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Research article

# Neglected children with severe obesity have a right to health: Is foster home an alternative?—A qualitative study

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ABSTRACT

*Objective:* To explore key person's perspectives of foster home placement or notification of risk of harm to Social Services of children with severe obesity.
*Methods:* This case study research was performed in the southwest of Sweden and based on interviews with nine informants: a foster home youth, two foster parents, a social worker, two hospital social workers, a pediatric physician, a pediatric nurse, and a psychologist. Content analysis was used for narrative evaluations, within- and cross case analyses and displays.
*Results:* Positive health outcomes of the foster home placement were described as a healthy and normalized weight status, a physically and socially active life, and an optimistic outlook on the future. The foster parents made no major changes in their family routines, but applied an authoritative parenting style regarding limit setting about sweets and food portions and supporting physical activity. The professionals described children with severe obesity as having suffered parental as well as societal neglect. Their biological parents lacked the ability to undertake necessary lifestyle changes. Neglected investigations into learning disabilities and neuropsychiatric disorders were seen in the school and healthcare sector, and better collaboration with the Social Services after a report of harm might be a potential for future improvements. Rival discourses were underlying the (in) decision regarding foster home placement.
*Conclusion:* A child's right to health was a strong discourse for acting when a child was at risk for harm, but parental rights are strong when relocation to a foster home is judged to be necessary.

## 1. Introduction

Children affected with severe obesity are a growing subcategory within childhood obesity (Kelly et al., 2013; Skelton, Cook, Auinger, Klein, & Barlow, 2009). The grading of childhood obesity has formerly not been made, but body mass index (BMI) cut off points for obesity and severe obesity are now defined by Bervoets and Massa (2014) as corresponding to a BMI of 30 and 35, respectively, for children two to eighteen years of age. In 2025, an estimated 268 million children will be overweight, and among those 91 million will be obese (Lobstein & Jackson-Leach, 2016). Obesity is a progressive disease (Bray, Kim, & Wilding, 2017) that includes the risk of several co-morbid conditions such as cardiovascular and metabolic disorders (Reilly et al., 2003) and the risk of developing type 2 diabetes (Narayan, Boyle, Thompson, Gregg, & Williamson, 2007). However, detrimental psychosocial effects of childhood and adolescent obesity are just as important as the medical effects (Strauss, 2000). For adolescents with obesity, higher

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rates of sadness, loneliness, and nervousness have been associated with decreased self-esteem (Strauss, 2000) in addition to reports of stigmatization, which is expressed as being avoided, ignored, or the subject of negative rumors (Puhl, Luedicke, & Heuer, 2011). In rare cases, there are monogenic or endocrine causes of obesity, but at a population level obesity is preventable and reversible if properly treated (Marild, Dahlgren, & Hochberg, 2009). Treatment effects of lifestyle therapy in children with severe obesity are of short duration and modest (Kelly et al., 2013) in contrast to the effects of gastric by-pass surgery, which has been shown to result in substantial weight loss and improvements of co-morbid markers and cardiovascular risk factors (Olbers et al., 2017). However, for young children neither surgery nor pharmacological treatment are options of choice (Uli, Sundararajan, & Cuttler, 2008). Instead, family lifestyle modifications of physical activity and diet are the primary treatment strategy (Uli et al., 2008).

Childhood obesity also has an ethical dimension. The individual parent is not solely responsible for a child's unhealthy weight development, and much responsibility has been put on society as a whole and on the contemporary obesogenic environment that is recognized as encouraging overconsumption of foods and beverages and a physically inactive lifestyle (Regber, 2014; Voigt, Nicholls, & Williams, 2014). However, parental engagement is indispensable for the outcome of obesity treatment programs, and it is essential to also recognize different parenting styles (Regber, Berg-Kelly, & Marild, 2007) as well as identifying parents who for different reasons are unable, or unwilling, to follow the treatment regimens (Varness, Allen, Carrel, & Fost, 2009). In some situations and in some families, medical neglect might justify the removal of a child to a foster home (Varness et al., 2009). However, studies on foster-placed children with a background of childhood obesity are scarce. In a British case study, though, a boy's BMI increased from 36.4 at eight years of age to 45.6 at twelve years of age with his biological parents (Williams, Bredow, Barton, Pryce, & Shield, 2014). After relocation to a foster home, the boy's BMI value fell from 45.6 to 35 in 18 months.

Rival discourses might be underlying the (in)decision of placement to foster care based on (i) child protection discourses founded, for example, on the rights of the child to the highest attainable standard of health and treatment of illness and rehabilitation of health (Article 24) (UNICEF, 1989) or (ii) reliance on attachment theories and fear of doing harm to the child if the child experiences multiple caregivers (Barth, Crea, John, Thoburn, & Quinton, 2005). In the current literature, there is a limited knowledge of values, perspectives, and experiences from key persons involved in foster home placements of children with severe obesity.

### *1.1. The Swedish child welfare and healthcare background*

In 2014, Sweden had 9.7 million inhabitants, and 2.2 million were under the age of 20 years (Statistics Sweden, 2017). About 22,300 children and adolescents were placed in out-of-home care for a short period or for a complete calendar year (National Board of Health & Welfare, 2017). Swedish legislation is based on the concept of children at risk of harm, and the Social Services Act (SFS 2001:453) requires personnel working with children to report to the Social Services, if there is a suspicion that a "child is at risk of harm". The Social Services and social workers have the responsibility for further investigation. In the Social Services Act, maintenance of contact between the child and biological parents and siblings is insisted upon when a child is placed in foster care. The concept "children at risk" involves a broad definition of child maltreatment (National Board of Health & Welfare, 2014). In this study, we use the concept "child neglect", which is characterized as inaction and failure to provide for the needs of the child, in contrast to the concept of "abuse", which is characterized as an action (Svärd, 2016). Child neglect can be due to parental neglect, but also to professional inaction and societal or institutional neglect (Dubowitz, 2013; Gilbert et al., 2009; Lucas & Jernbro, 2014).

The Swedish child welfare system consists of child protection aspects as well as family service aspects. According to the Swedish Parental Code (SFS 1949:381), parents are obliged to ensure a safe and good upbringing for their child until his or her 18th birthday. Treaties and guidelines within the health care sector are national, but regional implementations might also occur. In 1990, Sweden ratified the United Nations Convention on the Rights of the Child (UNCRC), a treaty for human rights of the child (UNICEF, 1989). The UNCRC is suggested by the Swedish government to be incorporated to the Swedish law by 2018 (SOU 2016:19).

The Swedish healthcare system is tax-financed, i.e. all healthcare services, including hospitalizations and long-term treatment programs, for children are free of charge. Although there might be small local differences, obesity treatment is offered at municipal medical healthcare centers for children and adolescents, and regional obesity centers with multidisciplinary teams are available for the assessment and treatment of children and adolescents with severe obesity. In addition, a regional web-based decision support system is available in the southwest of Sweden, including healthcare and community-based obesity prevention and treatment programs (Västra Götalandsregionen, 2017a). Children and adolescents with psychological, psychiatric, and social problems in need of multidisciplinary competence are the target group for the so-called "Västbus" guidelines in the southwest county of Sweden (Västra Götalandsregionen, 2017b). Sectors included are Social Services, preschools, schools, and the healthcare sector. The Social Services are responsible for collaboration with other sectors, but invitation to a collaboration meeting can be made by any of the other sectors.

The aim of this study was to explore the experience of foster care placement and/or notification to Social Services of children with severe obesity, without the requirements that the participants should have experience from the same case, from the perspectives of I) foster home-placed youth with a background of severe childhood obesity, (II) foster parents, III) social workers, IV) health care professionals, and V) anthropometric data from foster care youths' medical records. A second aim was to explore rival explanations for (in) decision of foster care placement.

## 2. Methods

A single case study research (CSR) design (Yin, 2007) was used to explore perspectives and experiences of children being placed in foster care. Events categorized as unique or highlighting an event that can increase our understanding of the phenomenon are characteristics of case study research (Yin, 2007). In this study, the unique event or case is the child with severe obesity a) being