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**ADMONITIONS OR ACCOUNTABILITY?: U.S.
IMPLEMENTATION OF THE HAGUE ADOPTION
CONVENTION REQUIREMENTS FOR THE COLLECTION AND
DISCLOSURE OF MEDICAL AND SOCIAL HISTORY OF
TRANSNATIONALLY ADOPTED CHILDREN**
D. MARIANNE BROWER BLAIR*

I. INTRODUCTION

One of the central, unifying themes of the Wells Conference on post-adoption challenges is the vital importance of thorough collection and disclosure of the medical and social history of children who are to be placed for adoption. Cognizant of serious and increasingly prevalent deficiencies in the collection and disclosure practices utilized in many transnational adoptive placements during the 1990s,¹ Congress and the U.S. Department of State responded. They devoted considerable attention to the regulation of these practices in the federal legislation and regulations that implement the Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption² (the Hague Adoption

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¹ See *The Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption: Treaty Doc. 105-51 and Its Implementing Legislation S. 682: Hearing Before the Senate Commission on Foreign Relations*, 106th Cong. 1-2 (1999) (opening statement of Sen. Jesse Helms, Chairman, S. Comm. on Foreign Relations).

² See, e.g., Hague Conference on Private International Law: Convention on Protection of Children and Co-Operation in Respect of Intercountry Adoption, May 29, 1993, 32 I.L.M. 1134, available at www.hcch.net/upload/conventions/txt33en.pdf [hereinafter Hague Adoption Convention]; Trish Maskew, *The Failure of Promise: The U.S. Regulations on Intercountry Adoption Under the Hague Convention*, 60 ADMIN. L. REV. 487, 492, 494 (2008).

Convention),³ an international agreement that entered into force for the United States on April 1, 2008.⁴

The Hague Adoption Convention provides a framework for international adoption practices for the eighty-five nations that are currently contracting states.⁵ It also shapes the development of practices in additional signatory nations that have not yet become parties.⁶ The Convention itself mandates the collection, preservation, and confidentiality of medical and social history in general terms, but it leaves the development of more specific standards and enforcement mechanisms to each contracting nation.⁷ In the United States, that regulatory scheme is primarily supplied by the federal Intercountry Adoption Act of 2000 (IAA)⁸ and federal regulations setting forth the accreditation standards for the agencies and other entities that bear primary responsibility for facilitating international adoptions.⁹ However, because U.S. state law requirements for collection and disclosure are not pre-empted by the federal regulations,¹⁰ adoption intermediaries are subject to an additional, and in some U.S. states a more stringent, regulatory layer.¹¹

³ The Hague Adoption Convention (or the Convention) is so-termed because it is one of several international family law agreements drafted under the auspices of the Hague Conference on Private International Law (HCCH), an intergovernmental organization of over seventy member nations created to negotiate and draft multilateral conventions with the goal of furthering the progressive unification of civil and commercial law. The United States became a member of the Conference in 1964. See HAGUE CONF. ON PRIVATE INT'L L., <http://www.hcch.net> (last visited Feb. 16, 2012).

⁴ *Convention of 29 May 1993 on Protection of Children and Cooperation in Respect of Intercountry Adoption: Status Table*, HAGUE CONF. ON PRIVATE INT'L L. (Sept. 11, 2011), http://www.hcch.net/index_en.php?act=conventions.status&cid=69.

⁵ *Id.*

⁶ *Id.*

⁷ See Hague Adoption Convention, *supra* note 2, arts. 16, 30, 31.

⁸ 42 U.S.C. §§ 14901–14954 (2006).

⁹ 22 C.F.R. §§ 96.1–96.111 (2011).

¹⁰ *Id.* § 96.27(g). See also 42 U.S.C. § 14953(a) (2006); Hague Convention on Intercountry Adoption; Intercountry Adoption Act of 2000; Accreditation of Agencies; Approval of Persons, 71 Fed. Reg. 8064, 8109 (Feb. 15, 2006) (to be codified at 22 C.F.R. pt. 96).

¹¹ See, e.g., D. Marianne Brower Blair, *Liability of Adoption Agencies and Attorneys for Misconduct in the Disclosure of Health-Related Information*, in 3 ADOPTION LAW AND PRACTICE 16–12 to 16–13 (Joan Hollinger ed., LexisNexis 2010) [hereinafter ADOPTION (continued)]

The rigor with which the IAA and its implementing federal regulations impose accountability for collection and disclosure of medical and social history became a focal point for intense debate during the drafting process,¹² and the resulting regulatory scheme is less robust than was originally anticipated.¹³ Now, three years after the federal statutes and regulations implementing the Hague Adoption Convention entered into effect, this article analyzes and critiques the collection and disclosure standards and enforcement mechanisms of this current federal regime and their interaction with the standards and liability imposed by U.S. state law. In addition, the author conducted a short empirical survey to explore the practices and perceptions of agencies and other entities that are currently accredited or approved to serve as primary providers of adoption services

LAW AND PRACTICE]; D. Marianne Brower Blair, *The New Oklahoma Adoption Code: A Quest to Accommodate Diverse Interests*, 33 TULSA L.J. 177, 257–70 (1997). See generally D. Marianne Brower Blair, *Lifting the Genealogical Veil: A Blueprint for Legislative Reform of the Disclosure of Health-Related Information in Adoption*, 70 N.C. LAW REV. 681 (1992).

¹² See Maskew, *supra* note 2, at 497 (describing intense reaction to the vicarious liability proposals in the proposed regulations); Sarah Sargent, *Suspended Animation: The Implementation on Intercountry Adoption in the United States and Romania*, 10 TEX. WESLEYAN L. REV. 351, 380 (2004) (noting that the federal regulations implementing the IAA were very controversial).

¹³ For other commentators who have reached this conclusion as well, see, for example, Johanna Oreskovic & Trish Maskew, *Red Thread or Slender Reed: Deconstructing Prof. Batholet's Mythology of International Adoption*, 14 BUFF. HUM. RTS. L. REV. 71, 100–03 (2008) (discussing how important provisions in the IAA were eviscerated in the regulations); Maskew, *supra* note 2, at 496–511 (critiquing the many ways in which the final regulations failed to fulfill the promise of protection against adoption intermediary abuses in disclosure of health information and other aspects); Anjanette Hamilton, Comment, *Privatizing International Humanitarian Treaty Implementation: A Critical Analysis of State Department Regulations Implementing the Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption*, 58 ADMIN. L. REV. 1053, 1064 (2006) (opining that the federal regulations implementing the IAA are “more likely to maintain the status quo of regulation rather than bring about the procedural changes necessary to remedy the abuses that the Convention and the IAA sought to prevent”); Olga Grosh, *A Call of Duty: Preventing Adoption Disruption by Expanding Adoption Providers' Duty to Investigate and Disclose Children's Medical History* (Feb. 28, 2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1772362 (critiquing broad exceptions in regulations).

in placements between the United States and other Hague Convention member nations. Data from this survey augments the author's analysis throughout the body of the article and is presented in greater detail in Appendix A. Part I of the article sets forth the backdrop for the creation of the federal standards by chronicling the rationale for comprehensive collection and transmission of medical and social history, the reform movement that brought increased regulation and liability under state law for non-disclosure in U.S. domestic adoptions, and the changing landscape of transnational adoptive placement that prompted attention to this issue on an international scale. Part II examines the requirements for collection and disclosure imposed by federal law on facilitators of incoming and outgoing adoptive placements with Hague Convention nations and the extent to which state provisions may supplement them. Part III explores the federal regulatory scheme's reliance on accreditation penalties rather than civil liability as the prime enforcement mechanism, the impact of federal standards on potential liability under state law, and federal treatment of exculpatory clauses.

Federal law contributes a considerable measure of uniformity and increased guidance to U.S. facilitators of incoming and outgoing transnational adoptive placements. The collection standards of federal law,¹⁴ in conjunction with global awareness generated by the Convention itself, appear to have positively impacted the transmission of information to some degree in transnational placements involving both Hague and non-Hague nations.¹⁵ Provisions in U.S. federal law that motivate compliance

¹⁴ 42 U.S.C. § 14923(b) (2006); 22 C.F.R. §§ 96.37, 96.14, 96.38, 96.44, 96.45, 96.46, 96.49 (2011).

¹⁵ A majority of the U.S. agencies responding to the author's survey who facilitate adoptions from non-Convention as well as Convention nations reported that the Convention regulations affected their own standard practices in non-Convention nations and also affected the practices of facilitators in those nations. See *infra* notes 211–15 and accompanying text. The 2010 Special Commission on the Practical Operation of the Convention has recognized that the *Guide to Good Practice No. 1*, developed under the auspices of the Permanent Bureau of the Hague Conference, provides valuable guidance to future as well as existing contracting states. Hague Conference on Private International Law, *Conclusions and Recommendations and Report of the Special Commission on the Practical Operation of the 1993 Hague Intercountry Adoption Convention*, ¶ 5 (2011), available at http://www.hcch.net/index_en.php?act=publications.details&pid=5458&dtid=2. Two Special Commissions on the Practical Operation of the Convention, in 2000 and 2005, recommended that parties to the Hague Convention should, to the extent possible, (continued)

and provide compensation for malfeasance, however, are far less rigorous than those originally proposed. Ultimately, state law will therefore continue to play a significant role in shaping the mandates of the overall U.S. legal regime, controlling collection and disclosure in transnational adoptive placements, and recompensing those for whom the system has failed.

II. THE PATH TO FEDERAL REGULATION

To assess implementation of the Hague Adoption Convention's mandate by the U.S. Congress and executive branch, one must understand the context in which the federal statute and regulations were created. This section provides this background, setting forth an overview of: (1) the rationale for accurate and thorough transmission of health information; (2) U.S. state reform efforts to create standards and impose liability; and (3) changes in the quantity and conditions of transnational adoptive placements during the 1990s that galvanized attention to the need for reform at the global and national level.

A. *Why Is Complete Transmission So Important?*

An analysis of the efficacy of federal law in fostering comprehensive collection and disclosure of medical and social history is compelling only if those involved first remind themselves why they care. In other words, why is the collection, preservation, and transmission of this information so vital to the well-being of adopted children?

First and foremost, comprehensive collection and full disclosure of a child's health-related information facilitates appropriate medical and psychological treatment for adopted children after placement. The tragic consequences of non-disclosure became evident in past placements, both domestic and transnational, when medical or psychiatric treatment was hindered or delayed.¹⁶ Children endured unnecessary, painful, and

apply the Convention's basic principles in their relations with non-member nations, and the 2010 Special Commission noted various examples of coordinated practices and bilateral agreements that had been initiated in this regard. *Id.* ¶ 72.

¹⁶ See, e.g., *Dresser v. Cradle of Hope Adoption Ctr. Inc.*, 358 F. Supp. 2d 620 (E.D. Mich. 2005) (holding that an adopted Russian child stated a valid claim based on the alleged failure to timely deliver medical records, resulting in medical treatment with a drug that was contraindicated by his medical history and causing permanent impairments); *Roe v. Catholic Charities*, 588 N.E.2d 354 (Ill. App. 1992), *appeal denied*, 602 N.E.2d 475 (Ill. 1992) (holding that children in three adoptive families could have received proper treatment

(continued)

hazardous diagnostic testing,¹⁷ and sometimes severe and irreversible physical or psychological damage,¹⁸ institutionalization, or permanent inability to function.¹⁹ In addition, children and their adoptive families

at a much earlier age had the agency released information that was in its possession); *Halper v. Jewish Family & Children's Servs.*, 963 A.2d 1282, 1284 (Pa. 2009) (failing to disclose birth mother's schizophrenia allegedly resulted in failure of child to receive necessary care). *See also* Dianne Klein, *Adoption Gone Awry: Psychotic Child Disrupts a Household*, WASH. POST, Jan. 5, 1988, at 10 (describing a case in which adoptive parents accepted \$70,000 in settlement of their lawsuit against a county social services agency for withholding vital medical information regarding their son's diagnosis of fetal alcohol syndrome and sociopathic behavior); Jane Lii, *Lawsuit Against Hospital over Adopted Boy's HIV Is Seen as a First*, N.Y. TIMES, Feb. 8, 1998, at 35 (describing mother of adopted son who asserted that a failure to disclose known medical history prevented her adopted son's HIV from being diagnosed for many years). *See generally* D. Marianne Brower Blair, *Getting the Whole Truth and Nothing but the Truth: The Limits of Liability for Wrongful Adoption*, 67 NOTRE DAME L. REV. 851, 878-81 (1992).

¹⁷ John R. Ball & Gilbert S. Omenn, *Genetics, Adoption, and the Law*, in GENETICS AND THE LAW II 277 (Aubrey Milunsky & George J. Annas eds., 1980); Ginny Whitehouse, *Consumers Viewpoint: Panel Discussion*, in GENETIC FAMILY HISTORY: AN AID TO BETTER HEALTH OF ADOPTIVE CHILDREN 19 (1984) [hereinafter GENETIC FAMILY HISTORY] (describing an adopted adult's discovery of history of fibrous breast lumps which helped the adult avoid repetition of painful treatment that might otherwise have not been avoided); Deborah Franklin, *What a Child Is Given*, N.Y. TIMES, Sept. 3, 1989, at 40-41 (reporting on an adoptee who underwent many painful tests until receiving a diagnosis of juvenile chronic arthritis, a condition he later discovered was prevalent in his birth family).

¹⁸ *See, e.g.*, *Foster v. Bass*, 575 So. 2d 967, 968 (Miss. 1990) (detailing a case in which a child suffered brain damage due to phenylketonuria, an inherited metabolic disease with symptoms that would have been entirely preventable with appropriate treatment, after an agency failed to confirm that no screening test had been performed); *Young v. Francis*, 820 F. Supp. 940, 943 (E.D. Pa. 1993) (describing a case in which adoptive parents alleged that their child's death due to Sudden Infant Death Syndrome might have been avoided if information regarding neurologic abnormalities had been released); Dianne Klein, "Special" Children: Dark Past Can Haunt Adoptions, L.A. TIMES, May 29, 1988, at 1 (following nondisclosure of known psychiatric history, adopted daughter endured years of inappropriate therapy before diagnosis of multiple personality disorder and schizophrenia). For additional examples and support, see Blair, *supra* note 11, at 701, 703-04.

¹⁹ *See, e.g.*, *Ross v. Louise Wise Servs. Inc.*, 812 N.Y.S.2d 325, 331 (N.Y. App. Div. 2006), *aff'd as modified*, 868 N.E.2d 189 (N.Y. 2007) (describing an agency's pre-adoption and post-adoption intentional misrepresentation and failure to disclose pertinent information
(continued)

frequently experienced years of turmoil, and adoptive family members have at times been subject to violent attacks or sexual abuse that might have been avoided with adequate forewarning.²⁰ When armed with

which prevented correct diagnosis and treatment and “brought about disintegration of the family unit, the ruin of Mr. Ross’s career, and his eventual hospitalization and treatment for severe depression”); *In re Lisa Diane G.*, 537 A.2d 131, 132 (R.I. 1988) (detailing a case by adoptive parents who were not told of their child’s pre-placement psychiatric evaluation recommending the child not be placed for adoption because of her behavioral problems). See also Lisa Belkin, *Adoptive Parents Ask States for Help with Abused Young*, N.Y. TIMES, Aug. 22, 1988, at A1, B8 (describing adopted children institutionalized following non-disclosure); Daniel Golden, *When Adoption Doesn’t Work*, BOSTON GLOBE, June 11, 1989 (Sunday Magazine), at 16 (describing the ultimate institutionalization of the child and resulting disintegration of the adoptive family in *In re Lisa G.*, and accounts of the institutionalization of other children after adoptions in which information was withheld); David Postman, *Sins of Silence*, SEATTLE TIMES, Jan. 14, 1996, at 6 (detailing a case with a child institutionalized after adoption following nondisclosure of violent past). See generally Blair, *supra* note 16, at 880–81.

²⁰ See, e.g., *Young v. Van Duyne*, 92 P.3d 1269, 1271 (N.M. Ct. App. 2004) (describing allegations in wrongful adoption action that an adoptive son beat his mother to death with a baseball bat); *Lord v. Living Bridges*, No. CIV. A. 97-6355, 1999 WL 562713, at *2 (E.D. Pa. July 30, 1999) (finding adopted children whose histories were allegedly not disclosed inflicted physical injuries upon adoptive parents); *Gibbs v. Ernst*, 647 A.2d 882, 885 (Pa. 1994) (relating allegations that adopted child attempted to amputate another child’s arm and suffocate his cousin, assaulted another child with a lead pipe, started a fire seriously injuring another child, and attempted to burn adoptive mother’s hands, after a placement in which information of previous physical and sexual abuse of the boy was withheld from adopters); RICHARD P. BARTH & MARIANNE BERRY, *ADOPTION AND DISRUPTION: RATES, RISKS, AND RESPONSES* 176 (1988) (describing satanic worship and self-mutilation by an eight year old); Belkin, *supra* note 19 (discussing an adopted child whose previous attacks and physical abuse had not been disclosed to parents and who later attempted to burn down home and threatened young sibling with a knife); Golden, *supra* note 19 (reporting an adopted child’s attempted suicide by fire which resulted in death of two younger siblings); Jane Hadley, *Parents Sue over Adoptions, State Blamed for Failure to Disclose Children’s Problems*, SEATTLE POST-INTELLIGENCER, Feb. 23, 1995, at 2 (describing an adopted child who sexually abused a sibling); John Painter, Jr., *Adoptive Parents Sue Washington State Agency*, THE OREGONIAN, Dec. 22, 1994, at C2 (reporting on litigation regarding the placement of a child who allegedly raped a sibling hundreds of times); Postman, *supra* note 19 (describing adopted children in two families who raped and sexually assaulted younger siblings). For further illustrations, see also Blair, *supra* note 11, at 700–04.

thorough medical and social history, post-placement providers are better able to diagnose and treat hereditary and other medical disorders,²¹ developmental delays are more readily identified and addressed at earlier stages,²² and appropriate psychiatric care has an increased chance for success when given at a younger age.²³

Comprehensive collection and disclosure also facilitate appropriate matching, placing children with adopters who are emotionally, physically, and financially able and adequately trained to address each child's individual needs.²⁴ Inadequate disclosure of known or suspected health

²¹ For example, familial polyposis causes symptoms in late childhood that if left untreated almost invariably develops into carcinoma. See *STEDMAN'S MEDICAL DICTIONARY* 1539 (28th ed. 2006); Gilbert S. Omenn et al., *Genetic Counseling for Adoptees at Risk for Specific Inherited Disorders*, 5 *AM. J. MED. GENETICS* 157, 162 (1980). Omenn also relates an incident in which a genetic clinic alerted adoptive parents to their child's 50% risk of a bleeding disorder called Von Willebrand disease following the birth mother's diagnosis so that they could take preventive measures and exercise caution before elective surgery. *Id.* at 161. See generally Laurie C. Miller & Linda G. Tirella, *Medical Issues in Domestic Adoption*, in *ADOPTION FACTBOOK V* 447–53 (National Council for Adoption 2011) (summarizing medical and social history factors that are particularly important to prospective adopters when planning for a child's post-placement medical care).

²² Early childhood therapy and educational programming maximize the potential of children with developmental delay. See, e.g., Susan Heighway, *Developmental Approach to Casefinding: Part 1*, in *GENETIC FAMILY HISTORY*, *supra* note 17.

²³ KEN MAGID & CAROLE A. MCKELVEY, *HIGH RISK: CHILDREN WITHOUT A CONSCIENCE* 149 (1987). Psychiatrists who treat psychopathic children report the chance that therapy will be successful is significantly increased when children are diagnosed at an earlier age. *Id.* at 216. For children over seven, the success rate was reported as approximately 50% and the prognosis is generally poor if treatment begins after age eleven. *Id.* at 149.

²⁴ *J.A. v. St. Joseph's Children's Maternity Hosp.*, 52 Pa. D. & C.4th 142, 151 (2001) (holding that adopted plaintiff stated a viable claim for placement in a family unable or unwilling to care for the plaintiff's special needs). Many other courts in "wrongful adoption" cases have noted the importance of full disclosure in making appropriate placements. See *Harshaw v. Bethany Christian Servs.*, 714 F. Supp. 2d 771, 797–98 (W.D. Mich. 2010); *Roe v. Catholic Charities*, 588 N.E.2d 354, 360, *appeal denied*, 602 N.E.2d 475 (Ill. 1992); *Mohr v. Commonwealth*, 653 N.E.2d 1104, 1112 (Mass. 1995); *M.H. v. Caritas*, 488 N.W.2d 282 (Minn. 1992); *Gibbs v. Ernst*, 647 A.2d 882, 889–90 (Pa. 1994); *Mallette v. Children's Friend and Serv.*, 661 A.2d 67, 73 (R.I. 1995). Some adopters have sought revocation in an attempt to obtain government assistance with unanticipated medical

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problems has resulted in unrealistic expectations on the part of adoptive parents and in placements with families who are unprepared to cope with a child's special needs.²⁵ This has, at times, created a heightened risk that the children may be subject to abuse.²⁶ Social scientists have also identified inadequate disclosure as a significant factor contributing to disruption of adoptive placements²⁷ or more rarely, dissolution,²⁸ resulting

expenses. See Klein, *supra* note 16 (discussing adoptive parents who were forced to sell family business and ultimately seek revocation of adoption to pay for child's psychiatric care); Marshall Marvelli & Sylvia Marvelli, *Tom and Janice Colella*, PEOPLE, August 1, 1988, at 6, 6 (revocation attempted to seek assistance with medical care).

²⁵ BARTH & BERRY, *supra* note 20, at 108–09; KATHERINE A. NELSON, ON THE FRONTIER OF ADOPTION: A STUDY OF SPECIAL NEEDS ADOPTIVE FAMILIES 72 (1985).

²⁶ As this article goes to press, yet another American couple is on trial for child abuse and first-degree murder of a Russian child placed in their care. *U.S. Court Starts Hearing Case of Craven Couple Suspected of Abusing Russian Boy*, ITAR-TASS, Sept. 6, 2011. Seventeen Russian children adopted by American parents are reported to have died, and recently another U.S. parent was convicted of cruel treatment of her adopted Russian son after she related on television that she forced him to ingest hot pepper sauce as a punishment. *Id.* Since 1990, American parents have adopted over 60,000 Russian children. Kim Newman, *The Sky Is Falling: Misleading Media Frenzy over Failed Adoptions*, in ADOPTION FACTBOOK V, *supra* note 21, at 343.

²⁷ BARTH & BERRY, *supra* note 20, at 20 (“Among families that reported no information gaps, the disruption rate was only 19%. Among families reporting one or more gaps, the disruption rate was 46%.”). *Id.* at 108–09. See also NELSON, *supra* note 25, at 74–75.

²⁸ Technically, the term “disruption” refers to placements that fail prior to finalization, while dissolution or annulment requires a court order to set aside an adoption decree. See Newman, *supra* note 26, at 341–42. Although dissolutions are rarer, they have been linked to inadequate disclosure when they do occur. Barth and Berry have reported that the dissolution rate for infants in domestic adoptions is currently less than 1%; however, at one time it was as high as 10% for older children. Other limited studies suggest the dissolution rates for domestic adoptions are between 3% and 6%. *Id.* at 342. From 1983 to 1987, sixty-nine adoption annulments in California were attributed to fraudulent misrepresentation by a county agency regarding a child that it placed. Klein, *supra* note 16. In several reported revocation or annulment decisions, the petitions for relief were linked to failure to disclose medical information. See *Christopher C. v. Kay C.*, 278 Cal. Rptr. 3d 907, 909–10 (Cal. Ct. App. 1991); *M.L.B. v. Dep’t of Health & Rehab. Serv.*, 559 So. 2d 87 (Fla. Dist. Ct. App. 1990); *Cnty. Dep’t of Public Welfare v. Morningstar*, 151 N.E.2d 150, 151 (Ind. Ct. App. 1958); *In re Leach*, 128 N.W.2d 475, 475–76 (Mich. 1964); *In re Anonymous*, 213 N.Y.S.2d 10, 12 (Surr. Ct. 1961); *In re Adoption of Haggerty*, No. CA-
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in emotional upheaval for the child which can be permanently damaging and which can diminish a child's chances for successful adoptive placement thereafter.²⁹ When children are placed outside of their country of origin, the damaging effects of disruption or dissolution may be further magnified.³⁰ Even when disruption does not occur, an adoptive parent's inability to cope with the challenges presented by unanticipated impairments or severe behavioral challenges can create a dysfunctional atmosphere in the adoptive home that is harmful to both the child as well as other family members.³¹ Thorough collection and disclosure thus facilitates informed decision-making by adopters and reduces the incidence of disrupted or dysfunctional placements.

Collection and preservation of medical and social history and transmission of that information to adopted individuals as they come of age also enhances their own medical decision-making and helps them maintain an important link to their origins and culture.³² Information about family

741, 1991 WL 115978, at *2 (Ohio Ct. App. June 7, 1991); Brigid Schulte, *Mom Wants to Dissolve Adoption: Lawsuit Claims Child's Problems Weren't Revealed*, FT. WAYNE J. GAZETTE, Oct. 12, 2006, at 6D; Jeff Stidham, *Couple Want Their Adoption of Boy Annulled*, TAMPA TRIBUNE, Nov. 24, 1996, at 1. Although "wrongful adoption" litigants generally maintain custody, attempted and successful dissolutions have been reported in such cases as well. See *Price v. Washington*, 980 P.2d 302, 306 (Wash. Ct. App. 1999) (relating attempted relinquishment of custody to state on grounds of nondisclosure when child was eleven); *In re Lisa Diane G.*, 537 A.2d 131 (R.I. 1988) (reporting that family court justice can grant relief to adoptive parents who sought nullification of adoption decrees).

²⁹ NELSON, *supra* note 25, at 74–76, 85–86; BARTH & BERRY, *supra* note 20, at 71–72, 156–57.

³⁰ The world reacted with horror in 2010 when an American adoptive mother put her seven year old adopted Russian son on a plane to return unaccompanied to Russia. *15 Months Later, Boy Rejected by U.S. Mother Lives in Orphanage*, WORLD NEWS CONNECTION (July 28, 2011), <http://www.themoscowtimes.com/news/article/15-months-later-boy-rejected-by-us-mother-lives-in-orphanage/441249.html>.

³¹ One Montana ranch has hosted hundreds of adopted children, most of them Russian, giving families a respite when they are unable to cope. Although 70% of the roughly three hundred children sent to the ranch do ultimately return to their adoptive families, approximately 30% do not. Kirk Johnson, *Russian Adoptees Get Respite on the Range*, N.Y. TIMES, Apr. 27, 2010, at A1. See also NELSON, *supra* note 27, at 31–33, 68–69, 73; BARTH & BERRY, *supra* note 20, at 169.

³² See generally CHILD WELFARE LEAGUE OF AMERICA, STANDARDS OF EXCELLENCE FOR ADOPTION SERVICE 87, standards 5.5, 6.21, 6.22 (2000) [hereinafter CWLA].

history and the potential of hereditary risk is critical to future childbearing decisions as well as the health of descendants.³³ A lack of access to information about social, cultural, and ethnic roots may exacerbate identity conflict in adopted individuals, particularly as they reach adolescence and adulthood.³⁴ For transnationally-adopted individuals, who may often be identified as racial or ethnic minorities in the nations in which they are raised, knowledge of their cultural, ethnic, and social heritage may be essential to their psychological well-being later in life.³⁵

³³ See, e.g., Rita Beck Black, *Genetics and Adoption: A Challenge for Social Work*, in SOCIAL WORK IN A TURBULENT WORLD 198 (Miriam Dinerman ed., 1981); Omenn, *supra* note 21, at 162; Mitch Stacy, *DNA Project Will Reunite Adoptees, Birth Parents*, GRAND RAPIDS PRESS, Aug. 24, 2004, at D4 (describing a situation in which an adopted adult did not discover a rare genetic disorder in her birth family until two years after her own child's death, a death that might have been prevented with a proper diagnosis).

³⁴ Decades ago, the term "genealogical bewilderment" was first coined in psychological literature to describe symptoms associated with this identity conflict. H.J. Sants, *Genealogical Bewilderment in Children with Substitute Parents*, 57 BRIT. J. MED. PSYCHOL. 133 (1964). See also *In re Assalone*, 512 A.2d 1383, 1388 n.5 (R.I. 1986) (summarizing opinion of expert witness that petitioner's deeply imbedded curiosity regarding her birth parents' identity and her "drifting behavior" were symptomatic of her "genealogical bewilderment" and that revelation of her parents' identities would help her resolve some of her identity conflicts); LINCOLN CAPLAN, AN OPEN ADOPTION 79-84 (1990); ARTHUR P. SOROSKY ET AL., THE ADOPTION TRIANGLE 113, 132-42 (1978). For further discussion of the role of background information in identity formation, see Black, *supra* note 33, at 203-05; Robin Henig, *Body and Mind: Chosen and Given*, N.Y. TIMES, Sept. 11, 1988, § 6, at 72; Maureen A. Sweeney, *Between Sorrow and Happy Endings: A New Paradigm of Adoption*, 2 YALE J. L. & FEMINISM 329, 347-48 (1990).

³⁵ See *The Implementation and Operation of the 1993 Hague Inter-country Adoption Convention: Guide to Good Practice*, Guide No. 1, HAGUE CONFERENCE ON PRIVATE INTERNATIONAL LAW (2008) [hereinafter *Guide to Good Practice*]. The Guide recognizes the importance of preserving background information, noting that "[t]he best interests of the child who is the subject of an intercountry adoption [] will be best protected if every effort is made to collect and preserve as much information as possible about the child's origins, background, family and medical history." *Id.* ¶ 61. The drafters further observed that

[t]he child's general history provides a link to his or her past and is important for knowledge and understanding of origins, identity and culture, and to establish or maintain personal connections if at any time he or she returns to the country of origin. The knowledge may contribute to the psychological well-being of the child later in life.

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B. Regulation and Liability Under U.S. State Law

During the mid-twentieth century in the United States and other western nations, a quest for confidentiality and a corresponding paradigm of adoption as a “rebirth” led adoption agencies and other intermediaries to place little emphasis on the collection or disclosure of the medical or social background of a child or a child’s biological family.³⁶ The conventional wisdom of that era was that adoptive parents and their children would fare better unburdened with any knowledge of the child’s background or the potential impact of genetic inheritance.³⁷

By the 1980s, however, the prevailing attitude of adoption experts had dramatically shifted.³⁸ The professional standards for adoption facilitators, drafted by the Child Welfare League of America (CWLA), were gradually amended to require a thorough investigation of medical, developmental, psychological, and family history and full disclosure of this information to prospective adoptive parents.³⁹ The standards also required ongoing supplementation⁴⁰ and subsequent full disclosure to adopted adults.⁴¹ The National Association of Social Workers, the American Academy of Pediatrics, the Donaldson Adoption Institute, and many other professional organizations similarly endorsed full disclosure.⁴² Adoption experts came

Id. ¶ 62.

³⁶ For a more detailed discussion of the prevailing philosophies and practices in the United States, Canada, Great Britain, and Ireland during the twentieth century, see D. Marianne Brower Blair, *The Impact of Family Paradigms, Domestic Constitutions, and International Conventions on Disclosure of an Adopted Person’s Identities and Heritage: A Comparative Examination*, 22 MICH. J. INT’L L. 587, 590–97, 619–21, 626, 629–37, 640–42 (2001).

³⁷ For more detailed discussion of the rationale for this mid-twentieth century approach, see ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–10 to 16–12.

³⁸ CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR EXCELLENCE FOR ADOPTION SERVICE, 25–28, 37–39 (1980).

³⁹ CWLA, *supra* note 32, standards 1.16, 1.21, 3.10–3.15, and 5.4–5.5.

⁴⁰ *Id.* at 6.16.

⁴¹ *Id.* at 6.21. See also *id.* at 6.22 (mandating support for access to identifying information).

⁴² *Harshaw v. Bethany Christian Servs.*, 714 F. Supp. 2d 771, 798 (W.D. Mich. 2010) (relating testimony of Dr. Joan Hollinger, an expert witness, who observed: “A resounding consensus . . . has emerged since the 1970’s among adoption and child welfare experts that disclosure of information about a child’s medical and social history before an adoptive
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to understand that disclosure strengthens the bond between adoptive parents and their child by facilitating a more appropriate placement and appropriate medical and psychological care.⁴³

Shifting professional norms, however, may take decades before they are fully reflected in day-to-day practices. During the 1980s and 1990s, state legislators and courts therefore took action to realize these necessary reforms.⁴⁴ Civil legal systems may influence behavior in several ways:

- (1) through legislation or regulation, they can establish detailed standards for professional practices in a particular field that provide guidance and direction; and
- (2) by imposing liability for breach of these standards or common law duties of care, they can further focus attention on professional responsibilities and motivate compliance.

Both of these approaches were utilized by state legislatures and courts beginning in the mid-1980s to address inadequate collection and non-disclosure of medical and social history.⁴⁵

Almost every U.S. state legislature had enacted legislation by the early 1990s compelling the collection and disclosure of some health-related information.⁴⁶ Since those initial efforts, many states have amended their statutes to impose detailed requirements addressing the methods for collection and the content of the information that must be gathered, if reasonably available.⁴⁷ Following the recommendations in CWLA national standards and model legislation drafted by adoption experts,⁴⁸

placement is always in the best interest of the child and serves to strengthen adoptive families”).

⁴³ *Id.*

⁴⁴ Blair, *supra* note 16, at 866.

⁴⁵ See D. Marianne Brower Blair, *The New Oklahoma Adoption Code: A Quest to Accommodate Diverse Interests*, 33 TULSA L.J. 177, 260 (1997).

⁴⁶ For a detailed analysis of this early legislative reform, see Blair, *supra* note 11, at 714–76.

⁴⁷ For examples of particularly comprehensive statutes, see OKLA. STAT. ANN. tit. 10, § 7504-1.1 (2011); MICH. COMP. LAWS ANN. § 710.27 (West 2002); VT. STAT. ANN. tit. 15A, § 2-105 (2010).

⁴⁸ UNIF. ADOPTION ACT § 2-106(a), 9 U.L.A. 36–37 (1994). For a detailed commentary on this section, see Marianne Brower Blair, *The Uniform Adoption Act's Health Disclosure*

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many statutes now require the preparation of reports to ensure comprehensiveness, often utilizing standard forms.⁴⁹ Many states have created statutory procedures to facilitate post-adoption supplementation of records by birth and adoptive family members as well as adult adoptees, with notification provisions to ensure that information regarding serious genetic conditions will be transmitted to those who could be affected.⁵⁰ Once information is collected, many states mandate its retention for at least ninety-nine years to ensure lifetime access by the adopted individual.⁵¹

At least forty-seven U.S. states now require the disclosure of some health-related history to adoptive parents.⁵² Following best practices, many of these statutes now specifically mandate that disclosure of the medical and social history report occur prior to placement,⁵³ sometimes “as early as practicable” before the adoptive parents even meet the child⁵⁴ and,

Provisions: A Model That Should Not Be Overlooked, 30 FAM. L.Q. 427 (1996).

⁴⁹ For example, Oklahoma’s medical and social history report, which was drafted by members of Oklahoma’s Adoption Law Reform Committee in the mid-1990s, incorporated substantial portions of a Model Medical/Genetic Family History Form for Adoptions which was prepared by the Education Committee, Genetics and Adoption Subcommittee of the Council of Regional Networks for Genetic Services, and was reviewed by geneticists at Children’s Medical Center in Tulsa and the Oklahoma Department of Health prior to its publication. Blair, *supra* note 45, at 261.

⁵⁰ OKLA. STAT. tit. 10, § 7504-1.1 (2011) requires the initial investigator to advise all who contribute information that additional information, as it becomes available, may be submitted to the agency that prepared the report or the clerk of the court that issued the adoption decree. *Id.* § 7504-1.2 requires court clerks and agencies to retain any supplemental medical information and current mailing addresses filed with them and to send a notice of the receipt of supplemental health information to a birth parent, adoptive parent, or adult adoptee at the last address on file in the court’s records. *See, e.g.*, MICH. COMP. LAWS ANN. § 710.68; OHIO REV. CODE ANN. §§ 3107.09–3107.091.

⁵¹ *See, e.g.*, ARIZ. REV. STAT. ANN. § 8-129(B) (2007); 750 ILL. COMP. STAT. ANN. 50/18.4 (West 2009); TEX. FAM. CODE ANN. § 162.006 (West 2008).

⁵² *See* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–12 to 16–14.

⁵³ *E.g.*, ARIZ. REV. STAT. ANN. § 8-129 (2007); CAL. FAM. CODE § 8706 (West 2004); MICH. COMP. LAWS ANN. § 710.27 (West 2002); TEX. FAM. CODE ANN. § 162.005 (West 2008); VT. STAT. ANN. tit. 15A, § 2-105 (2010).

⁵⁴ *E.g.*, OKLA. STAT. tit. 10, § 7504-1.2 (B) (2011); TEX. FAM. CODE ANN. § 162.005 (West 2008).

in any event, before they receive custody.⁵⁵ Typically, state statutes further specify that adoptive parents have a right to any additional information that becomes available, at least during the adoptee's minority, and the adoptee has a statutory right to all medical and social history, plus any supplementary material that has been added, upon reaching adulthood.⁵⁶ Some states offer equivalent disclosure rights to adults whose parents' rights were terminated but who were never adopted.⁵⁷ In some states, birth parents and birth siblings also have a statutory right to disclosure of genetically significant supplemental information that has been provided by an adoptive or foster parent or adult adoptee after a final decree of adoption or termination of parental rights has been issued.⁵⁸

Despite the strides achieved through state legislative reform, state statutory regulation has not been sufficiently uniform or comprehensive to fully curtail deficiencies in the collection and transmission of health-related information among members of the adoption triad. A few states still leave the decision regarding what non-identifying, health-related information should be disclosed to the discretion of adoption agencies.⁵⁹ At least two jurisdictions appear to continue to require court intervention to obtain medical and social history.⁶⁰ Some state statutes are not sufficiently comprehensive regarding the nature of the information to be collected and

⁵⁵ *E.g.*, TEX. FAM. CODE ANN. § 162.005(b) (West 2008); OKLA. STAT. tit. 10, § 7504-1.2(B) (2011).

⁵⁶ Many disclosure statutes provide for disclosure of health-related information to others, such as legal guardians of minor adoptees, adult direct descendants of deceased adoptees, and the parents or guardians of minor descendants of deceased adoptees. *See, e.g.*, ARIZ. REV. STAT. ANN. § 8-129 (2007); OKLA. STAT. tit. 10, § 7504-1.2 (2011); OR. REV. STAT. § 109.500 (2004); TEX. FAM. CODE ANN. § 162.006 (West 2008). In Oklahoma, descendants and their custodians are only entitled to medical, rather than social, information, as the social history would be of less importance to descendants and the privacy interests of those whose history is reported is considered paramount. *See Blair, supra* note 45, at 260.

⁵⁷ *E.g.*, CONN. GEN. STAT. ANN. § 45a-746 (West 2004); OKLA. STAT. tit. 10, § 7504-1.2 (2011); WIS. STAT. ANN. § 48.432 (West 2011).

⁵⁸ *E.g.*, ALA. CODE § 26-10A-31 (LexisNexis 2009); MICH. COMP. LAWS ANN. § 710.68 (West 2002); OKLA. STAT. tit. 10, § 7504-1.2 (2011); UTAH CODE ANN. § 78B-6-143 (LexisNexis 2008).

⁵⁹ DEL. CODE ANN. tit. 13, § 924 (2009); S.C. CODE ANN. § 63-9-780 (2010).

⁶⁰ D.C. CODE § 16-311 (2001); R.I. GEN LAWS §§ 15-7.2-1, 15-7.2-2, 15-7.2-4, 15-7.2-10 (2003).

disclosed;⁶¹ and few comprehensively describe the efforts that should be made to investigate.⁶² Some require or permit transmission only upon or after finalization, ignoring the need to inform prospective adopters.⁶³ Statutory enforcement provisions or sanctions for non-compliance are largely absent.⁶⁴ Thus, despite significant legislative regulation at the state level, prospective adoptive parents still do not always receive all reasonably available information, even in domestic placements.⁶⁵

Beginning in the late 1980s, state courts responded to nondisclosure on a second front by imposing liability in scores of lawsuits across the nation.⁶⁶ These suits were brought against adoption intermediaries for intentional or negligent nondisclosure of health-related information to prospective adopters in what came to be known as suits for “wrongful

⁶¹ Some statutes reference only the birth parents’ medical history, ignoring the child’s. *E.g.*, ALASKA STAT. § 18.50.510 (2010); KY. REV. STAT. ANN. § 199.520 (West 2006). Others reference health history only in the most general fashion. *E.g.*, ARK. CODE ANN. § 9-9-505 (2009) (noting only “a detailed, written health history and genetic and social history of the child” is required).

⁶² Many statutes, if they address the issue at all, simply require “reasonable effort.” *See, e.g.*, CONN. GEN. STAT. ANN. § 45a-748 (West 2004).

⁶³ *E.g.*, CONN. GEN. STAT. ANN. § 45A-746 (West 2004); KY. REV. STAT. ANN. § 199.520(4)(a) (West 2006); OR. REV. STAT. § 109.342 (2004).

⁶⁴ *See* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–23 to 16–25 (providing a more detailed critique of the gaps in the current state statutory framework).

⁶⁵ Bureaucratic and financial pressures are often cited as leading causes of nondisclosure. *See* Klein, *supra* note 16, at 31. Inadequate investigation and communication breakdowns are also attributed to understaffing and worker turnover, particularly with public agencies. *Id.* *See also* NELSON, *supra* note 25, at 35. Private agencies are not immune from these pressures either. *See* David Stires, *Sins of Omission*, SMART MONEY, Sept. 1, 2000, at 169 (observing agencies that charged \$15,000 to \$40,000 in fees per adoption in a one billion dollar per year industry, and describing that agencies are “on the hook” for birth and other medical expenses if a child is not adopted); Pamela Ferdinand, *Charges Put Curb on Agency Adoptions*, BOSTON GLOBE, Mar. 2, 1995, at 21 (describing a suit by the Massachusetts Attorney General against the executive director of a private agency for intentionally withholding birth mothers’ medical histories from adoptive parents on a regular basis). *See also* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–21 to 16–25.

⁶⁶ For a jurisdictional listing of published decisions and media references to “wrongful adoption” actions through 2004, *see* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–6 n.3.

adoption.”⁶⁷ Though brought under a variety of legal theories—fraud, constructive fraud, breach of fiduciary duty, negligence, negligent misrepresentation, intentional or negligent infliction of emotional distress, breach of contract, and even RICO⁶⁸—the essence of the harm alleged by plaintiffs is that they were denied the opportunity to make an informed decision about whether to undertake the emotional and financial responsibilities and challenges that their child’s condition entailed.⁶⁹ In some cases, courts have also recognized viable claims by children who failed to receive appropriate medical or psychological treatment because the adoption agency or other intermediary failed to transmit vital health-related information to their adoptive parents.⁷⁰ Despite the unfortunate label—“wrongful adoption”—the focus of these claims is not the adopted child’s impairment itself but rather the conduct of adoption intermediaries in failing to fulfill their common law and, in some cases, statutory duties to transmit information both pre- and post-adoption.⁷¹ Though successful prosecution of these claims is daunting,⁷² state and federal courts have

⁶⁷ *Id.* at 16–1.

⁶⁸ For a detailed analysis of the application of each of these theories in the context of “wrongful adoption” litigation, see *id.* at 16–55 to 16–140 and Blair, *supra* note 18, at 896–967.

⁶⁹ ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–1.

⁷⁰ *E.g.*, Harshaw v. Bethany Christian Servs., 714 F. Supp. 2d 771, 792 (W.D. Mich. 2010) (recognizing viability of adopted child’s claim under Virginia law for allegedly negligent conduct); Dresser v. Cradle of Hope, 358 F. Supp. 2d 620, 638 (E.D. Mich. 2005) (recognizing validity of child’s claim under Michigan law for damages resulting from failure to disclose records to parent); Halper v. Jewish Family & Children’s Serv., 963 A.2d 1282, 1288 (Pa. 2009) (awarding a verdict of \$75,000 to adopted son for failure to receive appropriate psychiatric care, allegedly due to agency negligently misfiling birth mother’s medical history that was subsequently unavailable when requested). For a discussion of additional cases in which courts examined potential liability to an adopted child, see ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–71 to 16–72 (discussing liability for constructive fraud), 16–87 to 16–89 (reviewing earlier unsuccessful claims based on negligence theories).

⁷¹ ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–2.

⁷² The statute of limitations defense has frequently obstructed successful prosecution of these claims. See, e.g., Campbell v. Abrazo Adoption Assocs., No. 04-09-00827-CV, 2010 WL 2679990, at *5 (Tex. App. July 7, 2010); Ross v. Louise Wise Serv., 868 N.E.2d 189, 197 (N.Y. 2007) (holding that negligence claims and intentional infliction of emotional distress claims were time barred); Siler v. Lutheran Social Servs., 782 N.Y.S.2d 93, 95

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consistently been willing to recognize liability under a variety of state common law causes of action for intentional misrepresentation and nondisclosure.⁷³ There is also widespread recognition of liability for negligent affirmative misrepresentations and negligent failure to disclose.⁷⁴ At the cutting edge, some courts have recently indicated a willingness to consider liability against adoption intermediaries for negligent failure to investigate,⁷⁵ negligent placement,⁷⁶ and breach of contract as well.⁷⁷

(N.Y. App. 2004). *See also* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–126 to 16–134. Sovereign immunity defenses also present obstacles for successful prosecution of claims against public defendants. *See, e.g.,* Ingrao v. County of Albany, Nos. 1:01-CV-730, 1:04-CV-769, 2007 WL 1232225, at *10 (N.D.N.Y. April 26, 2007). *See also* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–170 to 16–172.1. Proof issues related to damages similarly narrow potential recovery. *E.g., Harshaw*, 714 F. Supp. 2d at 808 (granting summary judgment to the defendant because adoptee cannot prove damages for pre-adoption or post-adoption non-disclosure); *Ross*, 868 N.E.2d at 196 (denying punitive damages where intentional failure to disclose was not vindictive or malicious). *See also* Blair, *supra*, at 16–68 to 16–71, 16–99 to 16–106, 16–113 to 16–114.

⁷³ *E.g., Harshaw*, 714 F. Supp. 2d at 817 (recognizing viability of adopter's claim under Virginia law for alleged intentional misrepresentation); *Moriarty v. Small World Adoption Found.*, No. 5:04-CV-394, 2008 WL 141913, at *3 (N.D.N.Y. Jan. 11, 2008) (recognizing validity of claim under New York law); *Ross*, 868 N.E.2d at 197. *See also* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–25 to 16–33.

⁷⁴ *E.g., Harshaw*, 714 F. Supp. 2d at 820 (recognizing viability of adoptive parents' claim under Virginia law for allegedly negligent conduct); *Halper*, 963 A.2d at 1288 (upholding verdict of \$225,000 to adoptive parents for post-adoption negligent failure to disclose birth mother's health history which was allegedly misfiled). *Cf. The Travelers Indemnity Co. v. Children's Friend & Serv., Inc.*, No. PC98-2187, 2005 WL 3276224, at *10 (holding that claims against adoption agency of negligent misrepresentation fall within agency's insurance policy), *13 (holding that insurer has duty to defend agency in another case) (R.I. Super. Ct. Dec. 1, 2005).

⁷⁵ *See McKinney v. State*, 950 P.2d 461, 467 (Wash. 1998). *Cf. Ambrose v. Catholic Social Servs.*, 736 So. 2d 146, 150 (Fla. Ct. App. 1999). *See also* ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–47 to 16–50.

⁷⁶ *See J.A. v. St. Joseph's Children's & Maternity Hosp.*, 52 Pa. D. & C.4th 142, 145 (recognizing that the child sought to pursue his own claim for negligent adoption), 151 (recognizing the child's complaint as cognizable) (Lackawanna Ct. C.P. 2001); ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–50 to 16–52.

⁷⁷ *Moriarty*, 2008 WL 141913, at *3 (recognizing validity of claim for breach of contract under New York law).

In conjunction with changing professional standards, this dual response at the state level to outmoded non-disclosure customs—new statutory regulation and the imposition of liability—had a marked impact upon domestic adoption practice in the United States in the 1980s, 1990s, and during the first decade of the twenty-first century. These new standards and reforms of the state legal regime gradually impressed the need for thorough collection efforts and full disclosure on the collective consciousness of public, nonprofit, and private adoption facilitators.

C. Mounting Concern Regarding Transnational Placements

During the same time period in which domestic adoption practices were undergoing significant reform, the transmission of health-related information in transnational adoptive placements presented growing challenges.⁷⁸ Although the new state statutes typically required U.S. facilitators to disclose whatever information they possessed to American adopters in international as well as domestic placements, the changing context of transnational placements during the 1990s often resulted in little information reaching U.S. facilitators through their customary routines.⁷⁹ Moreover, the opportunity to reap large profits during this period motivated non-disclosure at multiple levels in the process.⁸⁰

Optimum transmission of medical information in transnational placements during the 1990s was significantly hindered by the sheer explosion in the number of children placed.⁸¹ Between 1990 and 2003, the

⁷⁸ See, e.g., David Tuller, *Adoption Medicine Brings New Parents Answers and Advice*, N.Y. TIMES, Sept. 4, 2001, at F1 (discussing adoptive parents' need for specialized medical care because of the unreliability of pre-adoption medical records from abroad).

⁷⁹ See *The Intercountry Adoption Act of 1999: Hearing on H.R. 2909 Before the H. Comm. on Int'l Relations*, 106th Cong. 140–41 (1999) (testimony of Dr. Jerri Ann Jenista, American Academy of Pediatrics).

⁸⁰ See *The Hague Convention on Protection of Children and Cooperation in Respect to Intercountry Adoption: Treaty Doc. 105-51 and Its Implementing Legislation S. 682 Before the S. Comm. on Foreign Relations*, 106th Cong. 15-16 (1999) (statement of Ronald S. Federici, Psy.D., Clinical Director, Psychiatric and Neuropsychological Associates); *The Hague Convention on Protection of Children and Cooperation in Respect to Intercountry Adoption: Treaty Doc. 105-51 and Its Implementing Legislation S. 682 Before the S. Comm. on Foreign Relations*, 106th Cong. 25 (1999) (statement of Mark McDermott, The American Academy of Adoption Attorneys).

⁸¹ See Federici, *supra* note 80, at 16.

number of children adopted transnationally by Americans tripled.⁸² The sudden availability of many more children and the rise in interest in international adoption among Americans lured new agencies, attorneys, and other facilitators into the transnational placement field.⁸³ In the two decades between the early 1980s and 1999, the number of international adoption agencies more than tripled.⁸⁴ Many of these facilitators did not have the years of experience, training, or expertise to adequately solicit or transmit health-related information.⁸⁵

A second factor that may have had a deleterious affect on transmission of health-related information was a shift in the nature of transnational adoption facilitators. Prior to the 1990s, most international adoption agencies were philanthropic or missionary organizations.⁸⁶ Many of the new facilitators in the 1990s were private or for-profit companies and individual entrepreneurs.⁸⁷ Often these agencies were small and did not have their own staff in countries of origin.⁸⁸ Therefore, they often relied upon facilitators who were not well trained and who were paid only if the adoption was completed, an arrangement that discouraged transmission of information that the on-site facilitators thought might deter prospective adoptive parents from finalizing a placement.⁸⁹

Inadequate transmission was further exacerbated by the changing population of children placed transnationally for adoption who came with increased medical risks and from nations with less infrastructure in place to accurately relay their medical and social history.⁹⁰ Dr. Jerri Jenista, a specialist in the medical care of adopted children, summarized these changes in her testimony on behalf of the American Academy of Pediatrics

⁸² U.S. Department of State, *Immigrant Visas Issued to Orphans Coming to the United States*, 7 (on file with author). In 1990, the United States issued 7,093 orphan visas (the visas used for the vast majority of children immigrating to the United States for adoption prior to implementation of The Hague Adoption Convention). This increased to 21,616 in 2003. *Id.*

⁸³ See Jenista, *supra* note 79, at 141 (citing a study by the International Concerns for Children Committee that listed forty-six agencies in the early 1980s and 176 by 1999).

⁸⁴ *Id.*

⁸⁵ See McDermott, *supra* note 80, at 24.

⁸⁶ Jenista, *supra* note 79, at 141.

⁸⁷ *Id.*

⁸⁸ See McDermott, *supra* note 80, at 24.

⁸⁹ *Se id.* at 23, 25.

⁹⁰ Jenista, *supra* note 79, at 137–40.

before Congress in 1999.⁹¹ She observed that Korean and Latin American nations were the countries of origin for over half of the nearly 8,000 children who immigrated to the United States for adoption in 1989.⁹² During that era, children from these nations typically had excellent foster care prior to placement with well-trained foster families.⁹³ Korean infants in particular were unlikely to be exposed to alcohol or drugs in utero, and birth mothers often received some prenatal medical care.⁹⁴ The children were generally placed for adoption as infants, typically before their first birthdays.⁹⁵ Families adopting children from these nations normally received a detailed report on their child's medical condition, and usually some medical and social history about the birth parents as well.⁹⁶ Except for a slight increase in the risk of chronic Hepatitis B and minor developmental delays, most of these children encountered relatively few health problems after their placements.⁹⁷

Beginning in the early 1990s, children from Russia, China, and Eastern Europe gradually became available for placement in dramatically increasing numbers, so that by the mid-1990s, the vast majority of children adopted by U.S. parents from abroad were from these nations.⁹⁸ This sudden change in the countries of origin radically altered the medical risks and pre-placement care experienced by children available for placement.⁹⁹ By 1998, over 80% of the children entering the United States for adoption had been institutionalized prior to placement.¹⁰⁰ Their medical conditions were often affected by the risks attendant with institutional care: exposure to infections, growth delays and poor nutrition, lack of medical care, physical and emotional neglect, delayed cognitive development, and sometimes physical or sexual abuse.¹⁰¹

⁹¹ *Id.* at 136.

⁹² *Id.* at 137.

⁹³ *Id.*

⁹⁴ *Id.* at 137–38.

⁹⁵ *Id.* at 138.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ U.S. Dep't of State, *Immigrant Visas Issued to Orphans Coming to the United States, Statistics for FY 1999*, 7 (on file with author); Jenista, *supra* note 79, at 138.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 137.

¹⁰¹ *Id.* at 138–39. See also LAURIE C. MILLER, *THE HANDBOOK OF INTERNATIONAL ADOPTION MEDICINE* 28–36 (2005). Dr. Miller is quick to point out, however, that
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China and Russia were the leading countries of origin during the late 1990s and early 2000s, and they remain so today.¹⁰² Because adoptive placement is not a legal option for birth parents in China, children adopted from state institutions typically have no documentation of genetic history, and, during the 1990s, they often had very limited records of their own health histories.¹⁰³ Studies conducted in the year 2000 reported a prevalence of infectious diseases among Chinese children placed in the United States, and 75% of the children experienced a significant developmental delay in one or more areas, while 44% experienced global delays.¹⁰⁴ Chinese children were at increased risk for hepatitis, intestinal parasites, and tuberculosis,¹⁰⁵ and 14% of Chinese adoptees show elevated lead levels, a much higher percentage than children from other countries.¹⁰⁶

Russia, Ukraine, Kazakhstan, and Romania were all frequent countries of origin during the 1990s.¹⁰⁷ Russia and Ukraine continued to be on the list of the top five countries from which children immigrated to the United States for adoption in 2011.¹⁰⁸ Typically, children from these countries have spent several years in an institution before immigrating as toddlers or even older children.¹⁰⁹ They present medical problems similar to the Chinese children, but they often face additional challenges due to the circumstances that led to their institutionalization.¹¹⁰ Children from Russia

orphanages vary tremendously, and that there are good orphanages in some countries that provide “nurturing, stable, and consistent care” and in which children may experience superior nutrition, education, and social interaction as compared with children living with families in nearby areas that are severely economically depressed. *Id.* at 38–39.

¹⁰² *Statistics: Intercountry Adoption*, U.S. DEP’T STATE, http://adoption.state.gov/about_us/statistics.php (last visited Feb. 24, 2012). During the second half of the decade, from 2006 to 2010, China and Russia remained first and third, respectively, in the countries of origin from which children immigrate to the United States for adoption. *Id.* They were reported as first and third again for fiscal year 2011. U.S. DEP’T OF STATE, FY 2011 ANNUAL REPORT ON INTERCOUNTRY ADOPTION (Nov. 2011), available at http://adoption.state.gov/content/pdf/fy2011_annual_report.pdf.

¹⁰³ Jenista, *supra* note 79, at 138.

¹⁰⁴ MILLER, *supra* note 101, at 53.

¹⁰⁵ *Id.* See also Jenista, *supra* note 79, at 138.

¹⁰⁶ MILLER, *supra* note 101, at 53.

¹⁰⁷ Jenista, *supra* note 79, at 138.

¹⁰⁸ FY 2011 ANNUAL REPORT, *supra* note 102.

¹⁰⁹ Jenista, *supra* note 79, at 139.

¹¹⁰ *Id.* at 138.

and Eastern Europe were often relinquished due to economic hardship or family strife; involuntary termination of parental rights because of child abuse or neglect accounted for the institutionalization of over 25% of the children.¹¹¹ The rate of fetal alcohol syndrome was high; one study in the early 2000s estimated that it affected approximately 10%–15% of Russian adoptees.¹¹² Medical issues related to prematurity; low birth weight; prenatal exposure to drugs, tobacco, and alcohol; and sexually transmitted diseases such as HIV, Hepatitis B, Hepatitis C, and syphilis were all common in these children, as were long term developmental delays and behavioral issues.¹¹³ One 1997 study discovered that 53%–82% of the children from Russia and Eastern Europe experienced developmental delays.¹¹⁴ Attachment issues were sometimes exacerbated by the common practice of adopting two children simultaneously from these countries.¹¹⁵ In her testimony in 1999, Dr. Jenista testified that her own research indicated that approximately 10% of the children referred for intercountry adoption from institutions would be categorized as high risk, exhibiting a severe and irreparable medical, emotional, or developmental condition, and another 40% of the children were at moderate risk for these problems.¹¹⁶

All of these factors led to a high incidence of inadequate collection and disclosure of medical information,¹¹⁷ an increase in disruption and

¹¹¹ *Id.*

¹¹² MILLER, *supra* note 103, at 56.

¹¹³ Jenista, *supra* note 79, at 138–39.

¹¹⁴ MILLER, *supra* note 101, at 56.

¹¹⁵ Jenista, *supra* note 79, at 139.

¹¹⁶ *Id.*

¹¹⁷ See Federici, *supra* note 80, at 12. Dr. Federici testified that “of over 1,500 internationally adopted children [he had evaluated, the parents of] every one of them were informed by their adoption agency that they were healthy. All 1,500 of them were not healthy.” *Id.* Of that group, he estimated that approximately

50 to 60 percent of the children had long-term chronic problems; 20 to 30 percent had refractory or chronic difficulties that would require lifelong care and probably a lack of independence on the part of the child; and less than 20 percent of our sample . . . show that the children were able to be resilient.

Id. He went on to state:

I have seen a multitude of families disrupt their adoption because they were no longer able to care for the child’s financial and emotional needs. I have seen families separate

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dysfunctional placements,¹¹⁸ a rise in wrongful adoption litigation involving transnational placements,¹¹⁹ and concern among both

and divorce, or engage in abuse of their child because the child exhibited grossly out of control and aggressive behaviors. I have evaluated children who have severe attachment disorders, neuropsychiatric conditions, sexual offenders, killers of animals within the home, and several children who have attempted to murder their siblings, parents or commit suicide. I have consistently watched families feel devastated and enraged with their international adoption agency who had promised them a "healthy child."

Id. at 15.

¹¹⁸ *Id.* See also *The Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption: Treaty Doc. 105-51 and Its Implementing Legislation S. 682 Before the S. Comm. On Foreign Relations, 106th Cong. 18-19 (1999)* (statement of Barbara Holtan, M.A., M.S.W., Director of Adoption Services, Tressler Lutheran Services). She testified that in the previous five years her agency had received requests to re-place eighty-two children who had initially been adopted from Eastern Europe through other agencies, and whose placements were now disrupted. *Id.* at 19.

¹¹⁹ Many of the "wrongful adoption" lawsuits referenced in reported decisions involve international placements. See, e.g., *Regensburger v. China Adoption Consultants, Ltd.*, 138 F.3d 1201, 1204-05 (7th Cir. 1998); *Boe v. Christian World Adoption, Inc.*, No. CIV S-10-0181 KJM-CMK, 2011 WL 1585830, at *2 (E.D. Cal. April 22, 2011); *Harshaw v. Bethany Christian Servs.*, 714 F. Supp. 2d 771 (W.D. Mich. 2010); *Dresser v. Cradle of Hope Adoption Ctr., Inc.*, 358 F. Supp. 2d 620 (E.D. Mich. 2005), 421 F. Supp. 2d 1024 (E.D. Mich. 2006); *Moriarty v. Small World Adoption Found. of Missouri, Inc.*, No. 5:04-CV-394, 2008 WL 141913 (N.D.N.Y. Jan. 11, 2008); *Mulligan v. Frank Found. Child Assistance Int'l Inc.*, 584 F. Supp. 2d 1332 (M.D. Fla. 2008); *Derrick v. Frank Found. Child Assistance Int'l Inc.*, No. 03 C 5737, 2004 WL 1197249 (N.D. Ill. May 28, 2004); *McMullen v. European Adoption Consultants, Inc.*, 109 F. Supp. 2d 417 (W.D. Pa. 2000); *Ferenc v. World Child Inc.*, 977 F. Supp. 56 (D.D.C. 1997), *aff'd*, 172 F.3d 919 (D.C. Cir. 1998); *Lord v. Living Bridges*, No. CIV. A. 97-6355, 1999 WL 562713 (E.D. Pa. July 30, 1999); *Sherman v. Adoption Ctr. of Washington Inc.*, 741 A.2d 1031 (D.C. 1999); *Nierengarten v. Lutheran Soc. Servs. of Wisconsin*, 563 N.W.2d 181 (Wis. Ct. App. 1997); *Miles v. World Child, Inc.*, No. 213523, 2001 WL 34791093 (Md. Cir. Ct. Dec. 20, 2001). See also Howard M. Cooper, *Enforcement of Contractual Release and Hold Harmless Language in 'Wrongful Adoption' Cases*, 44 BOSTON B.J. at 14-15, 28 (May-June 2000) (discussing Memorandum of Decision and Order On Defendant Filis M. Casey's Motion to Dismiss in *Forbes v. Alliance for Children*, No. 97-04860-B, 1998 LEXIS 713 (Suffolk
(continued)

international experts and adoption professionals in the United States that these issues could not be addressed exclusively at a local level.¹²⁰ They required an international and, in the United States, a federal response.

III. THE HAGUE ADOPTION CONVENTION AND FEDERAL IMPLEMENTATION: STANDARDS FOR COLLECTION AND DISCLOSURE

The representatives of over fifty nations who gathered in the early 1990s to draft the Hague Adoption Convention were well aware of concerns about the transmission of accurate medical and social history.¹²¹ When the Convention was adopted by The Hague Conference in 1993, its terms created a general framework that addressed issues of collection, disclosure, and preservation of medical and social history in three articles:

- Article 16 requires countries of origin to prepare a report including information about a child's "identity, adoptability, background, social environment, family history, medical history including that of the child's family, and any special needs of the child."¹²²

Sup. Ct. Dec. 16, 1998)); MADELYN FREUNDLICH & LISA PETERSON, *WRONGFUL ADOPTION: LAW, POLICY, & PRACTICE* 27–29 (CWLA eds., 1998) (discussing *Harper & Johnson v. Adoption Ctr. of Washington, C.A.* 94-985 (D.C. Super Ct. Oct. 1995)). In many of these decisions, plaintiffs have been unsuccessful, often due to exculpatory clauses. For a discussion of these clauses, see *infra* notes 334–49. Dr. Federici reported pending cases involving ten different international adoption service providers at the time of his testimony in 1999. Federici, *supra* note 82, at 16.

¹²⁰ See Federici, *supra* note 80, at 17.

¹²¹ See *Guide to Good Practice*, *supra* note 37, at 84–86.

¹²² Hague Adoption Convention, *supra* note 2, art. 16(1)(a). Article 16 provides:

(1) If the Central Authority of the State of origin is satisfied that the child is adoptable, it shall —

a) prepare a report including information about his or her identity, adoptability, background, social environment, family history, medical history including that of the child's family, and any special needs of the child;

b) give due consideration to the child's upbringing and to his or her ethnic, religious and cultural background;

c) ensure that consents have been obtained in accordance with Article 4; and

d) determine, on the basis in particular of the reports relating to the child and the prospective adoptive parents, whether the envisaged placement is in the best interests of the child.

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Articles 9 and 22 permit member nations to have the reports prepared directly by the governmental unit designated as the Central Authority for the Convention¹²³ or to delegate preparation of the reports, under the responsibility of the Central Authority, to other public (governmental) bodies or private nonprofit agencies accredited by the government to perform this and other adoption services under the Convention.¹²⁴

- Article 30 mandates that governmental authorities in both countries of origin and receiving nations must preserve medical history and any information concerning the child's origin, and in particular information regarding the identity of the child's parents, and also must ensure that the child or the child's representative have access to that information under "appropriate guidance."¹²⁵

(2) It shall transmit to the Central Authority of the receiving State its report on the child, proof that the necessary consents have been obtained and the reasons for its determination on the placement, taking care not to reveal the identity of the mother and the father if, in the State of origin, these identities may not be disclosed.

Id.

¹²³ *Id.* arts. 9, 22. Following the model of many of the conventions drafted under the auspices of the Hague Conference on Private International Law, the Hague Adoption Convention requires each contracting nation to designate a governmental entity as its Central Authority, which bears responsibility for promoting intergovernmental cooperation and communication, exchanging information, eliminating obstacles to the Convention's application, and deterring child trafficking and other practices that would violate Convention standards. *Id.* arts. 6, 7, 8. In the United States, the Department of State serves as the Central Authority for the Hague Adoption Convention, and within that Department, the Office of Children's Issues in the Bureau of Consular Affairs will perform those duties. 42 U.S.C. § 14911(a) (2006). Some of the Central Authority functions under the Convention, however, such as reviewing the applications of prospective adoptive parents, will continue to be performed by the U.S. Citizenship and Immigration Services (USCIS) in the Department of Homeland Security. *See* 8 C.F.R. § 204.308 (2011). For further discussion of the operation of the Central Authorities under the Hague Adoption Convention and the Convention generally see D. MARIANNE BLAIR, MERLE H. WEINER, BARBARA STARK & SOLANGEL MALDONADO, *FAMILY LAW IN THE WORLD COMMUNITY* 744–53 (2009).

¹²⁴ Hague Adoption Convention, *supra* note 2, art. 22.

¹²⁵ *Id.* art. 30.

The extent of the disclosure permitted, however, is to be determined by each nation's domestic laws.¹²⁶

- Article 31 protects the confidentiality of the preserved information, providing that personal data, including medical and social history, may be used only for the purposes for which it was gathered or transmitted.¹²⁷

Inadequate collection and transmission of medical and social history was one of the primary issues brought to the attention of both Congress and the Department of State, as they labored to draft implementing federal legislation and regulations for the United States in preparation for United States' ratification of the Hague Adoption Convention in April of 2008.¹²⁸ In response to testimony before Congress by Dr. Jenista and many other concerned medical and adoption professionals and adoptive parents,¹²⁹ the federal implementing statutes (the IAA)¹³⁰ and the implementing regulations issued by the Department of State created accreditation standards for agencies and entities performing Convention adoption services. These standards incorporate requirements for the collection and disclosure of medical and social history as well as mandates for retention

¹²⁶ *Id.* Article 30 provides in full:

(1) The competent authorities of a Contracting State shall ensure that information held by them concerning the child's origin, in particular information concerning the identity of his or her parents, as well as the medical history, is preserved.

(2) They shall ensure that the child or his or her representative has access to such information, under appropriate guidance, in so far as is permitted by the law of that State.

Id.

¹²⁷ *Id.* art. 31. Article 31 provides in full:

Without prejudice to Article 30, personal data gathered or transmitted under the Convention, especially data referred to in Articles 15 and 16, shall be used only for the purposes for which they were gathered or transmitted.

Id.

¹²⁸ See Federici, *supra* note 80, at 12–13; Holtan, *supra* note 118, at 18; Jenista, *supra* note 79; McDermott, *supra* note 80, at 25.

¹²⁹ See, e.g., *supra* notes 79–118.

¹³⁰ 42 U.S.C. §§ 14901–14954 (2006).

and confidentiality.¹³¹ A small measure of additional oversight is imposed by Department of Homeland Security regulations governing immigration approval and adoption certification.¹³² This section examines and critiques these standards for collection and disclosure, acknowledging some of the areas in which they may be supplemented in some states by more detailed state regulations.

A. Narrowing the Field of Facilitators

One of the most important aspects of the Hague Adoption Convention regulatory scheme is that individuals or entities that perform certain critical functions must be either governmental entities or individuals or agencies that have been accredited or approved by the government.¹³³ In the United States, governmental entities that may provide services include authorities operated by State, local, or tribal governments.¹³⁴ Any nongovernmental primary provider of adoption services in a Convention adoption must be either an accredited agency or an approved person, a status achieved only by going through a federal accreditation process.¹³⁵ Accredited agencies must be private, nonprofit organizations that are also state licensed to provide adoption services.¹³⁶ Approved persons must satisfy the same accreditation standards, except that they may be private, for-profit individuals or entities and need not be state-licensed.¹³⁷ Together, accredited agencies and approved persons are generally referred to collectively under U.S. federal law and in this article as adoption service providers, or ASPs.¹³⁸

Thus, one of the primary contributions of the Hague Adoption Convention implementation process is simply to serve as a screening process for intermediaries who choose to facilitate international placements.¹³⁹ Specified adoption services that may only be provided by public governmental authorities or ASPs in Convention adoptions include:

- identifying a child and arranging for an adoption;

¹³¹ 22 C.F.R. § 96.1 *et seq.* (2011).

¹³² 8 C.F.R. § 204.313(h) (2011); 22 C.F.R. §§ 97.2, 97.3 (2011).

¹³³ Hague Adoption Convention, *supra* note 2, arts. 9, 22.

¹³⁴ 22 C.F.R. §§ 96.2, 96.12(b) (2011).

¹³⁵ 42 U.S.C. § 14921(a) (2006).

¹³⁶ *Id.* § 14923(b)(1)(G); 22 C.F.R. § 96.2 (2011).

¹³⁷ 42 U.S.C. § 14923(b)(2) (2006); 22 C.F.R. § 96.2 (2011).

¹³⁸ *See* 22 C.F.R. § 96.12 (2011).

¹³⁹ *See* Hague Adoption Convention, *supra* note 2, arts. 6, 10, 11, 22.

- securing consents;
- performing background studies or home studies and reporting the results (although these tasks may be performed by unaccredited social work professionals if approved by an accredited agency);
- determining the appropriateness of an adoptive placement for a child;
- post-placement monitoring until a final adoption; and
- assuming custody pending alternative placement following a disruption.¹⁴⁰

While other entities can provide certain of these services, they can only do so under the supervision and responsibility of an ASP.¹⁴¹

Convention accreditation standards impose fairly onerous requirements. ASPs must:

- have a sufficient number of appropriately trained and qualified personnel, with a chief executive officer, board members, and social service personnel who satisfy certain professional criteria;
- have sufficient financial resources;
- satisfy budget, audit, risk assessment, record maintenance, and annual reporting and documentation requirements;
- maintain a complaint registry;
- acquire professional liability insurance with at least one million dollars in coverage; and
- utilize appropriate procedures that enable them to provide all of the services mandated for Convention adoptions.¹⁴²

Enforcement mechanisms to ensure compliance with federal standards, however, are largely relegated to the accreditation process. To receive accreditation or approval, an ASP must demonstrate that it is in substantial compliance with all of the accreditation standards¹⁴³ to an accrediting entity with whom the federal government contracts to oversee the process. Currently, only two accrediting entities have been utilized: the Council on Accreditation and the Colorado Department of Human Services.¹⁴⁴ The ASP must attest annually that it has remained in substantial compliance

¹⁴⁰ 42 U.S.C. § 14902(3) (2006); 22 C.F.R. §§ 96.2, 96.12(a)(b) (2011).

¹⁴¹ 42 U.S.C. § 14921(a) (2006); 22 C.F.R. §§ 96.12–13 (2011).

¹⁴² See 42 U.S.C. § 14923(b) (2006); 22 C.F.R. §§ 96.30–55 (2011).

¹⁴³ 22 C.F.R. § 96.27(a) (2011).

¹⁴⁴ See Bureau of Consular Affairs, *Adoption Service Provider Search*, U.S. DEP'T STATE, http://adoption.state.gov/hague_convention/accreditation.php (last visited Feb. 25, 2012).

and provide supporting documentation.¹⁴⁵ Accreditation must be renewed every three to five years¹⁴⁶ and in a normal rotation will occur every four years.¹⁴⁷ Complaints registered with the Complaint Registry operated by the Department of State may be investigated and taken into account by the accrediting entities.¹⁴⁸ Serious, willful, grossly negligent, or repeated failures to comply with accreditation standards must be reported by these accrediting entities to the Secretary of State,¹⁴⁹ and the accrediting entities must, after consultation with the Secretary, refer to the Attorney General or other law enforcement authorities any substantiated complaints that involve conduct in violation of federal, state, or local law.¹⁵⁰ Accreditation may be suspended or canceled if the ASP “is substantially out of compliance” with accreditation requirements.¹⁵¹ An ASP may be temporarily (for at least three years)¹⁵² or permanently debarred, but only if “[t]here is substantial evidence that the [ASP] is out of compliance with” applicable requirements and that “[t]here has been a pattern of serious, willful, or grossly negligent failures to comply or other aggravating circumstances indicating that continued accreditation or approval would not be in the best interests of the children and families concerned.”¹⁵³ Suspension, cancellation, and debarment are subject to judicial review.¹⁵⁴ Other sanctions may include requiring an ASP to cease providing services in a specific case or Convention country.¹⁵⁵

The efficacy of the accreditation standards may be somewhat diluted by the requirement that an ASP demonstrate only “substantial compliance” with accreditation standards.¹⁵⁶ Nevertheless, the expense¹⁵⁷ and oversight

¹⁴⁵ 22 C.F.R. § 96.66(c) (2011).

¹⁴⁶ 42 U.S.C. § 14923(b)(3) (2006).

¹⁴⁷ 22 C.F.R. § 96.60 (2011). Although in the first cycle accredited entities will be staggered, thereafter the normal period of accreditation or approval is four years. *Id.*

¹⁴⁸ *Id.* § 96.71.

¹⁴⁹ *Id.* § 96.72(a)(1).

¹⁵⁰ *Id.* § 96.72(b)(3).

¹⁵¹ 42 U.S.C. § 14924(b)(1)(A) (2006); 22 C.F.R. § 96.83(a) (2011). *See also* 22 C.F.R. § 96.75 (2011).

¹⁵² 22 C.F.R. § 96.86(a) (2011).

¹⁵³ *Id.* § 96.85(b).

¹⁵⁴ 42 U.S.C. § 14924(d) (2006).

¹⁵⁵ 22 C.F.R. § 96.75(c) (2011).

¹⁵⁶ The U.S. Department of State Fiscal Year Annual Reports for 2010 and 2011 report that no accredited agencies or approved persons were temporarily or permanently disbarred

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required by the process may well screen out some entrepreneurs who casually entered the international adoption business prior to Convention implementation, at least for placements from Convention nations.

B. Collection Standards—Incoming Adoptions

1. Who Can Prepare Reports

Article 16 of the Hague Adoption Convention places responsibility for the collection of medical and social information on the country of origin and permits the actual reports to be prepared under the responsibility of governmental authorities or private nonprofit accredited entities, but not by for-profit entities that are merely “approved.”¹⁵⁸ Thus the actual collection of medical and social history need not be performed by Central Authority staff, or even by employees of governmental agencies or private nonprofit accredited entities, as long as the report preparation is supervised or reviewed by one of those bodies.¹⁵⁹ American facilitators thus no longer have carte blanche to hire or contract with local personnel to gather health information and entirely control the collection process, as might have been the case in the pre-Convention era (and possibly with certain non-Convention placements today). In fact, in many Convention placements, U.S. ASPs receive background reports on children referred for placement directly from the sending nation’s Central Authority and now have little input into the process.¹⁶⁰ In some sending countries, however, U.S. ASPs have working relationships with governmental authorities or accredited entities and thus continue to have some choice or influence regarding the entity or individuals who prepare the background reports on children placed with their clients.¹⁶¹ Therefore, federal regulations address who may prepare these reports even in incoming cases, despite the Convention’s delegation of responsibility for preparation of those reports to the country of origin.

in fiscal years 2010 or 2011. U.S. DEP’T OF STATE, ANNUAL REPORT ON INTERCOUNTRY ADOPTIONS (2010), available at http://adoption.state.gov/content/pdf/fy2010_annual_report.pdf; U.S. DEP’T OF STATE, ANNUAL REPORT ON INTERCOUNTRY ADOPTIONS (2011), available at http://adoption.state.gov/content/pdf/fy2011_annual_report.pdf

¹⁵⁷ The U.S. Department of State Fiscal Year Annual Report for 2011 stated that in 2011 the fees for accreditation or approval ranged from \$2,000 to \$14,750. *Id.*

¹⁵⁸ Hague Adoption Convention, *supra* note 2, art. 22(5)

¹⁵⁹ *See id.* art. 22(2).

¹⁶⁰ *See id.* art. 15.

¹⁶¹ *See* Hague Convention on Intercountry Adoption, *supra* note 10, at 8094.

These federal regulations do impose some limitations and criteria upon the individuals who are permitted to collect medical and social history.¹⁶² Background reports on children immigrating to the United States for adoptive placement may be prepared by one of the entities discussed below.

a. ASP Employees

ASP employees must be authorized or licensed to complete a child background study under the laws of the states in which they practice.¹⁶³ They must also be supervised by ASP employees with experience in family and children's services, adoption, or intercountry adoption, and must have either a master's degree in social work, a master's or doctorate degree in a related human service field, or significant experience in intercountry adoption and access to an individual with one of the described degrees.¹⁶⁴

b. Foreign Supervised Providers

Foreign supervised providers are nongovernmental agencies, entities, or individuals who act under the supervision of an ASP who is the primary provider of adoption services for the particular placement. The ASP must require a written agreement stating that the foreign supervised provider will comply with the standards for the background report set forth in the U.S. Code of Federal Regulations,¹⁶⁵ including 22 C.F.R. § 96.49(d) through (j), described below.¹⁶⁶

c. Foreign Unsupervised Providers

Background reports may be prepared by a foreign provider who is not supervised by the ASP, if the ASP that is acting as the primary provider for the adoption verifies through review of the documentation and "other appropriate steps" that the background report was performed in accordance with applicable foreign law of the sending country and Article 16 of the Hague Adoption Convention.¹⁶⁷ For reports prepared by foreign providers

¹⁶² 22 C.F.R. § 96.37(g) (2011).

¹⁶³ *Id.* § 96.37(g).

¹⁶⁴ *Id.* § 96.37 (d), (g).

¹⁶⁵ 22 C.F.R. §§ 96.14(c), (e); 96.44(a); 96.45(b)(1)–(2) (2011).

¹⁶⁶ See discussion *infra* Part III.B.2.

¹⁶⁷ 22 C.F.R. §§ 96.14(c)(3); 96.14(e); 96.46(b)(2); 96.46(c)(2) (2011) (no requirement to comply with standards in 22 C.F.R. § 96.49(d)–(j)). For a more detailed history and critique of the evolution of this exclusion, see Maskew, *supra* note 2, at 497–502.

who are not “supervised,” however, there is no requirement that the ASP verify that they comply with the various standards set forth in 22 C.F.R. § 96.49(d) through (j).¹⁶⁸

d. A Foreign Governmental Authority

ASPs are not required to provide supervision over foreign government authorities or to assume responsibility for their actions.¹⁶⁹

Federal regulations also address the training mandated for ASP employees who prepare child background studies or perform other adoption services.¹⁷⁰ They must be given comprehensive training in:

- intercountry adoption and the legal “requirements of the Convention, the IAA” and IAA regulations, the laws of sending nations, and relevant state law;
- “ethical and professional guidelines” and considerations;
- “the cultural diversity of the population(s) served”;
- factors in sending nations that lead to the need for adoptive placement;
- the feelings of separation, grief, and loss of the birth family experienced by children placed transnationally;
- “attachment and post-traumatic stress disorders”;
- the psychological issues of abused children;
- “the impact of institutionalization on child development”;
- outcomes and benefits of adoptive placement;
- “frequent medical and psychological problems experienced by children” placed from nations served by the ASP;
- the process of emotional bonding with an adoptive family;
- “acculturation and assimilation issues” of transnationally adopted children; and
- the impact of adoption on child, adolescent, and adult development.¹⁷¹

In addition to initial training, at least thirty hours of subsequent training every two years must be provided.¹⁷²

¹⁶⁸ 22 C.F.R. §§ 96.14(c)(3); 96.14(e); 96.46(c)(2)(2011).

¹⁶⁹ *Id.* §§ 96.14(c)(1); 96.14(d)(2); 96.44(a) (2011).

¹⁷⁰ *Id.* § 96.38(a)–(b) (2011).

¹⁷¹ *Id.*

¹⁷² *Id.* § 96.38(c) (2011).

While the training requirements are laudatory, they will have little impact in the majority of incoming cases. As part of the research for this article, the author surveyed the 209 accredited agencies and approved persons currently accredited to provide adoption services in incoming and outgoing placements between the United States and Hague Convention nations.¹⁷³ Approximately one-third (34%) of the ASPs responded. Of the responders who currently serve as primary providers for incoming placements, only two agencies (5%) reported that an agency employee prepares the background reports on children from the Hague Adoption Convention member nation from which it places children.¹⁷⁴

A mandate that may have slightly greater impact are the provisions in both the federal statute and implementing regulations that require ASPs to compensate employees, supervised providers, or other individuals who provide services on a fee for service basis rather than on an incentive or contingent fee basis.¹⁷⁵ This provision was designed to address concerns raised in the 1990s that in-country facilitators would withhold negative information regarding a child's medical or social history out of concern it might deter prospective adopters from proceeding with the placement.¹⁷⁶ Moreover, fees or salaries paid to employees or supervised providers may not be unreasonably high in relation to the services rendered, when considering the norms for the intercountry adoption community in the country in which the services are rendered.¹⁷⁷ While slightly more survey respondents reported that the background reports they received were prepared by foreign supervised (2) or unsupervised providers (4), only 15% of the total respondents received reports from these sources in at least some of the Hague Adoption Convention member nations from which they placed children.¹⁷⁸

Nevertheless, to the extent that the Hague Adoption Convention has diverted the bulk of the background report preparation to foreign governmental authorities, the goal of minimizing the influence of contingent fees on withholding information may still have been well-served by the Convention. In the author's survey, 81% of the respondents

¹⁷³ A list of current ASPs may be found on the website of the U.S Department of State. *Adoption Service Provider Search*, *supra* note 147.

¹⁷⁴ See Appendix A.

¹⁷⁵ 42 U.S.C. § 14923(b)(1)(A)(iv) (2006); 22 C.F.R. §§ 96.34(a), 96.46(b)(4) (2011).

¹⁷⁶ See *supra* text accompanying note 89.

¹⁷⁷ 22 C.F.R. § 96.34(d) (2011).

¹⁷⁸ See Appendix A.

who serve as primary providers for incoming adoptions from Hague Adoption Convention nations reported that background reports were prepared by foreign governmental authorities in all of the Hague Adoption Convention nations from which they received placements.¹⁷⁹ Further, 93% reported that foreign governmental authorities prepared the background reports on children from at least some of the Convention nations from which they received placements.¹⁸⁰ A breakdown of these responses for each country of origin can be found in Appendix A.

2. *What Must Be Collected*

Although the Convention requirements for collection of medical and social history are fairly general,¹⁸¹ U.S. federal regulations would appear on the surface to impose more detailed requirements for the collection of medical and social history. Federal accreditation standards require ASPs to use reasonable efforts, up to the time the adoption is finalized, to obtain available information, which must include:

- the child's medical records, including, to the extent practicable, "a correct and complete English-language translation," and if any medical records are summaries, the ASP must provide the underlying medical records if they are available;
- the date the governmental or other child welfare authority assumed custody of the child and the child's condition at the time;
- the changes in the child's medical condition since custody was assumed, including "any significant illnesses, hospitalizations, and special needs";
- the child's "growth data, including prenatal and birth history, and developmental status over time" and at the "time of the child's referral for adoption";
- "specific information on the known health risks" in the region or nation in which the child resides;
- if information is provided from sources other than foreign public authorities based on an examination or observation of the child, the information should include:
 - "the name and credentials of [any] physician who performed the examination" or observation, or if performed by a non-physician, that individual's

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ See Hague Adoption Convention, *supra* note 2, art. 16.

identity, training, and the data and perceptions on which any conclusions were drawn;

- the date, “how the report’s information was retained and verified,” and if the report has been reviewed by anyone responsible for the child’s care;
- a review of and reasons for any hospitalizations, significant illnesses or medical events;
- “any tests performed on the child,” including tests for “known risk factors in the child’s country of origin”;
- the child’s current health information;
- “information about the child’s birth family” and cultural, “religious, ethnic and linguistic background”;
- the child’s previous custodians, caretakers, and placements, including any social work or court reports;
- the existence and whereabouts of birth siblings; and
- when the above information cannot be obtained, documentation of the efforts made to obtain it.¹⁸²

Additionally, videotapes and photographs provided must be dated and made in compliance with the laws of the country of origin.¹⁸³

The federal regulation is reasonably comprehensive and provides a nice checklist for adoption facilitators seeking to follow best practices. Even when assessed for that limited purpose, however, there are gaps that render the federal regulation less effective than it could have been. Certain critical categories of information necessary to obtaining a thorough medical and social history are excluded, which is particularly surprising because their absence or withholding have been at the heart of much of the litigation involving both foreign and domestic adoptions.¹⁸⁴

Family history of genetic conditions and mental illness should be specifically mentioned, rather than being implied at best in the phrase “information about the child’s birth family.” Many mental health disorders—including psychotic disorders such as schizophrenia; mood

¹⁸² 22 C.F.R. § 96.49(a)–(g) (2011).

¹⁸³ *Id.* § 96.49(i).

¹⁸⁴ *E.g.*, *Ross v. Louise Wise Serv.*, 868 N.E.2d 189 (N.Y. 2009); *Burr v. Bd. of Cnty. Comm’rs*, 491 N.E.2d 1101 (Ohio 1986); *Halper v. Jewish Family & Children’s Serv.*, 963 A.2d 1282 (Pa. 2009); *Gibbs v. Ernst*, 647 A.2d 882 (Pa. 1994); *Lord v. Living Bridges*, No. CIV. A. 97-6355, 1999 WL 562713 (E.D. Pa. July 30, 1999).

disorders such as bipolar disorder and severe depression; anxiety disorders such as obsessive-compulsive disorder and phobias; eating disorders; childhood disorders such as ADHD and Tourette's syndrome; and memory disorders such as Alzheimer's disease—have strong genetic components,¹⁸⁵ and family history can facilitate post-placement treatment of these disorders.¹⁸⁶

A directive to explicitly inquire about a history of sexual or child abuse should be included.¹⁸⁷ This topic is not even referenced by implication in the categories addressed.¹⁸⁸

Information about the child's behavior, temperament, and psychological adjustment should also be specifically referenced, and an affirmative duty should be imposed to retrieve observations and perceptions of the child's caretaker.¹⁸⁹ Instead, the regulations allude to caretaker observations only if they are included as part of medical information provided, in which case the identity and perceptions of the observer must be provided.¹⁹⁰

Prenatal exposure to alcohol, drugs, or other risk factors should have also been specifically referenced rather than obliquely included in the term "prenatal history."¹⁹¹ This is especially important given that fetal alcohol syndrome and other issues of in utero exposure are significant risk factors in several of the leading sending nations.¹⁹²

¹⁸⁵ Miller & Tirella, *supra* note 21, at 447–48.

¹⁸⁶ Many of the "wrongful adoption" cases involved failure to disclose information regarding family mental history. See, e.g., *Halper*, 963 A.2d at 1282; *Ross*, 868 N.E.2d at 189; *Burr*, 491 N.E.2d at 1101.

¹⁸⁷ See, e.g., *BARTH & BERRY*, *supra* note 20, at 107–08 (reporting that a child's history of abuse is critical to pre-adoption assessment); *Belkin*, *supra* note 19, at B8; *Blair*, *supra* note 46, at 739–40.

¹⁸⁸ Many of the "wrongful adoption" cases involved failure to disclose available information about sexual abuse a child had experienced pre-placement. See, e.g., *Lord*, 1999 WL 562713; *Gibbs*, 647 A.2d 882.

¹⁸⁹ See *Blair*, *supra* note 46, at 739–40. Screening by health professionals indicate that up to 80% of children adopted transnationally manifest developmental delay upon arrival. Patrick Mason, *International Adoption: The Post-Adoption Experience*, in *ADOPTION FACTBOOK V*, *supra* note 21, at 457.

¹⁹⁰ 22 C.F.R. § 96.49(e)(3) (2011).

¹⁹¹ See *Miller & Tirella*, *supra* note 21, at 449–50.

¹⁹² *Id.*

Reasons for prior placements outside of the birth family should be specifically referenced. This information is an important component of the child's social history and can both affect medical issues and later impact the child's identity formation.¹⁹³

A major goal of regulations is to provide direction and guidance. The exclusion of these specifics renders the regulation less effective even as a checklist. Obviously, in transnational placements this information will often not be available, but the regulations should direct ASPs to affirmatively seek out this information when reasonably available.

Although the effectiveness of the federal regulations describing what must be collected is somewhat weakened by their generality, the scope of their application is of far greater concern. The duty to request all available medical records appears to apply to an ASP regardless of who is designated to collect the information.¹⁹⁴ However, the duty to use reasonable efforts to obtain the other information specified in the Code of Federal Regulations¹⁹⁵ applies only if the background report on the child is created by an employee of the ASP or if that task is assigned by the ASP to a foreign supervised provider for whom the ASP is responsible.¹⁹⁶ Because employees and foreign supervised providers prepare only a small percentage of these reports, as indicated by the survey of current ASPs set forth in Appendix A, the more specific provisions regarding the content of information to be collected will rarely be applicable.

In the author's survey, 81% of the respondents who serve as primary providers for incoming adoptions from Hague Adoption Convention nations reported that background reports were prepared by foreign governmental authorities in all of the Convention nations from which they placed children. Further, 93% reported that foreign governmental authorities prepared the background reports on children from at least some of the nations with which they worked. To the extent that the respondents accurately reflect the current practice of all ASPs, it appears that proportionately very few Hague placements will be subject to the specific requirements in the Code of Federal Regulations regarding the content of the information to be collected.¹⁹⁷ The regulations further provide that

¹⁹³ See BARTH & BERRY, *supra* note 22, at 108.

¹⁹⁴ *Id.* § 96.49(a).

¹⁹⁵ This other information is specified in 22 C.F.R. § 96.49(d)–(j).

¹⁹⁶ *Id.* § 96.49(d). For a more detailed history and critique of the evolution of this exclusion, see Maskew, *supra* note 2, at 497–502.

¹⁹⁷ This information is specified in 22 C.F.R. § 96.49(d)–(j).

ASPs are not required to provide supervision or assume responsibility for reports prepared by foreign governmental authorities.¹⁹⁸ This dispensation is sensible to some degree, as U.S. agencies often have little control over the practices of foreign governments.¹⁹⁹ In situations in which U.S. agencies have developed a cooperative relationship with foreign central authorities or other governmental entities charged with preparation of background reports, however, the guidance provided by the specific content requirements of the Code of Federal Regulations could be usefully employed by agencies proactively seeking out available information, to the extent that the countries of origin permit such inquiries.²⁰⁰

When foreign governmental authorities are not preparing the background reports, the current federal regulations afford ASPs the option to use foreign unsupervised providers²⁰¹ rather than foreign supervised providers, which also obviates the need to comply with the specific content collection requirements of the Code of Federal Regulations.²⁰² If an ASP obtains background reports from a foreign unsupervised provider, the ASP is simply required to verify by reviewing the document and taking other appropriate steps to ensure that the background report on the child was performed in accordance with the law of the country of origin and the very general requirements of Article 16 of the Convention.²⁰³ Responses to the author's survey indicate that when background reports are not prepared by foreign governmental authorities, unsupervised providers are chosen to prepare reports more often than foreign supervised providers or employees.²⁰⁴ Ten percent of the survey respondents reported that foreign unsupervised providers prepared background reports from at least some nations from which the ASP placed children. Only 5% of the ASPs reported that foreign supervised providers prepared background reports on children from at least some of the nations with which they worked, and another 5% reported agency employees prepared background reports for them. Thus, it appears that in the vast majority of transnational placements of children from Hague Adoption Convention nations today, the federal

¹⁹⁸ *Id.* § 96.14(d).

¹⁹⁹ *See* Hague Convention on Intercountry Adoption, *supra* note 10, at 8066, 8104, 8106.

²⁰⁰ *See id.* at 8106–07.

²⁰¹ *See supra* notes 167–68 and accompanying text.

²⁰² 22 C.F.R. § 96.49 (d)–(j).

²⁰³ 22 C.F.R. § 96.14(d) (2011).

²⁰⁴ Appendix A.

directives regarding what information should be collected²⁰⁵ are relegated to the status of admonitions for which ASPs are not held accountable.

The option to utilize foreign providers who are not supervised and not responsible to the ASP to prepare background reports was a change from the proposed regulations issued in 2003, which would have required ASPs to use only foreign supervised providers unless the reports were prepared by foreign governmental authorities or accredited entities in the sending nation.²⁰⁶ The Department of State suggests in its commentary to the final regulations that the change was made because contemporary supervision of the preparation of background reports is generally not possible.²⁰⁷ It is indeed understandable that when a report is created before an assignment is made to the client of a particular ASP, the ASP cannot supervise its initial preparation. The current regulatory provisions, however, also absolve most ASPs from the requirement to make reasonable efforts *up to the time that the adoption is finalized* to obtain the specific medical and social history information designated in the Code of Federal Regulations.²⁰⁸ This is because those provisions are now also rendered inapplicable when reports are prepared by foreign governments or foreign unsupervised providers.²⁰⁹ This broad dispensation is unfortunate.

To assess how ASPs view the impact of the Hague legal regime on the collection of medical and social history, ASPs were asked in the author's survey to compare the amount of detail regarding medical and social history that they collected as a general practice in the year before they began preparation to become an accredited Hague provider with the information they currently collect under the Hague Adoption Convention regulations.²¹⁰ Of those respondents who are currently primary providers for incoming placements, 62% reported that they received about the same medical and social history information from Convention countries as they received previously. Slightly over one-third (36%) reported they received more detailed or complete information than before Convention implementation efforts began, and, paradoxically, one ASP (2%) reported

²⁰⁵ 22 C.F.R. §§ 96.46, 94.49 (2011).

²⁰⁶ Hague Convention on Intercountry Adoption; Intercountry Adoption Act of 2000; Accreditation of Agencies; Approval of Persons; Preservation of Convention Records, 68 Fed. Reg. 54064, 54107 (Sept. 15, 2003).

²⁰⁷ Hague Convention on Intercountry Adoption, *supra* note 10, at 8104.

²⁰⁸ 22 C.F.R. §§ 96.46(b),(c), 96.49(d)-(g), 96.14(c), (e) (2011).

²⁰⁹ *Id.* §§ 96.46(b),(c); 96.49(g).

²¹⁰ *See* Appendix A.

receiving less. One of the responders who replied “about the same” did comment, however, that it was receiving more labs and hospital reports on special needs children from China.

The survey suggests that to some extent, the Hague regime may be having more of an impact on the information currently received from nations that are not yet parties to the Hague Adoption Convention. Respondents were asked if they also facilitated adoptions from non-Convention nations and 69% responded affirmatively.²¹¹ Of those who did, 62% responded that the Hague Adoption Convention regulations regarding collection and disclosure of medical and social history affected their standard practices in non-Convention nations. Those who replied in the affirmative often responded that they regarded the Convention standards as best practices and attempted to apply them to both Convention and non-Convention placements, to the extent that they were able. Some of the affirmative responders focused on the practices of the non-Convention countries of origin, observing that those nations also had higher expectations regarding what should be collected and were trying to mirror at least some of the data now required by the Hague Adoption Convention. Some of these nations (such as Russia) are now signatories and are influenced by the Hague Adoption Convention regime as they work toward implementation.

Those who responded in the negative typically reported that they had always followed high standards in regard to their collecting and reporting. Of the responders who responded negatively, one commented that the only non-Convention nation from which it places children is South Korea, which historically has provided a comprehensive medical and social history on the children whom it places.

The survey responses support to some extent the author’s intuition that the U.S. implementing regulations may have relatively little direct impact on the collection efforts of U.S. primary providers in most incoming Hague Convention placements. They provide insufficient guidance, and the specific mandate regarding what must be collected rarely applies in most placements because the reports are received primarily from foreign governmental authorities and foreign unsupervised providers. But even though the U.S. federal regulations may not have a great deal of impact on ASP conduct, the Hague legal regime itself may be having a gradual impact on the collection practices utilized by foreign governmental authorities or their accredited designees in countries of origin, and it may

²¹¹ See Appendix A.

be this effect that explains the replies of respondents who observe that they receive more data now. Although Article 16 of the Convention is very general in its directive to collect background information, guidance is offered by the Hague Conference in the form of a *Guide to Good Practice for Implementation of the Convention* (the Guide).²¹² Annex 7–6 through 7–10 of the *Guide* provides a Model Form for a Medical Report on the Child, which asks for some very basic information regarding weight and size at birth, the course of the pregnancy, a history of certain diseases and vaccinations, some basic developmental history, information regarding caregivers, and information to be provided by a medical examiner.²¹³ A supplemental form beginning at Annex 7–11 provides a report concerning the psychological and social circumstances of a small child.²¹⁴ Both forms are fairly cursory. They fail to reference much of the critical information suggested above. Nevertheless, the forms do provide some guidance to countries of origin that have not yet developed their own systems for collection and they focus attention on the importance of medical and social history.²¹⁵

Although the federal regulations may amount to mere admonitions for most ASPs facilitating placements from Hague Adoption Convention nations, state law may still impose additional collection duties that are worthy of note.²¹⁶ The IAA provides generally that inconsistent state law is not preempted by the Act,²¹⁷ and the Code of Federal Regulations specifically provide that the accreditation requirements do not eliminate the need for an ASP to comply fully and provide adoption services consistently with the law of the state in which it operates.²¹⁸ In addition,

²¹² See *Guide to Good Practice*, *supra* note 35.

²¹³ *Id.* at Annex 7–6 to 7–10.

²¹⁴ *Id.* at Annex 7–11 to 7–13.

²¹⁵ In the Conclusions and Recommendations of the Special Commission for Practical Operation of the Convention (Sept. 17–23, 2005), the Commissioners reaffirmed the usefulness of the form, although they did not mandate its use. See *Conclusions and Recommendations of the Second Meeting of the Special Commission of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption*, HAGUE CONF. ON PRIVATE INT'L L. (Sept. 17–23, 2005), available at http://www.hcch.net/upload/wop/concl33sc05_e.pdf.

²¹⁶ See 42 U.S.C. § 14953(a) (2006); 22 C.F.R. § 96.27 (2011); Hague Convention on Intercountry Adoption, *supra* note 10, at 8109.

²¹⁷ 42 U.S.C. § 14953(a) (2006).

²¹⁸ 22 C.F.R. § 96.27.

the Comment to the Final Rules for Section 96.49 clarifies that “[t]his regulation is not intended to preempt any applicable State standards that require more timely and/or comprehensive disclosure of medical history.”²¹⁹ Although that statement refers to “disclosure” and not “collection,” it is clear in combination with Section 96.27 that state collection requirements are not pre-empted by the federal regulations.²²⁰

Thus, ASPs are still subject to the duties imposed by state law in the states where they are placing children, and some of these duties may be far more comprehensive than the federal regulations.²²¹ State statutes that require “reasonable efforts”²²² to obtain a detailed list of information are generally applicable to all adoptions, domestic and international, although obviously the court’s expectations for “reasonable efforts” would be shaped by the context and constraints of the international placement. An agency placing a child to be adopted in Oklahoma, a state with a very detailed statute specifying the information to be collected in a medical and social history report,²²³ would therefore be held to the state standards as well. This would be true at least to the extent that the agency could reasonably influence the contents of a background report or would have the ability to seek additional information from a child’s caretakers after the match with one of the agency’s clients was proposed.

Some states also have statutes specifically regulating collection in international placements. For example, California regulates the contents of medical reports provided in international placements.²²⁴ Further, it provides for the storage of blood samples through the state’s Department of Human Services if birth parents voluntarily provide them.²²⁵ Thus,

²¹⁹ Hague Convention on Intercountry Adoption, *supra* note 10, at 8109.

²²⁰ See 42 U.S.C. § 14953; 22 C.F.R. § 96.27.

²²¹ See, e.g., OKLA. STAT. tit. 10, § 7504-1.1 (2011); MICH. COMP. LAWS § 710.27 (2002); VT. STAT. ANN. tit. 15A, § 2-105 (2010).

²²² See generally Steve Mulligan, *Inconsistency in Illinois Adoption Law: Adoption Agencies’ Uncertain Duty to Disclose, Investigate, and Inquire*, 39 LOY. U. CHI. L.J. 799, 816 (2008) (comparing different standards in U.S. state statutes regarding the duty to acquire medical and social information).

²²³ See OKLA. STAT. tit. 10, § 7504-1.1 (2011).

²²⁴ CAL. FAM. CODE § 8909(b) (West 2009) (“The report on the child’s background shall contain all known diagnostic information, including current medical reports on the child, psychological evaluations, and scholastic information, as well as all known information regarding the child’s developmental history and family life.”).

²²⁵ *Id.* § 8909(c)(1).

whether through their general adoption statutes or specific statutes regulating international placement, state laws often impose additional requirements that in some cases will provide for more robust collection efforts than those mandated by the federal Hague regulations.

C. Collection Standards—Outgoing Adoptions

Although U.S. children are placed abroad for adoption, these placements account for fewer than 1% of all international adoptions in which the United States participates.²²⁶ In fiscal year 2011, only seventy-three children emigrated from the United States for adoption. All but one of these children emigrated to nations that were a party to the Convention.²²⁷

Prior to the implementation of Convention standards, there were few formal controls on the placement of U.S. children abroad.²²⁸ To the extent U.S. state courts were involved, they applied state standards, but prior to the Convention the parties could sometimes avoid state court oversight by taking the child abroad for surrender.²²⁹ Thus, implementation of the Convention has had a significant impact on the regulation of outgoing adoptions.²³⁰ The U.S. Department of State will not certify the adoption of a U.S. child until it receives verification from a U.S. state court that both Convention and U.S. regulatory requirements have been satisfied.²³¹ This certification from the U.S. Department of State is essential to prospective

²²⁶ ANNUAL REPORT ON INTERCOUNTRY ADOPTIONS (2011), *supra* note 156, at tbl.3.

²²⁷ *Id.* In fiscal year 2010, even fewer children emigrated from the United States for adoption, and all forty-three of these children emigrated to nations that were a party to the Convention. ANNUAL REPORT ON INTERCOUNTRY ADOPTIONS (2010), *supra* note 156, at tbl.3.

²²⁸ See Peter Pfund, *Implementation of the Hague Intercountry Adoption Convention in the United States: Issues and Pitfalls*, in E. PLURIBUS UNUM 321, 324 (A. Borras et al. eds, 1996); Blair et al., *supra* note 123, at 750–51.

²²⁹ *Id.*

²³⁰ See generally, Galit Avitan, *Protecting Our Children or Our Pride? Regulating the Intercountry Adoption of American Children*, 40 CORNELL INT'L L. J. 489 (2007) (critiquing the U.S. regulations implementing the Convention, as applied to outgoing placements of African American infants).

²³¹ See U.S. DEP'T OF STATE, THE HAGUE CONVENTION ON INTERCOUNTRY ADOPTION: A GUIDE TO OUTGOING CASES FROM THE UNITED STATES 11–14, 22 (2011), available at <http://adoption.state.gov/content/pdf/OutgoingCasesFAQs.pdf> [hereinafter GUIDE TO OUTGOING CASES].

adopters, as it may be required by other Convention nations to allow a U.S. child to immigrate or to finalize the adoption,²³² and it will be a necessary prerequisite to recognition of the adoption by other nations under the Convention.²³³

1. Who Can Prepare Reports

Background reports on children emigrating from the United States to Convention countries for adoption must be prepared by ASP employees, exempted providers, supervised providers, or public domestic authorities.

a. ASP employees

Employees who prepare background reports must be authorized or licensed to complete a child background study under the laws of the states in which they practice.²³⁴ They must also be supervised by ASP employees with experience in family and children's services, adoption, or intercountry adoption who have earned either a master's degree in social work, a master's or doctorate degree in a related human service field, or who have significant experience in intercountry adoption and access to an individual with one of the described degrees.²³⁵

b. Exempted Providers

Social work professionals or organizations who are not providing other adoption services and not themselves accredited as an ASP may prepare background reports.²³⁶ The report must be reviewed and approved in writing by an agency accredited to provide Convention adoption services.²³⁷

c. Supervised Providers

Supervised providers are nongovernmental agencies, entities, or individuals who are permitted to provide certain adoption services under a written agreement with and supervision of an ASP, in compliance with the

²³² *Id.* at 13–15, 22 (2009).

²³³ See Hague Adoption Convention, *supra* note 2, art. 23.

²³⁴ 22 C.F.R. §§ 96.37(a), (b), (d), (g), 97.3(a) (2011).

²³⁵ *Id.* §§ 96.37(d),(g).

²³⁶ 42 U.S.C. § 14921(b)(1) (2006); 22 C.F.R. § 96.2 (2011) (definition of “exempted provider”); 22 C.F.R. §§ 96.12(a)(3), 96.13(a), 96.53(a)(3), (b) (2011).

²³⁷ 42 U.S.C. § 14921(b)(1) (2006); 22 C.F.R. §§ 96.12(a)(3), 96.13(a), 96.53(a)(3), (b) (2011).

applicable accreditation standards.²³⁸ Preparation of background reports is one of the services supervised providers may perform.²³⁹ The background report must be reviewed and approved in writing by an agency (and not an approved person) accredited to provide Convention adoption services.²⁴⁰

d. Public Domestic Authorities

Domestic governmental authorities are permitted to prepare child background studies.²⁴¹ They need not be accredited, but they must comply with the Convention itself, the IAA, and other applicable law when providing services in Convention cases.²⁴²

Only twenty-one (10%) of the ASPs accredited as primary providers for Hague Convention adoptions facilitate outgoing placements.²⁴³ Eight of those responded to the author's inquiry regarding which individuals or entities prepared background reports. The majority of those (75%) utilized their own employees to prepare at least some portion of the background reports and three of the eight reported that the reports were prepared exclusively by their employees.²⁴⁴ Five of the eight (63%) reported that supervised providers prepared at least some portion of their background reports, and only one reported using supervised providers exclusively for this purpose.²⁴⁵ One ASP responded that its reports for outgoing placements were prepared by domestic governmental authorities or supervised providers.²⁴⁶ None of the ASPs reported using exempted providers.²⁴⁷ Given that very few outgoing placements are made each year, the percentages may not carry much weight; the responses do, however, appear to indicate that background reports are prepared predominantly by agency employees or supervised providers.²⁴⁸

²³⁸ 22 C.F.R. §§ 96.12, 96.45(b) (2011).

²³⁹ *Id.* §§ 96.2, 96.12, 96.45(b)(1) (2011).

²⁴⁰ *Id.* §§ 96.53(b) (2011). *See also* Hague Convention on Intercountry Adoption, *supra* note 10, Comment to 22 C.F.R. § 96.53, at 8111.

²⁴¹ 22 C.F.R. §§ 96.12(b), 96.44(a), 97.3 (2011).

²⁴² *Id.* §§ 96.16 (2011).

²⁴³ *See Adoption Service Provider Search, supra* note 147.

²⁴⁴ *See* Appendix A.

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *See generally* Appendix A.

2. *Content Requirements*

Federal regulations specifying content for background reports containing medical and social history of American children emigrating for adoption abroad are much less specific than are the regulations regarding the required content for incoming placement.²⁴⁹ U.S. implementing regulations simply track the language of Article 16, requiring ASPs to take “all appropriate measures” to ensure that background reports include information about the child’s “identity, adoptability, background, social environment, family history, medical history (including that of the child’s family), and any special needs of the child.”²⁵⁰ ASPs must also confirm that an appropriate ASP employee or other appropriate provider prepared the report and that it was reviewed by an accredited agency.²⁵¹ The regulations further provide that a child’s ethnic, religious, and cultural background and other information in the background study must be considered in placement decisions.²⁵²

In essence, the federal regulations leave the details regarding the collection of medical and social history to state law, providing that ASPs must comply fully and provide adoption services consistently with the laws of the jurisdictions in which they operate, including U.S. state laws.²⁵³ Thus, an agency in Oklahoma, for example, would need to complete the thirty-page medical and social history required by Oklahoma state law.²⁵⁴ In another state, however, the collection requirements may be far less detailed, leaving the information provided to prospective adopters of American children to the vagaries of state law.

D. Disclosure Standards

1. To Prospective Adopters and Adoptive Parents—Incoming

At the heart of the controversy about medical and social history in transnational placements during the decades leading up to U.S. implementation of the Hague Adoption Convention were concerns over perceived inadequacies in agency efforts to transmit health information to

²⁴⁹ See 22 C.F.R. §§ 96.53(a), 97.3(a) (2011).

²⁵⁰ *Id.* §§ 96.53(a), 97.3(a) (2011).

²⁵¹ *Id.* §§ 96.53(b), (e), 97.3(a) (2011).

²⁵² *Id.* §§ 96.54(e), (f), 97.3(b) (2011).

²⁵³ *Id.* § 96.27(g) (2011).

²⁵⁴ See OKLA. STAT. tit. 10, § 7504-1.2 (2011).

prospective adoptive parents.²⁵⁵ Although many of the specifics of accreditation standards were left to federal regulation, Congress included a directive addressing this issue at the top of the list of statutory accreditation requirements.²⁵⁶ This directive required that ASPs must, at a minimum, provide prospective adoptive parents in Convention adoptions with a copy of the medical records of the child “which, to the fullest extent practicable, shall include an English language translation of such records.”²⁵⁷ Disclosure is mandated no later than “2 weeks before: (I) the adoption; or (II) the date on which the prospective parents travel to a foreign country to complete all procedures in [the] country relating to the adoption,” whichever is earlier.²⁵⁸

Federal regulations further modified the timing of disclosure to require that the medical records be provided “as early as possible, but no later than two weeks before either the adoption *or placement for adoption*” or the date on which the parents travel to the foreign nation “to complete all procedures . . . relating to the adoption or placement for adoption, whichever is earlier.”²⁵⁹ This critical addition ensures that parents who do not travel to their child’s country of origin receive medical and social history information before a child is placed in their custody. The additional restrictions in the regulation are in line with Congressional intent and circumvent a literal construction of the statute that otherwise might have permitted disclosure to prospective adopters to be delayed until many months after a child was placed in their home, if the child was immigrating to the United States for finalization of the adoption in a U.S. court.²⁶⁰

As supplemented by the federal regulations, the federal disclosure deadlines are generally consistent with many state law disclosure requirements.²⁶¹ Should any states mandate an earlier disclosure, however,

²⁵⁵ See, e.g., Federici, *supra* note 80, at 12–16; McDermott, *supra* note 80, at 25.

²⁵⁶ 42 U.S.C. § 14923(b)(1)(A)(i) (2006).

²⁵⁷ *Id.*

²⁵⁸ *Id.*

²⁵⁹ 22 C.F.R. § 96.49(a) (2011) (emphasis added).

²⁶⁰ Hague Convention on Intercountry Adoption, *supra* note 10, at 8107.

²⁶¹ See, e.g., ARIZ. REV. STAT. ANN. § 8-129 (2007) (requiring disclosure before placement); OKLA. STAT. tit. 10 § 7504-1.2 (2011) (requiring disclosure as early as practicable before the first meeting of the prospective adoptive parents with the child and before the prospective adoptive parents accept physical custody of the minor); WASH. REV. CODE ANN. § 26.33.380 (2011) (requiring disclosure prior to placement).

ASPs would be required to disclose on the state's earlier timetable because the Code of Federal Regulations requires ASPs to fully comply with the state laws of the jurisdictions in which they operate.²⁶²

To further promote informed decision-making by adoptive parents, the regulations provide that, absent exceptional circumstances relating to the needs of the child, an incoming placement may not be withdrawn by an ASP for at least two weeks after the available medical and descriptive information, including videotapes, has been provided. This window is designed to enable adopters to obtain review of the records by a physician and to make a well-considered decision, taking into account the child's needs and their ability to meet them.²⁶³

Federal regulations also expand upon the statutory directive regarding the breadth and method of the disclosure. They provide that if the medical records provided are a summary or compilation of other records, the underlying medical records must also be provided if they are available.²⁶⁴ A correct and complete English translation of the medical records must be provided to the fullest extent practicable, and "any untranslated medical reports or videotapes or other reports" must also be transmitted by the ASP to prospective adopters so that they can arrange for their own translation, including into a language other than English, if needed.²⁶⁵ Videotapes or pictures of the child must be identified by the date on which they were recorded or taken, and an ASP must ensure they were taken in compliance with the laws of the country in which they were made.²⁶⁶

ASPs are expressly prohibited by the federal regulations from withholding or misrepresenting to prospective adoptive parents a child's medical or social history or other pertinent information concerning the child.²⁶⁷ The final regulations are less stringent, however, than the proposed 2003 regulations, which prohibited non-disclosure by ASPs or their agents.²⁶⁸ Under those proposed regulations, ASPs had no option to use foreign unsupervised providers, and they were required to assume responsibility and liability for the compliance of their foreign supervised

²⁶² 22 C.F.R. §§ 96.27(g), 96.30(b) (2011).

²⁶³ *Id.* § 96.49(k) (2011).

²⁶⁴ *Id.* § 96.49(b).

²⁶⁵ *Id.* § 96.49(a), (b).

²⁶⁶ *Id.* § 96.49(i).

²⁶⁷ *Id.* § 96.49(j).

²⁶⁸ Standards for Cases in Which a Child Is Immigrating to the United States (Incoming Cases), 68 Fed. Reg. 54106, 54108 (Sept. 15, 2003) (to be codified at 22 C.F.R. pt. 96).

providers with both the collection and the disclosure provisions.²⁶⁹ These liability provisions were eliminated in the final federal regulations,²⁷⁰ and while ASPs must still contractually require compliance with both the collection and the disclosure provisions from foreign supervised providers,²⁷¹ there are no requirements that foreign providers disclose information they possess.²⁷² Although this seems reasonable to the extent that ASPs have no control over the selection of those who prepare background reports in countries of origin, it is highly problematic in those instances when ASPs do in fact have a working relationship with foreign providers that would enable the ASPs to exert influence over their selection and actions. This is particularly true in instances in which compensation is being paid to a foreign provider by the ASP.

More general disclosure policies and training requirements for incoming placements are designed to further promote realistic behavioral and financial expectations on the part of prospective adoptive parents. ASPs must fully disclose their policies and practices and the disruption rates of their placements for intercountry adoption, as well as all fees they will charge for the adoption.²⁷³ Before providing services, ASPs must disclose in writing all fees connected with an adoption, including fees for care and medical care of the child, translation, and document expenses.²⁷⁴ ASPs are also required to provide prospective adoptive parents with at least ten hours of training (independent of the home study) that include counseling and guidance before they travel to adopt the child or before

²⁶⁹ Service Planning and Delivery, 68 Fed. Reg. 54105, 54106 (Sept. 15, 2003) (to be codified at 22 C.F.R. pt. 96).

²⁷⁰ Hague Convention on Intercountry Adoption, *supra* note 10, at 8103.

²⁷¹ 22 C.F.R. § 96.46(b)(2) (2011).

²⁷² The words “or agents” inserted in the text of the proposed regulation, were deleted from the final version of 22 C.F.R. § 96.46(j) (2011). Compare Proposed 22 C.F.R. § 96.46(j), Standards for Cases in Which a Child Is Immigrating to the United States (Incoming Cases), *supra* note 268, at 54108 (“Neither the agency or person nor its agents withhold from or misrepresent to prospective adoptive parent(s) any medical, social, or other pertinent information concerning the child”), with 22 C.F.R. § 96.46(j) (2011) (“The agency or person does not withhold from or misrepresent to the prospective adoptive parent(s) any available medical, social, or other pertinent information concerning the child.”).

²⁷³ 42 U.S.C. § 14923(b)(1)(A)(v) (2006); 22 C.F.R. § 96.39(b)(1) (2011).

²⁷⁴ 22 C.F.R. § 96.40(b) (2011).

placement of the child with the parents.²⁷⁵ Training must address general topics, such as:

- (a) the adoption process, the needs of children awaiting adoption, and the in-country conditions that affect those children;
- (b) the effects of malnutrition, relevant environmental toxins, maternal substance abuse and other known genetic health, emotional, and developmental risk factors associated with children from the country of origin from which the prospective adopters plan to adopt;
- (c) the impact on children of the expected child's age of leaving familiar ties and surroundings;
- (d) data on the impact of institutionalization on children, specific to the country of origin and typical length of institutionalization for children in that country;
- (e) attachment disorders and other emotional problems of institutionalized or traumatized children and children with multiple caregivers;
- (f) the laws and process for adoption in the country of origin, including possible delays and impediments;
- (g) long-term implications for multicultural families that have experienced transnational adoption; and
- (h) reporting requirements of the country of origin.²⁷⁶

In addition, training must include counseling and preparation for the particular child, including information on topics such as:

- (a) the child's history and cultural, racial, religious, ethnic, and linguistic background;
- (b) known health risks in the specific region or nation where the child resides; and
- (c) any medical, social background, birth history, educational data, developmental history, or other data known about the particular child.²⁷⁷

Training may be provided through agency collaboration, group seminars, individual counseling sessions, video or computer-assisted or distance learning methods, extended home study processes, and through the use of print, internet, and other resources, parent support groups, and

²⁷⁵ 42 U.S.C. § 14923(b)(1)(A)(iii) (2006); 22 C.F.R. §§ 96.48(a), (c) (2011).

²⁷⁶ 22 C.F.R. § 96.48(b).

²⁷⁷ *Id.* § 96.48(c).

adoption clinics and experts.²⁷⁸ Additional in-person individualized counseling and preparation must be provided, as needed, to meet the needs of the prospective adoptive parents, in light of the child's special needs, background study, or the home study.²⁷⁹

Disclosure to adoptive parents is an on-going duty.²⁸⁰ Federal regulations require an ASP to make all non-identifying information in its custody about the adoptee's health history or background readily available to an adoptive parent at any time upon request.²⁸¹ Because ASPs are required to comply with the statutes of the jurisdiction in which they operate,²⁸² they may also be subject to a more proactive state law duty to supplement and to affirmatively notify adoptive parents, and the adoptees themselves after they reach the age of majority, about additional information that becomes available and is transmitted to the ASP. Oklahoma statutes, for example, create an affirmative duty to provide supplemental information that is given to an agency or individual who facilitated an adoption, if the facilitator knows the location of the adoptive parents or adult adoptee.²⁸³

In addition to health-related disclosure and training, ASPs must also inform prospective adoptive parents if the agency provides post-placement services.²⁸⁴ If a placement is in crisis, an ASP must make an effort to provide or arrange for post-placement counseling.²⁸⁵

If state law disclosure, training, or counseling requirements are more extensive, however, ASPs again must comply fully and provide adoption services consistently with the laws of the jurisdictions in which they operate.²⁸⁶ For example, Colorado state law requires that for children placed in Colorado, adoptive applicants must complete sixteen hours of core training in a face to face format, regardless of whether the adoption is

²⁷⁸ *Id.* § 96.48(d), (f).

²⁷⁹ *Id.* § 96.48(e). Some prospective adoptive parents may be exempted from parts of training due to their prior training or previous experience with transnational adoption. All training provided to each adopter must be recorded in agency adoption records. *Id.* § 96.48(g)–(h).

²⁸⁰ *See generally id.* § 96.42(a).

²⁸¹ *Id.* § 96.42(b).

²⁸² *Id.* §§ 96.27(g), 96.30(b).

²⁸³ OKLA. STAT. tit. 10, § 7504-1.2(F) (2011).

²⁸⁴ 22 C.F.R. § 96.51(b) (2011).

²⁸⁵ *Id.* § 96.50(c).

²⁸⁶ *Id.* § 96.27(g) (2011).

finalized in Colorado or in a foreign nation.²⁸⁷ This training must address a lengthy list of issues, including attachment and bonding, boundary setting and discipline, loss and grief, parenting issues with children of different cultural or racial backgrounds, and disclosure issues related to the accuracy of family history information.²⁸⁸ An additional eight hours of training, which may be face to face or in other formats, must be provided for parents completing an international adoption, for a total of twenty-four hours.²⁸⁹

2. *To Prospective Adopters and Adoptive Parents—Outgoing*

Federal regulation of disclosure in outgoing Hague Convention placements is sparse. The child's background study must be transmitted to a governmental authority or accredited body in the receiving nation, but no time limits are provided in the federal regulations.²⁹⁰ Therefore, the only federal mandate appears to be the statutory requirement that medical records be provided to prospective adoptive parents two weeks before the adoption or two weeks before the prospective parents travel, whichever is earlier.²⁹¹ It is somewhat unclear whether this federal statutory requirement was intended to apply to outgoing placements.²⁹² If it was not, or if state law requirements provide for earlier disclosure to prospective adopters,²⁹³ the state law requirements would control.²⁹⁴ ASPs working with government entities or accredited entities in the receiving nations, rather than working directly with prospective adoptive parents, would presumably be required to forward the reports to those entities in sufficient time for them to be timely transmitted to the adoptive parents.

²⁸⁷ COLO. CODE REGS. § 2509-8:7.710.55(A)–(B) (2011).

²⁸⁸ *Id.*

²⁸⁹ *Id.* § 2509-8:7:710.55(C).

²⁹⁰ 22 C.F.R. § 96.53(e) (2011).

²⁹¹ 42 U.S.C. § 14923(b)(1)(A)(i) (2006).

²⁹² The language of the statute raises a question regarding whether it was intended to apply to outgoing adoptions, because it refers to adopters traveling “to a foreign country.” *Id.* Nevertheless, the provision is found in the statute dictating general standards for accreditation or approval for entities providing adoption services in the United States for Convention adoptions, and those entities include ASPs facilitating outgoing placements as well as those facilitating incoming placements. *Id.*

²⁹³ *See supra* note 262.

²⁹⁴ 22 C.F.R. §§ 96.27(g), 96.30(b) (2011).

3. *Preservation*

Obviously, preservation of medical and social history as well as information concerning the identity of birth parents are of critical concern to adopted individuals who may wish to access information about their origins at any point throughout their lifetimes. Article 30 of the Convention mandates that government authorities of each contracting nation ensure that this information is preserved.²⁹⁵

U.S. federal regulations require the Department of State and the Department of Homeland Security to preserve Convention records for both incoming and outgoing adoptions for a minimum of seventy-five years.²⁹⁶ “Convention records” include any records generated, received, or in the custody of the Departments of State or Homeland Security.²⁹⁷ For incoming adoptions, these records should at least include a summary of the background report on the child, because Title 8 of the Code of Federal Regulations requires that a summary of the child’s medical and social history be provided to the Department of Homeland Security with the application for an immigrant visa.²⁹⁸ The only information that the regulation specifically requires the summary to contain, however, is a statement regarding whether the child is inadmissible for immigration purposes.²⁹⁹ This would require a determination regarding whether the child has certain contagious or communicable diseases, such as tuberculosis, syphilis, or HIV, which might in some circumstances render the child inadmissible.³⁰⁰

The original copy of the background report, however, may often be directed only to the ASP facilitating the placement, and under the federal regulations, it would then be considered to be an “adoption record” rather than a “Convention record.”³⁰¹ ASPs are required to retain adoption records only as required by applicable state law,³⁰² which may be far less

²⁹⁵ See Hague Adoption Convention, *supra* note 2, art. 30(1).

²⁹⁶ 22 C.F.R. § 98.2 (2011).

²⁹⁷ *Id.* § 98.1.

²⁹⁸ 8 C.F.R. § 204.313(d)(4)(iv) (2011).

²⁹⁹ *Id.* § 204.313(d)(4)(iv)(A).

³⁰⁰ *Id.*

³⁰¹ Adoption records include information maintained by an ASP, “including . . . photographs, videos, correspondence, personal effects, medical and social information, and any other information about the child.” 22 C.F.R. § 96.2 (2011).

³⁰² *Id.* § 96.42.

than seventy-five years³⁰³ or may not be mandated by state law for any prescribed period of time.³⁰⁴

Thus, preservation of critical medical and social history receives inadequate protection under the federal regulations if ASPs are located in states with inadequate preservation standards. This information is often vital to an adopted adult's medical care and sense of identity later in life. Frequently, adoptees are well into adulthood before the importance of this information becomes clear to them and they initiate a search.³⁰⁵ In its Conclusions and Recommendations, the 2010 Special Commission on the Practical Operation of the Hague Adoption Convention recommended that receiving states preserve adoption records in perpetuity.³⁰⁶ In its *Guide to Good Practice*, the Hague Conference observed:

Adoption is not a single event, but a life-long process. The need to know is not confined to young adult adoptees. In one receiving country [New Zealand], the oldest adoptee applying for his original birth certificate was 96. The oldest age of a birth mother searching for her child was 89.³⁰⁷

³⁰³ For example, until a new law entered into effect in November of 2011, Oklahoma required adoption records to be preserved for only twenty-two years. OKLA. STAT. ANN. tit. 10, § 7508-1.1 (West 2009).

³⁰⁴ See Marley Elizabeth Greiner, *Comments, Hague Convention on Intercountry Adoption; Intercountry Adoption Act of 2000*, BASTARDS.ORG (Dec. 15, 2003), <http://www.bastards.org/activism/Hague-IAA-Comments.html> (observing that retention of adoption records by agencies is governed by a “hodgepodge” of laws that vary both from state to state and from county to county).

³⁰⁵ See Penny Partridge and Miriam Robinson, *Access to Origins: A Study of Ninety-Five Adoptees*, ADOPTING.ORG, <http://www.adopting.org/AccessToOrigins.html> (last visited Oct. 30, 2011) (reporting that of ninety-five adoptees searching for information on their birth parents, the average age of those questioned was twenty-nine, and that almost two-thirds of them desired the information to “hav[e] a means of learning medical history”).

³⁰⁶ *Conclusions and Recommendations Adopted by the Special Commission on the Practical Operation of the Hague Convention of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption*, ¶ 28, HAGUE CONF. ON PRIVATE INT'L L. (June 17–25, 2010), available at http://www.hcch.net/upload/wop/adop2010concl_e.pdf.

³⁰⁷ *Guide to Good Practice*, *supra* note 35, at 565.

4. *Disclosure to Adopted Individuals*

As suggested by the Hague Conference's observations above, adults who were adopted as children often wish to access not only their medical history and non-identifying social information but also identifying information about their birth families.³⁰⁸ Federal law ensures access to non-identifying medical and social information, at least to the extent it has been preserved.³⁰⁹ Federal regulations require ASPs to make all non-identifying information in their custody about health history or background readily available to an adopted individual upon request.³¹⁰ Access to identifying information, however, receives little protection under either the Convention itself or under implementing federal law.

Although the Hague Adoption Convention requires in Article 30 that identifying information be preserved, its disclosure is left to both the law of the state of origin and the law of the receiving state.³¹¹ In particular, Article 30 provides that adopted individuals and their representatives may have access to information identifying their birth parents only in so far as disclosure is permitted under the domestic law of each nation.³¹² Countries of origin may therefore choose to exclude identifying information from the background reports that are transmitted to receiving nations, even though they are under a duty to preserve the identifying information. Furthermore, receiving nations may also regulate the extent to which any information they receive is disclosed.

In outgoing adoptions, U.S. regulations, in conformity with Article 16 of the Convention,³¹³ provide that ASPs may not reveal identifying information when transmitting background reports if those identities may not be disclosed under state law.³¹⁴ Although some U.S. states maintain

³⁰⁸ *Id.*

³⁰⁹ 22 C.F.R. § 96.42 (2011).

³¹⁰ *Id.*

³¹¹ Hague Adoption Convention, *supra* note 2, art. 30(2).

³¹² *Id.*

³¹³ *Id.* Article 16(2) provides that when a sending nation transmits the background report and other information to the receiving nation, it must take "care not to reveal the identity of the mother and the father if, in the State of origin, these identities may not be disclosed." *Id.*

³¹⁴ 22 C.F.R. §§ 96.53(e), 97.3(b) (2011).

open adoption records,³¹⁵ the majority restrict or prohibit the release of identifying information without a court order.³¹⁶

Similarly, state law will control the disclosure of identifying information contained in most of the records of incoming adoptions as well. This is because background reports on the children as well as records of state adoption proceedings, if any are normally contained in “non-Convention adoption records,”³¹⁷ and the IAA provides that disclosure or access to non-Convention records is governed by applicable state law.³¹⁸ Records designated in the regulations as “Convention records”³¹⁹ may be disclosed only to the extent necessary to administer the Convention or if the record is maintained under the authority of the Immigration and Nationality Act and disclosure or access is required or permitted by federal law.³²⁰ Identifying information could potentially be contained in these Convention records because visa applications must contain copies of the child’s birth certificate or secondary evidence of the child’s age, as well as copies of the consents. However, Title 8 of the Code of Federal Regulations permits countries of origin to certify the child’s age and that the required consents exist, rather than reveal identifying information, if the law of the country of origin protects against disclosure of the identifying information.³²¹ Even when identifying information is contained in Convention records, the extent to which federal law will actually permit access is yet to be resolved.³²² While it is possible that a small window to identifying information in Convention records may exist, federal law in most instances appears to hold little opportunity for

³¹⁵ See *Access to Identifying Information*, in 3 ADOPTION LAW AND PRACTICE 13A-7 (Joan Hollinger ed., LexisNexis 2010).

³¹⁶ *Id.* at 13-24 to 13-31.

³¹⁷ See *supra* note 301 and accompanying text.

³¹⁸ 42 U.S.C. § 14941(c) (2006).

³¹⁹ See *supra* notes 297-300 and accompanying text.

³²⁰ *Id.* § 14941(b)(1)(2). Unlawful disclosure is subject to penalties under the statute. *Id.* § 14941(b)(3).

³²¹ 8 C.F.R. § 204.313(d)(4)(ii) (2011).

³²² See *supra* note 320. When the Convention regulations were first proposed, advocates of open records suggested that the Freedom of Information Act might provide access to the Convention records, but even they expressed uncertainty regarding whether this Act would provide an avenue to access. See Greiner, *supra* note 304.

respite from laws in the majority of states that restrict access to adult adoptees seeking identifying information about birth parents.³²³

5. *Disclosure to Birth Relatives*

Federal law says little on the subject of disclosure of information to birth parents. In regard to outgoing placements, federal regulations provide that, if state law so requires, ASPs must disclose to birth parents that their child is to be adopted by parents who reside outside the United States.³²⁴ Beyond that limited mandate, any rights birth families may have to medical or identifying information regarding an adopted individual will be dependent upon the law of individual states.³²⁵

Thus, while many aspects of the regulation of collection, preservation, and disclosure of medical and social information are now regulated by federal law in Hague Convention adoptions, state law still plays a significant role in defining the collection duties of facilitators, particularly in outgoing placements. In addition, state law still heavily influences disclosure responsibilities, especially in the post-adoption stages.

IV. THE HAGUE ADOPTION CONVENTION AND FEDERAL IMPLEMENTATION: ENFORCEMENT

A. *Civil Liability*

While imposition of civil liability played an important role in motivating disclosure at the state level, the federal government chose a different path to motivate compliance. As reviewed in detail in Part III, the federal collection and disclosure directives were incorporated into accreditation standards rather than tied explicitly to the imposition of civil liability.

In the Intercountry Adoption Act, Congress explicitly announced that neither the Convention nor the IAA create a private right of action in U.S. courts or administrative proceedings.³²⁶ While the IAA creates civil and criminal penalties for certain other infractions, none relate to collection or disclosure of health-related information.³²⁷ Moreover, provisions in the proposed implementing regulations that would have imposed tort or

³²³ See *supra* note 316 and accompanying text.

³²⁴ *Id.* § 96.54(d).

³²⁵ See *supra* notes 50 and 58 and accompanying text.

³²⁶ 42 U.S.C. § 14954 (2006).

³²⁷ *Id.* § 14944.

contract liability on ASPs for non-compliance of foreign supervisors were deleted from the final regulations.³²⁸

Although the federal law and regulations themselves create no right of action, breach of statutory duties can create a common law claim for negligence per se under state tort law.³²⁹ While the 2003 proposed regulations were pending, it appeared that they might present potential plaintiffs with useful standards in that context. The circumstances in which the final regulations might profitably be used by plaintiffs asserting state law claims, however, appear far narrower. The limited applicability of the collection provisions³³⁰ would appear to severely constrain their potential utilization as a basis for liability in a negligence per se claim for failure to investigate.

The federal regulations clearly do create a duty to disclose health information to prospective adoptive parents,³³¹ so intentional withholding or misrepresentations regarding medical and social history and failure to provide medical records in the ASP's possession might bolster a negligence per se claim that could be actionable. These claims are already typically actionable under state law, so the federal regulations may add little in this context.

Potential plaintiffs with state law claims may, however, be boosted by the federal regulations in another respect. Accreditation standards require that an ASP have in force adequate liability insurance for professional negligence and any other insurance required by federal regulatory bodies.³³² The amount must be reasonably related to its exposure to risk, but cannot be for an amount less than \$1,000,000 in the aggregate.³³³

B. Exculpatory Clauses

Exculpatory clauses have become increasingly common in the standard contracts used by ASPs.³³⁴ These clauses have long been criticized by

³²⁸ Standards for Cases in Which a Child Is Immigrating to the United States (Incoming Cases), 68 Fed. Reg. 54106, 54106 (Sept. 15, 2003) (to be codified at 22 C.F.R. pt. 96).

³²⁹ RESTATEMENT (SECOND) OF TORTS § 288B (1965).

³³⁰ See *supra* notes 194–209.

³³¹ See *supra* notes 256–67 and accompanying text.

³³² 42 U.S.C. § 14923(b)(1)(E) (2006).

³³³ 22 C.F.R. § 96.33(h) (2011).

³³⁴ See Bureau of Consular Affairs, *The Hague Convention on Intercountry Adoption: A Guide for Prospective Parents*, U.S. DEP'T STATE, 15 (2006), http://travel.state.gov/pdf/Prospective_Adoptive_Parents_Guide.pdf.

advocates for adoptive parents, who have argued that clauses waiving liability for negligent conduct and misrepresentations are particularly inappropriate for contracts with noncommercial actors, and even more so for prospective adoptive parents who are emotionally vulnerable and face few alternatives.³³⁵ The proposed federal regulations in 2003 would have prohibited an ASP from requiring a client to sign a “blanket waiver of liability in connection with the provision of adoption services in Convention cases.”³³⁶ Responding to concerns expressed by adoption agencies regarding their ability to obtain insurance without the clauses, the Department of State withdrew its original prohibition of a blanket waiver.³³⁷ The final version of the regulation permits ASPs to require clients to sign a waiver of liability, if the waiver complies with state law, is limited and specific, and is based on risks that have been discussed and explained to the client in the adoption services contract.³³⁸

Because of this green light in the federal regulations, it is not surprising that almost all adoption agencies incorporate exculpatory clauses into their contracts. In the author’s survey, forty-seven (92%) of the respondents who replied to the question regarding whether they included a waiver of liability provision in their adoption service contract with prospective adoptive parents replied in the affirmative, and only four (8%) replied that they did not include a waiver provision.³³⁹ Some agencies have also chosen to include a binding arbitration clause in their contracts.³⁴⁰ On the one hand, many of these contracts perform a laudable function by thoroughly surveying the medical and health risks attendant in international placement and the limited ability of agencies in some

³³⁵ Cooper, *supra* note 119, at 28.

³³⁶ Information Disclosure, Fee Practices, and Quality Control Policies and Practices, 68 Fed. Reg. 54103 (Sept. 15, 2003) (to be codified at C.F.R. pt. 96).

³³⁷ Hague Convention on Intercountry Adoption, *supra* note 10, at 8068.

³³⁸ 22 C.F.R. § 96.39(d) (2011).

³³⁹ See Appendix A.

³⁴⁰ See, e.g., International Families Inc., *Int’l Adoption Servs. Agreement*, para. 16.3, available at http://ifiadopt.org/index.php?option=com_content&view=article&id=61 (last visited Mar. 3, 2012); An Open Door Adoption Agency, Inc., *International Adoption Serv. Agreement*, para. 17, available at http://www.opendooradoption.org/uploads/documents/international_adoption_service_agreement.pdf (last visited Mar. 3, 2012); *Boe v. Christian World Adoption*, No. CIV S-10-0181 KJM-CMK, 2011 WL 1585830, at *8 (E.D. Cal. April 22, 2011) (enforcing a binding arbitration clause in an agency contract, which stayed the court action and forced the parties to submit to arbitration).

circumstances to obtain accurate information.³⁴¹ These clauses may in fact help foster realistic expectations. On the other hand, clauses that waive liability for conduct that would otherwise be deemed negligent, or in some cases even intentional misrepresentation, dampen the deterrent effect that the risk of liability should normally have on unreasonable, reckless, or even intentionally fraudulent conduct.

The courts' treatment of exculpatory clauses in the wrongful adoption context thus far exacerbates that concern. International adoption facilitators have frequently successfully asserted exculpatory clauses as a defense against "wrongful adoption" claims.³⁴² In at least three published decisions and one unpublished decision, federal and state courts have held that exculpatory clauses in contracts for international adoption services precluded recovery on negligence claims.³⁴³ Further, in one case, a court was willing to find that an exculpatory clause precluded recovery on a fraudulent misrepresentation claim.³⁴⁴

However, not all exculpatory clauses have resulted in the dismissal of plaintiffs' claims.³⁴⁵ In *Moriarty v. Small World Adoption Foundation*,³⁴⁶ a

³⁴¹ For examples of particularly thorough treatment of the risks of health problems and the inability to guarantee accurate information, see the contracts of One World Adoption Servs., Inc., pp. 10–13, <http://www.oneworldadoptions.org/international-programs> (last visited Jan. 29, 2012); International Families Inc., *Int'l Adoption Servs. Agreement*, para. 8.1–8.3, 21.6, 21.7, available at http://ifiadopt.org/index.php?option=com_content&view=article&id=61 (last visited Mar. 3, 2012); Holt Int'l, *Int'l Adoption Servs. Agreement*, para. 7.2, 7.2.1, available at <http://www.holtinternational.org/adoption/IASA.pdf> (last visited Mar. 3, 2012).

³⁴² See *Ferenc v. World Child, Inc.*, 977 F. Supp. 56, 61 (D.C. Cir. 1998); *Dresser v. Cradle of Hope Adoption Ctr., Inc.*, 358 F. Supp. 2d 620, 638 (E.D. Mich. 2005); *Regensburger v. China Adoption Consultants, Ltd.*, 138 F.3d 1201, 1206 (7th Cir. 1998); *Forbes v. Alliance for Children*, No. 97-04860-B, 1998 LEXIS 713 (Suffolk Sup. Ct. Dec. 16, 1998) (Summary Judgment), reported in Cooper, *supra* note 119, at *15. For a more detailed discussion of these cases, see ADOPTION LAW AND PRACTICE, *supra* note 11, at 16–146 to 16–148.

³⁴³ *Ferenc*, 977 F. Supp. at 61; *Dresser*, 385 F. Supp. 2d at 638; *Regensburger* 138 F.3d at 1206; *Forbes*, C.A. No. 97004860, reported in Cooper, *supra* note 119, at *15 (finding an exculpatory clause a valid defense to a negligence claim and not violative of public policy).

³⁴⁴ *Regensburger*, 138 F.3d at 1207.

³⁴⁵ See, e.g., *Moriarty v. Small World Adoption Found.*, No. 5:04–CV–394, 2008 WL 141913 (N.D.N.Y. Jan. 11, 2008).

³⁴⁶ *Id.*

federal trial court in New York determined that a clause holding the agency harmless unless the agency “has withheld knowledge” of a child’s health issues left an issue of fact to be resolved at trial, because plaintiffs alleged information of the child’s medical condition was withheld by the defendant.³⁴⁷ In another federal action in Michigan, the trial court found that although the parents’ negligence claims were barred by a waiver provision, the adopted child was not bound by the waiver provision and could assert claims for negligence.³⁴⁸ Nevertheless, the decision of the Department of State to endorse waiver clauses, combined with the willingness of federal and state courts to enforce them, may reduce the effectiveness of potential liability as a deterrent to nondisclosure and tepid collection efforts.³⁴⁹

V. CONCLUSION

Federal law implementing the Hague Adoption Convention makes important contributions to ensuring transmission of medical and social history in Convention adoptions. Through accreditation standards in the federal statutes and regulations, the duty of adoption facilitators to disclose medical and social history to prospective adoptive parents is strongly reinforced. The regulations provide guidance and advice to adoption facilitators in an effort to foster more effective collection efforts, despite the fact that the mandates of the collection regulations have limited applicability. Moreover, the global legal regime created by the Convention may have focused attention on the importance of health-related information and enhanced the level of collection and disclosure in both Convention and non-Convention transnational adoptions.

The many gaps in the federal legal regime, however, render the federal scheme less effective than it could have been in establishing collection and

³⁴⁷ *Id.* at *3.

³⁴⁸ *Dresser*, 358 F. Supp. 2d at 638.

³⁴⁹ Generally, in other contexts, exculpatory clauses are construed narrowly. See Anita Cava & Don Wiesner, *Rationalizing a Decade of Judicial Responses to Exculpatory Clauses*, 28 SANTA CLARA L. REV. 611, 612 (1988). Many courts have refused enforcement for claims of reckless behavior, gross negligence, or for intentional torts. RESTATEMENT (SECOND) OF CONTRACTS § 195(1981). Some state courts have observed that even in proceedings for simple negligence exculpatory clauses may sometimes be unenforceable on public policy grounds, particularly if the parties have disparate bargaining power, as is often the case in adoption. *Cf. Schmidt v. United States*, 912 P.2d 871 (1996); *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441 (Cal. 1963).

disclosure standards and motivating compliance. Because state law is not preempted by federal regulations in this area, state law often works in conjunction with federal law to shore up these standards, complimenting some aspects of federal regulation and sometimes providing superior protections. ASPs facilitating Convention adoptions must be cognizant that they are still held to the standards of the states in which they operate, and thus they must investigate and disclose information to the extent reasonably possible in the context of international placements, with both state as well as federal criteria in mind.

APPENDIX A

**Report on Empirical Study of 209 Adoption Service Providers
Accredited or Approved to Provide
Adoption Services as a Primary Provider
in Hague Convention Adoptions**

As of August 11, 2011, 209 adoption service providers (ASPs) were reported on the U.S. Department of State website³⁵⁰ to be currently operating and accredited or approved to serve as primary providers of adoption services in either incoming outgoing, or both incoming and outgoing international adoptive placements between the United States and other nations that are currently parties to the Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (Hague Convention).

Of those 209 providers, the U.S. Department of State reported the providers engaged in the following types of adoptions:

- 205, or 98% handled incoming placements
- 21, or 10% handled outgoing placements
- 188, or 90% handled only incoming placements
- 4, or 2% handled only outgoing placements
- 17, or 8% handled both incoming and outgoing placements.

ASPs on the U.S. State Department list were initially contacted via e-mail by the author in March, 2011, with a short survey regarding practices and opinions related to the implementation of U.S. regulations addressing collection of medical and social history. Non-responders or newly accredited providers were again contacted with a follow-up e-mail in August, 2011.

Thirty-four percent, or 71 of the 209 ASPs, responded to the survey. Of the 71 respondents, the replies were as follows:

- 42, or 59% of the respondents currently serve as primary providers for incoming placements from at least one Hague Convention member nation; and
- 29, or 41% of the respondents replied that they were not currently serving as a primary provider for incoming adoptions from a Hague nation.

³⁵⁰ *Adoption Service Provider Search*, *supra* note 144. This list is continually updated by the U.S. Department of State and thus the number of accredited or approved providers will vary depending on the date the website is consulted.

Many ASPs responded that they were not currently acting as a primary provider, even though they were accredited to do so. Instead, some served as a supervised provider, supplying home studies or other services in conjunction with adoptions facilitated by other ASPs. Some currently worked only with non-Hague nations, although they hoped at some point to also work with Hague nations. (Several of these ASPs worked with Russia or other nations that have signed but not yet ratified the Hague Adoption Convention.) A handful worked only with outgoing placements.

The survey asked five short questions related to the collection and disclosure of a child's medical and social history. The questions and responses are set forth below.

1. *For each Hague Convention nation for which you act as primary provider for incoming adoptions (i.e. adoptions by U.S. residents of children immigrating from abroad), which of the following types of individuals/entities prepares the background reports in all or the vast majority of your adoptions from each nation?*

Of the 42 respondents who currently serve as primary providers for incoming placements from at least one Hague Convention member nation:

- 34, or 81% responded that, for all the Hague Adoption Convention nations with which they worked, the reports were prepared by a *foreign governmental authority* (Central Authority or any other public authority)
- 2, or 5% responded that, for all the Hague Adoption Convention nations with which they worked, the reports were prepared by a *foreign provider that is not under the ASP's supervision* pursuant to 22 C.F.R. § 96.46(c)
- 1, or 2% responded that, for all the Hague Adoption Convention nations with which it worked, an employee of the agency prepared the reports. [Because the sole nation from which this agency places children requires significant involvement by its Central Authority, reports prepared by the employee are in all likelihood reviewed by this foreign governmental authority.]
- 1, or 2% responded that, for at least some of the Hague Adoption Convention nations with which it worked, the reports were prepared by *an employee of the agency* and a *foreign governmental authority*; and for at least some nations with which it worked, the reports were prepared by a *foreign governmental authority*
- 2, or 5% responded that with at least some nations with which it worked, the reports were prepared by a *foreign supervised provider* (i.e., an individual or entity with which the ASP has a

written agreement pursuant to 22 C.F.R. § 96.46(b)) and a *foreign governmental authority*; and for at least some nations with which it worked, the reports were prepared by a *foreign governmental authority*

- 1, or 2% responded that with at least some nations with which it worked, the reports were prepared by a *foreign provider that is not under the ASP's supervision* (i.e., an individual or entity with which the ASP has a written agreement pursuant to 22 C.F.R. § 96.46(b)); and for at least some nations with which it worked, the reports were prepared by a *foreign governmental authority*
- 1, or 2% responded that with at least some nations with which it worked, the reports were prepared by a *foreign provider that is not under the ASP's supervision* (i.e., an individual or entity with which the ASP has a written agreement pursuant to 22 C.F.R. § 96.46(b)) and a *foreign governmental authority*; and for at least some nations with which it worked, the reports were prepared by a *foreign governmental authority*.

Thus, of the 42 respondents who currently serve as primary providers for incoming placements from at least one Hague Convention member nation (because some ASPs who work with multiple Hague nations receive reports from different sources in those nations):

- 39, or 93% report that a *foreign governmental authority* prepares the background reports on children from some or all of the Hague Adoption Convention nations from which they place children
- 4, or 10% report that a *foreign provider not under the supervision of the ASP* prepares the background reports on children from at least some of the Hague Adoption Convention nations from which they place children
- 2, or 5% report that a *foreign supervised provider* prepares the background reports on children from at least some of the Hague Adoption Convention nations from which they place children
- 2, or 5% report that an *agency employee* prepares the background reports on children from the Hague Adoption Convention nation from which it places children.

Respondents were asked to report on the preparer of background reports for each sending Hague Convention nation for which the ASP acted as a primary provider for incoming adoptions. The following table reports the aggregate data for the nations reported by the 42 respondents:

Nation	ASP employee	Foreign Supervised Provider	Foreign Provider Not Supervised by ASP	Foreign Government Authority	Combination
Armenia				2	
Belize				2	
Brazil				1	
Bulgaria			1	11	
Burkina Faso				2	
Canada				2	
China	1			19	
Columbia				3	
Costa Rica				1	
Dominican Republic				1	
Ecuador				1	
France				1	

Nation	ASP employee	Foreign Supervised Provider	Foreign Provider Not Supervised by ASP	Foreign Government Authority	Combination
Georgia				2	
Hong Kong		1	1		
Hungary			1	1	1 - employee + government
India		1	2	1	1 - employee + government
Kenya				1	1-foreign unsupervised + government
Latvia				1	
Madagascar				1	
Mexico				3	
Moldova				1	
Mongolia				1	1 - foreign supervised + government
Peru				1	
Philippines			1	8	1 - foreign supervised +

Nation	ASP employee	Foreign Supervised Provider	Foreign Provider Not Supervised by ASP	Foreign Government Authority	Combination
					government
Poland				2	
Romania				1	
Thailand				2	1 - foreign supervised + government
Turkey				1	
United Kingdom				2	

2. *In comparing the amount and detail regarding medical and social history that you collected as a general practice in the year before you began preparation to become an accredited Hague provider and currently, under the Hague Convention regulations, how would you regard the medical and social history information that you currently receive from Convention countries?*

- 15, or 36% more detailed or complete than before Convention implementation efforts began
- 26, or 62% about the same
- 1, or 2% less detailed or complete than before Convention implementation efforts began

3. *Do you also facilitate adoptions of children from non-Convention nations?**

- 35, or 69% Yes
- 16, or 31% No

If so, have the Hague Convention regulations regarding the collection and disclosure of medical and social history of the adopted children affected your standard practices in non-Convention adoptions?

- 18, or 62% Yes
- 11, or 38% No

If so, how?

For ASPs that replied in the affirmative, many responded that from their own perspective, the ASP applied the Hague Adoption Convention standards to both their Hague and non-Hague placements, to the extent that they could obtain the same information from non-Hague nations. Responses of this nature were similar to the following:

- We use Hague standards as best practice regardless of country. It seems this is a general practice across agencies. I do not find one set of rules for Hague and another for non-Hague.
- We request that they give us the same as Convention countries and they do most of the time.
- Because we can cite the Hague Convention as the expectation and use it as a model, even though it is not mandated by law.
- We do our best to follow Hague standards, but we cannot ensure information from Ethiopia will follow the Hague standards. It is more sparse and less detailed.
- We request more information.

Other affirmative responses focused on the practices of the non-sending nations and noted improved reporting which they attributed to some extent to the Hague Adoption Convention standards. Some of the nations involved, of course, were Hague signatories, even though they had not yet ratified or acceded to the Convention. Responses of this nature were similar to the following:

- [The non-Hague member sending nations] are trying to mirror at least some of the data collected on children.
- [There is a] higher expectation of what should be collected, and standardization of reporting methods and documentation.

* Some of the agencies that are not currently serving as primary providers for incoming adoptions from Hague Convention nations also responded to this question.

- The information provided appears to be much more accurate and thorough. It includes a wide range of information about the child typically.
- Russia is developing new regulations to better collect and disclose medical and social histories of their children, in addition to the promise that these will be available prior to the family traveling to meet the child. Haiti has not really changed, although we still have hope that they will expand the information provided on their children.
- The information provided by other countries is more than before implementation of the Hague but not as much as Convention countries.

One supervised provider responded to this question with the following observation:

- We are getting more information, but it has more to do with the fact that families are adopting special needs children since the Hague was implemented, due to the long time frames for basically healthy children.

Many of the negative responses, when an explanation was given, reported that the ASP had always followed high standards in regards to its collecting and reporting. One response in this category specifically referenced South Korea as the non-Hague nation from which it placed children and complimented that nation's practice of providing comprehensive medical and social history.

4. Do you act as primary provider for outgoing Convention adoptions, i.e. adoption of children residing in the United States by adopters residing in foreign nations?

- 10 Yes
- 44 No

If so, which of the following types of individuals/entities prepares the background reports on U.S. children in all or the vast majority of your outgoing Convention adoptions?

- 3 — an employee of your agency
- 0 — an exempted provider (a social work professional or organization that prepares a background study, but does not provide services other than background and home studies)
- 1 — a supervised provider (i.e. a private entity providing services by written agreement and under the supervision of your agency, pursuant to 22 C.F.R. § 96.45(b)(1))
- 0 — a domestic governmental authority

- 3 — a combination of the above, employee and supervised provider
- 1 — a combination of the above, domestic governmental authority and supervised provider.

Only 8 of the 10 affirmative respondents provided specific information regarding the nature of the entity which prepares the reports for their outgoing placements. One of the remaining two responded that it had not completed any outgoing placements since accreditation.

Nevertheless, because only 21 of the 209 ASPs are reported by the U.S. State Department to handle outgoing placements, the 8 respondents constitute 38% of that group. Of those 8 respondents:

- 6, or 75% utilize their own *employees* to prepare at least some portion of their background reports
- 5, or 63% utilize a *supervised provider* to prepare at least some portion of their background reports
- 1, or 13% utilize reports prepared by a *domestic governmental authority* in at least some of the outgoing placements.

5. *In your adoption service contract with prospective adopters, do you include a waiver of liability provision (pursuant to 22 C.F.R. § 96.39(d))?*

- Yes: 47, or 92% of the ASPs who responded to this question
- No: 4, or 8% of the ASPs who responded to this question.