Current Practice

CHILD CARE IN GENERAL PRACTICE

Adoption

HILDA N. LEWIS,* M.D., M.R.C.P.

The family doctor's concern with adoption may begin when he is consulted by a couple who cannot because of sterility or impotence have children of their own. As he will have tried to help them in overcoming the disability, it is to him that they will naturally turn for advice if they decide to adopt a child. He may be asked to supply a medical report either on the baby who is to be adopted or on the prospective adopting parents. Thereafter he may have the adopted child as a patient and he may be needed not only for physical illness but also for dealing with the emotional difficulties which are prone to occur in an adopted child from time to time.

Legal Aspects

It is difficult for any doctor to intervene helpfully in the management of an adoption unless he has a fairly clear idea of the main legal requirements. A child may be legally adopted (1) by one of its parents, who has only to apply directly to the Court for permission, (2) through a local authority or registered adoption society, who must comply with statutory requirements, (3) through the agency of a private third party (who could be a doctor), or (4) by the mother's direct placement of her child in the home of persons unrelated to her.

The Adoption Act, 1958, governs these arrangements. In the case of (3), where a private third party acts as intermediary in the adoption, he has to give notice to the local children's department at least two weeks before—or in an emergency within seven days after—the arrival of the child in his new home. In all adoptions, after the notice of application to adopt has been lodged with the Court, the Court appoints a "guardian *ad litem*" similarly to protect the interests of the child during the probationary period of at least three months that follows before the Court hearing. The mother must give her written consent before the child is placed with strangers, and in certain circumstances other consents—for example, the father's—may be required. The mother's final consent to the child's adoption cannot be given before the child is 6 weeks old. This, and the requirement of a three-month probationary period in the adoptive home after the notice of application has gone to the Court, make it impossible for an infant to be legally adopted before he is 4½ months old.

Doctors acting as third parties sometimes overlook the legal requirement to notify the local authority, and forget that they must obtain the necessary written consents. They may also be unaware of a clause in the Act which states that, if the mother wishes the child to be brought up in a particular religious faith, her wishes must be honoured. For example, if the mother wishes her child to be a Roman Catholic and he has been placed

in a Protestant home, the adopters would be legally required to bring up the child as a Roman Catholic.

These omissions may cause trouble. Another worry for the third party may occur if he becomes responsible for finding the child's mother and returning the baby to her because the prospective adopters are not satisfied with the baby and have decided not to apply for an adoption order.

The legal provisions for protection of the child on initial placement do not at present apply to cases in which the parent of the child has placed it with someone who may be a complete stranger to her, often introduced to her by someone before the baby was born. Arrangements made before the baby is born are sometimes effected by general practitioners or obstetricians. They have led to some very unsuitable placements which were not notified to the local authority. Too often in these cases they are made with an eye solely to the mother's benefit, or the adopters', while the interests of the child are barely considered. Apart from the regrettable cases where adoption of a child is advocated to help a neurotic woman or bolster up a shaky or unconsummated marriage, there are instances where a doctor has arranged an adoption though he did not have sufficient knowledge of the family into which the child was born or of the adopters, and was not in a position to make the full social inquiries that were necessary. It is wiser for doctors to leave this part of the procedure to the experienced social workers of the local authority and voluntary adoption societies.

Adoption agencies (whether local authorities or voluntary societies) must comply with regulations issued in 1959. They must (1) ensure that the parent or guardian has read and understood an explanatory leaflet and given provisional consent to the adoption; (2) have received a report on the health, history, and background of the infant, which must be approved by a committee before placement; (3) have obtained a satisfactory report on the character and suitability (including health) of the applicants as ascertained by personal interviews and public and private references, and the premises of the applicants must have been visited and approved; (4) the placing of the infant with the adopters must be approved by a committee; (5) the child must be supervised in the adoptive home after placement until official adoption papers have been applied for, when a welfare officer, as guardian *ad litem*, will continue these functions of "protecting" the child; (6) confidential records of all cases must be kept in a safe place for a specified number of years, and a yearly report of the work of the society submitted to the local authority.

Once an adoption has been legalized the adoption agency has no further power to intervene. Up to this point the natural mother has the right to withdraw her consent (unless she is considered to be refusing it unreasonably), but she cannot remove the infant from the adopters' home except with leave of the Court while the adoption application to the Court is pending.

* Psychiatrist to the Children's Society. Formerly Assistant Physician, Maudsley Hospital.

The adopters can, however, withdraw their application ; if so, they must return the child to the adoption agency. On the other hand there is no time limit within which they must apply to the Court for an order or return the child who has come to them provisionally, but if an interim order (maximum period two years) is granted by the Court after the hearing of the application to adopt, then, at the expiry of the period laid down by the Court, if no final order is issued by the Court, they must return the child to the agency—or in private arrangements to the mother. The advice of the Children's Department should be sought here.

The Doctor's Part

Before Adoption

The doctor's position is crucial and delicate. His first consideration must be the physical and mental well-being of any child who may come into the home of would-be adopters who consult him ; yet his professional training may make him think first and foremost of how he can help his patients who are childless or infertile and who want to adopt a child to fulfil their marriage. If he thinks that they are for some reason unsuitable as parents he is in a dilemma, especially if he foresees distant problems which may mar their happiness as well as their adopted child's.

The Adopting Parents.—As a rule the causes of the couple's infertility will have been investigated. If there is little or no chance of their having a child, and neither of them has an incurable or progressive disease which will prevent them from together seeing the adopted child through to late adolescence, the requirements are clear: they should be emotionally mature and mentally stable, get on well with each other, be equally keen to adopt a child, and generally have the concurrence of their near relatives.

When the doctor knows the would-be adopters well enough to size up these aspects he can usually give a considered opinion and advice. Sometimes, however, he has seen little of them, or he feels insufficiently acquainted with the pros and cons of adoption. His best plan then is to answer their questions as well as he can and to tell them where they can get reliable information about procedure—that is, usually from one of the recognized adoption societies. If he sees definite obstacles which would make adoption undesirable in their case, he can, by tact and sympathy, help them to realize the grounds for this and make the necessary adjustment. A woman, for example, who has had little to do with children and feels great misgivings about her ability to bring up a child, can be put in touch with a crèche or nursery where she can do voluntary work and acquire confidence and experience, so that she becomes better fitted to adopt a child. Some boroughs provide classes for expectant parents at which prospective adopters might be welcomed. More serious obstacles may call for psychiatric help.

A doctor needs to be very cautious when his patients insist that only a certain type of child will do for them to adopt. Their stipulations often derive from ambitions and fears which lead to unhappiness for all concerned if the adopted child cannot fulfil their—often undue—expectations.

He needs also to assure himself that the husband is as desirous as the wife to adopt a child. When the husband seems lukewarm and in agreement only in order to satisfy his wife's wishes there may be trouble later on in the form of hostility to the child. When the wife concurs only to please the husband it is potentially even more disastrous. The possibility that a childless couple may finally have a child of their own need not be a contraindication to adopting, provided they are otherwise suitable and have no misgivings.

Conversely, however, people who already have children of their own sometimes wish to adopt another child. Unless they have a strong love of children and great success in handling

them, this can store up trouble. The attitudes of the existing children of the family have to be taken into account, as does the age of the youngest child ; in most cases it is unwise for the gap between the last natural child and the adopted child to be less than five years. The safest plan is to have an initial period of foster-care, especially if the child to be adopted is a year or more old.

Mental illness and emotional disturbance are strong objections. As a general rule a history of definite psychological illness—whether psychotic or neurotic—or of a persistently depressive outlook makes adoption undesirable. Doubtful cases should be referred for a psychiatric opinion. Immature and egocentric but plausible people, especially some attractive women who claim that their neurotic troubles will disappear once they have a child to occupy their attention, may succeed in beguiling their doctors into believing this too: they are dangerous for adopted children. The doctor needs also to be on his guard when the prospective adopters describe their own disturbed and unhappy childhood in a broken home—the poor pattern of parental behaviour to which they were exposed may have left its stamp on their own capacity to be wholly suitable parents of an adopted child (Lewis, 1965).

Physical illness is on the whole easier to assess in its bearing on adoption, especially if a consultant's recent opinion on the prognosis is at hand. The child's physical safety and his general enjoyment of life have to be considered in the presence of a condition such as epilepsy or deafness. Each disease has its risks. It is desirable that both parents, but especially the mother, should have a life-expectancy of at least 20 years.

In all cases, even though the doctor is satisfied that the couple are suitable adopters, the adoption agency to which they apply may, because of factors of which the doctor is unaware or because of a different view of the risks, reject the application, to the great disappointment, and perhaps embitterment and indignation, of the couple in question. If the doctor is convinced that a mistake has been made he may do his best to help them by putting them in touch with another adoption agency ; but in general it will be his concern to help them to accept the decision, and certainly to avoid inflaming their reactions.

The reports which adoption societies and local authorities ask the doctor to fill out regarding the medical history, physical condition, personality, mental stability, fertility, and marital problems of would-be adopters are strictly confidential. The applicants have given permission for them to be obtained, and, if an application is rejected, the reasons for this and the source of information are not disclosed. The doctor can therefore give his findings and opinions frankly, and, if he wishes, can request that some of the information he provides shall be available only to the medical adviser to the adoption agency. In the majority of cases, of course, the couple are suitable, and there is no reason for provisos about special care about confidentiality.

The Child.—The child may have been handicapped from the start because its unmarried mother has been ashamed and has not made proper arrangements for her care during pregnancy and delivery, or inquired about its after-care, or about adoption if during her pregnancy she has made up her mind that she will not keep the baby.

The doctor will be in a much better position to fill out the statutory form required by the regulations for adoption societies if he has looked after the mother and her family. If, however, he fills out the form in virtue of his post as visiting doctor to a home for mothers and babies or as medical officer of health he will find it necessary to get information from others—for example, the general practitioner, moral welfare worker, obstetric hospital, or adoption agency. When the baby has to be placed just after leaving the lying-in hospital the doctor cannot by examination of the child answer questions about its mental state, vision, hearing, and so on ; he has to rely on reports from the hospital and the family history. Prematurity, low birth-

weight, neonatal asphyxia, persistent jaundice, fits, twitching, or failure during the first few weeks to suck, cry, or thrive will be grounds for caution, and a paediatric report will be desirable. Fortunately most babies born to healthy young mothers are well nourished and lively, and the doctor can sign the form with some confidence, provided that he has thoroughly examined the child undressed. If this precaution is neglected malformations or minor defects may be overlooked. Such abnormalities can cause disproportionate trouble later if the adopters have not been warned about them.

The statutory form also requires the results of special tests, such as examination of the urine for albumin and sugar, serological tests for syphilis at the age of 6 weeks or later, and tests for phenylketonuria between 6 weeks and 2 years of age. In very prompt placements these tests are impracticable, and have to be carried out later. Obtaining blood and other specimens may occasion difficulty: advice on this and other special points in the examination may be found in a previous paper (Lewis, 1960). In judging the development of the infant's mental faculties and special senses Sheridan (1960) and Illingworth (1964) may prove helpful guides.

In the case of older children for adoption, the practitioner will often have known them as foster children in the home of one of his patients. The foster parents will then have adequate knowledge of the child and of any physical or mental handicaps he may have. If there are behaviour or educational problems an assessment at a child guidance clinic may be indicated.

During the Process of Adoption

When the adopters receive the infant into their home they usually take him to the baby clinic or to the general practitioner, and ask about any details on the medical report sent them by the adoption agency which are causing them concern. If they have taken the child privately or through a non-medical third party they will have little or no information about the child's parentage and condition and will be still more likely to be anxious on this score. The questions they ask or the reassurance they hope for may demand expert advice—for example, from an authority on heredity or mental subnormality. On such issues obviously the practitioner is well advised to refrain from over-confident or discouraging statements. If the adopters are worried about a history of epilepsy, mental defect, or mental illness in some members of the child's family, it may be helpful for the practitioner to ask the adoption agency to let him have, in confidence, fuller details of the abnormality, its severity, and form. Unsuitability because of an inheritable morbid condition is, however, rare. Guidance on these matters is available in various conference reports of the Standing Conference of Societies Registered for Adoption (see Appendix).

The next point at which the doctor is involved is when the adopters apply to the Court for an adoption order. This is usually done as soon as the infant is 6 weeks old—the earliest date at which the mother can give her consent—or, if he is older, directly the adopters are certain they want to keep him, because they are afraid the mother may change her mind. Once the application papers are completed and lodged with the Court no one may take the child from them during the probationary period which follows.

A medical report, usually on a form obtainable from the clerk to the Court, the children's officer, or H.M.S.O., and identical with that required before placement, has to be submitted with the application papers. The only new item is the doctor's assurance that he has pointed out any defects to the adopters and explained their significance. The adopters may like to have this form and the corresponding examination entrusted to a paediatrician. In either case they must pay an appropriate fee unless the doctor makes a concession because of their limited means. (For the medical report on the adopters before placement the same applies.)

The medical report and examination of the child must have been made not earlier than one month before the application to the Court if the child is under 1 year old, or not more than six months before if the child is 1 year or more old. If the baby has not been thriving a paediatric examination is especially desirable before the papers go to the Court.

A medical report on the applicant is limited to a certificate (which is unnecessary if one of them is the child's parent, or if the child is over compulsory school age). It runs: "I examined . . . on . . . and have formed the opinion that he/she is physically, mentally, and emotionally suitable to adopt a child."

If the doctor does not know the applicants, and they have made their arrangements for getting the baby privately, it is very difficult for him to gather the evidence on which he can fill out the requisite certificate. A cursory examination and inquiry is obviously insufficient. If the guardian *ad litem* is not satisfied about the applicants' suitability she may ask for a more detailed report for the Court; conversely the doctor may have misgivings about the applicants' suitability, in which case he must either refuse to sign the certificate or get in touch with the guardian *ad litem* in confidence if the adopters give him permission to do so. Once the adoption has been legalized it will be too late to have second thoughts.

After the Adoption Has Been Legalized

After the adoption has been legalized most adoptive parents settle down to the tasks of baby-care with enjoyment and efficiency, and serious problems of management do not arise oftener in the early years than in the families of ordinary parents. Unsuspected defects in the infant—or in the adopters—may reveal themselves, but they are mostly coped with as they would be in a natural family.

There is, however, a proportion of adoptive parents—often rather elderly—who worry and need reassurance even though the baby is developing normally. They often continue to need support for many years, especially in the matter of when and how to tell the growing and inquiring child about his adoption. These people tend to seek out other adopters to share their problems with, and well-directed discussion groups may give them much help.

In later childhood and adolescence the adopted child may show behaviour problems requiring psychiatric advice.

Telling the Child About His Adoption.—At the Court, or beforehand, the adopters are usually told that they ought to inform the child as soon as possible of his adoption, but they are seldom given enough advice about how they should do this. The adopters often need help to overcome their emotional resistance to making the disclosure, or their anxiety tends to make them do it in a way that may, by its unexpectedness and intensity of feeling, cause the adopted child needless distress. To guide the parents in this matter calls for much psychological insight on the doctor's part. He may in difficult cases find it desirable to seek some psychiatric help—for example, through a child guidance clinic if the child is disturbed. Commonly, however, the special leaflets prepared and distributed by the adoption societies suffice to guide adopters through this awkward problem. The process of telling the child should be gradual as the child grows, and should begin when he asks his first questions bearing on the topic or about the facts of life. A simple story (like *Mr. Fairweather and his Family*, by M. Kornitzer; see Appendix) read and re-read to a young child, with appropriate modifications, prepares the way admirably. If *You Are Adopted*, a letter for adolescents specially written with their difficulties in mind—for example, worry about their illegitimate birth, and about their natural parents—may be very helpful, even if it is the parents who read it as a guide to giving the adolescent further information (see Appendix).

Unsatisfactory Adoptions

Outright rejection and hostility are fortunately rare in adoptive families. But if the doctor sees that the adopted child is openly or covertly disliked, or the object of very mixed feelings on the part of one adopter, he should refer the child (even if the overt symptoms of disturbance in the child are very slight, such as enuresis) to a children's psychiatric clinic as early as possible, and send separately a confidential intimation of his reasons for the referral. To remedy a situation of this sort obviously calls for the utmost tact and skill. If things go from bad to worse, or if there is reason to suspect actual cruelty, a confidential communication to the children's officer is the right course to pursue. She can, if there is a case for a Court action, apply for a Fit Person Order enabling her to take the child into care and take steps to bring about re-adoption by new parents, the previous adoption order being rescinded. But she also has wide powers for dealing with such a problem, even without removing the child from the adoptive parents' home.

Unsatisfactory Private Placements

If a child's parent or guardian chooses to arrange privately for him to be with foster parents—without payment—with a view to adoption, preliminary investigations and medical examinations of the child and foster parents are not obligatory, and the child may remain indefinitely in their home without legal status. The children's officer, however, has wide powers to investigate and ask for reports. If the doctor who is involved in the matter (possibly because he has been called in to treat the child for some illness) forms the opinion that the child is not being properly cared for he should inform either the medical officer of health (if the child is under 5) or the children's officer direct. The health visitor or children's officer will visit the foster-home and, if she sees fit, see the child's parent or guardian, so that the latter may either take steps to improve the foster-home situation or remove the child.

If physical or mental cruelty can be proved the children's officer may take the matter to Court and get an order for the child to be moved and placed under "care and protection" with a fit person. In the worst cases the doctor may feel it his duty to inform the police immediately; an example of this would be the "battered baby syndrome" which has lately received publicity (Griffiths and Moynihan, 1963).

Some of the most serious instances of neglect and cruelty arise in cases where the child's mother has given it away (either directly or through a third party) to a strange couple who have either not applied for power to adopt or who have had their application rejected by the Court; nevertheless the child has continued to live with them and be maintained by them. In such cases of *de facto* adoption the children's officer can do little to alleviate the child's situation without the willing co-operation of the foster-parents or child's mother (if she can be found) unless there are sufficient grounds for laying a legal charge of cruelty or neglect.

The powers of the children's department to investigate and help neglected or unhappy children (without taking them into care) have been reinforced by the Children and Young Persons Act, 1963. The children's officer is encouraged to seek the help of workers in other statutory and voluntary bodies, such as health visitors, home helps, special officers of the N.S.P.C.C., or the Family Service Units. A carefully planned attack can thus be made on the adverse situation in which a child may be placed. The help of the family doctor is essential for the satisfactory implementing of the new Act. It is therefore of

the utmost importance that his relationship with the local children's department and the medical officer of health should be close and friendly.

I am indebted to Mrs. M. E. Edwards, Miss J. Rowell, Mrs. O. Renier, and Dr. Naomi Lewis for helpful criticisms in the preparation of this paper.

REFERENCES

- Griffiths, D., and Moynihan, F. J. (1963). *Brit. med. j.*, 2, 1558.
 Illingworth, R. S. (1964). *Ibid.*, 2, 1245.
 Lewis, H. (1960). *Ibid.*, 1, 1197.
 — (1965). "Psychiatric Aspects of Adoption" in *Modern Perspectives in Child Psychiatry*, ed. J. G. Howells. Oliver and Boyd, Edinburgh.
 Sheridan, M. (1960). *Developmental Progress of Infants and Young Children*. Ministry of Health Reports on Public Health Subjects, No. 102. H.M.S.O., London.

Appendix

Useful Addresses

Information and help for the mother and her child may be obtained from:

National Council for the Unmarried Mother and Her Child, 255 Kentish Town Road, London N.W.5. (Tel. Gulliver 8383.)

Local moral welfare associations.

Local children's officers.

Standing Conference of Societies Registered for Adoption:

Hon. Secretary, A. Rampton, Esq., Gort Lodge, Petersham, Surrey.

In addition to its functions in respect of its member societies, this Standing Conference watches over the interests of adopted people and adopters, issuing various booklets and leaflets of use to them as well as reports and literature specially for those engaged in adoption work.

Information for Adopters

The following pamphlets and leaflets are obtainable from the Standing Conference:

Adopting a Child.—A pamphlet for intending adopters, which also contains names and addresses of adoption societies in England and Wales. Price 1s., post free.

Adopting an Older Child, by M. E. Edwards. 3d. per copy, post free.

What Shall We Tell Our Adopted Child? 3d. per copy, post free.

If You Are Adopted, by Hilda Lewis and Margaret Kornitzer. A letter designed to help adolescents and some adopters. Price 6d. per copy, post free.

Other leaflets are obtainable from the individual adoption societies explaining their particular conditions—that is, their religious affiliations, and so on. Particulars of a new society, the Agnostics Adoption Bureau, are available from the British Humanist Association, 13 Prince of Wales Terrace, London W.8. (Tel.: Western 2341.)

Books for Adoptive Parents

Kornitzer, Margaret (1959). *Adoption*. Putnam, London.

— (1960). *Mr. Fairweather and His Family*. (A story for the young adopted child.) Bodley Head, London.

Rowe, Jane (1959). *Yours By Choice*. Mills and Boon, London.