which works towards ensuring that intercountry adoptions are made in the best interests of the child (http://www.hcch.net). However, as highlighted by Triseliotis (2000), the application of these

universal regulations can be fraught with difficulties due to the complex circumstances of children in care. One result of these regulations is that in *some* sending countries international adoptions have decreased in recent years as rates of domestic adoption begin to rise. This is linked with the implementation of policies encouraging domestic residents to adopt, increased levels of education and political and economic growth in sending countries (www.UN.org). Figures show that internationally 45,000 intercountry adoptions took place in 2004, dropping by more than 50% to 22,000 in 2011 (Selman, 2009). During 1998 and 2004 Ireland experienced a rise of 171% in intercountry adoption. From 1991 to 2012 approximately 5,600 children were adopted into Ireland from abroad (www.aai.gov.ie). However between 2010 and 2014 approximately 60 children were adopted into Ireland from abroad from Hague compliant countries including India, Thailand, Mexico and China. There has been an increase in 2015 as 40 children have been adopted into Ireland between January and June 2015 (www.aai.gov.ie). As the children arrive in Ireland to their receiving families, medical assessment is required to ensure both mental health and physical well-being.

Health assessments of children adopted from abroad

Adoption processes and systems can vary considerably depending on country of origin (www.UN.org). With a focus on healthcare, many children adopted from abroad have experienced limited to no prenatal or paediatric care. Many children arriving to their adoptive families have complex care needs (Gagnoon-Oosterwaal et al, 2012) and are known to experience psychological deprivation and neglect (Gunnar et al, 2000; Juffer and van IJzendoorn 2005). Prior to adoption, children often have no standard medical evaluation in their country of origin and in many cases have no family medical history records (Hostetter et al, 1991; Miller et al, 2005). This lack of transparency can make it difficult to ascertain their medical history and needs. Children may require various medical treatments for curable pathologies including infections and deficiencies that are linked to their original environment (Webb et al, 2005). In some instances, these children may require repeat vaccinations resulting from missing vaccine documentation and gaps in completeness and accuracy of vaccination schedules (Webb et al., 2005). They may further need to be screened for genetic disorders and infectious diseases such as tuberculosis and hepatitis. Repeat screening for HIV is often advised also (Mather, 2007).

Children with specialised care needs are increasingly being adopted from abroad. The body of literature to date is consistent in identifying elevated risks to mental health problems in children adopted from abroad (Brodzinsky, 1993; Miller et al, 2000; Nickman et al. 2005; Keyes et al, 2008). Studies have shown that children adopted from abroad when compared to non-adopted children are at an elevated risk for mental, developmental and behavioural problems (Webb et al, 2005; Bramlett et al, 2007; Gibson, 2009; Ward, 2011; Woolgar and Baldock, 2015). Institutional care standards can vary country to country (Greene et al, 2007). Within this, quality of care is ambiguous. In general very poor conditions prevail in many institutions. A number of studies suggest that positive engagement and work with children was predominately non-existent. Children's basic care needs were barely met and children were left to their own devices for stimulation with little or no opportunity to develop relationships with staff (Human Rights Watch, 1996 and 1998; UNICEF, 1997; Johnson, 2000). As a result, high instances of emotional and behavioural difficulties have been recorded in children adopted from abroad (Sempick et al, 2008). Neurobiological research indicates inconsistent caregiving, abuse and/or neglect can have a long term negative impact on the brain and

nervous system of infants and young children (Glaser, 2000). This psychological impact in the formative years of a child's can result in maladjustment and affect their abilities to form secure interpersonal attachments (Verhulst et al, 1990; O'Connor et al, 2000; Dozier et al, 2001; Howe, 2006).

It can be difficult for medical professionals and clinicians to separate the disabilities children are genetically predisposed to or those pertaining to their quality of environment. Two major studies have been conducted in England and Canada which addressed this relationship by examining a sample of children adopted from Romania during their childhood (Rutter and ERA, 1998; Le Mare and Audet, 2006). The UK longitudinal study on English and Romanian adoptees points to the persistent effects of severe early and prolonged (more than six months) institutionalisation on intelligence quotient (IQ) (Rutter et al, 2009). Recent findings indicate that persistent under-performance due to poor brain development can occur in conditions of prolonged early and severe deprivation (Clarke and Clarke, 1976; Anda et al, 2006; Beckett et al, 2006; Rutter et al, 2009). One third of children placed for adoption over the age of six months were found to experience issues including "autistic-like qualities", attachment disorders, social issues and poor mental functioning which required educational, psychological or psychiatric services (Rutter et al. 2009). One UK-based study compared the referral letters by GPs regarding adopted children's mental health assessment against expected rates of relevant disorders (Woolgar et al., 2015). These were then compared against national data which found that ADHD, conduct disorders, anxiety and autism are being broadly under-identified by clinicians, while attachment disorders are over-identified. One third of referral letters suggest attachment disorders were present. However, upon specialist assessment only one child was diagnosed with significant levels of insecure attachment. In many cases children may be subjected to services and treatments with do not adequately address their mental or physical care needs (Woolgar et al, 2015).

Adoptive families can and do provide an environment where children can recover from very serious developmental delay, disadvantage and emotional deprivation; although the age at which a child is sent to a receiving family abroad can be a positive influence on their long-term well-being. As mentioned previously, in the ERA study, it was found that children adopted before six months of age were likely to completely recover from emotional or attachment problems (Rutter et al, 2009). However, those adopted after six months are likely to experience mid to long-term problems as they develop (Rutter and ERA, 1998; Greene et al, 2007).

Mental health of children adopted from abroad

With regard to mental health, international literature suggests that adopted children are more likely than non-adopted children to display higher levels of defiance, aggression, hyperactivity and other acting out behaviours, learning difficulties and substance abuse (Brodzinsky and Steiger, 1991; Fullerton et al, 1986; Kotsopoulos et al, 1988; Marshall et al, 1994). While there is a general agreement that the vast majority of adoptees are well-adjusted members of the community, a small proportion have psychological adjustment problems (Wierzbicki, 1993; Rutter and ERA, 1998; Cederblad et al. 1999). Intercountry adoptees have been noted as showing more mental health concerns than non-adopted children with a particular overrepresentation in males during adolescence (Verhulst et al, 1990; Juffer and van IJzendoorn, 2005). Research in Scandinavian

countries showed that 25-30% of children adopted through intercountry adoption have problems linked to language, learning, identity and ethnicity (Dalen, 2001). However, there are many factors which impact on these rates, including the accepted view that there is increased readiness to use services among adoptive parents (Gagnon-Oosterwall et al, 2012). This active help-seeking behaviour is often associated with adoptive parents having higher levels of educational attainment (Ingersoll, 1997; Miller et al, 2000).

General practitioners and the adoptive family

The Health Service Executive (HSE) outlines that GPs are the primary point of contact for referral to specialist HSE services, including; Tusla – Child and Family Agency and Child and Adolescent Mental Health Services (CAMHS). Tusla is a dedicated State agency responsible for improving wellbeing and behavioural outcomes for children. CAMHS is a public specialist service for youths, under the age of 18, who have emotional, behavioural and mental health difficulties. Their team is comprised of youth psychiatrists, clinical psychologists, clinical nurse specialists, social workers, speech/language therapists and occupational therapists. In the *Fifth Annual Report of Child and Adolescent Mental Health Services* (HSE, 2014) it was found that children aged 15 years were the most common age group attending community CAMHS in Ireland. Children aged 16-17 and 10-14 were the second and third most common ages attending CAMHS services. Between the October 2012 and September 2013, 12,022 referrals were accepted by community CAMHS teams (HSE, 2014).

A national Irish study highlights that GPs are the first point of contact for medical advice by receiving adoptive families (Greene et al, 2007). Despite that there is no legal obligation for adoptive parents to obtain a medical assessment for their child, this study shows that 86% of parents undertook a consultation with their GP on their child's health. Parents within this study found that the GP consultation was both helpful and reassuring in light of their child's health.

GPs often encounter barriers in their assessment and referral of their child's mental and physical health. Firstly, children arrive with medical issues relating to their country of origin. Hostetter and colleagues (1991) found that 81% of medical problems of internationally adopted children were only detected through their screening process, rather than physical examination. Secondly, professional standards which GPs may seek to apply may be compromised by poor family medical records and pre and post notes for their patient. Additionally, the medical reports provided to GPs may be brief due to language barriers (Mather and Kerac, 2002). In one UK study, medical reports were available for 63%, in which most were incomplete with few details.

Following this, children's subsequent referral and access to public services can be difficult due to delays. Obstacles impacting such delays include long-waiting lists and lack of availability of specialist public health services. In the study conducted by Trinity College Dublin for the Adoption Board, 25% reported a difficulty in accessing services and expressed that the complex needs of their sent child had not been met by the service provision (Greene et al, 2007). To guarantee appropriate treatment in efficient timelines, GPs may refer patients to private sector medical specialists, which can have a large financial impact on the adoptive families.

Due to the specialist nature of the care needs often presented, GPs are susceptible to lacking education and knowledge of these issues. Given the infrequent occurrence of treating children adoptive from abroad, GPs may not be in a comprehensive position to assess and provide advice on the child's required care (Mather and Kerac, 2002).

Summary

The international literature on the subject of intercountry adoption is extensive however there is a dearth of information in the subject area of general practice and children adopted from abroad particularly in an Irish context.

The literature suggests that treating children adopted from abroad can be a challenge for GPs due to poor medical records, differences in medical practice from country of origin and the complex needs of some children which are unidentifiable during general health consultations. However the lack of comprehensive research in this area makes it difficult to integrate the literature and to make general conclusions.

This study aims to contribute to the knowledge base by providing information on the impact, challenges and possible supports that Irish general practitioners require for this specialist patient population in Irish general practice, given the key role that GPs play as the first point of contact for medical advice by receiving adoptive families (Greene et al, 2007).

Methodology

In this chapter the study aims, objectives, study design, methods and ethical procedures will be described.

Aims and objectives of study

The aim of this study was to explore Irish General Practitioners' experiences of treating children adopted from abroad in order to establish the possible supports needed in Irish general practice.

Specifically, the objectives of this study were:

- To investigate the types of referral made by GPs for early intervention assessment for children adopted from abroad.
- To determine whether GPs are treating any children from abroad with behavioural, psychological or attachment issues.
- To investigate GPs views on the outcomes of these referrals for early intervention assessment for children adopted from abroad.
- To investigate the average waiting times from referral to assessment for children adopted from abroad.
- To determine the services currently available and services which GPs require to meet the needs to children adopted from abroad.

Study design

The study consisted of a literature review and a quantitative survey of GPs.

A pilot survey of 23 participants was undertaken in advance at a Continuing Medical Education (CME) tutors meeting in February 2015 to test the questionnaire and to gain information to improve the efficiency of the main survey and the appropriateness of the questions for the GP population. Reponses were positive however some clarifications and slight modifications were made to the questionnaire based on feedback.

Data collection was achieved through the use of postal questionnaires which were designed based on the literature by the Irish College of General Practitioners (ICGP) research team in consultation with the Adoption Authority of Ireland (AAI) advisory committee. Questionnaires were sent to 2,822 ICGP members in the Republic of Ireland, excluding retired GPs and Trainees in March 2015. These 2,822 members were based in 1,577 practices. Included with the questionnaire was an information sheet which informed potential participants of the details of the study including the purpose, process and data collection procedures. Return freepost envelopes were also included to encourage response. A postal reminder was sent two weeks following the initial posting. Return of the completed questionnaires was taken as consent.

The questionnaire consisted of eight questions in three sections over three pages. GP and practice details were collected in Section 1, including practice location, total of number of doctors in practice and the number of whole time equivalent GPs working in their practice. Patient information was collected in Section 2, including age at adoption, country of origin, age first seen in practice, any behavioural/psychological issues, information on referrals for assessment and referral outcomes. Section 3 asked about service information, specifically waiting times for referral for assessment and information on services required to meet the needs of children adopted from abroad which were a) available or b) required in the GPs local area. The questionnaire ended with an open ended question seeking further comments, if any.

Data analysis

Overall, 426 completed questionnaires were returned, a valid response rate of 15.2% of all individual members and 27% of all practices. Quantitative data were entered into the Statistical Package for the Social Sciences version 22 (SPSS) for analysis. Frequency distributions and descriptive statistics were generated to describe participants' scores on each measure to establish the extent to which key objectives of the study had been achieved. Categorical data are summarised in terms of percentages and continuous data were summarised using means and, where appropriate, medians. The open-ended survey questions giving qualitative data were entered into a Microsoft Excel spreadsheet and were analysed thematically.

Data protection

A data processing and protection procedure was devised for the purpose of this study and considered appropriate by the Data Protection Commissioner's Office.

Ethical considerations

Ethical approval was granted by the Irish College of General Practitioners' Research Ethics Committee in February 2015. Data collection commenced post receipt of ethical approval. A clear and concise information sheet, outlining the aims and process of the study was included in each survey pack. All participants were asked to read this information prior to completing the survey to best ensure an informed decision was made. The rights and dignity of participants were respected throughout by adherence of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice.

As outlined above the completion and return of the questionnaires by participants to the research team was taken as evidence of consent. No personal data identifying any person was recorded on questionnaires resulting in the questionnaires being totally anonymous. To ensure privacy, in this report no references are made to individual participants. Data were password protected and stored in accordance with the Data Protection (Amendment) Act 2003.

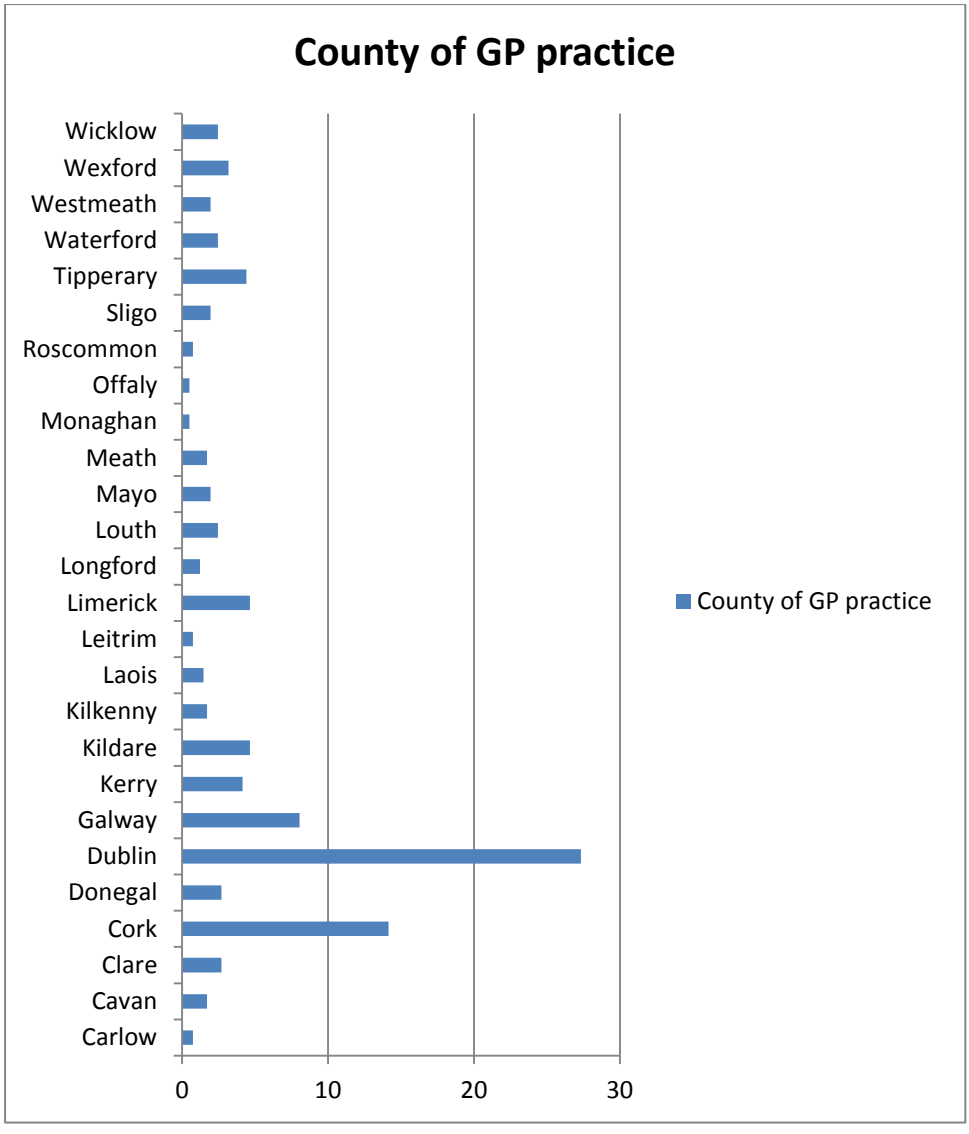
Findings

The Post Placement Intercountry Adoption questionnaire sought information about GP practice location and GP working hours, patient information on each child adopted from abroad who attended their practice and service information. A total of 426 completed surveys were included in the analysis. This section of the report provides key findings based on the GP practice location and GP working hours for all 426 respondents.

Practice profile

Overall, 39% were based in a city location, 42.9% in a town and 18.2% in a village, consistent with published data (O'Dowd, 2006). All counties in the Republic of Ireland were represented. Of the counties in which the GP practices were located, the most frequently occurring were Dublin (27.3%), Cork (14.1%) and Galway (8%).

Figure 1. County in which respondents located



Single handed practices comprised 19.3% of the respondents, which is consistent with the overall ICGP membership population (ICGP, 2015).

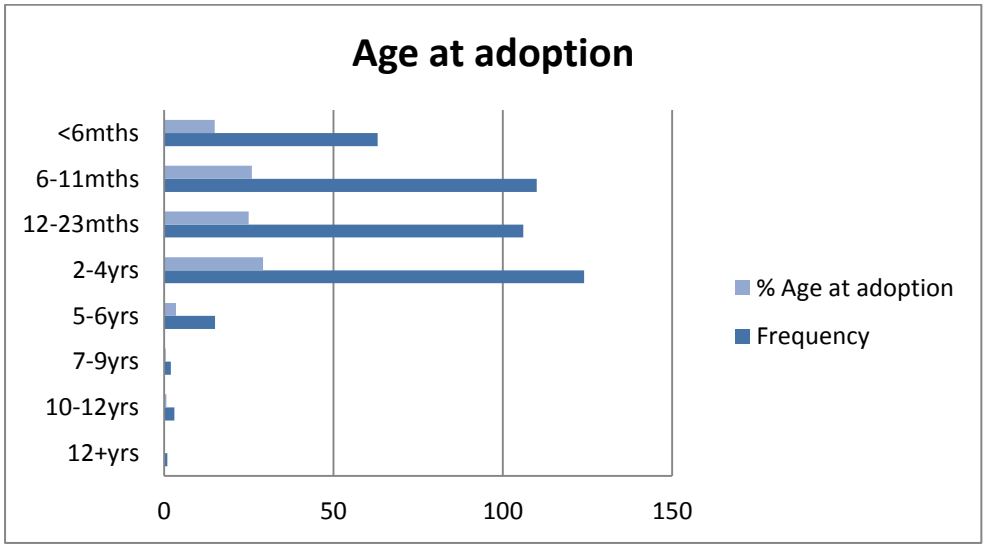
Of the 426 GP respondents, 243 indicated that they had 461 children adopted from abroad attending their practice.

Of this sample, 34% were located in a city, 44.5% in a town and 21.4% in a village location, showing slightly fewer in cities and more village locations compared to all respondents. Similar proportions were located in the most frequently occurring areas, namely, Dublin (24.2%), Cork (16.9%) and Galway (6.8%). Slightly fewer were based in single handed practices 17%.

Patient Information

Among GPs who reported having children adopted from abroad attending their practice, the number of such children attending ranged from one to 13 with a median of two children. GPs were asked what age their patients were when adopted if known. Age at adoption from abroad ranged from 3 days week to 15 years. Just over 40% (n=99) of children were less than one year old, 25% (n=106) one to than two years, 29.2% (n=124) between the ages of 2-4 years and 4.9% (n=21) over 4 years of age when adopted.

Figure 2. Age at adoption



Average age at adoption pre 2010 was 18.09 months, 2010-2012 (inclusive) was 18.14 months and since 2013 was 25.71 months.

Table 1. Age group at adoption by timeframe (pre 2010, 2010 through 2012, 2013+)

Age at adoption	Pre 2010 (n=318)	2010 through 2012 (n=57)	Since 2013 (n=18)
<1 year	43.4%	43.9%	22.2%
1 - <2 years	26.1%	17.5%	16.7%
2+ years	30.5%	38.6%	61.1%

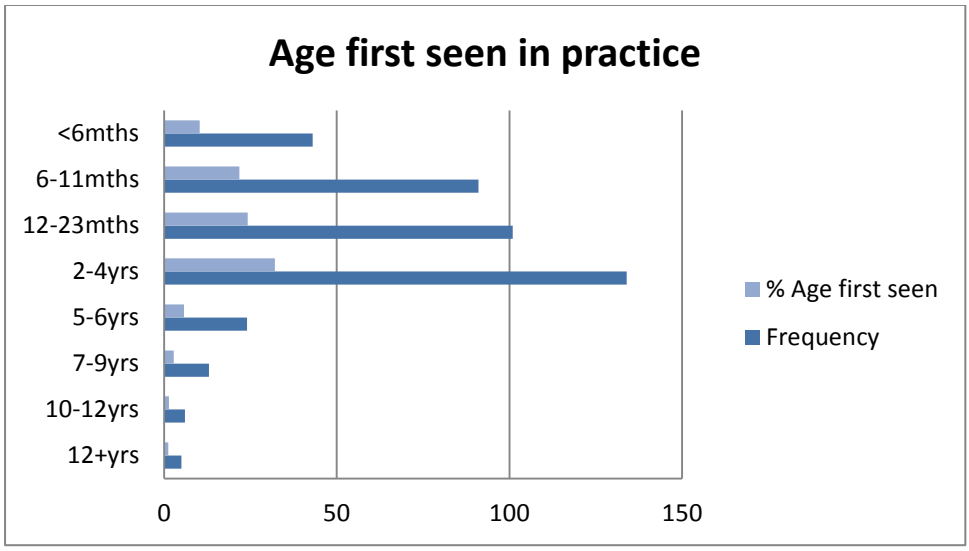
Comparing pre and post 2012 shows an increasing proportion of those adopted from 2012 in the over two year old age group.

Table 2. Age group at adoption by timeframe (pre 2012 and since 2012)

Age at adoption	Pre 2012 (n=365)	Since 2012 (n=28)
<1 year	43.8%	25.0%
1 - <2 years	24.9%	17.8%
2+ years	31.2%	57.1%

Children ranged in age from two weeks to 16 years when first treated in their GP practice. Just over 32% (n=134) of children were less than one year old, 24.2% (n=101) one to less than two years, 32.1% (n=134) between the ages of 2-4 years and 11.2% (n=48) over 4 years of age when first seen in the practice. Tables 3 and 4 summarise the key findings relating to the age of the children when first seen in GP practice.

Figure 3. Age first seen in GP practice



Comparison between age at adoption and age first seen in practice shows that according to data reported by the GPs in this study, the overall average time from age adopted to age first seen in the practice was six months. However, there was no delay for 73.1% of children adopted. Where a delay occurred this ranged from two weeks to 13.5 years with a mean of 23.6 months (see Table 4).

Table 3: Comparison of age at adoption and age first seen in GP practice

	Age adopted (months) n=424	Age first seen in practice (months) n=416
Mean age	18.9	26.1
Standard deviation	18.11	28.74
Median	12	16
Minimum age	0.1	0.5
Maximum age	132	192
Age at or below which one quarter adopted	7	9
Age at or below which half adopted	12	16
Age at or below which three quarters adopted	24	36

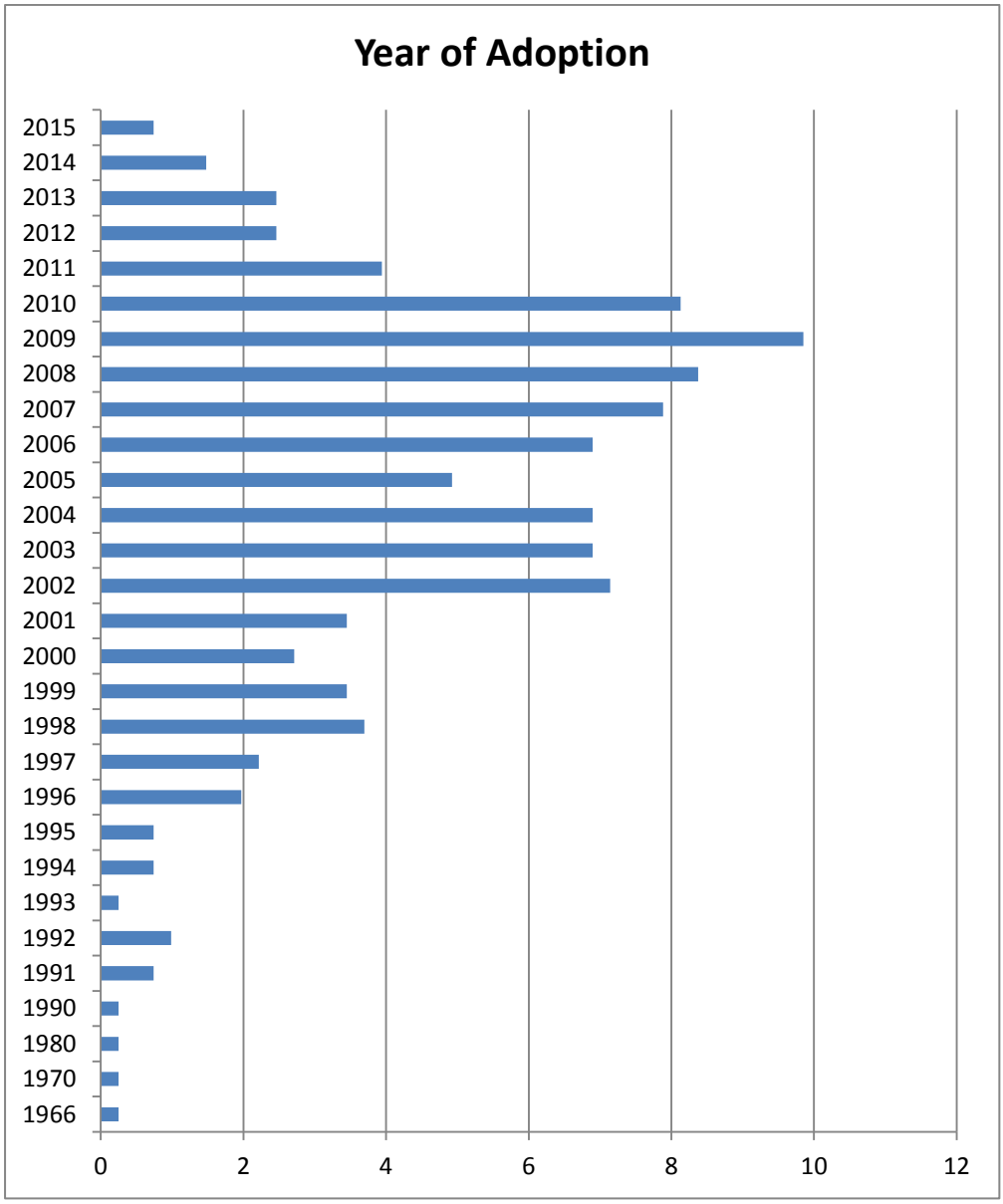
Where there was a delay (i.e. difference between age adopted and age first seen is greater than 0); mean delay was 27.07 months (n=80) pre 2010 and 5.26 months since 2010 (n=19) (p=0.023).

Table 4: Difference between age adopted and age first seen in practice

	Age difference ALL (months) n=398	Age difference if delay (months) n=107
Mean delay	6.35	23.6
Standard deviation	22.3	38.1
Median	0	6
Minimum	0	0.5
Maximum	162	162
Months at or below which one quarter delayed	0	1
Months at or below which half delayed	0	6
Months at or below which three quarters delayed	1	24

Figure 4 indicates the year of adoption if known by the GP. Just over 66% (n=262) of patients identified in the study were adopted between the years 2002 and 2010. From 2011 there was a steep decline in the number of children (n=42) adopted from abroad attending the GP participants, which correlates with known national data on the number of inter-country adoptions.

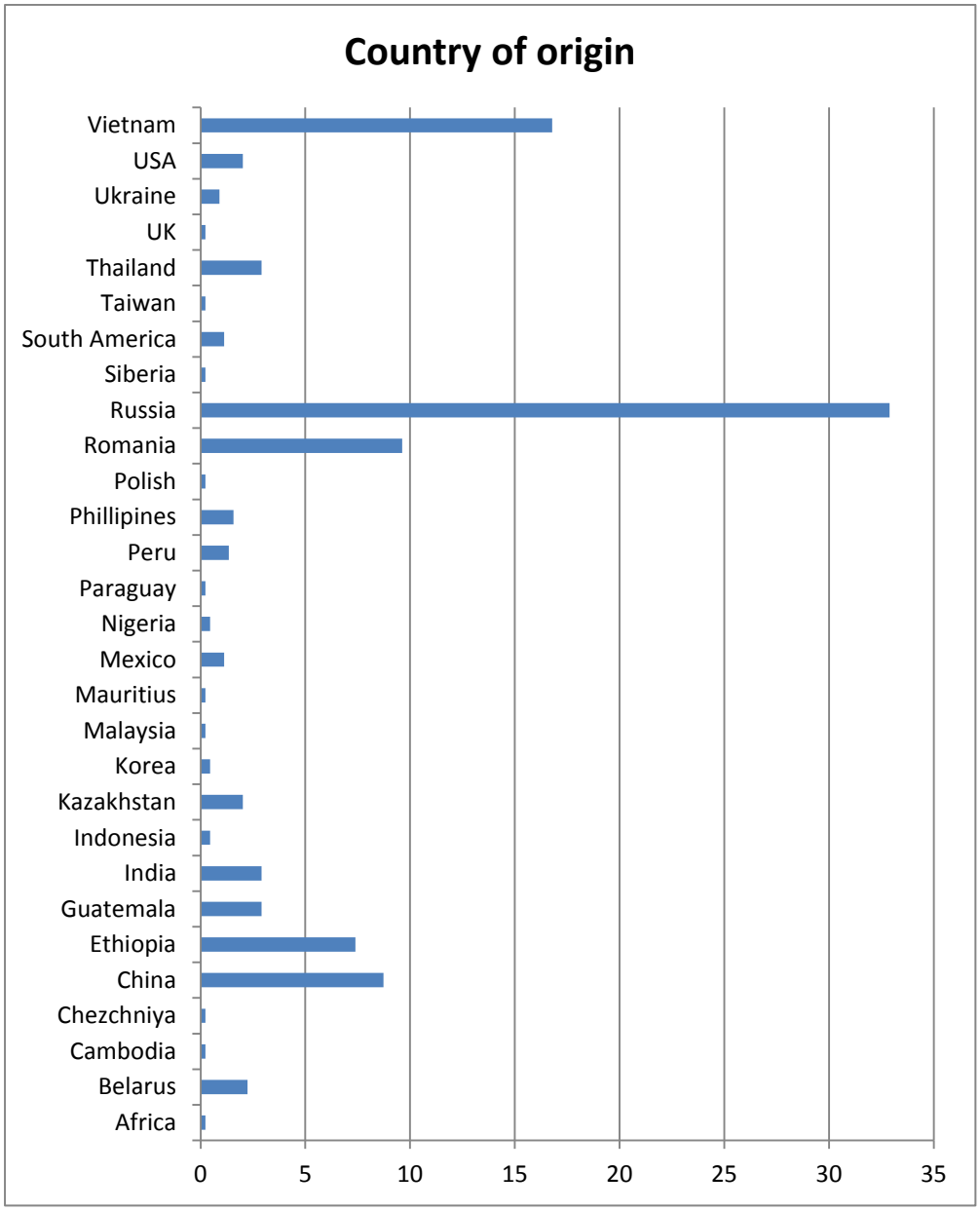
Figure 4. Year of adoption



Country of Origin

Twenty–nine countries were represented in the sample. Nearly one third of the children were adopted from Russia (32.9%, n=147) and one sixth were adopted from Vietnam (16.8%, n=75). Other countries with higher numbers of children were Romania (9.6%, n=43), China (8.7%, n=39) and Ethiopia (7.4%, n=33). Figure 5 identifies the country of origin for the 447 children attending the respondents' practices where country detail was provided.

Figure 5. Country of origin



Comparing pre 2012 and 2012 or later, some changes were noted in terms of the countries from which children were adopted. The proportion of children adopted from abroad coming from Russia and Romania dropped from 32.2% to 17.4% and from 9.1% to 0% respectively of adoptions in that time period. Increased rates of adoption from Ethiopia (28.6%) and Russia (35.7%) were noted from 2010 through 2012, while there was notable decrease in adoptions from Vietnam (3.6%) during this period (see Table 5).

Table 5: Year of adoption for children by Country of origin (pre 2010, 2010 through 2012, 2013+)

Age at adoption	Pre 2010 (n=320)	2010 through 2012 (n=56)	Since 2013 (n=19)
Russia (n=128)	33.1%	35.7%	10.5%
Romania (n=32)	10.0%	0%	0%
Vietnam (n=74)	20.9%	3.6%	26.3%
Ethiopia (n=32)	4.7%	28.6%	5.3%
China (n=27)	6.9%	7.1%	5.3%

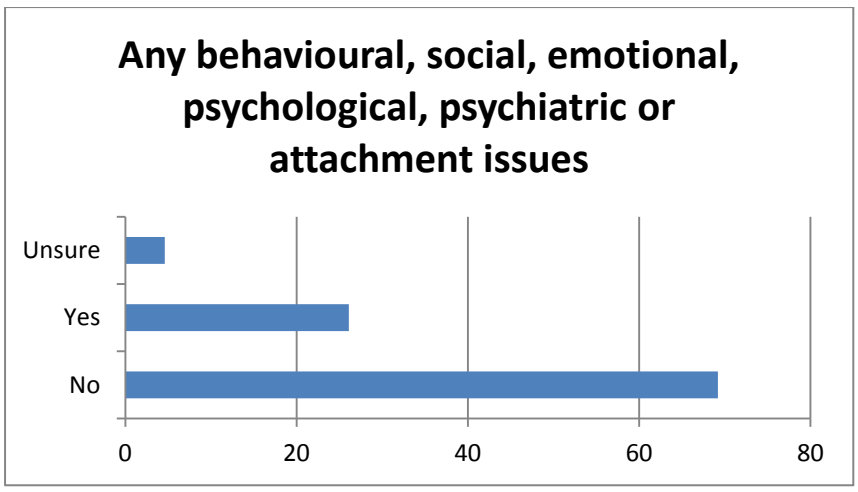
Taking the countries from which numbers are sufficiently large to compare across age groups, we see differences in terms of age at adoption by country.

Table 6: Age at adoption for children by Country of origin

	Age at adoption		
Country	**<1 year**	**1-<2 years**	**2+ years**
Russia (n=135)	23.7%	31.1%	45.1%
Romania (n=40)	27.5%	17.5%	55.0%
Vietnam (n=73)	76.7%	15.0%	8.2%
Ethiopia (n=33)	69.6%	21.2%	9.1%
China (n=30)	40.0%	36.6%	23.3%

GPs were asked whether their patient(s) have some form of behavioural, social, emotional, psychological, psychiatric or attachment issues. Overall 69.2% of children were considered by the GP to have no emotional, social or mental health related issues. A little over one quarter (26%) of children were identified as having some form of the above.

Figure 6. Signs of behavioural, social, emotional, psychological, psychiatric or attachment issues



Overall children adopted since 2010 were significantly less likely to have behavioural, social, emotional, psychological, psychiatric or attachment issues according to GPs with the proportion (where both data items recorded) considered to have these difficulties decreasing from 29.5% of children adopted pre 2010 to 12.2% adopted since 2010 ($p<0.05$). A non-significant trend with age group at adoption was noted with those aged two or over at adoption being more likely to have these difficulties, 34.9% compared to 21.4% and 21.6% of those < 1 years and aged 1-<2 at adoption. A significantly high proportion of children from Russia and Romania were noted to have such difficulties.

Table 7: Signs of behavioural, social, emotional, psychological, psychiatric or attachment issues by Country

Country	%
Russia (n=49)	34.5%
Romania (n=19)	44.2%
Vietnam (n=10)	13.3%
Ethiopia (n=3)	9.4%
China (n=7)	18.9%

Nearly 80% (n=338) of children had not been referred for HSE/Child and Family Agency (CFA) early behavioural intervention assessment or for Child and Adolescent Mental health Services (CAMHS) assessment. Just over 18% (n=78) had received such a referral. A non-significant trend was noted with more referrals among children adopted pre 2010, 21.4% compared to 10%. Referral for assessment was significantly related to age at adoption ($p=0.011$) with 28.6% of children adopted at two or older referred compared to 13.3% and 15.8% respectively in the younger age groups.

Figure 7. GP referral for assessment

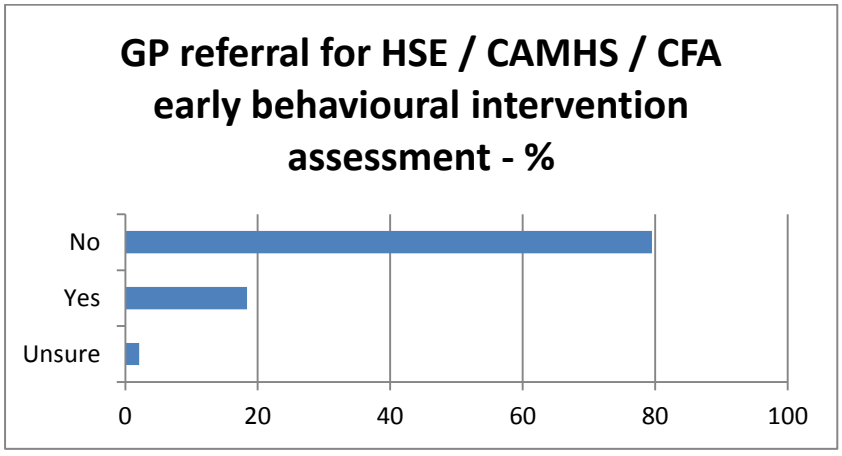
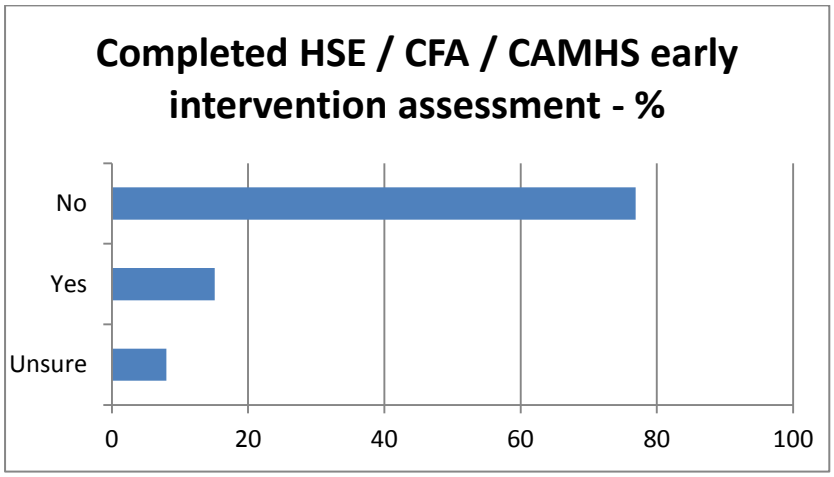


Table 8: Referral for assessment by Country

Country	%
Russia (n=32)	36.6%
Romania (n=15)	24.1%
Vietnam (n=7)	9.6%
Ethiopia (n=4)	12.5%
China (n=3)	8.8%

Of the 18% (n=78) of children noted above who had received a referral, GPs indicated that 15.1% (n=53) of those had *completed* a HSE/Child and Family Agency (CFA) or CAMHS early intervention assessment and 76.9% (n=270) had not; the information was unknown by the GP for 8% (n=28) of children.

Figure 8. Completed early intervention assessment



With regard to outcomes of the HSE/Child and Family Agency (CFA) or CAMHS early intervention assessment, 42.5% (n=48) of children had an 'unsatisfactory' result according to their GP and 26.5% (n=30) had a 'satisfactory' outcome. For 31% of children, the GP responding to the survey was 'unsure' of the outcome. The proportion of children adopted at <1 year of age with an unsatisfactory result was 44.4%, compared to 52% aged between 1-<2 years and 44.4% of those adopted at 2 years and over.

Approximately one fifth (19.8%) of children had been referred for '*other*' behavioural, psychological or psychiatric service while 79% had not. Referral here was related to year adopted with 24.5% of children adopted before 2010 referred compared to 3.1% of later adoptions (p=0.001). The proportion of children adopted at <1 year of age who were referred was 16.8% compared to 15.1% aged between 1-<2 years and 33.3% of those adopted at 2 years and over.

Figure 9. Early intervention assessment outcome

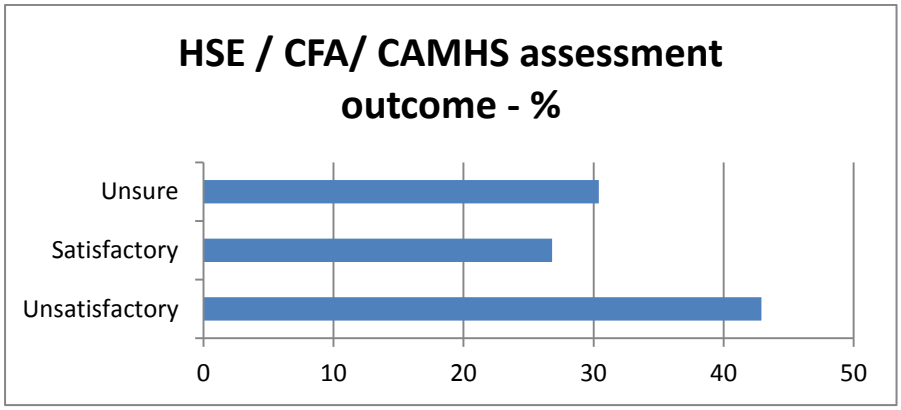
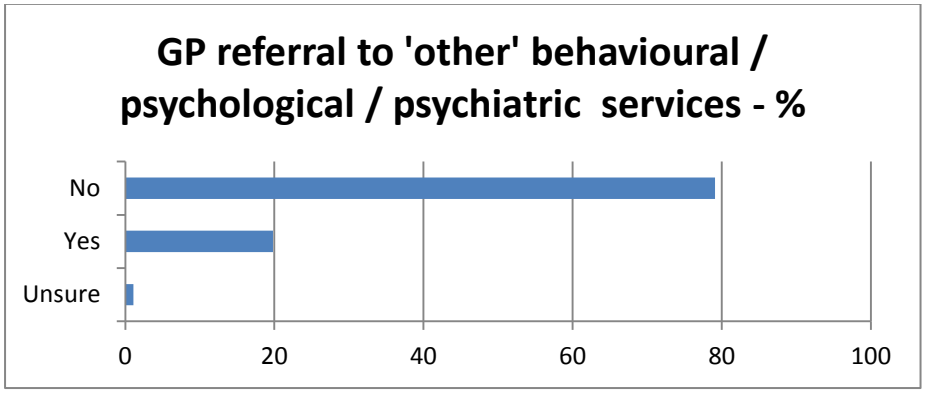


Figure 10. GP referral to 'other' services



With regard to outcome, in the GPs opinion, the outcome of this assessment was 'unsatisfactory' for 27.7% (n=28) of children, while for 34.7% (n=35) of children it was 'satisfactory'. The GP was unsure of the outcome in respect of approximately 30% of children. The proportion of children adopted pre 2010 with an unsatisfactory result was 33.7% (n=28) compared to 75% (n=6) of those adopted in later years.

Figure 11. Outcome of 'other' referral

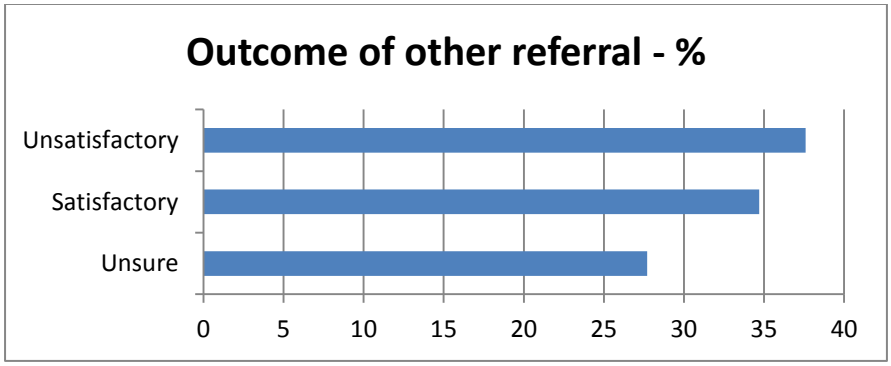


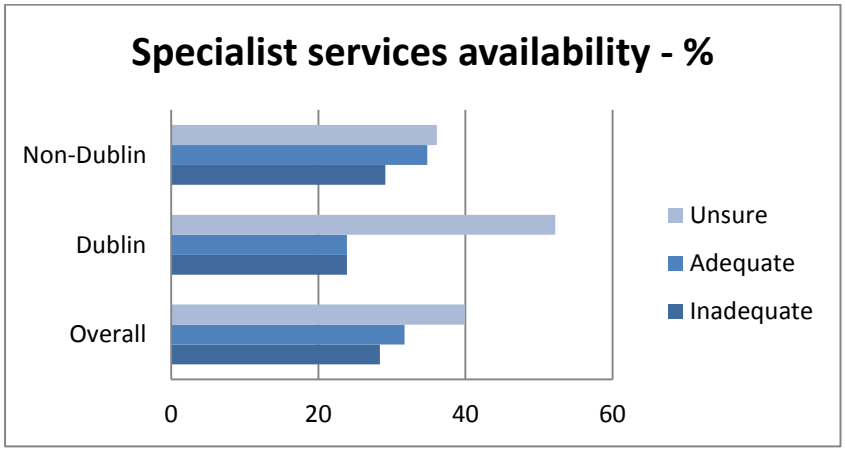
Table 9. Outcome of 'other' referral by age group

Age Group	Satisfactory (n=32)	Unsatisfactory (n=35)	Unsure (n=25)
<1 year	35.3%	29.4%	36.3%
1 - <2 years	35.0%	45.0%	20.0%
2+ years	34.2%	42.1%	23.7%

Service Information

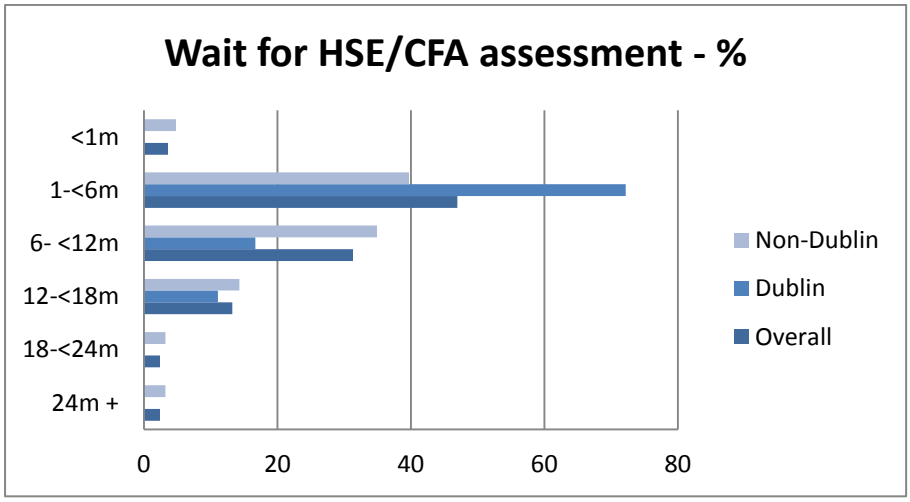
Respondents who reported having children adopted from abroad attending their practices were asked questions in relation to service available and quality. Less than one third (31.7%) of GPs considered the level of specialist services available to their intercountry adopted patients as 'adequate', while an equivalent proportion 28.4% indicated they were 'inadequate'; a relatively large proportion (39.9%) were unsure about the quality of services. There was no observed statistically significant relationship between Dublin and non-Dublin based GPs in their assessment of such services although Dublin based GPs were slightly more likely to be unsure about service quality (52.2% compared to 36.1%).

Figure 12. Specialist services availability



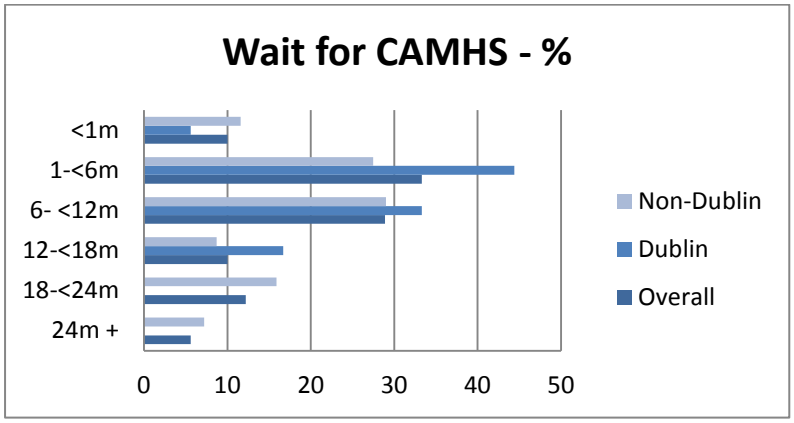
Respondents who had referred to the various services were given six time period options and asked to indicate the average waiting time from time of referral. With regard to HSE/CFA assessment, while almost half (47%, n=39) of GPs indicated their experience of average waiting times to be 1-<6 months, just over 31% (n=26) reported waiting times of 6-<12 months and 13.3% (n=11) 12-<18 months. Only three GPs experienced an average waiting time of less than one month and four more than 18 months. Comparing Dublin and non-Dublin practices, we see that fewer Dublin based GP reported an average waiting time of one year and none a waiting time of 18 months; 72.2% of Dublin based GPs reported average waits within six months compared to 44.5% of non-Dublin based GPs.

Figure 13. Wait for HSE/CFA assessment



Less than one in ten (10%) of GPs reported an average waiting time of less than one month from time of referral to CAMHS assessment; while the average waiting times reported by 33.3% was 1-<6 months and 6-<12 months for 28.9%. Over a quarter of GPs (27.8%) reported average waiting times of one year or more for CAMHS assessment. While Dublin based GPs were slightly more likely to report average waiting times less than six months (50% compared to 39.1%); they were substantially less likely to report average waiting times of one year or more (16.7% compared to 31.8%).

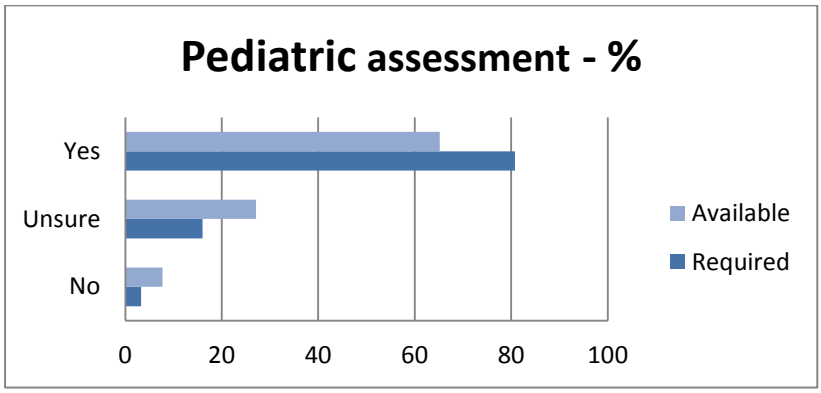
Figure 14. Wait for CAMHS assessment



Respondents were asked to indicate separately from a list of six services those which they think are required to meet the needs of children adopted from abroad and to also indicate which of these services are currently available in their area. The services listed were 'paediatric assessments', 'development assessments', 'post assessment intervention services', 'roadmap of services for GPs', 'roadmap of services for parents' and 'relevant training for GPs and practice nurses'. The responses indicate that GPs consider all six services necessary to support children adopted from abroad, however that availability is limited.

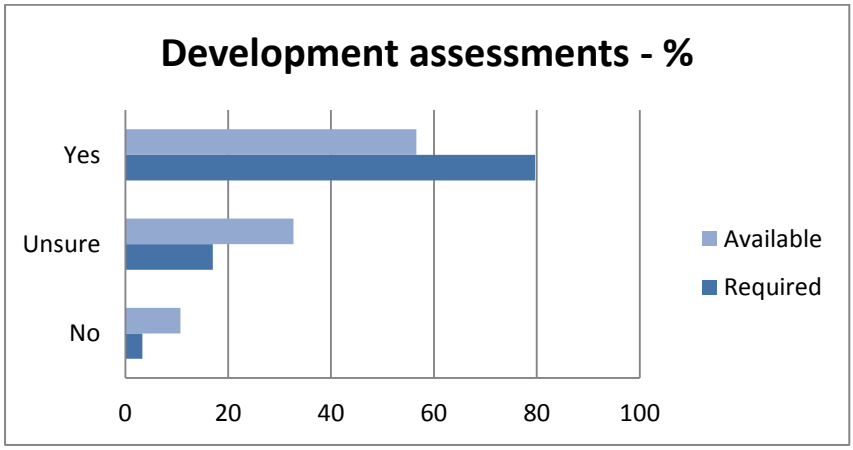
Nearly 81% (n=172) of GPs considered ‘paediatric assessment’ to be ‘required’ or necessary services however just over 65% (n=135) indicated that the service was available in their area. Just over 27% (n=56) were ‘unsure’ whether this service was available in their area.

Figure 15. Paediatric assessment



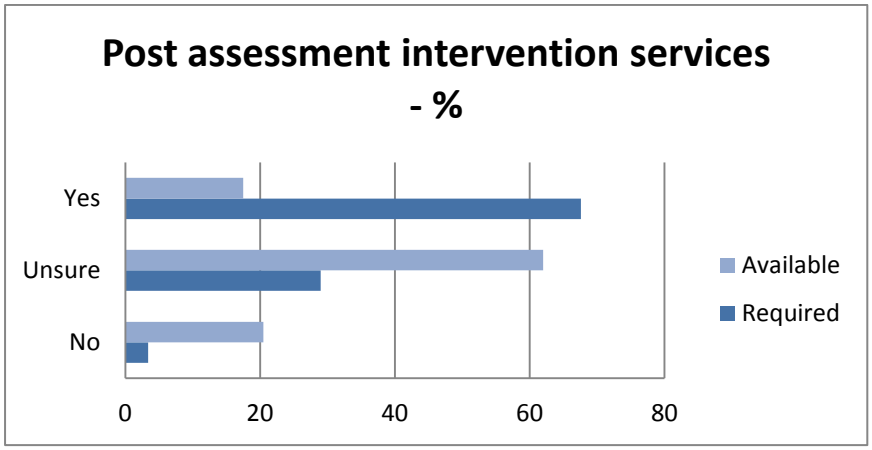
Over three quarters of GPs (79.7%, n=169) indicated that ‘development assessment’ services were a required service, yet only 56.6% understood this service to be available in their area. Just 17% (n=36) of GPs were ‘unsure’ if ‘development assessment’ services were even required. Nearly 32.7% (n=67) of GPs indicated that they were ‘unsure’ if this assessment type was available in their area.

Figure 16. Development assessment



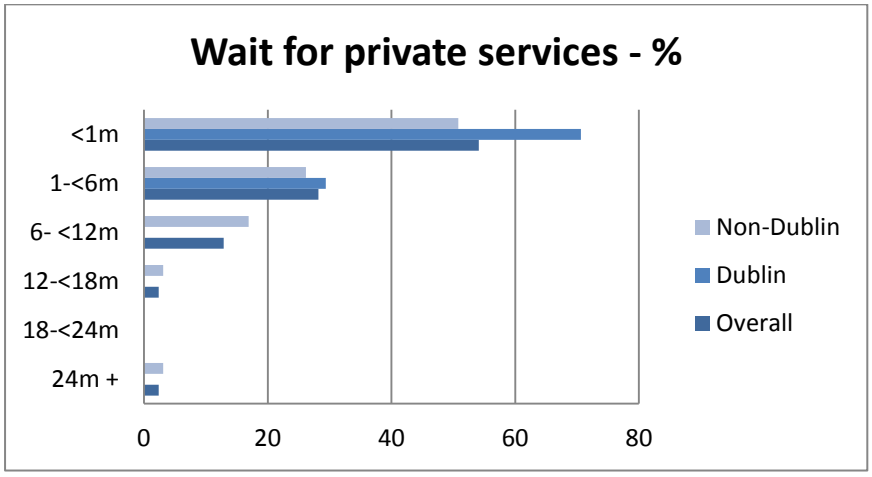
Just over 67.6% (n=140) of respondents estimated that ‘post assessment intervention services’ were necessary, however a significantly lower number (17.5%) considered these services to be available to their patients.

Figure 17. Post assessment intervention services



Over half of GPs (54.1%, n=46) who requested a patient referral for assessment via private services reported an average wait of less than one month with another 28.2% of GPs reporting 1-<6 months, and 12.9% 6-< 12 months. Only four (5%) GPs reporting average waiting times for private assessment as one year or more. No one in Dublin reported an average waiting time for private assessment over six months and 70.6% of Dublin based GPs reported the average wait to be under one month compared to 50.8% of non-Dublin based GPs.

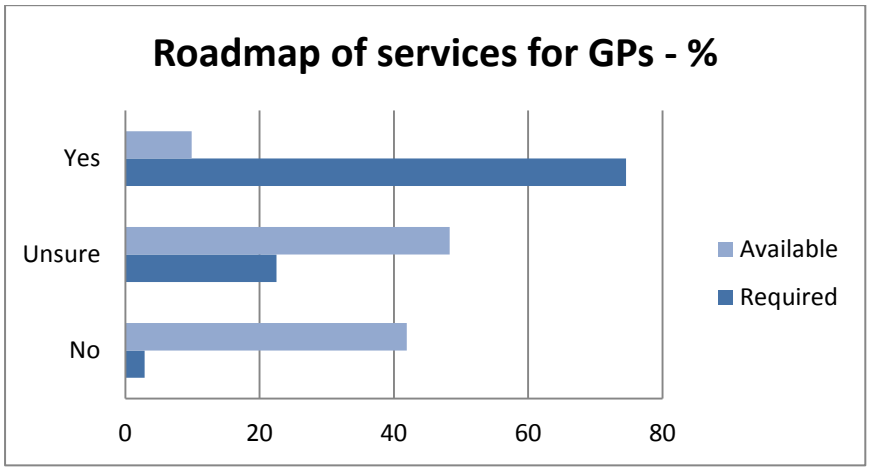
Figure 18. Wait for 'private' services



Taking paediatric assessments, developmental assessments and post assessment intervention services as the three key services for children, we see that 40.7% of GPs report that they do not have any of these services, 13.6% have one of these services, 32.9% have two and 12.8% report having all three services. The counties in which GPs responding reported on average one or none of these services are: Carlow, Donegal, Dublin, Leitrim, Limerick, Longford, Mayo, Offaly, Roscommon, Waterford and Wicklow.

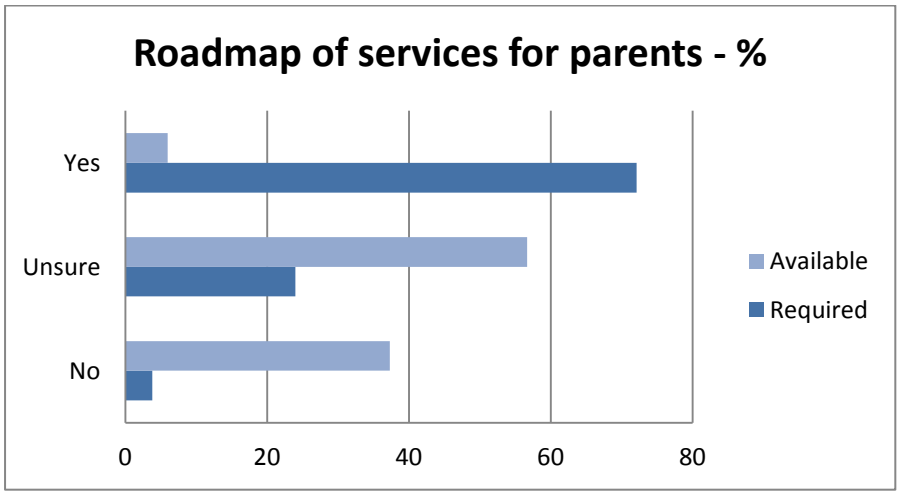
Respondents were asked whether a 'roadmap of services for GPs' was both required and available in their local area. In the context of this study, a roadmap related to a clear referral pathway to ensure consistent and equitable access to services such as speech, physio and occupational therapies. The majority (74.6%) indicated that this service was required however only 9.9% confirmed that this service was available to them. A little over half of respondents (48.3%) were unsure whether this roadmap of services was available in their area.

Figure 19. Roadmap of services for GPs



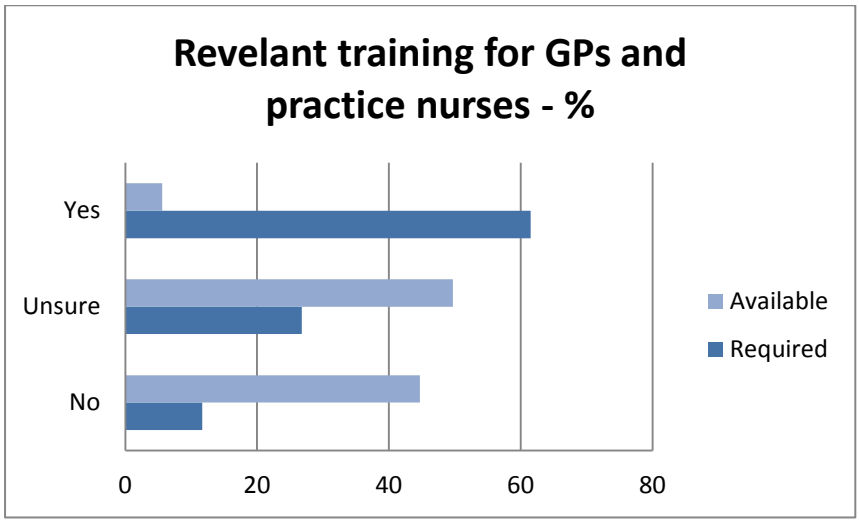
Respondents indicated a major lack of availability of a 'roadmap of services for parents' of children adopted from abroad. Only 6% indicated that they knew of a clear referral pathway in this area; while nearly 57% of GPs were unsure whether this service was available or not. The majority of GPs (72.1%) felt that this service was required for parents.

Figure 20. Roadmap of services for parents



Based on responses, GPs perceive there to be a considerable lack of relevant training available for GPs and practice nurses to help to support and meet the needs of children adopted from abroad. Just over 61% (n=126) of GPs indicated that training was required, yet 94.4% of GPs selected 'no' or 'unsure' when asked whether this training was provided in their local area.

Figure 21. Relevant training for GPs and practice nurses



Qualitative Survey Comments

Respondents were given the opportunity to add additional open-ended comments at the end of the survey. A total of fifty-five comments were noted. These were then data entered and thematically analysed into four main themes including time issues, service issues, no patients adopted from abroad and suggestions. Feedback provided further information about time limitations, issues with services and suggested information and guidelines to support GPs.

Of the eleven respondents who provided feedback in relation to issues with services, some illustrated difficulties with the referral process and waiting times. One GP "*recently had to send eight letters to get a referral*". Communication issues with and between services were highlighted by some GPs. The importance of receiving assessment results in a timely fashion in order to provide bespoke treatment for their patients and a sense of being excluded from treatment information was identified by others.

"*Limited communication back from HSE/CFA and CAMHS and Early Intervention. In order to provide useful GP services we need timely information."* _GP01

"They do not let us in. They rarely give out any discharge letters if they do (and they usually don't)." _GP02

One GP identified their frustration with insufficient child and adult mental health service provision and follow-up in their locality and spoke of a "*reluctance*" from the service in getting "*involved*" initially.

"*Regarding all children in this area… CAMHS provide a very poor, inconsistent service with lack of any appropriate follow up, and reluctance to even get involved in the first instance. Utter waste of time referring. Very frustrating."*_GP03

*"The Service provided by CAMHS in our area is completely inadequate. There are very lengthy delays in seeing children and families in crisis"*_GP08

Approximately eleven GPs identified issues with accessing the patient information the survey requested due to time limitations related to their intense workload, an inability to identify patients adopted from abroad via their records and an inability to recall patients from memory.

Sixteen GPs recorded that they had either had none or they were unaware whether they had any children adopted from abroad attending their practice. Comments included:

"*Am not personally aware of child adopted from abroad who is attending the practice."*_GP04

*"If there are adopted children - there are not flagged in the computer system."*_GP05

Two respondents identified a need for further information in the area of intercountry adoption and patient health. One GP suggested that an information booklet outlining available services would be of use:
*"Did not come across any cases since working here but I feel definitely we would need some training information booklet with services available."*_GP06

*"An ICGP roadmap or guidance would be very useful."*_GP07

Discussion

Clearly the response rate is a limiting factor in this study and it is expected that GPs who felt the survey did not apply to them (e.g. who did not have any children adopted from abroad attending the practice) were more likely not to reply. However, the profile of those who did reply is consistent with national GP data.

Furthermore, recall bias is an issue with GPs experiencing some difficulties with some of the child specific detail requested. This is evident from both comments received and in the proportion who could not provide certain information, for example, the proportion unsure of referral outcomes is substantially higher for children adopted pre 2010 compared to those adopted in later years. However, while the level of detail requested was kept to an absolute minimum to encourage response, GPs clearly had difficulty recalling or accessing the information on their systems and one reason for same is the absence of a flag of children adopted from abroad on GPs' systems.

Despite the limitations above, the data obtained is broadly consistent with findings from other countries and with the data regarding intercountry adoptions in Ireland.

The age profile of children as per the data from this GP survey is consistent with the data from a previous study in 2007 in Ireland among parents of children adopted form abroad (Greene et al, 2007), noting that the current study includes children adopted up to 2015 and it is known that there is an increase in age at adoption in the latter years (AAI, 2013; www.UN.org). Similar trends are also apparent with regard to age at adoption and country with for example, fewer children from Russia being younger than one year and more children from Vietnam being younger than one year at adoption.

Table 10: Comparison of age at adoption statistics from Irish studies

	Greene et al, 2007 Data from parents	Current survey Data from GPs
Mean age	16.9	18.9
Standard deviation	18.03	18.11
Minimum age	<1	<1
Maximum age	129	132
Age at or below which one quarter adopted	8	7
Age at or below which half adopted	12.5	12
Age at or below which three quarters adopted	19	24

Greene et al (2007) reported that 86% of parents visited a GP upon immediate return to Ireland. Within this study, GPs reported that 81.4% of children were first seen in their practice within one month of adoption age.

A little over one quarter (26%) of children were identified as having some form of emotional, social or mental health related issues with a non-significant increase as age at adoption increases. A notably higher proportion of children from Romania and Russia were reported as having such difficulties, which may be explained by the recorded pre-adoption experience in these countries,

namely, the lack of engagement and care in Romanian orphanages (Human Rights Watch, 1996, 1998; UNICEF, 1997; Rutter and ERA, 1998; Johnson, 2000;) and the over-representation of medically and developmentally disabled children in Eastern European and Russian orphanages (Johnson, 2000).

Just over 18% of children had been referred for HSE/Child and Family Agency (CFA) early behavioural intervention assessment or for Child and Adolescent Mental health Services (CAMHS) assessment. Referral for assessment was significantly related to age at adoption with referral rates higher for children adopted at two or older. Data for the general population in Ireland reports that CAMHS teams are providing support to 1.5% of young people under the age of 18 years old (IASW, 2012). This suggests that there is a higher rate of referral for such services among children adopted from abroad compared to the general population of children in Ireland. This is consistent with the international literature showing complex care needs (Gagnon-Oosterwaal et al, 2012), higher risks to mental health problems (Brodzinsky, 1993; Miller et al, 2000; Nickman et al. 2005; Keyes et al, 2008) and elevated risks for mental, developmental and behavioural problems (Webb et al, 2005; Bramlett et al, 2007; Gibson, 2009; Ward, 2011; Woolgar and Baldock, 2015) among children adopted from abroad compared to non-adopted children. Criticisms levelled by GPs via qualitative survey comments in relation to difficulties in accessing CAMHS services pertain to the services in general rather than specifically the service provided by CAMHS to adopted children. The issue with regard to waiting times is also global across all referrals and not confined to adopted children.

The central role of the GP to families with children adopted from abroad has been reported (Greene et al, 2007). Hence, the preparedness of GPs to provide services and advise parents is critical. The findings reported here indicate that GPs have difficulties accessing public services in a timely fashion, particularly outside Dublin. Such delays were also reported by parents previously (Greene et al, 2007). Furthermore, less than one third of GPs in this survey considered the level of specialist services available to their intercountry adopted patients as ‘adequate’. The availability of services such as paediatric assessment, developmental assessment and post assessment intervention services is varied with only 57-68% of GPs overall reporting that such services are available in their area.

The literature suggests that due to the specialist nature of the care needs often presented and the infrequent occurrence of treating children adopted from abroad, GPs may not be in a comprehensive position to assess and provide advice on the child’s required care (Mather and Kerac, 2002). GPs in Ireland who responded to this survey share these concerns and have highlighted the need for roadmaps to service for both GPs and parents and for relevant training for GPs and practice nurses.

The results of our survey are consistent with findings from elsewhere and provide corroborating evidence that this group of patients attending Irish general practice have increased risks and hence a greater need for services; that there are service gaps and that GPs consider themselves in need of guidance and training.

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