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EDITORIAL

The medical assessment of prospective adoptive parents: How far should it go in the child's best interests?

The prospectice adoptive parents' health is a key element when assessing their ability to adopt. Even though the undertaking of quality evaluations is relevant to the child's well-being, the issue of respect for the applicants' privacy may be raised in some circumstances.

As provided for in article 15 of the HC-1993, the medical situation of prospective adoptive parents must be examined within the framework of the report establishing their suitability to adopt. The term 'medical' relates to the physical as well as mental health of each of the applicants, which must be examined by competent professionals. Practices vary from one country to another, pushing the limits of this assessment in order to ensure that the child has a family suitable to take care of him. Faced with this diversity, and the absence, at international level, of a 'standard' model of report on the health of prospective adoptive parents[1] – like the one that exists for the child, reflection should be drawn to its content.

More or less detailed models of assessment

In general, each prospective adoptive parent is requested to undergo, with his General Practitioner, a health check-up – the content of which may, however, vary considerably. Even though, in some cases, no precise guideline is provided to the Doctor, in others, a more or less detailed questionnaire, drafted by the Central Authority or accredited adoption body, is provided to the latter, such as, for example, in Sweden, Belgium, Switzerland as well as in the state of New South Wales in Australia (see p. 5). Following this initial assessement, and depending on its results, additional examinations undertaken by specialists may, in principle, be requested. Furthermore, complementary information may sometimes be requested from the applicant, such as an in-depth cardio-vascular examination or a HIV test. On the basis of this series of data, the professional will be able to determine whether the applicant has health problems that may impair his parental functions. Given the difficulty of establishing a precise list of illnesses that may be causes for the refusal of a suitability certificate, the professional is sometimes faced with delicate choices.

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What about the respect for the privacy of prospective adoptive parents?

From the prospective adoptive parents' perspective, the interviews and examinations relating to their health are not always experienced positively. The latter may, once again, feel put to the test, in particular when they have previously resorted to treatments against infertility, which have overwhelmed them mentally and physically. When a professional then comes to interfere with their private life with requests relating, for example, to their tobacco consumption, their weight, or even the number of sick days granted in their professional environment, they may, rightfully, feel that their privacy is being violated. The same applies to the personality tests, which they must sometimes undergo in order to assess their ability to manage stress.

Furthermore, when a prospective adoptive parent has a chronic condition, such as depression or cancer, or has a disability, the assessment will be even more delicate and difficult, for the applicant as well as for the professional in charge of the latter. The resort to specialists is required in such cases and a review of the present and prospective consequences of these conditions on the applicant's life, on the adopted child and on the whole family must be carefully undertaken. Even though the private life of the applicants must be protected within certain limits, as for the professional, he must be able to offer, to the adopted child, parents, who are able to provide him with security, stability and continuity.

Health is also linked to the issue of the prospective adoptive parents' age. Without fully addressing here the difficult debate of the upper age limit of applicants, it remains important to take into account not only the age at the time of the adoption procedure, but also to foresee the family's future: how old will the adoptive parents be when the child starts his adolescence, for example, and what will be their physical and mental resources to confront this period, which is known to be a complex period?

The search for a fair balance?

What should be done, then, to respect a certain privacy of the prospective adoptive parents whilst also giving priority to the child's well-being? First, the professional's explanation of the objective of the medical assessment plays a crucial role. Indeed, in order to obtain the best possible cooperation and transparency from the applicants, the latter must be able to understand the impact of their health on the child's care. For example, as highlighted by Johanne Lemieux in her latest publication[2], 'a better understanding by the adoptive parent of his own reactions to stress is of uppermost importance (…)' in order to test his abilities to face the changes linked to the adopted child's arrival. In relation to weight issues, they will most probably be better accepted by the applicants if one explains to them that eating disorders may, in some cases, be a sign of mental weakness, which the adopted child may disrupt.

Secondly, applicants, who are suitable to become the parents of an adopted child, must be able to understand, accept and even request a comprehensive assessment of their skills, in particular at psychological level. Indeed, they must be able to display a certain independence and emotional stability in order to face the child's potential attachment and interaction difficulties. Such an approach already reveals their realistic view of the challenge of adoption: to offer a healthy life environment and one that is suitable to his full development to a child with an already difficult background.

Finally, in the particular case in which an applicant suffers from a chronic condition or a disability, the professional – trained and supported by a multidisciplinary team – will have to consider the impact of this condition on the child and, should the suitability certificate be granted, the follow-up that he will need to undergo following the latter's arrival. The professional will also have to raise the applicant's awareness as to the fact that his potential disability or other health condition may be an obstacle to his adoption request in the country of origin, which also has its say.

Health is a key element in matters of shared responsibility and cooperation between the country of origin and the receiving country. The latter, in particular, is responsible for offering adequate resources to adoptive families, who require a medical follow-up. Furthermore, the professionals must be prepared for the interpretation of medical reports and for potential delicate discussions with prospective adoptive parents throughout the procedure. Their final decision should be able to assure to the adopted child that his parents are able to physically and mentally care for him and, in particular, avoid any new form of abandonment due to one of the parents' potential death or incapacity.

The ISS/IRC team
September 2013

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Sources:

[1] The Hague Conference on Private International Law, *The implementation and operation of the 1993 Hague Intercountry Adoption Convention - Guide to Good Practice N°1*, Annex 7.

[2] Lemieux, J., *La normalité adoptive : les clés pour accompagner l'enfant adopté*, 2013 (see Monthly Review N° 172, May 2013).

BRIEF NEWS

Ghana: ISS working with Government, UNICEF and other stakeholders to improve adoption and foster care procedures

ISS has been mandated by UNICEF Ghana to provide technical assistance to the Ghanaian Government in its efforts to finalise its adoption and foster care regulations that have been drafted by technical working groups in the country. A team of experts from within ISS, as well as international child protection consultant Nigel Cantwell and two experts from Ghana, will carry out the work. ISS has undertaken its first of three missions focusing on adoptions in the last week of September to meet with stakeholders including, among others, government representatives, residential homes for children, accredited adoption bodies, lawyers, embassies of receiving countries as well traditional leaders including a Queen mother association. The issues raised at these meetings (e.g.: consent, matching, number of courts with adoption powers, fees, licensing and accreditation of actors, etc) will inform the revisions to the regulations, with a view of ensuring that they are culturally relevant as well as compliant with international standards, notably the HC-1993. A second mission will be undertaken in the latter part of the year with a view to finalising the adoption regulation, undertaking training on the functions of a Central Adoption Authority as well as the development of an implementation plan for ratification of the HC-1993. The last two missions will also focus on foster care regulations and training. ISS looks forward to advancing children's rights in Ghana and is hopeful of progress given the clear commitment of actors in the field.

ACTORS

- **Germany:** This country has updated the contact details of its accredited adoption bodies.

Source: Hague Conference on Private International Law, http://www.hcch.net/index_en.php?act=conventions.publications&dtid=43&cid=69.

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Haiti: A new law on adoption compliant with international standards

The new Haitian law on adoption, whose date of enactment is currently not known, is presented below[1]. This instrument realises the efforts of the Haitian Government to reform its child protection and adoption system. This article presents the main lines and innovations of this instrument.

On 29 August 2013, the Deputies of the Haitian Parliament unanimously adopted the report of the Commission of Social Affairs and Women's Rights, which recommended – in similiar terms to those of the Senators – the approval of the draft law aimed at reforming adoption. This may be described as a historic date, given that the reform of the legislation governing adoption in Haiti has been a long path full of obstacles, which has lasted for many years before finally becoming a reality.

A 'Hague-compliant' law

The new law naturally follows the ratification of the Hague Intercountry Adoption Convention in June 2012, and has been conceived as the latter's implementation instrument. The instrument has benefitted as much from the contributions of Haitian Family Law experts as from the Permanent Bureau, UNICEF and ISS. Finally, the law covers the best part of the stages of the adoption process throughout its 80 articles, but some aspects remain to be addressed in complementary regulations (for example, the issue of costs).

The main innovations

The law introduces several important changes to the situation existent to date. Let us mention, in particular, the following aspects:

- From the start, the instrument highlights that '*the situation of poverty or extreme poverty of the parents may never be a sufficient motive for adoption*' and confirms the principle of subsidiarity.
- Intercountry adoption will always be a full adoption, whereas domestic adoption may be a simple or full adoption.
- In addition to undue material gain, the law prohibits independent and private adoptions, the selection of the adopters by the biological family, contacts between the latter prior to the adopiton and the fact of consenting to the adoption before the child is three months old.
- Consent to adoption must be given in writing before the Children's Judge, following a social assessment undertaken by the IBESR.
- The introduction of an upper age limit for prospective adoptive parents, set at 50 years.
- Particular attention must be drawn to the adoption of children with special needs.
- The opportunity for common-law partners to adopt, if they can provide evidence of minimum five years of life together (but preservation of the prohibition for same-sex couples).
- The introduction of a probationary period between the child and the prospective adopters of minimum two weeks.
- The confirmation of the IBESR as the Central Authority '*in charge of examining all requests submitted for adoption, of preparing the files, of authorising the adoption in accordance with the norms and administrative procedure approved by the IBESR before its submission to the competent tribunals*'.
- Articles 66 to 72 govern the activities of accredited adoption bodies, their tasks and their responsibility. Their number is limited and may be adapted in accordance with the needs of the country of origin.

A complex implementation

Even though the new law is undoubtedly an essential element of the child protection system in Haiti, its implementation – like in all countries – will still require many efforts. In a difficult socio-economic context, the transition towards the new system will take time in order to reach an efficient operation. The pursuance of the technical support offered by the Permanent Bureau is therefore an essential element. But once again, support to these steps forward is incumbent upon all national and international actors, by offering their support and by refraining from interfering in the ongoing process. The efforts of the Republic of Haiti and of its Central Authority deserve our encouragement and our respect.

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Note:

[1] The ISS/IRC will keep its partners informed on the entry into force of the law and the HC-1993 as soon as the information becomes available.

READERS' FORUM

Perspectives from an adoption caseworker in Australia

This short interview discusses the benefits of medical assessments of prospective adoptive parents from the perspective of the best interest of the child.

Name and surname : Nicole Prodigalidad
Place of residence and work: New South Wales, Australia
Profession: Adoption Caseworker, Department of Family and Community Services

1. What types of medical forms and information do you seek from prospective adoptive parents?

The use of medical forms is mandatory with the New South Wales adoption regulation of 2003, requiring the relevant decision maker to 'have regard' to the 'person's health, including emotional, physical and mental health'. We use three different standardised forms for every application to become an adoptive parent. One form is completed by each applicant's General Practitioner, another is a 'self report' in which each applicant lists any significant medical history they are aware of, and the third is an assessment of cardiovascular risk factors completed by a General Practitioner when he identifies that an applicant's Body Mass Index is over 30. This form tests for factors such as high cholesterol and blood pressure as well as family history and alcohol and cigarette consumption.

If any of these forms indicate that an applicant has medical issues that are of concern, we will request a written report from the applicant's treating specialist. Depending on the advice given in the report, we may seek the applicant's permission to speak to their specialist directly or refer their report to an independent medical practitioner for their opinion (at the applicant's expense).

2. What do you think are the main benefits of using the medical forms to assess prospective adoptive parents?

Our job is to ensure that, to the best of our ability, we are approving applicants, who have a reasonable expectation of raising a child to adulthood. We feel that this is a responsibility both to the child and to the child's birth parents.

3. What do you think are the specific benefits for the child, by using such medical forms?

In New South Wales, adoption is always about the best interests of children. We are not seeking to assist childless couples to become parents; we are seeking to find the most appropriate alternative families for children, who are unable to live with their families of origin. We are acutely aware that children, who have been adopted, have already endured the significant loss of being unable to live with their birth family, and it is for this reason that we seek to ensure that – to the best of our ability – we are placing children in families where they will not suffer another significant loss, such as the untimely death or incapacitation of an adoptive parent.

4. Are there any limitations in using the medical forms in the assessment process? Do you think that the use of standard medical forms could be a breach of the 'right to privacy'? Are there any limits to their use?

Any standardised forms have limitations; however, our medical forms were devised by independent medical experts, whose brief was to ensure that any medical concern that may possibly impact on an applicant's capacity to care for a child would be covered. I believe that the form we currently use does this sufficiently well.

In relation to a breach of privacy, I actually believe that, to an extent, an applicant is required to forgo this right if he wishes to adopt a child. This is because adoption is about children, not adults, and in order for us to assess an applicant's suitability to parent an adopted child, we need to be sure that they have the capacity to do this in all areas of life, including their health. All information we accumulate in the process of assessing an applicant's suitability is provided

willingly by the applicant, and any further information we require is obtained with the permission of the person concerned. During our prospective adoptive parents' training, we spend time educating them about the reasons why this information is so important. We see it as our role to educate all prospective adoptive parents that adoption is about children, and we find that when a prospective adoptive parent has a child-focused perspective, they begin to understand why we need to assess their health. Of course, the information provided on medical reports – like all adoption applicant information – is secured, and only the 'relevant decision makers' are given access to this material. Our office is also secured from the rest of Community Services, as is any data entered onto our Community Services' database.

5. What types of medical issues could result in an application being rejected? Why?

Any medical issue that has the potential to significantly decrease the prospective adoptive parents' lifespan or an on-going chronic illness (either physical, emotional or mental) that would decrease a their capacity to effectively parent a child could result in a decision to reject the their application. In local adoption, where birth parents select the family for their child[1], we also require that where a prospective adoptive parent has been diagnosed with a significant health issue in the past (*e.g.* cancer) that this information is disclosed in their profile, which is provided to the birth parent when choosing the family for their child. We believe that a birth parent has a right to this information when deciding on the most appropriate family for their child.

6. What kinds of medical cases are particularly difficult to discuss with prospective adoptive parents?

All medical issues are difficult to discuss with prospective adoptive parents and require a great deal of sensitivity on the part of the caseworker involved. We recognise that prospective adoptive parents are very anxious and concerned about the possibility of not being approved. Some of them are more sensitive than others, and this is often a reflection of their level of understanding and insight into the reasons why we require this information. The more child focused the applicant, the more understanding they are of our need to seek clarification on matters such as their health (and incidentally, they often make for the best adoptive parents).

7. Are there cases where the medical report requires a post-adoption follow-up after the arrival of the child?

Yes. All adoptive placements are monitored for a period of at least a year. We assess all areas of the placement's progress, including the health and welfare of the adoptive parents. Any new issues, or on-going health issues that were of concern when approved, will be monitored to ensure that they are not adversely impacting on the prospective adoptive parents' ability to parent. A common issue that we monitor could be an applicant with a history of circumstantial depression resulting from their infertility. Sometimes, the placement of a child can lead to the resurfacing of depressive illness as the parent comes to terms with the reality of parenting a child that is not biologically related to him.

We also regularly update the prospective adoptive parents' health checks whilst they are awaiting placement at two years and four years from their original approval decision. We are able to revoke their approval if a medical issue arises during this waiting time that would significantly impact on their capacity to parent.

The final check that is conducted post placement, is the requirement of the Court to be satisfied that the prospective adoptive parents' health is satisfactory before they will make an Adoption Order in favour of the applicants. If a medical issue is identified at approval, we are able to 'conditionally approve' an applicant, and that may require that additional supervision of the placement occurs at the applicant's expense.

Clarifying note:

[1] In local adoptions, the Central Adoption Authority first selects a number of dossiers of prospective adoptive parents, from which the biological family can select from. This method allows the biological family to participate in the decision making process after a professional match has occurred, facilitating open adoption (see Monthly Review № 01/2006).

Embedding research in practice: CFAB[1] outcomes of new research initiatives to assist children separated from their families

CFAB has undertaken new efforts to ensure that emerging issues in intercountry casework are systematically identified and addressed in order to influence policy-making, develop best practice and to promote the child's safety and well-being.

CFAB is the United Kingdom branch of the International Social Service. Through our casework and advice line (465 cases resolved and 1,480 calls in 2012), CFAB becomes aware of emerging intercountry issues as they arise. With the creation of the new post of Social Work Research and Project Development Assistant, CFAB is embedding research into its social work operations. CFAB is working alongside academic partners to develop a unique organisational model that will see emerging issues in intercountry casework routinely documented and to develop research initiatives that will examine emerging issues in more depth.

CFAB bases its work on international standards such as the United Nations Convention on the Rights of the Child, the Guidelines for the Alternative Care of Children (hereafter, 'Guidelines') and the Bangkok Rules, as well as, of course, regional instruments and national legislation including, *inter alia*, the 2000 Charter of Fundamental Rights of the European Union, the 2004 Children's Act (United Kingdom), the 2013 Children and Families Bill (United Kingdom), and the 1999 Prison Rules (United Kingdom). Two projects[2] are already underway, as described below.

'Children Placed Across Borders: Understanding the Outcomes for Children Placed in Alternative Care Arrangements with Family Outside of the United Kingdom' (see part VIII of the Guidelines)

Many children in foster care have prospects for family life with extended family, who reside in another country. Partly due to the complexity of arranging these international placements, there is a risk that children may languish in care despite the opportunity for a family life. The project's objective being to learn the outcomes – including permanency, education, health, etc – for children placed with extended family overseas. This will influence policy and practice on alternative care for children. As its method, CFAB will contact the carers in 35 cases known to CFAB and request that they complete a short questionnaire.

In terms of preliminary findings, between 2007 and 2010, CFAB was involved in at least 101 cases requesting an assessment of a kinship carer living overseas for a child in foster care in the United Kingdom. In 34% of these cases, children were successfully placed with family overseas, avoiding the possibility of spending the remainder of their childhood in foster care. The average age of children placed was six years old.

'Children of Foreign National Female Prisoners: Impact of Incarceration on Children' (see para. 48 of the Guidelines)

There is a significant impact on children when they are separated from one or both parents due to incarceration, amplified when their parent is incarcerated in another country. While social services may have a duty to check on the welfare of a child within national borders, when the child is overseas, the procedures to safeguard children fall short. The project's objective is to promote the safety and well-being of all children of incarcerated parents and better understand the impact of incarceration on children. The method consists of CFAB conducting outreach to prisons across England to raise awareness of the safeguarding issues for children overseas and offer intercountry services to promote the welfare of these children.

As for preliminary findings, in the summer of 2012, CFAB undertook a case audit of Foreign National Female Prisoners at a women's prison in England to determine the prevalence of children separated from their mothers and to better understand the characteristics of this issue. The small-scale study revealed that there were 131 foreign women incarcerated at the prison during the one-week period of the study. Of these, 62% were mothers and 40% of the mothers had children overseas.

Into the future

CFAB looks forward to working with partners and its ISS network to ensure that children and families are

truly protected in cross-border issues – and not forgotten.

Ms. Angela Wilson

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Sources:

[1] Children and Families Across Borders

[2] Other projects include 'Assisted Voluntary Return (AVR) for Unaccompanied Minors: Review of the Choices AVR programme to reintegrate unaccompanied minors in their home country', and 'Informal Care: Safeguarding for Children from Overseas in Informal, Non-Kinship Care Arrangements in the UK'.

SPECIAL SERIES: THE RIGHTS OF CHILDREN IN ALTERNATIVE CARE AT THE UNITED NATIONS

Protecting children against racial discrimination in the family and in alternative care settings

This fourth article in the series examines analogous issues covered by the Guidelines for the Alternative Care of Children and the Convention Against Racial Discrimination, highlighting how these standards provide safeguards to protect children against such discrimination.

Racial discrimination against children regrettably exists within the family and in alternative care settings. This article presents instances of such discrimination as well as identifies safeguards in the Convention Against Racial Discrimination (CERD), supplemented in more detail by the Guidelines for the Alternative Care of Children (hereafter, 'Guidelines'). It is based on a presentation[1] to the Committee on the Elimination of Racial Discrimination by ISS and SOS-Children's Villages International.

Racial discrimination - a reason for the child's separation from his family

Systematic confrontation of economic hardships and obstacles in accessing services is particularly true for certain ethnic groups. Such prevailing racial discrimination can, thus, be a factor leading to the child's removal, abandonment or relinquishment. For example, in New Zealand, it was observed in 2011 that there was 'continuing manifestations of discrimination against the Maori population, including children, as evidenced by their unequal access to services'. Likewise, in the Dominican Republic, there are widely shared discriminatory practices in administrative bodies against children of migrants and other origins. In Slovakia, the Roma population lives in vulnerable and marginalised situations as a result of similar hurdles.

Racial discrimination in alternative care settings

As a consequence of these difficulties, as well as sometimes excessive State intrusion in the family, children from certain ethnic minorities and indigenous communities are regularly over-represented in alternative care matters. For example, in Slovakia, the great majority of maternity units have observed that among abandoned children, higher numbers of certain ethnic minority groups are found, mostly from the Roma population. Similarly, in Bulgaria, over half the children in institutions have Roma origins. Moreover, in countries such as Australia and Canada, children from indigenous groups are significantly over-represented in care settings. Regrettably, few 'official' statistics are collected in a disaggregated manner, let-alone specifically identify the race of children. The Committee on the Rights of the Child regularly asks States to improve upon this in their conclusions as well as provide better protections to such groups.

Racial discrimination in other situations

Unaccompanied and separated children, such as those outside their country of habitual residence and living in emergency situations,, may be housed in inappropriate settings – again with significant numbers from certain ethnic groups. For example, in Algeria, 'Sub-Saharan child asylum-seekers and refugees lack birth certificates and are denied most of their economic, social and cultural rights, especially their right to health, and education; and the UNHCR has still not been able to conduct proper registration of Sahrawi refugees who still live in precarious conditions in the Tindouf province under the administration of the Polisario Front and has not been granted access to detention centres where migrants deemed "irregular", including children are held'.

Some protections against racial discrimiantion as included in the Guidelines

Para. 9: '[…] States should seek to ensure appropriate and culturally sensitive measures: To support family caregiving environments whose capacities are limited by factors such as […] discrimination against families with indigenous or minority backgrounds […]'

Para. 10: 'Special efforts should be made to tackle discrimination on the basis of any status of the child or parents, including poverty, ethnicity, religion […] and socio-economic stigma [...]'

Para. 16: 'Attention must be paid to promoting and safeguarding all other rights of special pertinence to the situation of children without parental care, including, but not limited to, access to education, health and other basic services, the right to identity, freedom of religion or belief, language and protection of property and inheritance rights.'

Para. 32: 'States should pursue policies that ensure support for families in meeting their responsibilities towards the child and promote the right of the child to have a relationship with both parents. These policies should address the root causes of child abandonment, relinquishment and separation of the child from his/her family by ensuring, inter alia, […] access to adequate housing and to basic health, education and social welfare services, as well as by promoting measures to combat poverty, discrimination, marginalization, stigmatization […]

International Conventions provide protections against racial discrimination in alternative care

The United Nations Convention on the Rights of the Child, as well as other key international conventions, including CERD, have provisions to address the above situation. CERD affords children with special protections, by its all-encompassing definition of what racial discrimination includes (article 1), protections within the family, equal access to services and rights to housing (article 5), and inclusion of all persons within the territory (article 6). Supplementary protections are provided by the Guidelines (*see box*). We trust that advocates on the ground can use these provisions to lobby for a better protection against racial discrimination within the family and in alternative care settings.

Source:

[1] Briefing Note available at the ISS/IRC, including references to country examples.

FORTHCOMING CONFERENCES AND TRAININGS

- **France:** *Les adoptions tardives: Aspects actuels, psychologiques, juridiques et cliniques* [Late adoptions: Current, psychological, legal and clinical aspects], COPES, Paris, 2 December 2013 (beginning of session). For further information, see: http://www.copes.fr/Annexes/Formations.
- **Italy:** Eurochild 10th Conference: Building an inclusive Europe – The contribution of children's participation, Milan, 13-15 November 2013. For further information, see: http://www.eurochild.org/fileadmin/Events/2013/11_AC2013/AC2013_ConceptNote.pdf.
- **Kenya:** *East African Families for East Africa's children*, The Child Adoption Network - East Africa, Nairobi, 21-22 November 2013. For further information, see: www.adoptionea.org.
- **Serbia:** *Foster Care Challenges at the beginning of XXI century - Experiences creating the future*, The Center for family accommodation and adoption, Belgrade, 16-17 December 2013. For further information, contact: Ivana Lišanin, ivana.lisanin@hraniteljstvocps.gov.rs / +381 60 88 11 224 or by post to The Center for family accommodation and adoption Belgrade, Radoslava Grujića 17.
- **Spain:** *I Congreso "El interés Superior del Niño", Acogimiento y Adopción* [First Congress 'The best interests of the child' – Care and adoption], Asociación Estatal de Acogimiento Familiar and Asociación de Menores de la

Comunidad de Madrid, in collaboration with the Ministry of Health, Social Services and Equality, Madrid, 19-20 November 2013. For further information, see: http://www.interessuperiordelnino.com/bienvenida.html.

- **United Kingdom:** *The neuroscience of adoption and fostering*, BAAF, London, 13 November 2013. For further information, see: http://www.baaf.org.uk/training/allevents/2013-11-13t000000.
- **United States of America:** *5th Annual ISS-USA Conference – Cooperation, Communication and Compassion: Developing Child-Centered Practice in Law, Social Work and Policy for Cross-Border Families*, Baltimore, 22 November 2013. For further information, see: http://www.iss-usa.org/site.asp?PageId=5&SubId=45.

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