Addressing childhood obesity among children in care: The missing link to promoting physical well-being outcomes

Kellie O’Dare Wilson and Diane L. Scott

Department of Social Work, University of West Florida, Pensacola, Florida, USA

ABSTRACT
Information on the childhood obesity epidemic in the United States abounds. However, the impact of overweight and obesity specifically among children receiving child welfare services (children in care) has received little attention. Although relatively little is known about obesity among children in care, limited studies suggest children in foster care are disproportionately affected, with children in long-term foster care or group homes at highest risk. Although child welfare work has not historically focused on reducing and preventing childhood obesity, child welfare agencies have an obligation to protect children’s physical and mental well-being, and the social work profession is uniquely qualified to deliver evidence-based obesity mitigation efforts among children in care.

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The burgeoning impact of childhood obesity in the United States is probably not new news to child welfare professionals. Currently, nearly one third (31.8%) of children are considered overweight, of which 16.9% are obese (Ogden, Carroll, Kit, & Flegal, 2014). However, the impact of overweight and obesity specifically among children receiving child welfare services, and related intervention programs, has received little attention. Although a paucity of generalizable studies exist relative to the importance of childhood obesity among children in the child welfare system, recent research has determined children who are maltreated incur an elevated risk of becoming obese over the course of a lifetime (Danese & Tan, 2014). Current rates of obesity are significantly higher among children in foster care, with an estimated 40% of these children overweight and 23% obese (Schneiderman, Arnold-Clark, Smith, Duan, & Fuentes, 2013). In fact, the primary body composition concern for children in care has shifted from issues of underweight status to that of overweight and obesity. Historically, the primary weight-related medical problems identified in children who are maltreated were malnutrition, failure to thrive, and underweight status (Schneiderman, Leslie, Arnold-Clark, McDaniel, & Xie, 2011). For example, research in the 1990s found on average 20% of children in foster care...
underweight, compared to 7% in 2011 (Schneiderman, Smith, Arnold-Clark, Fuentes, et al., 2013). However, as obesity rates among children in care have increased, the rates of underweight and normal weight children have decreased, and obesity is “the most prevalent medical condition noted” in the medical exams among a study of foster care children (Schneiderman, Smith, Arnold-Clark, Fuentes, & Duan, 2013, p. 833).

Particularly concerning is the prevalence of obesity in very young children in care, given that obesity in infants and young children is one of the strongest predictors of obesity into adulthood (McCarthy et al., 2007; Nader et al., 2006). Research shows that for children ages birth to 23 months, 11% of those in care were obese compared to 9.5% in the general population. Similarly, obesity among 2- to 5-year-olds in care was 32.6% compared to 24.4% of the general population (Ogden, Carroll, & Flegal, 2008). In addition, children in long-term foster care or group homes are at the highest risk for obesity and are almost twice as likely to be obese than those placed in kinship care (Schneiderman, Arnold-Clark, et al., 2013). Furthermore, given the over-representation of factors contributing to overweight and obesity among children in care, researchers caution that actual incidence and prevalence among the child welfare population may be much higher than estimated (Hadfield & Preece, 2008). The purposes of this article are to (1) bring attention to childhood obesity as an essential child welfare issue, (2) explore the role of child welfare practice in obesity mitigation, and (3) provide practice, policy, and research recommendations to guide future work in the area.

**Current literature**

The authors of this article conducted a systematic review of the current literature regarding the prevalence of childhood obesity among children in care and the role of obesity prevention/intervention efforts and child welfare work. The authors retrieved published, scholarly articles via a systematic keyword search in online academic databases (Medline, One Search, PubMed, PsychInfo, Web of Science, and relevant others) and supplemented with a “snowball method,” wherein references from selected articles were also included if relevant. The most commonly accepted working definition of childhood obesity is “Body Mass Index at or above the 95th percentile for children and teens of the same age and sex” (Centers for Disease Control and Prevention [CDC], 2015a, p. 1). Although childhood is commonly defined as ages birth through 18, the CDC growth charts include height and weight percentiles for persons from birth through age 20. Given that the authors hypothesized a dearth of articles regarding children in care and obesity, the range of developmental stages children progress through which may affect weight status, and the varying definitions of children in care, any study
containing relevant key words related to child welfare and childhood obesity were screened for inclusion in this review, regardless of what age range of childhood the study focused on. Keyword searches included combinations of words pertaining to child welfare, foster care, looked-after children, obesity, and overweight. The search included articles through September 2015. Although the review yielded several dozen individual articles, we also discovered one prior systematic review and meta-analysis of studies through August 2012 in the United States that incorporated most of the individual articles. Danese and Tan (2014) conducted a review and analysis of 41 studies, including 190,285 participants, examining the association between “child maltreatment and obesity” (p. 544). Danese and Tan’s review included studies up through August 2012 and found that “childhood maltreatment was associated with elevated risk of developing obesity over the life-course (odds ratio = 1.36; 95% confidence interval [1.26, 1.47]) (p. 544), and that “results were not explained by publication bias or undue influence of individual studies” (p. 544). Danese and Tan review also provides a detailed table of the characteristics (sample size, age ranges, variables, measures, covariates, results) of each study selected for inclusion in their review (p. 547).

Since Danese and Tan (2014) review, several other authors have published studies examining child maltreatment and obesity. Researchers thoroughly examined variables related to children in care and overweight and obesity among primarily Hispanic children in Los Angeles, California and found that children in the child welfare system have a higher prevalence of overweight and obesity compared to national statistics (Schneiderman, Arnold-Clark, et al., 2013; Schneiderman et al., 2011; Schneiderman, Mennen, Negriff, & Trickett, 2012; Schneiderman, Smith, Arnold-Clark, Fuentes, & Duan, 2013, Schneiderman, Smith, Arnold-Clark, Fuentes, et al., 2013). In addition, this research identified that placement in group homes, those with non-English speaking caregivers, and parental substance abuse was also associated with higher BMIs among children in foster care. Shin and Miller (2012) employed latent curve modeling to investigate the longer-term effects of child abuse on BMI in a nationally representative sample. This longitudinal research included a number of confounding variables that had not been explored in previous studies, including parental weight status and frequency of maltreatment. The study found that children with a history of maltreatment had a greater rate of increase in BMI over time compared to those with no history of maltreatment, net of control variables. Helton and Liechty (2014) also explored the relationship between child abuse and obesity using secondary data analysis from the 2008 National Survey of Child and Adolescent Well-Being II, a large, nationally representative sample of children ages 2 to 17. The researchers found that 25.4% of all children in care in the study were affected by obesity, with obesity higher among boys than girls (30% vs. 20.8%). This study also demonstrated risk for obesity based on child age,
race, and maltreatment type. African American boys were at lower risk of obesity than White boys, and girls with sexual abuse allegations and those with prior family history of investigations were at greater risk of obesity.

In addition, several studies on populations outside of the United States (not included in Danese & Tan, 2014) have resulted in similar findings. For example, Hadfield and Preece (2008) examined children in care in the United Kingdom and found that 35% of children, who were not obese when entering care, became obese while in care. Kim, Ham, Lee, and Lee (2009) studied a sample of South Korean children ages 3 to 6 and found no differences for girls, however boys under guardianship were more likely to be obese compared to those living with biological parents. Furthermore, Skouteris et al. (2011) performed a review including three Australian studies (Nathanson & Tzioumi, 2007; Osborn, 2006; Tarren-Sweeney, 2006) examining obesity among children in out-of-home care. Although the studies found mixed results regarding obesity among children in care, the authors cautioned the findings due to the self-reported nature of BMI and called for further research.

Although some similarities exist among studies on obesity and children-in-care worldwide, all geographic regions may not share the phenomenon. For example, a study in Rome by Ferrara et al. (2013) found no significant differences in BMI between children in foster care and those in the general population. As the incidence and prevalence of childhood obesity continues to increase across the globe, further studies with more rigorous methodologies, representative sampling techniques, and longitudinal designs are needed both in the United States and abroad.

**Significance for child welfare work and social work**

Although child welfare work has not historically focused on reducing and preventing overweight and obesity, child welfare agencies have an obligation to protect children’s physical and mental well-being. Through the Children and Family Services Review (CFSR) process, the Children’s Bureau (2015) ensures state compliance with federal child welfare requirements. The CFSR measures outcomes related to child safety, permanency, and well-being. The CFSR outcomes for well-being include, “Families have enhanced capacity to provide for their children’s needs” (outcome #5) and “Children receive adequate services to meet their physical and mental health needs” (outcome #7) (Children’s Bureau, 2015, p. 1). Yet, even though children in foster care are at high risk for childhood obesity, as well as the physical and psychological consequences associated with childhood obesity, the child welfare system does not systematically target obesity prevention and/or reduction efforts, creating gaps in optimal provision of services to meet physical and mental health needs.
However, given that child welfare is rooted in a systems approach to care, has expertise in working with families in poverty, and is dedicated to helping children at risk, the profession is uniquely qualified to address obesity among children in care (Evers & Barber, n.d.). Furthermore, childhood obesity among children in care, considered a highly vulnerable and marginalized population, constitutes an issue of social justice. Evidence suggests children in care share a disproportionate burden of diseases, including obesity, and lack of access to resources to mitigate the burden (Danese & Tan, 2014; Helton & Liechty, 2014). Children in foster care often “come from impoverished families with chaotic lives fraught with social difficulties, including unfilled basic needs” (Cheng, 2012, p. 1976). Cheng (2012) further describes the home environment of two foster care children struggling with obesity

Lucy and Jackie S. live in a crowded, run-down tenement in a high-crime neighborhood; they would like to ride their bikes but are often afraid even to step outside. Their single mother had long given up trying to find a job, and she battles bouts of depression as she struggles to provide for her children by piecing together supplemental security income and nutrition-assistance benefits. Recapitulating a cycle of indigence, Ms. S. grew up with few positive role models and faltered academically, dropping out of school in the 10th grade. She was never taught how to cook or keep a budget, and her meager supplemental income forces her to choose between food and utilities; in fact, the reason she had not responded to our calls was that her phone service had been disconnected for nonpayment. Ms. S. has also had difficulties navigating the complexities of the Medicaid system, with resultant lapses in insurance coverage and trouble filling needed prescriptions for her children. (p. 1777)

As advocates for marginalized populations and champions of social justice (National Association of Social Workers, 1998), social workers in child welfare work should strive to ensure that all children in care have equitable access to the rights and opportunities necessary to mitigate obesity, such as adequate medical care, healthy food options, access to safe spaces for physical activity, and accurate health education.

**Childhood obesity in perspective**

The effects of overweight and obesity are particularly harmful in childhood and may result in long-term physical suffering and psychological distress. Children in the child welfare system are at a higher risk for obesity as well as acquiring physical and psychological comorbidities. Childhood obesity is associated with developing a host of painful and costly comorbid chronic diseases, such as metabolic syndrome, cardiovascular disease, diabetes, retinal and renal complications, fatty liver disease, sleep apnea, polycystic ovarian syndrome, infertility, asthma, orthopedic complications, psychiatric disease,
and increased rates of cancer (Kelsey, Zaepfel, Bjornstad, & Nadeau, 2014). Furthermore, childhood obesity is the strongest predictor of adult obesity, and children who remain obese into adulthood suffer greater comorbidities than obese adults who were of healthy weight in childhood (Reilly & Kelly, 2010). Of specific concern is that childhood-onset type 2 diabetes cases have increased 30.5% since 2001, yet pediatric endocrinologists, particularly those who accept Medicaid, are insufficient to satisfy current and future demand (Dabelea et al., 2014; Decker, 2011; Vigersky et al., 2014). Consequently many of the complex childhood diabetes cases among poor children and those in foster care may not be adequately identified or managed.

Although the physiological consequences of childhood obesity are profound, the psychological and social consequences are equally as concerning. Children who are overweight and obese experience higher rates of eating disorders, body dismorphia, anxiety, depression, elevated stress, low self-esteem, depression, bullying (victim and perpetrator), poor social skills, and overall lower quality of life in general than their peers who are not obese (De Nete & Naiman, 2011; Kalra, De Sousa, Sonavane, & Shah, 2012). Furthermore, children who are obese are subjected to stigma, bias, discrimination, and stereotyping and are generally viewed more negatively than those who are not. The detrimental effects of obesity stigma and ridicule can be particularly damaging to children throughout the course of their lives (Puhl & Latner, 2007). A growing body of evidence also demonstrates that childhood obesity is associated with risk for poorer academic performance (Gable, Krull, & Chang, 2012; London & Castrechini, 2011). For example, children who were obese as kindergarteners had poorer math performance in first grade, and this difference persisted through fifth grade (Gable et al., 2012).

Obesity is a long-term condition that contributes to the global disease burden. In addition to the short- and long-term consequences of obesity on a child’s physical and mental well-being, the issue is costly to families and to the public. Although systematic data are not currently collected regarding the actual costs of obesity-related medical care specifically for children in the child welfare system, the average annual Medicaid costs for a child with obesity-related conditions is $6,730, compared to $2,446 for children who are not obese (Robert Wood Johnson Foundation, 2013). Furthermore, data suggest children in foster care do not receive adequacy or equity in health care services for chronic issues, even though Medicaid expenditures for children in foster care is high. This is largely because “children in foster care account for a disproportionate share of Medicaid expenditures, relative to their share of Medicaid enrollment” (Urban Institute, 2005, p. 1). Given that children in foster care do not receive adequacy or equity in health care services, are more likely to be overweight and obese, and that these children account for a disproportionate amount of Medicaid spending, reducing
obesity among children in care has the potential to reduce Medicaid-related costs (Schneiderman, Arnold-Clark, et al., 2013; Urban Institute, 2005).

The overall indirect costs of childhood obesity, including absenteeism from school and reduced parental productivity, are also difficult to quantify (Finkelstein, Chen, Graham, & Malhotra, 2014). However, the direct costs of childhood obesity in the United States annually are estimated at $14.3 billion, the vast majority of which is preventable (Hammond & Levine, 2010). To put the cost of potentially preventable expenditures into perspective, Congress appropriates approximately $8 billion annually to support state, tribal, or territorial child welfare agencies (Congressional Research Service, 2015). Consequently, we spend 55% more on direct costs associated with childhood obesity than on federal child welfare efforts. Furthermore, in addition to the positive impact on health and well-being, research has demonstrated that the money saved for each case of prevented childhood obesity would be great enough to pay for one full year of the costs of a college education at a 4-year state university (Finkelstein et al., 2014).

**Children in care and increased risk**

Children in care are a medically vulnerable population, with increased health care needs compared to the general population (Hadfield & Preece, 2008; Kools, Paul, Jones, Monasterio, & Norbeck, 2013; Steele & Buchi, 2008). Many children enter care with existing health problems, reflecting the trauma they have experienced prior to involvement in the child welfare system (Chernoff, 1994; Hadfield & Preece, 2008). Of a national sample of children in care, 27.9% had chronic medical conditions (Ringeisen, Casanueva, Urato, & Cross, 2008). Although some research has shown protective factors from certain medical conditions once children are removed from neglectful environments, the evidence suggests foster care does not protect children from obesity, and in fact weight problems may become worse while in care (Hadfield & Preece, 2008; Schneiderman et al., 2013).

It is difficult to disentangle the cause-and-effect variables surrounding obesity among children in care. Foster care may interact with other preexisting risk factors to worsen weight gain for some children (Schneidermann, Arnold-Clark, et al., 2013). For example, a common diagnosis among children who are maltreated is fetal alcohol spectrum disorder. Obesity rates among adolescents diagnosed with fetal alcohol spectrum disorder are higher (40%) than in the general adolescent population, particularly high among girls (50%) (Fuglestad et al., 2014). For these children, foster care may compound already existing risk for unhealthy weight gain.

Because children in care are at higher risk for obesity, they are also at risk for acquiring the physical and psychological comorbidities associated with obesity, and additional poor health outcomes overall (Committee on Early
Childhood, Adoption, and Dependent Care, 2002; Schneiderman, Arnold-Clark, et al., 2013). Many foster caregivers report children in their care experience the chronic physical and mental health issues commonly associated with childhood obesity. For example, a study reported that 20.9% of foster children in Florida counties were being treated for attention deficit and attention deficit hyperactivity disorders, 15.9% with depression or other mental illness, 15.3% with asthma, 7.4% with an eating disorder, 5.1% with a sleep disorder, and .6% with diabetes or related disorder, all common childhood obesity-related comorbidities (University of South Florida, n.d.).

The reasons for increased risk among children in care are primarily due to poverty and economic influences, educational insufficiencies, and the instability of caretakers, and/or toxic stress (Barber, 2012; De Niet & Naiman, 2011). For example, frequent changes in placements among children in foster care and lack of access to health education may result in an insufficient knowledge of what contributes to weight gain. The psychological effects of abuse and neglect are also related to weight gain among children in foster care (Dockray, Susman, & Dorn, 2009). Overeating is commonly triggered by mental health issues such as anxiety, depression and low self-esteem, and/or medications prescribed to treat mental health issues may contribute to weight gain (Evers & Barber, n.d.). For example, children in foster care are frequently placed on psychotropic medications that contribute to weight gain (Raghavan et al., 2005; Zito et al., 2008). In addition, children in care are more likely to engage in problematic food-related behaviors that may contribute to weight gain, such as binge eating and bulimia nervosa (Casey, Cook-Cottone, & Beck-Joslyn, 2012).

Lower socioeconomic status, common among children in care, may result in low access to healthful foods and safe places for physical activity. Furthermore, factors contributing to childhood obesity such as inadequate prenatal health care and diet; inadequate breastfeeding; improper infant formula; premature introduction of solid foods; insufficient amounts of nutritious foods; insufficient feedings and/or inappropriate feeding practices; inadequate exposure to sunlight; lack of fortified foods, beverages, and vitamin supplements; and the stress of transitioning between multiple caregivers and homes are common among children in the child welfare system (Spoon Foundation, n.d.). For example, infants who are not breastfed for the recommended duration after birth are at higher risk for childhood obesity, and children in care are less likely to have breastfed (Gribble, 2006; Tawia, 2013). Premature birth and low birth weight, common among children in care, may increase obesity risk (Cheng, 2012). Children in care may also have less access to safe places to engage in physical activities and little or no opportunities to engage in organized sports (Murray, 2013). Finally, research has demonstrated that children who rely primarily on Supplemental Nutrition Assistance Program (SNAP) benefits and school lunch programs
for food may be at higher risk for obesity, including children in foster care who are categorically eligible for these programs (Larson & Story, 2011; U.S. Department of Agriculture, 2014; Wolfson & Bleich, in press).

**Child welfare’s role in obesity prevention and reduction**

“Treating weight problems is essential to well-being for children in foster care” (Schneiderman, Arnold-Clark, et al., 2013, p. 832). Yet childhood obesity is a complex issue influenced by a myriad of forces, including genetic, behavioral, and environmental factors (Papoutsi, Drichoutis, & Nayga, 2013; University of Minnesota, 2013). Although many of these variables are outside of volitional control, families are often the most critical factor influencing the nutritional and physical activity choices of children (Harvard School of Public Health, 2015). Caregivers play an important role in combating unhealthy weight by overseeing a child’s eating habits and physical activity (Helton, 2011). Research supports that family and home factors significantly predict the physical activity and eating behaviors of children and adolescents, and some of the most effective childhood obesity interventions include parents as the primary agents of change (Golan, Kaufman, & Shahar, 2006; Golan, Weizman, Apter, & Fainaru, 1998). Changing the home environment, such as through placement in foster care, may have powerful effects on childhood weight status.

Researchers have identified four primary areas related to the reduction of obesity among children in low-income environments (a useful proxy for children in the child welfare system): (1) increasing physical activity and consumption of fruits, vegetables, and healthier beverages; (2) reducing sugary drinks and energy dense foods; (3) ensuring enough sleep; and (4) decreasing screen time—all of which can be encouraged and practiced within the home (Centers for Disease Control, 2015b). Emerging research is demonstrating that interventions focusing on these four primary areas, when adopted and practiced within families in combination with social and environmental approaches, may have a positive effect on reducing obesity in children (Blanck, 2015; Centers for Disease Control, 2015b). However, given that overweight and obesity has largely been excluded as a child welfare issue, many foster families may not have awareness of or have access to critical information necessary to improve the health and well-being of the children in their care. For example, with the exception of referring eligible families for school lunch programs, SNAP, or Women, Infants and Children (WIC) benefits, nutrition education opportunities within the foster care system are largely overlooked.

Although neither school lunch menus nor the array of food choices available under SNAP or WIC fall within a family’s personal proximal control, there are other mechanisms by which foster families strongly
influence children’s eating and physical activity behaviors. Parental modeling has been shown to be the primary influencer of dietary and physical activity behaviors in children (Papoutsi et al., 2013). Parents have a certain level of freedom in food and activity choices, however the food environment created by the parents dictates a child’s choices (Barlow & Dietz, 1998). The family food environment establishes eating habits and food preferences, behavioral traits, and feeding practices, which are all shown to be associated with childhood obesity risk (Gibson et al., 2012; Nixon et al., 2012). Therefore, foster caregivers have a primary role and vital responsibility in establishing leptogenic family food environments. Child welfare practitioners are called to enable foster families to create and maintain healthy food environments within the home.

**Role of theory in promising interventions**

Social cognitive/social learning (SCT/SLT) theories provide a framework for understanding and influencing the behavioral change necessary to mitigate obesity. SCT/SLT emphasize a reciprocal model, wherein human thoughts, behaviors, and the larger environment continually interact (Glanz, Rimer, & Lewis, 2002). Childhood obesity prevention programs based on SCT/SLT paired with high levels of parental involvement have demonstrated efficacy in assisting parents to create leptogenic home environments, particularly with younger children (Bayer et al., 2009; Fitzgibbon, Stolley, Schiffer, Braunschweig, Gomez, Van Horn, & Dyer, 2006, Nixon et al., 2012). The components of SCT/SLT found most effective in reducing and preventing childhood obesity were methods of observational learning, skill development, and increased self-efficacy. In particular, these methods are most effective when paired with high levels of parental involvement, and when parents learn to use positive reinforcement, praise, and model the healthful behaviors themselves (Nixon et al., 2012). Interventions utilizing SCT/SLT have demonstrated success in the four primary areas targeted for obesity reduction with children in low-income environments discussed above. For example, Bayer et al., (2009) conducted a randomized controlled measuring the efficacy of a SCT-based program with high levels of parental involvement and modeling intended to increase fruit and vegetable consumption, physical activity, and water intake while reducing sugary drink consumption. The program was particularly effective with children who were high risk, including those from families with lower education levels (Bayer). Fitzgibbon et al. (2006) conducted an implementation and evaluation of their SCT/SLT-based program specifically targeting children who were minority and in low-income environments. The program focused on facilitating self-regulatory skills, exploration of new foods and activities, and avoided coercion. The program also involved a high level of parental involvement, support, and
modeling (Fitzgibbon et al., 2006). In addition, Fitzgibbon et al. (2011) expanded their previous research to include interventions aimed at reducing screen time among children who were minority and in low-income environments. Along with culturally adapted education on healthy eating and physical activity, the intervention included strategies to reduce TV and movie viewing, video game playing, and computer use. The children in the intervention group had significant decreases in screen time (Fitzgibbon et al., 2011; Schmidt et al., 2012). Studies also demonstrate that sleep quality and duration (another correlate of childhood obesity) is enhanced when children spend less time on electronic devices (Buxton et al., 2015).

**Recommendations**

Children in care are a medically vulnerable population with increased health needs, particularly with regard to childhood obesity (Hadfield & Preece, 2008). Given the demonstrated efficacy of SCT/SLT-based childhood obesity reduction programs with children who in low-income environments, child welfare agencies could consider incorporating similar programs into their service plans with children in care. For example, The Home, a child welfare provider in the state of Massachusetts, has incorporated wellness initiatives to address childhood obesity as an integral part of all their programs (The Home, 2011). The Home (2013) reported that, as of December 2013, 69% of youth aging out of foster care met or exceeded their wellness goals. In addition, The Home has partnered with Schools of Social Work in the area to provide internship opportunities for BSW and MSW students interested in child welfare wellness initiatives. Child welfare agencies should consider the following factors when selecting a childhood obesity reduction programs: (1) evidence based and grounded in SCT/SLT; (2) specifically target the outcomes of increasing physical activity and consumption of fruits, vegetables, and healthier beverages, reducing sugary drinks and energy dense foods, ensuring enough sleep, and decreasing screen time; (3) include a high level of foster caregiver support involvement, modeling, and positive reinforcement; (4) health-centered rather than weight-centered (measuring the target outcomes as opposed to changes in weight); and (5) originate from a strengths-based approach that minimizes any potential stigma associated with participation in an obesity reduction program. In addition, standardization across interventions is particularly important for foster children who are regularly moved in placements and to evaluate the effectiveness of interventions.

Although a preventable condition, the current foster care system has not protected children from obesity or ensuing future health risks (Hadfield & Preece, 2008). To inform the incorporation of obesity mitigation among child welfare agencies, researchers should partner with agencies and health care
providers to develop approaches to further investigate the incidence and prevalence of obesity among children receiving child welfare services. For example, given the increased risk among infants and young children in care, health care provider education should include information on how to properly identify obesity risk among very young children (Schneiderman, Arnold-Clark, et al., 2013). Further research should include longitudinal analysis of the relationship of child welfare involvement to obesity, include additional control variables, and utilize more representative sampling when possible. In addition, future research should address concerns with the method and precision in how childhood obesity is measured. Although BMI does appear to be a valid measure of obesity and risk for children, future research should incorporate other measures such as skinfolds, waist circumference, or others measures deemed valid and feasible for use in this population (Freedman & Sherry, 2009). Future research studies should also consider exploring any barriers and challenges child welfare agencies might encounter when incorporating overweight and obesity into well-being measures and identify best practice resources with regard to government-led obesity prevention and mitigation efforts.

Delaying research and intervention in this important area would forgo a magnitude of prevention of short- and long-term physical and psychological distress, as well as minimize the opportunity for cost savings in state expenditures.

Notes

1. Unfortunately, childhood obesity may be under diagnosed. Current methods may fail to detect up to 25% of children who have excess body fat (Javed et al., 2014).
2. The responsibility of child welfare agencies to define obesity as medical neglect and remove obese children from their homes is widely debated, and outside of the scope of this paper which focuses on obesity while in care. For more information on obesity as a form of medical neglect and the role of child protection see Garel (2014), Goldbas (2014), Jones et al. (2014), and Lang (2012).

ORCID

Kellie O’Dare Wilson http://orcid.org/0000-0002-3550-3930

References


