Communication Needs and Services of Children Adopted from China's Waiting Child Program

Brenna Cowden, Alyssa Lee

Supervisor: Karen Pollock; Reader: Lu-Anne McFarlane

Short Header: China's Waiting Child Needs and Services

ABSTRACT

Purpose: Adoptions of non-special needs children from China have decreased dramatically over the past decade, while adoptions from the Waiting Child program have increased. Waiting children have identified medical needs or are over the age of 10 years. The purpose of this study was to determine the communication needs of children adopted from China's Waiting Child Program.

Method: Parents of 16 children adopted from China's Waiting Child Program completed a survey containing questions about the child's type of disability and their needs for speech-language pathology and audiology services. The survey also asked about their experiences accessing services that met their needs. The impact of different medical conditions on these needs and access was also examined.

Results: The majority of parents did not have difficulty accessing services and most parents were very or extremely satisfied with the services their children received. Three parents expressed specific concerns they had in accessing the services they felt their child needed or continued to need.

Conclusion: While the majority of parents did not experience difficulty accessing speech-language or hearing services and in general were very satisfied with the services received, future research could examine a greater number of parents to ensure this is a representative trend.

INTRODUCTION

A reduction in number of children adopted from China has occurred over the last decade. The year 2005 saw a high of 14,493 children adopted by families around the world from China (Selman, 2012). By 2013, only 3,406 children were adopted from China (Hilborn, 2011; Selman, 2012). This decline occurred due to multiple factors, including China implementing new guidelines about who is eligible to adopt (i.e., heterosexual couples who have been married for at least two years), an improvement to China's welfare system, and more interest in domestic adoption (Hilborn, 2011). However, this decline was seen for children who were typically developing, not for children with special needs. In fact, adoption of children with special needs was on the rise after 2005. In 2005, 9% of children adopted from China had special needs, but this percentage grew to 49% in 2009 (Hilborn, 2011; Selman, 2012).

Children in China who are available to be adopted and who have special needs or medical conditions are part of a special program called the Waiting Child Program. "A "Waiting Child" is a child of any age with an identified medical need, or, more rarely, with no known medical conditions who is at least age 10" (Harmon, 2015, p. 3), though some consider "older children" to be over 7 years of age (Selman, 2015).

Currently there is a lack of information regarding the distribution of special needs among those being adopted. Chinese Children Adoption International (CCAI) Adoption Services in the United States, has a list of medical conditions they provide to prospective parents (CCAI, 2015a). From this list, parents are asked to indicate their openness in terms of age, gender, and medical condition of the child they are hoping to adopt. The list includes ten different categories that cover 81 different medical conditions (see Table 1).

Table 1. *Medical condition categories (CCAI, 2015a)*

Medical Condition Category	Examples of Specific Conditions
Ear, eye, and head conditions	Cleft lip and/or palate, hearing loss, blindness
Heart/blood conditions	Turner's Syndrome, moderate to major heart condition
Bone, muscle, and joint conditions	Club foot/feet, missing or malformed limbs or fingers
Infectious diseases	HIV, Hepatitis B, Hepatitis C
Neurologic conditions	Cerebral palsy, epilepsy, spina bifida
Feeding/colon conditions	Esophageal atresia, Hirschsprung's Disease
Reproductive/urologic/nephrological conditions	Kidney condition, liver condition, genital malformation
Skin/vascular conditions	Albinism, burns
Developmental conditions	Autism, Down Syndrome
Healthy older children	Age 10 and older

While we know the possible medical conditions, we know less about the distribution of these conditions among those children actually being adopted. Table 2 outlines the distribution of the top ten special needs reported for adoption between January and November 2015 through CCAI Adoption Services (CCAIc, 2015). The Children's Bridge adoption agency in Canada commented that 95% of their Chinese Waiting Child adoptions are children with cleft lip and/or palate (personal communication, March and April 2015).

Table 2. *The top ten medical conditions adopted through CCAI in the year 2015.*

Medical Condition	Number of Children Adopted with Condition
Brain/developmental delays	65
Cleft lip and palate	63
Limb difference	35
Anal atresia	25
Heart disease/condition	23
Cerebral palsy	21
Spina bifida	17
Down Syndrome	14
Hydrocephalus	13
Albinism	7

Speech and Language Development

There is also a current lack of research regarding communication development of children adopted from China's Waiting Child Program. Previous research has focused on the language development of children adopted through China's and other countries' mainstream (or non-special needs) adoption programs. This research has shown that despite the sudden interruption in language development and introduction of a second first language, children adopted as infants or toddlers catch up quickly within the first year or two post adoption and as a group fall within normal limits when compared to norms for non-adopted peers (Roberts, et al., 2005; Scott, et al., 2008.). Furthermore, they tend to follow the same developmental pattern as monolingual children (Dalen, 2012). However, it has been found that 5-22% of children adopted internationally struggle with the acquisition of language beyond the first two years of adoption (Pollock, 2015). In Norway, a discrepancy has been found between the development of day-to-day language (language that anchors meaning and understanding in the here-and-now) and academic language (language that is more abstract and decontextualized) of children adopted internationally. No significant differences were found for day-to-day language, but differences were found for academic language with adopted children performing more poorly (Dalen, 2012; Dalen & Rygvold, 2006).

A potential risk for delayed development (of language and other domains) is the amount of time spent in an institution or orphanage prior to adoption with longer times relating to higher chances of delay (Johnson & Dole, 1999; Scott et. al, 2008). Studies looking at children adopted from Romania in the 1990's found the extremely poor orphanage conditions were related to cognitive and language delays exhibited by the children (Johnson & Dole, 1999).

Another study found that children adopted from the former Soviet Union scored below average; however, positive adoptive family environments helped mitigate the institutionalization risks experienced by the children (McGuinness, McGuinness, & Dyer, 2000). The authors commented that "clearly, adoptive families can steer the development of their children in positive directions" (McGuinness, McGuinness, & Dyer, 2000, p. 115).

What does this mean for children in the Waiting Child Program? We would expect some of these children to have communication needs based on the nature of their medical need (e.g., children with cleft lip and/or palate and children with hearing loss), but others (e.g., those with a limb deformity or heart condition) may not. In addition, given the variable quality of care provided in orphanages and the potential that children may have more attention given to their medical needs than their communication development, any child in the Waiting Child program could need speech, language, and/or hearing services post-adoption. As Pollock (2015) describes, "any child adopted internationally is potentially 'at risk' for speech-language delays, by virtue of the abrupt language switch and inadequate stimulation in orphanages" (p. 146).

Age at Adoption

There has also been a lack of research investigating children adopted at older ages (2-5 years). Of the studies that have been conducted, some have found that more time spent in an institution was correlated with a higher possibility of having developmental delays (Krakow, Tao, & Roberts, 2005; Miller & Hendrie, 2000; Roberts et al., 2005; Scott et al., 2008). Furthermore, children adopted at an older age have more linguistic "catching up" to do in order to match their monolingual non-adopted peers (Glennen, 2009; Pollock, 2015). This is an important consideration for older children (older than 7 years) from the Waiting Child program,

whose only disability is their age. These children will face a dramatic shift post adoption when their native language is no longer experienced, and they are expected to learn a second first language without continued support of their first language. A possible advantage for children adopted at older ages is that they may have a higher ability in their birth language that they can use to scaffold their second first language learning (Glennen, 2007; Glennen, 2009; Krakow, Tao, & Roberts, 2005). This boost seems to help older children in some areas. Glennen (2009) found that children adopted at age two were within normal limits for vocabulary and mean length of utterance (MLU) one year post-adoption. She also found that children adopted at ages 3 and 4 were also within normal limits for the same measures (Glennen, 2009). This makes sense given that comprehension development usually precedes production development (Benedict, 1979; Clark & Hecht, 1983). However, children at older ages have a "steeper language-learning curve" (Glennen, 2009, p. 61) to face and it is not clear if these children reach full age-level proficiency at the same rate as children adopted at younger ages, or if they need more years to fully catch up with their non-adopted monolingual peers (Glennen, 2009). Signs of interference and facilitation between birth and adoptive languages has been seen in children adopted at older ages; however, it is also unclear if these follow the same patterns as bilingual children, or if they transition from one language to another differently compared to children adopted at a younger age (i.e., under two years) (Glennen, 2007).

Speech-Language Assessment and Intervention

A final consideration related to age at adoption and speech-language development is how children are assessed post-adoption and what services are available to children adopted internationally. In the first year post-adoption, communication assessment poses a problem for

speech-language pathologists (SLPs) because children adopted internationally are rapidly losing their birth language while also transitioning into their adopted language (Pollock, 2015). This shift makes assessment of communication delays very difficult because the child is not bilingual, but they are also not yet proficient in English (Glennen, 2007). According to Gindis (as cited in Glennen, 2007), "children adopted at ages 3-4 lose most expressive use of L1 within 6-12 weeks of adoption [and] receptive abilities are lost within 16-22 weeks" (p. 4). The delays observed in some children may be related to the language transition or they may be evidence of developmental communication delays present prior to adoption (Pollock, 2015). Ideally, parents should try to obtain as much information as is available concerning their adoptive child's communication development in their birth language. This information can be important for identifying true disorders or qualifying for services (Pollock, 2015). When children adopted before age two are being assessed within the first few months of being adopted, they need to be assessed using methods based on guidelines for children adopted internationally (Glennen 2007). Measures such as the *Communication and Symbolic Behavior Scales–Developmental Profile* (CSBS-DP; Wetherby & Prizant, 2002), which looks at joint attention, gestures and symbolic play, and the *Macarthur-Bates Communicative Development Inventories – Words and Gestures* (MCDI-WG; Fenson et al., 1993), which looks at linguistic measures including vocabulary comprehension, are recommended because they look at prelinguistic foundation skills that are not affected by adoption (Glennen, 2007; Pollock, 2015). Similarly, during the first few weeks or months post-adoption, phonetics/phonology can be assessed by observing the quality and quantity of vocalizations and the size and diversity of the child's phonetic inventory

because the developmental trend is the same regardless of language environment or adoption status (e.g., the development of canonical babbling at about 10 months of age) (Pollock, 2015).

For children adopted at older ages (i.e., over 5), there are no assessment guidelines which makes getting as much language development history prior to adoption that much more important. A concern for these older children is that they will be classified as an English Language Learners (ELL) in school. Anecdotes of children being denied SLP services due to their classification as an ELL student were shared by Pollock (2015). Regardless of whether stories like these are common, it is important to investigate and develop assessment guidelines for these children.

Glennen (2007) addressed the myth that "now that evidence-based information is available, professionals are making better decisions about speech and language in internationally adopted children" (p. 6). Many treatment and assessment decisions are made using anecdotal evidence and "best guesses". Of the children adopted internationally, more than 54% to 62% are referred for speech and language assessments, and only 35-50% of them receive intervention (Glennen, 2007). There have been reports of children who were functioning at the top of their peer group receiving intervention services, while some other children are put on "wait and see" lists or are put in ELL classes that do not meet the child's language learning needs (Glennen, 2007). While a poor outcome is not likely for a child receiving intervention services when they are functioning typically, the outcome for children in need of intervention who do not receive it in a timely manner or at all, is much more negative. Tan (2014) investigated the extent of developmental delays in girls adopted from China, and their later enrollment in early intervention for either physical therapy (PT) or speech-language

pathology (SLP). 37.4% of the girls with identified delays received either PT or SLP early intervention services (Tan, 2014). The recorded distribution of delays within the realm of SLP service is depicted in Table 3.

Table 3. *Distribution of delays and receiving SLP early intervention services (Tan, 2014).*

Delay	SLP Service YES	SLP Service NO
Gross Motor yes	**22**	61
Gross Motor no	10	82
Fine Motor yes	**20**	32
Fine Motor no	17	111
Language yes	15	**25**
Language no	**22**	118
Social Skills yes	10	14
Social Skills no	**27**	129
Cognitive Skills yes	13	9
Cognitive Skills no	**24**	134

It is concerning that more children with no identified language delays got early intervention services than children *with* language delays and that the same trend was true for social skills. Another interesting fact is that more children with gross and fine motor delays got SLP services than children with language and social skill delays. This distribution of service enrollment demonstrates how assessment and intervention decisions have been based on best guesses or pro-active parents who advocate for broad-based services that often include speech and language services.

Current Research

Much of previous research the researchers found is from 2005-2009 and since that time trends in adoption have changed. With the shift from mainstream adoptions from China to adoptions from the Waiting Child Program, the needs of the children post-adoption are

changing. The purpose of the current study was to bring awareness to and describe the speech-language and hearing needs of children adopted from China's Waiting Child Program and the speech-language and hearing services they have and have not been accessing.

METHODS

Participants

Prior to recruitment, researchers contacted two large adoption agencies, one in Canada and one in the United States, to inquire about the adoption process and current adoption statistics. The full set of questions can be found in Appendix A. Recruitment began in March 2015 and was conducted over an eight month period. Participants were recruited through various adoption agency and organization newsletters, emails and various social media platforms including Facebook and forums on Yahoo. Researchers emailed a total of 43 agencies and received three replies confirming the message was sent out to adoptive families. A link containing the Google survey form was included in the recruitment statement. Responses were obtained through the completion of the survey form. Consent was obtained by checking off a box at the end of the survey and submitting contact information.

Seventeen responses were received by the survey deadline; however, one participant was not adopted from the Waiting Child Program and was excluded from analysis. Therefore, participants consisted of 16 children adopted from China's Waiting Child Program. Ten participants were female and six were male. Age at adoption ranged from 9 months to 6 years and 5 months (M = 29.75 months). Originally, only children adopted from the program within the last five years were invited to participate; however, due to difficulties recruiting

participants, eligibility was extended to include children adopted from the program at any time. Participants resided in both Canada and the United States, 12 from Canada (across four different provinces) and four from the United States (across 4 different states). Children had various medical conditions which are outlined in Table 4. All but one child had their medical condition confirmed by a medical/developmental specialist post-adoption.

Table 4: *The distribution of medical conditions*

Medical Condition	Number of Children
Cleft lip and/or palate	9
Hearing impairment	4
Heart disease	2
Limb deformity	2
Global developmental delay	2
Physical developmental delay	2
Genital malformation	1
Nervous system condition	1
Hepatitis B	1

Inclusion criteria required English to be the language spoken at home. Prior to adoption, eleven children were exposed to Mandarin and two children were exposed to Cantonese. Three children did not have information on their language history. Children's language development status in Chinese at the time of adoption was also determined through the survey. Six children had not developed language yet, five had age appropriate language abilities, and two were moderately and two were mildly delayed. There was no language development information for one child. Individuals who determined the child's language ability consisted of adoption facilitators/translators, orphanage caretakers, and physicians. The language abilities of four children were determined through orphanage reports. At the time of the survey, twelve

children had continued exposure to Chinese. In regards to current English language/ communication development, eight had age appropriate language, four were mildly delayed, three were severely delayed, one child was moderately delayed, and one had no language.

Survey

The survey was created using a Google survey form. There were a total of 55 questions - some multiple choice and some short answer. Questions asked about basic information (e.g. gender, birth date, and adoption date), language history, speech-language and audiology services, access to services, experiences within the school, and satisfaction with services. Parents did not answer selected questions which depended on their answers to previous questions. For example, if their child did not require the services of a speech-language pathologist or audiologist, parents did not need to answer questions pertaining to types of services they received. The full survey can be found in Appendix B.

Results

Obtaining Services

On a scale of 1 to 5 (1 being not important at all to 5 being extremely important), participants rated how important it was to them to receive the services that they did. Of the 13 families that received services, 10 selected extremely important (76.9%), two selected very important (15.4%), and one selected important (7.7%). Ten children required audiology and speech-language pathology (SLP) services, one required audiology services only, two required SLP services only, and three did not require SLP or audiology services. The age at which children received SLP and audiology services ranged from 11 months to 6 years. Figure 1 depicts the ages at which the 13 children received services.

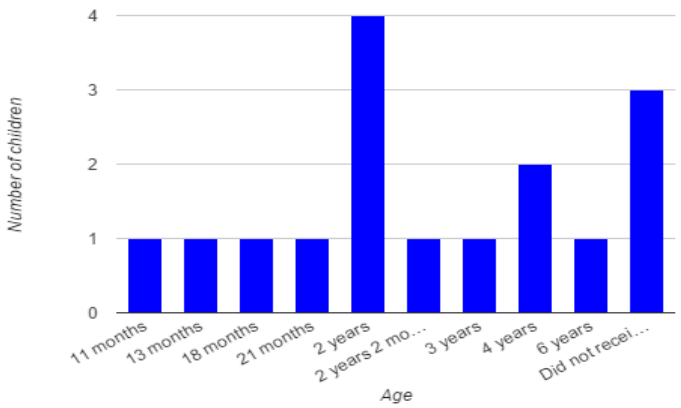

Figure 1. Age at which children first received services.

Figure 2 shows how long it took families to obtain SLP and audiology services. Of the families who received services, the majority (nine) were able to obtain services in one to six months and only one family responded that it took nine months to a year for them to receive services.

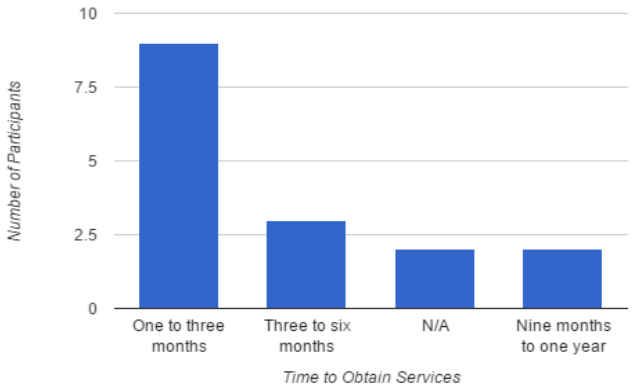

Figure 2. Amount of time taken to obtain speech-language pathology and audiology services.

Table 5 lists three questions regarding obtaining services that families elaborated on. Most of the concern comments were due to the child still having delays (e.g., speech sound/articulation delays, delays in comprehension, delays in language use). One parent commented that their child's delays were due to cleft palate surgery complications and another commented that their child's delays were due to profound hearing loss. Five families indicated

that they had difficulty obtaining services for their child. Difficulties noted by parents included challenges with insurance coverage, expenses, and qualification for services. Four parents also reported that there are services that they feel their child needs, but have not been able to gain access to yet. These four parents noted that their child needed more services for speech/articulation, language, and aural rehabilitation (i.e., working with someone who has a hearing loss) needs.

Table 5. *Survey questions pertaining to the acquisition of services*

Question	Yes	No
Do you have any concerns about your child's language development in English?	8/16	8/16
Did you experience any difficulties accessing the services needed?	5/13	8/13
Are there any services you feel your child needed or still needs, but you were not/have not been able to access?	4/16	12/16

In response to how parents gained access or learned about the services they later used, answers were varied. Many received information from children's hospitals, some got information through medical professionals (e.g., social workers and family doctors or pediatricians), others gained access through their local health authority or child's school while others obtained the information through personal contacts such as friends. One parent noted an international adoption clinic as a source of information and another commented on an organization specializing in helping children with hearing loss.

Audiology Services

Thirteen children required audiology services. The specific services required (e.g., hearing screening) are outlined in Figure 3. The participants received these services from audiologists primarily at children's hospitals as well at community audiology clinics. Parents

reported variations in how often their child sees or had seen an audiologist. Four families reported having ongoing appointments every three to six months for hearing assessments and tube evaluation or reinsertion. One parent said that their child had a 45-minute appointment with an audiologist for testing, but that their child did not cooperate and needs to be retested.

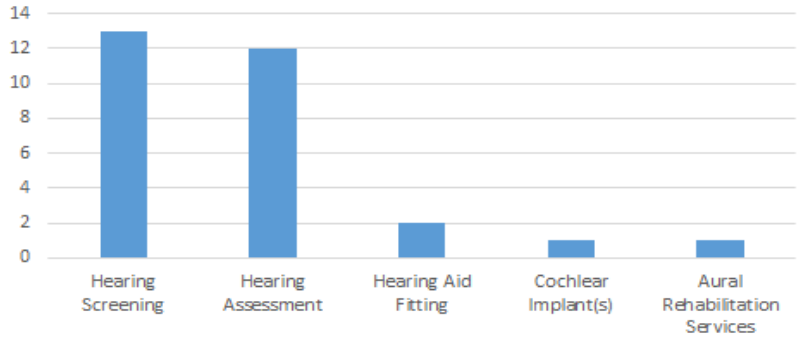

Figure 3. Audiology services required by participants.

Speech-Language Pathology Services

Twelve children required speech-language services. The specific services obtained (e.g., articulation assessment or language therapy) are outlined in Figures 4 (assessment) and 5 (treatment/therapy). The participants received these services primarily from speech-language pathologists at children's hospitals, community health centers, schools, as well as at private clinics. One family reported use of an online therapy service which they found doing a general search for services. One child also received services from a speech-language pathology assistant and another received reading services from an education assistant. Six families reported weekly sessions with their SLP ranging from one month of service to six years. Three families reported bi-weekly sessions. One family reported that their child saw their SLP once a month while another family reported their child saw their SLP twice a year. Session durations ranged from 20 minutes to 90 minutes with the majority of sessions lasting 30 to 45 minutes. One family

commented that they were allotted 15 hours per year of public SLP services and so they chose to supplement with private services every two to three weeks depending on the child's needs. Two other families also noted their use of private services to supplement publically accessed services. Four families mentioned school-age services. Three of the families commented that their child received fewer service hours since entering school. Two of the families said that they have accessed private services to supplement the school services, one had private sessions bi-weekly and the other reported having three sessions in two months.

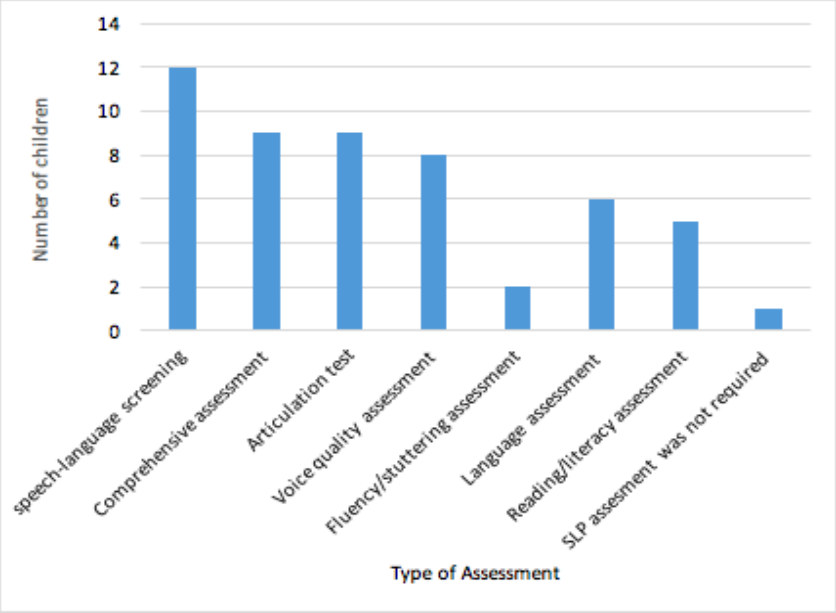

Figure 4. Speech-language assessments required by the thirteen participants who required speech-language services.

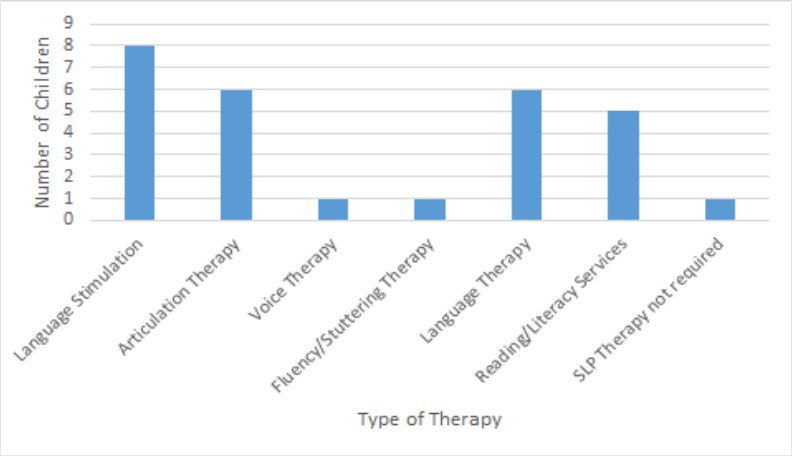

Figure 5. Specific speech-language therapies required by the 12 participants who needed speech-language services

School-Age/School Services/English as a Second Language Services

Three questions addressed children who have entered school, the type of classroom the child is in, and if there is any support the child receives outside the classroom. Additionally, participants were asked if their child has received English as a Second Language (ESL) services, also known as English Language Learning (ELL) services. The yes/no responses are reported in Table 6. Of the children who have entered school, only one was not enrolled in a regular classroom. This child attended a dedicated school for children with hearing loss. The majority of the children who have entered school also receive additional support outside the classroom. The specific supports that parents reported included ESL, language, reading, writing, spelling, speech/articulation, private tutoring, and private SLP services.

Table 6. *Survey questions regarding school attendance and use of ESL/ELL services.*

Question	Yes	No
Has your child entered school yet?	11/16	5/16
Is your child enrolled in a regular classroom?	10/11	1/11
Did or does your child receive additional support outside the classroom?	7/11	4/11
Did your child receive English as a Second Language (ESL) services?	2/13	11/13

Service Outcomes

Participants were asked if the services their child received were helpful and if their child has met or is making progress towards their communication goals. Table 7 shows the breakdown of responses to these questions. One participant responded "no" to both questions. Their reasoning was that they feel their child needs more time and that sessions once a week for only six weeks was not enough. Comments regarding the helpfulness of services included: "her speech is coming along beautifully," "they build self confidence," "we have had the best results with our private speech therapist," and "we got great tips for monitoring and encouraging her language development."

Table 7. *Services satisfaction survey questions and responses from participants who received services of some kind.*

Question	Yes	No
Were the services your child received helpful?	13/14	1/14
Did your child meet their communication goals or are they making progress towards their communication goals?	13/14	1/14

The parents were asked to rate their level of satisfaction with the speech-language and/or audiology services their child had received. The breakdown of responses from very satisfied to dissatisfied are depicted in Figure 6. No parents selected "very dissatisfied."

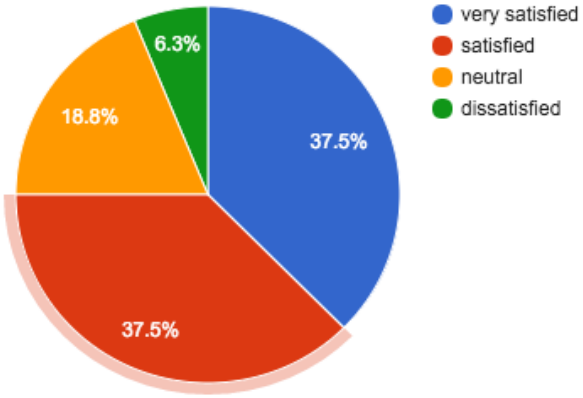

Figure 6. Level of satisfaction of services received for the 13 participants that received speech-language and/or hearing services.

Final Comments

Three participants made additional comments. First, one family commented that the biggest challenge they faced in obtaining services was that they were forced to choose one of three possible agencies in order to gain access to services and programs. The family found this stressful as each agency was different and they found it difficult to decide which agency would best meet the needs of their child. They would have preferred to have access to all three agencies and then use the services and programs to create an individualized plan addressing the child's and family's goals. Second, one family noted that their child had feeding difficulties after his/her cleft palate repair which were addressed by an occupational therapist and a dietician. Finally, one family reported that their child's academic standing almost six and a half years post adoption was superior to the child's three older non-adopted siblings at the same

grade level. This family also noted that they had significant difficulty obtaining services in their small province and that they preferred to receive services in a larger neighboring province. However, the parent also noted that the culture is changing and that their province's health system has come a long way since their family's experience.

Discussion

There has been an overall decrease in international adoptions in the past decade (Selman, 2012) while special needs adoptions increased from 9% in 2004 to 49% in 2009 (Hilborn, 2011; Selman, 2012). Specific to adoptions from mainland China, 2,583 special needs adoptions were processed in 2009 which nearly double compared to in 2005 when 1,285 special needs adoptions were completed (Hague Convention Permanent Bureau, 2010). The opposite pattern was seen for non-special-needs adoptions: in 2005 there were 14,496 adoptions from mainland China, which decreased to 5,068 in 2009 (Hilborn, 2011). The present study focused on children adopted from China's Waiting Child program from 2009 onwards. Two prominent organizations, CCAI and Children's Bridge, noted that within the past five years, the percentage of children being adopted remained stable. Because of the stable increase in number of adoptions of children with disabilities, there is a need to determine which services these children require post-adoption (Glennen, 2009; Hansson, Svensson, & Becker, 2012; Krakow, Tow, Roberts, 2005; Miller, Hendrie, 2000; Tan, 2014). The purpose of this study was to determine whether the needs of children being adopted from China's Waiting Child program were met in the area of speech-language and hearing services.

Due to minimal research specifically pertaining to access to speech-language and audiology services, researchers wanted to investigate this issue. Few studies examined access

to speech-language and audiology services but one studied the importance of access to behavioural intervention services. Bruder, Dunst, and Mogro-Wilson (2009) discovered the need for early behavioural intervention services for children adopted from China but oftentimes families did not seek professional advice for need for services or professionals who came into contact with the children did not raise any concerns about the need for early intervention (Bruder, Dunst, and Morgo-Wilson, 2009, pg. 62). While this study examined behavioral development, the same can be applied to families with speech-language and hearing concerns. In this case, it was not a problem with access to services but rather the family's perceived need for services.

Our goal was to obtain parents' views on the need for, and access to, speech-language and hearing services. Survey results showed a majority of parents (57.1%) had concerns about their child's language development in English but most did not experience any difficulties accessing the services needed. Concerns about needs not met included articulation errors, an unrepaired palate, and a child not receiving a cochlear implant until the age of 2. While most children were age-appropriate in their language, some were mildly to severely delayed in language and one was not yet talking. For those parents who had difficulty accessing services, one issue was not enough funding. There were also three special cases. The first child did not get the service she needed because she was not deemed severe enough to qualify for services. In another case, the child did not receive needed services because parents had to use insurance money to pay for extra speech-language pathology services. In the third case, parents did not have access to a reliable pediatrician in their area which forced them to drive to another area to receive needed services. Preliminary evidence and responses from surveys indicated a need for

more services in a few areas despite the fact the majority of respondents felt they did not have difficulty accessing needed services.

The time it took to obtain services was also examined. A majority of parents indicated it took about one to six months to obtain needed services. Unfortunately, two parents revealed that it took nine months to a year to obtain needed services. One was due to a lack of services within the location of the family; the other was a result of being on the waitlist for a program. Despite the amount of time to access services, most parents eventually attained desired services within the year.

Researchers were hoping to explore was how many children were receiving ESL/ELL services instead of needed speech-language pathology or audiology services. Glennen (2007) found most children were put on "wait and see" protocols for extended periods of time due to the assumption their language delay was due to a language barrier rather than a developmental delay. She stated speech-language pathologists should be making decisions based on evidence-based research rather than "best guesses" (Glennen, 2007). Therefore, researchers wanted to determine if any parents experienced this controversy with their adopted child. Of the children who were attending school, one child (aged 3;3 at the time of adoption) was receiving ESL/ELL services. While this was the case, parents felt this service was helpful and had no complaints. This suggested ESL/ELL services were perceived as assisting and may have been suitable when other services were not available.

Overall, there were no major issues in accessing speech-language and audiology services reported by the participants in this study. While it took longer for some parents to obtain these services, eventually they did, at least within one year and had access to a variety of services.

Survey results revealed a majority of parents were either extremely or very satisfied with these services. A minority of parents were satisfied or somewhat satisfied with these services and none indicated they were dissatisfied with services provided. All respondents but one indicated their child was meeting or making progress towards their communication goals. They noted that they believed their child was not making progress because six weeks was too short of a time to make gains in language development.

Another reason why there may have not been any major issues in accessing speech-language and audiology services is because adoption agencies have been helpful in providing support for accessing these services. In an interview, two large adoption agencies (personal communication, March and April 2015), one in Canada and one in the United States, reported they provide various avenues of support for obtaining required services. One agency reported they gave prospective parents a full complete medical report along with two to three pictures of the child, encouraged parents to do a pre-adoption medical screening, gave a list of medical clinics across the country and gave a breakdown of resources and services for their region. Subsequently, this agency would follow up with families a year after adoption to ensure families have all the information they need. The representative from this agency noted that over time they have been more thorough with the adoption process. Even if a family were geographically too far away from a service, the agency would contact the family to get in touch with the physician in their area to help them obtain the service they need.

A representative from the other agency noted they would give prospective parents all the medical developmental background that the agency received on the child and required them to take parent training classes where they also discussed normal and delayed

development. Families were also encouraged to visit an international adoption clinic following adoption where they could receive a list of resources for services they needed. The agency commented that most families receive services through their school district, and therefore do not have a full list of speech-pathology and audiology resources and services for parents. She noted parents do not commonly request these resources post-adoption.

It is inconclusive as to whether or not families have trouble accessing speech-language and audiology services but professionals in these areas need to be aware of the child's speech and language development, age at adoption, and speech-language assessment and intervention when dealing with children adopted from China's waiting child program. As previously mentioned, there is a need for research on communication development of children adopted from China's waiting child program. Speech-language pathologists should be aware of this need and keep in mind that 5-22% of children adopted internationally struggle with the acquisition of language beyond the first two years of adoption (Pollock, 2015). They should also keep in mind that the amount of time spent in an institution or orphanage and the child's age at adoption affects the child's language development. These factors can affect speech-language assessment and intervention as these children rapidly lose their first language while transitioning into their adopted language (Pollock, 2015).

Future Directions

This study reports on the results of only 16 families. A larger sample is needed to capture an accurate representation of parents' perspectives on their child's communication needs and their access to speech-language and hearing services. Much effort was devoted to recruitment through emailing and calling a number of adoption agencies and support groups

involved in international adoption. Despite extensive recruitment efforts, many adoption agencies and support groups did not respond to the request for support with recruitment or were not willing to support recruitment. It is impossible to calculate response rate, as the number of invitations to participate is not known.

That being said, the responses received were representative of the existing data regarding gender and type of disability of children being adopted. Both agencies disclosed that more girls were being adopted and children with cleft lip and/or palate were adopted the most. The majority of the participants were females and the majority had cleft lip and/or palate.

It was hypothesized there was a lack of responses because parents did not have a problem accessing speech-language and audiology services and therefore did not feel the need to fill out the survey. Future research could continue to focus on this area but recruitment statements should mention that parents should complete the survey even if they have had positive experiences accessing speech-language and audiology services. To ensure recruitment statements were being sent out, future researchers could call agencies instead of emailing them. The researchers attempted to contact agencies through email but found it was unreliable in that they were unsure as to whether or not recipients read and acknowledged the email. It would also be helpful to contact more adoption agencies in the future to ask about the resources and information they provide to parents and determine if other smaller adoption agencies provided similar resources.

Research could also focus on communication development of children adopted from China's waiting child program and children adopted at older ages. If more information were

provided in these areas, both professionals and families may be more aware of a need for speech-language and hearing services and advocate for better access to them if needed.

This study serves as a positive first step towards describing services needed for children who are adopted from China's Waiting Child program. A representative from one of the adoption agencies noted that a list of resources would be helpful to give prospective parents, which further results from this study could provide. While so far it seems there are no glaring issues in access to, or satisfaction with services, further research obtaining a larger number of survey responses would be helpful to paint a more representative picture of parents' access to and satisfaction with speech-language and hearing services.

Appendix A - Questions for adoption agencies

- What percentage of children are currently being adopted from the waiting list?
- Has it increased or decreased over the past 5 years?
- Are there any restrictions on whether or not a child can be put on the waiting list? (ie. Are there policies which state if a child is too disabled they cannot be adopted? If so, how is that decided?)
- Are there some disabilities adopted more often?
- What kind of medical developmental background do you give for the child?
- What information regarding speech-language and hearing services do you give parents during the adoption process?
- What information regarding speech-language and hearing services do you give parents after the adoption process?
- Do you have a list of speech-language pathology and audiology resources and services to give to parents? If not, do you think there is a need for it?
- Is there any information you wish you had for parents but you don't currently have? (eg. do you wish you knew more about different services children would need after coming from the waiting list and coming from a foreign country)

Appendix B - Survey questionnaire

(attach it in PDF)

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