

# When does childhood obesity become a child protection issue?

Childhood obesity is an increasing problem, but when does it constitute grounds for a charge of neglect? **Russell Viner** and colleagues review the evidence and propose a framework for practice



The suggestion that childhood obesity may raise child protection concerns has generated increasing media and professional interest.<sup>1-3</sup> The British Medical Association annual meeting in 2007 rejected a motion suggesting that childhood obesity in under 12s should result in legal protection for the child and parents being charged with neglect.<sup>4</sup> However, a BBC survey of 50 consultant paediatricians that month reported that obesity had been a factor in at least 20 child protection cases in the previous year.<sup>3</sup> In October 2008, the UK Local Government Association warned that increasing child protection actions related to childhood obesity would be a future cost pressure for local councils.<sup>5</sup> Similar concerns are evident internationally,<sup>6,7</sup> with case reports of US courts acting to remove obese children from their parents.<sup>8</sup>

Most recently, UK researchers reported that four out of the five obese children in their study identified with an extremely rare genetic deletion associated with overeating had also been on child protection registers.<sup>9</sup> This was widely reported as evidence that families of obese children were being unfairly accused of abuse.<sup>10,11</sup> Despite the high degree of contention, there are few published data and no published guidelines for professionals.

## Why is there a problem?

The rising epidemic of childhood obesity is caused by a long term positive energy balance in modern children. This is related to a host of lifestyle factors affecting both energy intake (type and energy density of food, access to healthy foods, speed of consumption, family eating, meal behaviours, etc) and energy expenditure (activity, sedentary behaviours, safety concerns, and access).<sup>12</sup> It is therefore not surprising that par-

ents and schools have become the focus of government and media attention as agents of change in preventing childhood obesity.

It is but a short step from seeing parents as agents of change to blaming them for their child's obesity. Childhood obesity can be seen as a failure to adequately care for your children by failing to provide a healthy diet and sufficient activity, whether through direct neglect or more subtly through an inability to deny children the pleasures of energy dense fast food and television viewing. This is particularly the case when children have become morbidly obese and have potentially life threatening complications of obesity.

## What is known

It is unclear whether child protection actions related to obesity have increased in the UK, as we were unable to identify reliable data. Another complicating factor is the likely causative association between child abuse and obesity.<sup>13</sup>

Evidence linking adolescent and adult obesity with childhood sexual abuse, violence, and neglect is growing.<sup>14-17</sup> In a cross sectional study in US preschool children, those who had been neglected or received corporal punishment were more likely to be obese after socioeconomic status was taken into account.<sup>18</sup>

Neglect may be on the causal pathway for obesity, and potential mechanisms include greater use of food in response to stress,<sup>19</sup> neuroendocrine responses that alter metabolism or appetite,<sup>20</sup> or poor later mental health, which is itself associated with obesity.<sup>21</sup> Alternatively, this association may reflect shared aetiological factors for both obesity and neglect, such as socioeconomic deprivation.

Removing children from their parents may not help obesity. There are few data on the weight

of children in public care. A recent study found that 37% of 106 children in care in one UK county were overweight or obese (body mass index  $\geq 91$ st centile).<sup>22</sup> However, only one child was known to be overweight before being in care, and most became overweight while in care, with risk of being overweight increasing with duration of being in care.<sup>22</sup>

We found no studies examining the relation between child protection actions and childhood obesity. Data are also lacking on the long term outcomes of child protection strategies in relation to weight control, metabolic comorbidities, and psychological health. Anecdotally, foster placement can result in dramatic weight loss. However, our and others' experience is that placing children on the child protection register usually makes little or no difference to body mass index.<sup>23</sup>

## Causes for concern

In our experience, child protection concerns are generally raised when a child or adolescent is extremely obese, has continued to gain weight despite intensive contact with health and social services over several years, has developed complications related to obesity, and professionals have had concerns about whether the parents have consistently acted in the child's best interests. Professional concerns usually fall into two categories: firstly, relating to the child's continued weight gain and obesity related comorbidity and, secondly, relating to inability of the parents or carers to meet the child's needs. This inability may be because of a child's special needs, limited parental capacity, or failure to fully engage with interventions and support offered by health and social services.

It is important to distinguish neglect or abuse as a factor in the development (cause) of child overweight from failure to act when a child is identified as at risk (maintenance). Reviews from the United States<sup>7</sup> and Australia<sup>6</sup> have suggested that parental neglect may cause obesity and that child protection action is a reasonable response for children with serious obesity related morbidity and clear evidence of neglect. Advice from the Royal College of Paediatrics and Child Health is brief: "Obesity is a public health problem, not



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- ▶ Adult socioeconomic, educational, social, and psychological outcomes of childhood obesity (*BMJ* 2005;330:1354)
- ▶ Establishing a standard definition for child overweight and obesity worldwide (*BMJ* 2000 320:1240)

a child protection issue . . . There may be a few families that give cause for concern where there are other matters of neglect or emotional harm and this is where a paediatrician might have discussions with social services.<sup>24</sup>

**Suggested framework for action**

In the absence of evidence, we suggest the following as a framework to understand child protection concerns with children who are obese.

- *Childhood obesity alone is not a child protection concern*—A consultation with a family with an obese child should not raise child protection concerns if obesity is the only cause for concern. The aetiology of obesity is so complex that we believe it is untenable to institute child protection actions relating parental neglect to the cause of their child's obesity. However, clinicians should be mindful of the possible role of abuse or neglect in contributing to obesity. Older children and adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues.
- *Failure to reduce overweight alone is not a child protection concern*—The outcomes of weight management programmes for childhood obesity are mixed at best,<sup>25</sup> with the body mass index of some children falling substantially and that of others increasing despite high family commitment.<sup>26</sup> As obesity remains extremely difficult for professionals to treat, it is untenable to criticise parents for failing to treat it successfully if they engage adequately with treatment.<sup>27</sup>
- *Consistent failure to change lifestyle and engage with outside support indicates neglect, particularly in younger children*—Parental failure to provide their children with adequate treatment for a chronic illness (asthma, diabetes, epilepsy, etc) is a well accepted reason for a child protection registration for neglect. We suggest that childhood obesity becomes a child protection concern when parents behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity and when the parents or carers understand what is required, and are helped to engage with the treatment programme.

**“It is but a short step from seeing parents as agents of change to blaming them for their child's obesity”**

Parental behaviours of concern include consistently failing to attend appointments, refusing to engage with various professionals or with weight management initiatives, or actively subverting weight management initiatives. These behaviours are of particular concern if an obese child is at imminent risk of comorbidity—for example, obstructive sleep apnoea, hypertension, type 2 diabetes, or mobility restrictions. Clear objective evidence of this behaviour over a sustained period is required, and the treatment offered must have been adequate and evidence based.

- *Obesity may be part of wider concerns about neglect or emotional abuse*—Obesity is likely to be one part of wider concerns about the child's welfare—for example, poor school attendance, exposure to or involvement in violence, neglect, poor hygiene, parental mental health problems, emotional and behavioural difficulties, or other medical concerns. It is essential to evaluate other aspects of the child's health and wellbeing and determine if concerns are shared by other professionals such as the family general practitioner or education services. This would typically require a multidisciplinary assessment, including psychology or other mental health assessment. If concerns are expressed, a multiagency meeting is appropriate. A high index of suspicion is needed for children who are extremely obese. In adult bariatric programmes, up to one third of patients reported childhood sexual abuse, with another third reporting other forms of abuse.<sup>28</sup>
- *Assessment should include systemic (family and environmental) factors*—As with any childhood behaviour, understanding what maintains a problem involves understanding factors within the child and their context. Assessment of parental



capacity to respond to that particular child's needs is central to this, such as parent(s) struggling to control their own weight and eating, but they are not the only factors. For example, a child who lives in an area where it is unsafe to play outdoors is inevitably at greater risk. Admission to hospital or other controlled environment may be useful because it allows a more detailed assessment of behaviours and parent-child interactions. However, admission removes a child from his or her wider obesogenic environment as well as from parents so weight loss in a controlled environment is not evidence of neglect or abuse.

Although children who are extremely obese are more likely to raise concerns and to have serious comorbidities, the framework should still apply. There are multiple definitions of childhood obesity, and even the most conservative—the International Obesity Taskforce thresholds<sup>29</sup>—are too inclusive to be useful as a guide to child protection concerns, encompassing some 5% of current UK children.

As in all areas of child health, we have a duty to be open to the possibility of child neglect or abuse in any form. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary. Guidelines for professionals are urgently needed,<sup>6</sup> as is further research on the outcomes of child protection actions in obesity and links between early adversity and later obesity.



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## Even simple village medicine is complicated

UK doctor Saqib Noor is out in flood stricken Pakistan with aid agency Doctors Worldwide and is posting update blogs on doc2doc, BMJ Group's global online clinical community. "The job at hand is enormous. Effectively, we are starting to run a hospital from scratch, from the back of a hotel room. Spraying walls with water is not enough. We also need to disinfect and repaint. We cracked open the original hospital and found goodies covered in slime: an upturned doctor's desk, a drip stand, an examining table, and a dysfunctional light box. "From complex orthopaedic trauma surgery in the NHS to backyard village medicine is quite a jump. The patients I see have skin infections, multiple foot problems (from wading around in flood water), and diarrhoea. "Help is on its way and I am in good health, despite a few insect bites which are of some concern given the amount of stagnant waters," he says.

Read Saqib's blogs at <http://bit.ly/bcli4g>

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"Is there such a thing as evidence based management?" asks Martin McShane. "Having evolved into NHS management, I am struck by how often it is subject to fashion. Every year or two a new craze sweeps from the central catwalk onto the high streets across the nation. From ISIP (Integrated Service Improvement Programme) to WCC (World Class Commissioning) to, now, QIPP (Quality Innovation Productivity and Prevention). However, beneath all these fashions in management, which purport to be the magical solution to all ills, I have gradually learnt that there is a core set of principles, based on accumulated evidence as to what really works. Some years ago, a friend recommended that I read Scholtes's *The Leader's Handbook*. If anyone wants a book of evidence based management, then this should be top of the list. The principles it sets out are, too often, woefully ignored," he says.

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