Is Childhood Obesity a Child Protection Concern?

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Is childhood obesity a child protection concern?

Abstract

Childhood obesity is a key public health concern. Obesity has an impact on morbidity and mortality, child development, and has links to child sexual abuse. The costs of childhood obesity on the health service and society are well recognised. Whether childhood obesity should also be a child protection concern has divided commentators and professionals. They pose a juxtaposition questioning whether childhood obesity is a consequence of neglect and obese children should potentially be removed from parents who do not seek to reduce their child's weight, whilst expressing resistance to a role focused on bodily surveillance. This research sought to identify existing practice, through interviews (N23) and focus groups (N3:24) with key professional stakeholders, from social care, health and education, in one area in the UK. The research aimed to explore the decision making, views and experiences of those working with obesity and the child protection system. The data was

subject to Framework Analysis. Key findings include multi-agency working, personal and professional standpoint, and the complex and nuanced impact of individual and agency thresholds on practice. The research demonstrates how the tensions surrounding a child protection paradigm impact on individual and agency practice, potentially inhibiting the support offered to service users.

Key words: child protection, childhood, obesity.

Introduction

Obesity - and particularly child obesity - is a ubiquitous public health concern, not least because of its significant impact on morbidity and mortality, child development, links to child sexual abuse and the wider costs to the health service and society (Department of Health, 2016). Whilst its salience to public health is clear, whether obesity in childhood should be considered a child protection issue is more controversial and where it has been debated in the literature, has divided commentators (Viner et al 2010). Whilst many health and social care professionals have major anxieties about whether a child should be removed from parents who do not seek to reduce their child's weight or where significant obesity is identified, there is considerable ambivalence to a role focused on bodily surveillance. However, this ambivalence also exists alongside an acknowledgement of the need to investigate neglect where evidence exists of a clear parental failure to manage a child's diet, health and fitness (Griffiths 2010). Similar divisions exist in the medical profession and debates on this issue have taken place in Australia (Alexander et al 2009) and the USA (Jones et al 2014). By contrast, there has been little empirical research to inform policy and practice for social workers.

In the United Kingdom (UK), there is a variety of practice with a consideration of obesity being incorporated in some multi-agency child protection procedures but with no mention in others. Where procedures are incorporated, they can include well-developed assessment tools alongside clear guidance for practitioners (Norfolk Safeguarding Children's Partnership Manual 2019). Alternatively, there can be the briefest mention of childhood obesity in an area's neglect strategy,

with little research existing to explain variations. Obesity is a difficult problem which arguably medical and public health services have failed to solve. Passing the problem to individual families and requesting significant life changes where agencies lack the evidence based tools to support change can ignore the complex systemic nature of obesity which makes weight loss so difficult to achieve.

Obesity as a public health concern

In simple terms, obesity is caused by the imbalance of energy in (food consumed through diet) and energy out (energy used by the body to be physically active) (Department of Health (DH) 2008). However, obesity is not simply a result of overeating and inactivity (Townsend and Lake 2017). It is a complex, systemic problem with a number of complex roots, and commonly linked to socioeconomic status and deprivation (McLaren 2007), with much higher levels of obesity seen amongst the most disadvantaged sections of the population. What this indicates is that whilst obesity is the product of a complex inter-play between family and individual practices and the social environment in which individuals find themselves, many of the latter are not straightforwardly amenable to change or modification(Bissell et al 2016).

The increased prevalence of childhood obesity has been tracked in England through the National Childhood Measurement Programme (NCMP) which measures the height and weight of over one-million children aged 4-5 and 10-11 years each year in primary schools in England. The surveillance data highlights that those children from the poorest income groups of reception (aged 4-5 years) and year 6 (aged 10-11 years) are twice as likely to be obese compared to their more affluent peers. 2017/18 NCMP data indicated that in England 9.5% of reception aged children are classed as obese and 20.1% obese at year 6 (National Office of Statistics 2018).

Under nourishment is also a significant public health concern, with Health Survey for England data pointing to the clusters of chronic health conditions around under nourishment, as well as obesity

(Health Survey for England, 2018). In the context of under eating managing the compulsory treatment of young people with severe eating disorders can be as controversial as child protection interventions with obesity, raising complex ethical issues regarding patient autonomy and negative impact on outcome (Aynton, Keen and Lask 2009). Here however the intervention occurs under mental health legislation and guidance is more fully developed (National Institute for Health and Care Excellence, 2017). This study chose to focus on obesity because of available funding, although we recognise there may be equally valid practitioner concerns around under nourishment and the requirement for interventions to protect child welfare.

The short-term and long-term risks of obesity for children are severe. Obese children are likely to become obese adults (Simmonds et al, 2015). Whilst symptoms of the associated morbidity may not become apparent until children reach adulthood, an increased number of children are being diagnosed with illnesses such as Type 2 diabetes. In the short term, overweight and obese children suffer from the negative psychological effects of their excess weight (Reilly et al 2003). There is an increased likelihood of children suffering from depression, poor educational attainment, increased risk of peer bullying and social exclusion (Rees et al 2011).

Obesity, Safeguarding and Child Protection

Within England and Wales (but also replicated more widely) there is an important distinction between the concepts of *Safeguarding* and *Child Protection.* Safeguarding, and promoting the welfare of children, is a broader term than child protection. It encompasses protecting children from maltreatment, and preventing impairment of children's health or development. Child protection is part of safeguarding and crucially involves the concept of significant harm which was introduced under sections 31 (9) and (10) of the Children Act 1989 as amended by the Adoption and Children Act 2002 (HMSO 1989, HMSO 2002). Child protection refers to activities undertaken to prevent children suffering, or likely to suffer, significant harm as a result of the care given to a child not being what it would be reasonable to expect a parent to give to a child or that the child is beyond parental

control. Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

Significant harm is the term that is used to denote the threshold that justifies compulsory intervention in family life in the best interests of children. There are no absolute criteria on which to rely when judging what constitutes significant harm but rather a test of reasonableness. Significant harm may be the result of a single violent incident or consist of significant events, both short and long term, which damage a child's development. (Adcock and White 1998). It is in this legal and practice context that the question of whether childhood obesity is a child protection concern is located. Does childhood obesity constitute *significant harm*? Does childhood obesity provide the grounds for the compulsory removal of a child from their parents?

Within the UK it is a question which has attracted considerable media interest; in the tabloid press, (Daily Mirror 2014) the broadsheets (The Independent, Johnston 2014), radio (BBC radio 4 2012) and television (BBC 2007). The impact of obesity on child health seems clear yet the public and social commentators are divided on whether a child should be removed from parents who do not seek to reduce their child's weight. It is a division which is reflected in social work where reluctance to undertaking a role based on bodily surveillance is set against the need to investigate neglect (Griffiths 2010); in the legal profession where inconsistency and discrepancy has been identified in court decision making in both the UK and the USA (Garel 2013) and in the medical professions (Viner et al 2010) where research indicating children with a rare genetic deletion associated with overeating had also been on the child protection register which was reported as indicating families of obese children were being unfairly treated. However, where there appears to be growing evidence is the association of obesity with childhood interpersonal violence including physical and sexual abuse and peer bullying behaviour (Midei and Matthews, 2011). Here however the primary cause for intervention is the abusive behaviour with obesity an associated factor.

In the UK a child is described as 'Looked After' if they are provided with accommodation for more than 24 hours or are subject to a care order. Children taken into care are defined as those who started to be looked after under a care order obtained from court or who are detained on child protection grounds. (Vickerstaff 2014:24) Data on the number of children brought into care on the basis of their obesity is difficult to find. The most accessible information, obtained by the Daily Mirror in 2014 under a Freedom of Information request, indicates that over a five year period, in 128 Local Authorities in the UK between 26 and 46 obese children were taken into care (Bagot 2014). Taken as a snapshot the Mirror suggests this indicates that overall 74 obese children may have been taken into care. This remains a small percentage of the overall 30,430 children who started to be looked after during the year ending 31 March 2014. (Vickerstaff 2014). There appears to be little if any research evidence on the outcomes of those interventions involving obesity. There is however evidence that being a looked after child does not necessarily protect from obesity (Croft and Frith 2011).

Whether separate guidelines on the identification of obesity as a child protection concern are required is a further contested area. Arguments indicating that a surfeit of guidelines inhibits practice are set against practitioners welcoming guidance that helps separate out the impact of poverty and education from neglect (Griffiths 2010). Garel (2013) has proposed a framework to aid decision making in USA and UK courts. In the UK the most influential guidance for health and social care remains the 2010 paper by Viner et al (2010:376) which suggests a framework to understand child protection concerns with children who are obese. In summary Viner et al argue:

- Childhood obesity alone is not a child protection issue
- Failure to reduce overweight alone is not a child protection concern
- Consistent failure to change lifestyle and engage with outside support indicates neglect, particularly in younger children

- Obesity may be part of wider concerns about neglect or emotional abuse
- Assessment should include systemic (family and environmental) factors

It is this framework which is both quoted and incorporated into the child protection procedures of some local authorities but there appears to be no research which has tested its usefulness or applicability in practice. It is against this background, that the current research was conducted.

Methods

The research was undertaken in one local authority, in the north of England with data collected in 2017-18. Ethical approval was obtained from the lead university ethics committee and research governance from the local authority. Funding and support were provided by the National Institute for Health Research, Collaboration for Leadership in Applied Health Research & Care for Yorkshire & Humber (CLAHRC-YH).

The project used qualitative methods to explore the views and experiences of staff working within health, social care and education services, regarding child protection and obesity. A project advisory group was set up from health and social care professionals which met virtually at the outset of the project, to guide the direction of the research, interviewing content and protocol, and to inform sampling. This was conducted in a purposive manner to include a range of participants (see table one and two). Individual semi-structured interviews (n=23) and 3 focus groups (n=24) were held; with interviewees and focus group participants forming unique groups with no overlap between participants.

Interview and focus group structure involved an initial exploration of the participants understanding of childhood obesity and how, in their opinion, obesity might impact upon child development. Whether current or past roles had led to involvement in childhood obesity issues and if any training on the issues had been accessed were all explored. The interviews then directly asked if the participants felt obesity should be regarded as a child protection concern. This was followed by

eliciting examples from their practice which had involved obesity as a child protection concern exploring process and outcome. Participants were asked if they were aware of the Viner Framework. They were then provided with a hard copy and asked to comment on any perceived strengths and weaknesses. In conclusion the participants were asked what might help them to identify and respond to child protection and obesity concerns in the future. The focus groups allowed the research questions to be debated by participants and individual ideas and views were challenged and tested through group discussion. Consequently although guided by a schedule comparative to that used in individual interviews, the focus groups provided different data which both complemented and enriched that obtained from individual interviews.

Table One - Interview participant characteristics

Participant Number	Job Title	Role	Organisation
1	Stronger Communities Manager	Manager	Local Authority
2	Deputy Director of Nursing Midwifery	Senior Manager	Hospital Trust
3	Named Nurse for Safeguarding Children	Manager / Practitioner	Hospital Trust
4	Family Support Worker for Stronger Families	Practitioner	Local Authority
5	Head of Service for Learning Engagement	Senior Manager	Local Authority
6	Public Health Specialist	Manager	Local Authority
7	Head of Stronger Families	Senior Manager	Local Authority
8	Stronger Families Community Manager	Manager	Local Authority
9	Senior Environmental Health Practitioner	Practitioner	Local Authority
10	Named Nurse for Safeguarding Children	Manager / Practitioner	Hospital Trust
11	Lead Nurse for school Nursing	Practitioner	Local Authority

12	Chair Initial Child Protection Conference	Practitioner	Children's Services Trust
13	Training and Development Safeguarding Manager	Manager	Children's Services Trust
14	Supervising Social Worker	Practitioner	Children's Services Trust
15	Child Protection Conference Chair	Practitioner	Children's Services Trust
16	Independent Reviewing Officer	Practitioner	Children's Services Trust
17	Head of Service for Safeguarding and Standards and Policy	Senior Manager	Children's Services Trust
18	Independent Reviewing Officer	Practitioner	Children's Services Trust
19	GP-Senior Partner	Practitioner	NHS
20	Community Staff Nurse	Practitioner	NHS
21	Paediatrician	Practitioner	Hospital Trust
22	GP 2	Practitioner	NHS
23	Primary School Head Teacher	Practitioner	Local Authority

Table Two - Focus Group participant characteristics

	Job Role
Focus Group 1 - Voluntary Community Sector	8 x Project Worker 2 x Senior Project Worker

	2 x Social Work Student 1 x Stronger Families Officer
Focus Group 2 - Children's Services Trust	1 x Team Manager 1 x Social Worker 1 x Social Work Assistant 1 x Intensive Family Support Worker
Focus Group 3 - Local Authority Children's Centre	2 x Play Worker 2 x Family Support Workers 1 x Children's Centre Manager 1 x Admin receptionist

Framework analysis methods were used to generate categories, codes and themes that capture the experiences, views and perceptions of the sample. Framework analysis has emerged from policy research and is a pragmatic and systematic approach to qualitative data analysis (Gale et al 2013). It involves a systematic process of sifting, charting and sorting the material into key issues and themes. A fuller description of methods including a thematic table, focus group and interview proforma appear in the online supplementary material.

Findings

The analysis of the interviews and focus groups identified seven key themes of relevance to this paper.

Obesity: Obesity was thought to be caused by a complex web of issues including, social factors such as culture and poverty. Culture was linked to behaviours that young people were exposed to within their own environments, especially where others in the family were obese themselves. Specific examples provided were the influence of food preparation or cooking methods linked to traditional heritage. Poverty was described in reference to the impacts of Government reforms of welfare systems and the day to day challenges of living on limited income such as prioritising rent over healthy food. The influence of parents on children's diets was described variously as operating through a parent's lack of cooking skills, knowledge about the impacts of a poor diet and the impact of parental dietary behaviours.

The professionals interviewed understood the short and long-term impacts obesity could have on a young person's physical and psychological health and child development. Whilst the depth in knowledge of these impacts varied, some participants were able to provide examples of previous cases they had been involved with where the short term consequences of obesity included issues with personal hygiene; oral health; academic attainment; bullying and social isolation. Long term consequences on physical health reported included: future risk of comorbidities; the impacts of poor educational attainment on future prospects; and, long term social relationships.

> *And by the time this little girl came into school, she had acute asthma in the respect that she couldn't walk down the corridor without being extremely breathless. She was so overweight she couldn't get on and off the lavatory in the school and therefore was wetting herself all the time because she couldn't use the toilet appropriately and really suffering educationally because of the emotional aspect of her being so grossly obese. (P3)*

Knowledge of issues relating to obesity was often linked to the personal experiences in relation to their own weight. This shaped the responses that professionals gave to situations; especially if the professional was overweight themselves and were more reluctant to give advice to the families they worked with.

Assessing obesity was also reported to be problematic. The understanding of how to measure child obesity and where the responsibility for this rests varied between the participants. Generally health care professionals were identified as key to assessing levels of obesity. Yet, some health care professionals reported limited knowledge of how to accurately measure obesity and what support to provide. There was a demand for more training on assessing and identifying obesity in children.

Thresholds: For child protection services to undertake work requests need to meet a severity threshold for interventions to occur (the legal definition of significant harm) and there was considerable discussion about where that threshold should be located. Thresholds did not operate simply as a line to be crossed but rather were nuanced and complex and could act as inhibitors to providing services. The concept of a double threshold for intervention appeared to operate. For example, a line had to be crossed in order for a referral to be accepted by social services but also in respect of individual practitioner thresholds regarding personal views and values regarding obesity.

> *I think most social workers will just go on their own personal thoughts about what is obesity based on their own experiences*. (P17)

Individual agencies were seen as having their own threshold for action which may or may not fit with that operated by social care. From the view of health, these thresholds were clinical measures of obesity, compared to social care, who tended to use a much broader concept of neglect. There was a lack of knowledge about the thresholds operated by the differing agencies.

We would expect that health would be the main people to alert us to that… But I suppose it's where their thresholds lie as well. (FG2)

This was set against a nursing perspective:

I made attempts at that time to get a referral into social services and really at that time it wasn't viewed as a safeguarding issue, although to me it was definitely one in that case. (P3)

Staff from differing agencies viewed the thresholds of social work as high in terms of the level of concern required prior to a referral being accepted and this impacted on an individual's decision as to whether a referral should be made. Referrals about obesity were being made based on an assumption of the level of thresholds rather than clear knowledge of where the threshold was located or whether issues related to obesity met that threshold.

I think teachers, school nurses, GPs are probably well aware of where they feel there are child protection issues. I think the question …is how do we interest social services, are they really going to want to take this on? And some of that is a resource issue, in that social work is stretched at the moment. (P21)

Value judgements made by individual workers about parental behaviour influenced the judgement that a threshold had been crossed:

I received a letter for disability living allowance asking, saying the child couldn't walk more than 100 yards and asking me to …sign a form so they could get disability living allowance and that was purely because of nutrition obesity. And I felt actually, you know, if this child,

the family are now saying this child is so disabled that they need the £50-60 a week benefit, you know, something needs to change. And so I made a referral then. (P21)

Child Protection: Respondents were divided as to whether child obesity should be considered a child protection concern. For some the impact of obesity on long and short term outcomes for children made obesity unequivocally a child protection concern, yet for others excess weight itself was not sufficient and was considered relatively common-place.

For some respondents obesity alone is not a child protection issue.

Not in itself, not if that is the only concern with the family…I think it's just education more than anything (FG1)

For two respondents the nuances surrounding the issue made an answer either way difficult. For example one respondent drew the distinction between a family recognising obesity and not taking action, from one who didn't recognise the issue and took no action, posing the question of whether one or the other was a child protection issue.

If they do recognise it as an issue, but won't do anything about it, is that child protection, or if they don't recognise anything about it? I think it's not as easy as saying it should, it shouldn't. (P4)

For a number of practitioners the question was not nuanced at all but very clear; child obesity was a child protection concern. This clarity of view spanned professions and was not specific to health, early help or social workers.

Yes. Absolutely, categorically I do. I think if we can identify that there is no physical, medical reason for a child to be overweight, then absolutely, passionately I do, yeah. You know, a child doesn't go to the shop and buy their own food. They don't prepare it, they don't cook it. And that is a key part of parenting for me, absolutely, so yeah. (P11)

Almost all of the respondents did however think that when other factors are present alongside obesity, particularly familial failure to accept and engage with support and to change lifestyles where obesity was identified, it could potentially become a child protection issue. The respondents emphasised that once obesity had been recognised, a failure to address the issues may be a form of neglect:

Failure to reduce overweight alone is not a child protection concern – i.e. if they can't lose weight, that's not a child protection concern. Failure to change lifestyle, engage with outside support indicates neglect particular in younger children. (P19)

Respondents were able to identify a range of stresses on families, alongside the impact of a parent's self-obesity on problem identification. But as one respondent commented, it was important to apply the test of reasonableness contained in the definition of significant harm:

That's the bits about being reasonable ain't it, about what our expectations on a parent is. …We'd expect them to make reasonable attempts. It's when you've got the parent that dismisses it and says nah, it's not an issue to me, I'm not bothered. Or usually I have heard it dismissively as I'm big myself, so it's just in family. Well no it's not is it? (FG2)

The initial and primary aim of a child protection approach was to try to ensure compliance with the support package offered to the family. Where early help initiatives had not been taken up statutory

intervention was a potential catalyst, with the fear of consequences encouraging acceptance of support. Fear could however be something of a double edged sword preventing acceptance of support through the anticipation of individual blame. The pre court stage was the time when financially expensive interventions such as residential summer camps were considered, in part because the court would require evidence of every possible early help being offered to a family. Where children had been removed to foster care one respondent identified a case where the children had remained permanently away from their parents, but more common was the aim of family reunification, with the work required similar to that undertaken in early help but this time in the setting of foster care:

> *working alongside with mum and the child in a foster placement assisting mother to acknowledge and understand the role of food, the role of being able to parent and say no and stick to it, (P 12)*

Viner Framework: In the interviews and focus groups, the Viner framework (see previous p3) was introduced as a point for discussion and reflection. Almost all participants had no prior awareness of the framework. Respondents were divided as to whether obesity could be a standalone child protection concern. Linking obesity to wider issues of neglect, and identifying a consistent failure to change lifestyle and engage with support as indicative of neglect had wide support. So too did the emphasis on systemic assessment. Overall the framework was welcomed as a useful tool, with the caveat that over reliance on a framework can lead to over simple assessment. The framework was not seen as overcoming problems inherent in measuring and identifying obesity, and not identifying the association of obesity with sexual abuse.

> *As with many of these frameworks and processes you can't use them in a one dimensional way, because you can often be wrong (P5)*

Good Practice: Good practice was seen as beginning with what was considered to be a holistic understanding of obesity and its impact followed by a multi-agency approach including health, school and social care. Direct work with the whole family is given prominence in achieving change, both within and without a child protection context. Family involvement in the development and implementation of that work in a way that empowers but does not stigmatise was identified as a goal. Parental education was seen as important as part of a preventative approach and in sustaining change.

> *Well it needs a multi-agency response doesn't it? Health and school and social care working together and doing a holistic assessment which looks at the whole family and environmental factors…And you have to do all that in a way what's not further abusive to that child, and do it in a way that's supportive and sensitive. (P 15)*

Challenges for Practice: Challenges to practice included basic resource or structural issues such as a lack of funding for preventative services and a scarcity of evidence-based targeted interventions for disadvantaged groups. Psycho-social barriers to families accepting support were identified such as poverty impacting upon individual behaviour. Multi–agency working was a source of frustration with a lack of clarity regarding roles and responsibilities. Direct work with families was central but could be contentious. Challenges included the potential reinforcement of unhealthy eating patterns and the need to balance risk management with building trust and relationships in order to bring about change.

> *"We're not statutory, and we can only work with families on what they identify that they feel they want the support with. We can probe, we can lead, but we can't force anything that they don't want to do……and because of your working relationship…. You've got to keep that relationship because of everything else that you're working. (FG1)*

Suggestions for Future: Suggestions included training on obesity and service availability, and providing a framework and procedures to guide practice. Evidence on short and long-term outcome measurements was identified as a deficit. More research and dissemination of findings on outcomes and what works regarding interventions is required.

> *"better education about at what point does being overweight start to become neglect, …when does it really start to impact and when does the parents failure to address that impact start to become neglect." (P21)*

Discussion

In reporting the findings of qualitative research resorting to numbers in respect of respondent's views is not always helpful. It can however be illustrative of the ambiguity and contested nature of the research we undertook. In respect of the interviews undertaken ten (out of 23) respondents were of the view that child obesity was a child protection concern with a further three thinking it was if associated with neglect. Seven were of the view that it was not a child protection concern with three thinking the problem was too complex for a view either way. A similar variance of view was expressed by the focus groups and all of which resonate with the sparse literature (Alexander et al 2009).

Where there was more common ground was in respect of the links between obesity and parental neglect. This could be in the form of associated factors such as failure to attend school or mental health issues but also a failure on the part of families to engage with support plans and services offered. A child protection referral and subsequent action is unlikely to take place until some form of support has been offered to the child and family and seen not to be successful. Where this lack of success can be linked to parental failure to take up support and make changes then a consequent link is made to parental neglect. This connection is supportive of the framework proposed by Viner

(2010) but awareness of this framework was low and participants challenged how the framework could be used in practice.

Child protection services were seen by many participants as a continuum of intervention levels from universal to statutory with child protection and legal interventions part of that continuum rather than a separate entity. A child protection approach could act as a catalyst for families to take up support as well as a gateway to more expensive and intensive support offers. For some participants a child protection approach could also act as an inhibitor to parents accessing support fearing blame and condemnation for their inability to bring about change in their children's weight. This view has some support in the medical literature which indicates that health services find obesity extremely difficult to treat and blaming parents is merely passing responsibility and 'smacks of hypocrisy' (Fitzpatrick 2008:742). It was possible for work with families to become 'stuck' and a child protection referral could be seen as one way of motivating families to engage with the support offered. At times this approach was described as meeting with some success but the challenge for all professionals is to avoid bringing families into the child protection system because they cannot think of what else to do. (See the case study in supplementary materials for a practice example.)

The emphasis given to professional knowledge regarding the level, the seriousness and whether action should be taken to reduce the impact, varied on the basis of personal values and beliefs about obesity and children rather than any evidence base. Social factors such as culture and poverty combined with parent's lack of skills and knowledge about the impacts of a poor diet and their own dietary behaviours were often blamed for young people being obese. There was an acknowledgement of the impact of poverty on obesity but greater emphasis was given to parental responsibility. This emphasis became greater and more dominant as an individualised child protection approach took hold with interventions focussing on maximising household income rarely mentioned.

This research found that in making judgements regarding whether obesity amounted to significant harm, both as regards to a child's health and the extent to which parental care was contributory, the threshold of reasonableness as contained in the definition of significant harm was problematic. In particular what emerged from the research was that both individual and agency assumptions about thresholds were as important as the actual thresholds themselves. At an individual practitioner level, personal beliefs and values about obesity impacted on assessment, and assumptions about child protection thresholds being high could then guide future action without testing the actual threshold by making a referral. For non-medical staff the lack of detailed knowledge about obesity or a framework to guide judgement making reinforced the reliance on personal beliefs about child obesity – whether this amounted to normal pre-pubescent weight gain or parental neglect. At an agency level participants discussed the way individual threshold decisions impacted on meeting their own agency threshold for a child protection concern and then on whether this would meet a social care threshold. Similar processes then operated within agencies regarding whether to refer for specialist support through mental health services or to initiate court proceedings.

Child protection services and the concept of thresholds have long had a complex relationship and the issue is by no means restricted to childhood obesity (Brandon et al 2008). There is a consistency of criticism from Ofsted reports in the UK related to thresholds in respect of inconsistency in application, a lack of clarity between agencies and a variation of response from individual workers (Garboden 2010, Stevenson (2016). An assumption that social work thresholds have risen over time prevails, (Children's Commissioner 2016), a view strongly supported by school nurses in our study. That there is some variation in decision making about thresholds is hardly surprising given that central to the process is professional judgement making about unique individual situations. To seek national conformity is perhaps a fool's errand (Platt and Turney 2013). As one paediatrician summed up the problem from a medical perspective - '*When do we say Oh well you are going to die young but whey hey and when do we decide to do something about it?* (P21)

Implications for practice

The identification and implementation of direct work with the child and family appears central to successful work with childhood obesity, and for this work to be undertaken whether or not the child is receiving universal services, family support, is subject to a child protection plan or is living in foster care seems important. The fact of having been removed from parental care and being a looked after child is no guarantee of protection from obesity (Hadfield and Preece 2008, Croft and Frith 2011). Similarly the longer term outcomes for looked after children tend to be poor regarding educational attainment, and mental and physical health (Jay, M.A. and Mc Grath-Lone, L., 2019). When compared with children with similar experiences who remained cared for at home, however, the positon is less clear and perhaps reinforces the need for direct work with the child wherever they are living.

A key challenge for social work concerns the extent to which a child protection paradigm continues to define professional identity. Debates in the UK and more widely are challenging that paradigm by considering whether child wellbeing is better served by broader definitions of child maltreatment with safeguarding being located within a public health agenda, rather than a narrow focus on significant harm and child protection (Higgins 2017). The findings from this research are centrally located within that debate.

The findings are also located within an ethical and moral debate. Obesity, similar to many 'wicked' problems is a difficult problem to address, and the medical profession alongside public health has arguably failed to adequately resolve the problem. Health and social care agencies are often asking for significant, lasting and drastic lifestyle changes for parents and children, which are in many respects very difficult to achieve and where agencies often lack the evidence based tools which can address these changes. The questions to ask are whether by taking a child protection approach we are passing the problem of child obesity onto families and then blaming them individually when they fail to achieve the expected outputs, and in so doing, ignoring the clear links between obesity

and disadvantage. Or could a child protection approach act as a catalyst for families who fail to engage to take up support as well as a gateway to more expensive and intensive support offers? Failure to address the issues now will lead to potentially lasting damage to each child's health and wellbeing. As always in social work doing nothing is doing something.

Limitations

The sample size was limited by the funding available and consequent researcher time but was broadly successful in covering a range of participants. The increased participation of school teachers and health visitors would have been beneficial. A limitation was not including the perspectives of children and their parents / carers but capacity prevented their involvement. As with any qualitative research it is important not to draw generalised conclusions. The research was located in one geographical area and could be limited by findings unique to that area, although attempts were made to offset this by asking participants to reflect on experiences throughout their career and in other workplaces. The study team included academics with professional expertise of working in social care and public health services. Whilst a potential strength of the project the potential of researcher bias from this experience should be recognised. There are instances in the text where body shaming language occurs. This is included only where comments relate to direct quotations from participants.

Conclusion

This research has offered a unique insight into current multi-agency practice in respect of child obesity and child protection. What emerges is a contested view as to whether obesity alone can be a child protection concern, and to a lesser extent whether non-familial recognition of obesity as potentially harmful to children, and non-familial engagement in support services offered, amounts to neglect. In making judgements about child obesity and levels of harm, personal views about obesity and value judgements regarding parenting skills appeared to be as important, if not more so,

than any factual knowledge about the impact of obesity. These views come to the fore explicitly in threshold judgements and subsequent referral behaviour regarding identifying and acting on potential and actual significant harm. The services offered to and accepted by service users in respect of child obesity are both influenced by and a consequence of those threshold judgements. Direct obesity focussed work with children and families is seen as key to bringing about change whether through universal services, family support or child protection statutory interventions. Undoubtedly, more research is required on the short and long-term effectiveness, outcomes and financial viability of those interventions to guide strategic and front line service delivery.

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Supplementary on line material

Methods

The research was undertaken in one local authority, in the north of England with data collected in 2017-18. Ethical approval was obtained from the lead university ethics committee and research governance from the local authority. Funding and support were provided by the National Institute for Health Research, Collaboration for Leadership in Applied Health Research & Care for Yorkshire & Humber (CLAHRC-YH).

The project used qualitative methods to explore the experiences in practice of staff working within child protection and obesity services regarding child protection and obesity. The data collection technique was semi-structured interviews and focus group methods. Individual semi-structured interviews (n=23) and 3 focus groups (n=24) were held with health and social care staff. The interviews and focus groups explored perceptions and practice of childhood obesity as a child protection issue. A project advisory group was set up consisting of senior managers from social care, (both statutory and third sector), and health services that mirrored the particular structure of safeguarding and health services in the host authority. This group was identified with guidance from public health and social care professionals in the host authority and met virtually at the outset of the project, to guide the direction of the research, interviewing content and protocol, and to inform sampling.

Sampling

Sampling was conducted in a purposive manner to include a range of participants linked to child protection and social care (Table 1). Participants were initially identified in consultation with the project advisory group and the host local authority that supported recruitment through dissemination of information leaflets, email contact and the provision of interview facilities. Snowball methods identified participants within specific professional groupings. Participants were

from local authority, primary and acute care organisations. The interviewees and focus group participants formed unique groups with no overlap between participants in the focus groups and those who participated in the individual interviews.

Table 1- Interview Participant Characteristics

Table 2 - Focus group Participants Characteristics

Data collection

Prospective participants were provided with a participant information sheet and allowed time to consider participating in the study. Following agreement to participate and signing of a consent form, semi-structured interviews were conducted in a private area at their place of work. Interviews lasted around 60 minutes. Focus groups were conducted both to maximise the time commitment of participants, to utilise existing staff meetings and to bring a discursive element to the data collected. The structure of both the interviews and the focus groups involved an initial exploration of the participants understanding of what constitutes childhood obesity and how, in their opinion obesity might impact upon a child's development. Whether current or past roles had led to involvement in childhood obesity issues and if any training on the issues had been accessed were all explored. The interviews then directly asked if the participants felt that obesity should be regarded as a child protection concern. This was followed by eliciting examples from current practice which had involved obesity as a child protection concern with process and outcome explored. Given the prominence of the Viner Framework participants were asked if they were aware of the framework. They were then provided with a hard copy and asked to comment on any perceived strengths and weaknesses. In conclusion the participants were asked to identify what factors or approaches may help them to identify and respond to child protection concerns where obesity may be an issue in the future. The interviews and focus groups were recorded and anonymised and transcribed in full. The

data was stored securely within a protected base in accordance with data protection protocol. Role and profession information was retained for the analysis phase of the research.

Three focus groups were undertaken (Table 2). The focus groups allowed the research questions to be debated by participants and individual ideas and views were challenged and tested through group discussion. Participants shared their professional experiences and case examples which then became the subject of group analysis and discussion. Consequently although guided by a schedule comparative to that used in individual interviews, the focus groups provided different data which both complemented and enriched that obtained from individual interviews.

Interview and focus group schedule

CHILD PROTECTION AND OBESITY

SEMI-STRUCTURED INTERVIEW QUESTIONS AND SCRIPT

Welcome my name is…

The overall aim of the research is to aid the understanding of issues relating to childhood obesity as a potential child protection concern. The aim of this interview is to explore current practice and staff perceptions relating to the subject. The interview will be recorded and transcribed in full. The transcriptions will be anonymised and any data identifying staff or service users will be removed.

The results will be used for dissemination via conferences and research publications and to inform future practice relating to protecting children where childhood obesity may be an issue.

The interview should last no more than an hour.

Here is a copy of the information sheet and if you have no further questions a copy of the consent form for you to sign.

Role

1. What is your current job title?

2. Which agency do you work for?

3. What do you do in your professional role?

Obesity

1. What is your understanding of child obesity?

2. What impact do you think child obesity has on child development?

3. Have you had any training on child obesity?

4. Have you had any involvement in your work with child obesity issues?

- could you tell me about your involvement?

- were other agencies involved and if so what was their involvement?

Child Protection

1. In your opinion should childhood obesity be regarded as a child protection concern? (Objective 2)

-Yes- Please tell me why?

-No-Please tell me why?

2. Could you provide any examples from your current practice where you have identified child protection concerns where childhood obesity may have been a factor? (Objectives 1 and 2)

-What issues triggered you concern/s?

-What action/s did you take?

-What other individuals or agencies did you involve if any and why?

-In your opinion, how effective were the responses and outcomes?

3. Are you aware of the Viner (2010) Framework for Action to Understand Child Protection Concerns for Children who are Obese? (Objective 3)

Yes -No – record awareness

Here is a copy of the framework - What, in your opinion are the strengths and weaknesses of the framework?

4. In your opinion what would help practitioners to identify and respond to child protection concerns where obesity is an issue? (Objective 4)

5. Have you any other comments to make regarding our discussion? (Objectives 1-4)

FOCUS GROUP PROMPTS AND FACILITATOR SCRIPT

Welcome/Introductions, our/my role is to facilitate the group discussion

The overall aim of the research is to aid the understanding of issues relating to childhood obesity as a potential child protection concern. The aim of this focus group is to explore current practice and staff perceptions relating to the subject.

The focus group discussions will be recorded and transcribed in full. The transcriptions will be anonymised and any data identifying staff or service users will be removed

The results will be used for dissemination via conferences and research publications and to inform future practice relating to protecting children where childhood obesity may be an issue.

You were selected because you may have experience of directly working in this area

Please remember: Please could we ensure that only one person is speaking at a time. There are no right or wrong answers, only differing points of view. Although you might not agree with some of the opinions within the group, please listen respectfully and challenge appropriately if needed.

Please address your discussion and comments to other group members rather than the facilitator.

Here is a copy of the information sheet relating to the research - Are there any questions? If there are no more questions could you please sign the consent form before we begin.

FOCUS GROUP PROMPTS

When speaking for the first time it would be useful to state your role.

1. What is your understanding of child obesity?

2. What impact do you think child obesity has on child development?

3. In the groups opinion should childhood obesity be regarded as a child protection concern? (Objective 2)

Please explain why?

4. Could anyone provide examples from their current practice where they have identified child protection concerns where childhood obesity may have been a factor? (Objectives 1 and 2)

-What issues triggered the concern/s?

-What action/s was taken?

-What other individuals or agencies were involved if any and why?

-In your opinion, how effective were the responses and outcomes?

5. Is anyone in the group aware of the Viner (2016) Framework for Action to Understand Child Protection Concerns for Children who are Obese? (Objective 3)

Here is a copy of the framework

What, in your opinion are the strengths and weaknesses of the framework?

6. As a group of practitioners what do you think would help your practice in identifying and responding to child protection concerns where obesity may be an issue? (Objective 4)

7. Have you any other comments to make regarding our discussion? (Objectives 1-4)

Data Analysis

Framework analysis methods were used to generate categories, codes and themes that capture the experiences, views and perceptions of the sample. Framework analysis has emerged from policy research and is a pragmatic and systematic approach to qualitative data analysis (Gale et al 2013, Ritchie and Lewis 2003). It involves a systematic process of sifting, charting and sorting the material into key issues and theme and allows the integration of pre-existing themes such as those that had guided the development of the data collection tools, into the emerging data analysis. Framework analysis has been used and is particularly useful in multi-disciplinary health research teams (Gale et al 2013).

The research was undertaken by a multi-disciplinary team with professional backgrounds in social work and public health and took a collective analysis approach. Alongside coding, analytic memos were created by researchers. These memos followed sub headings: of definition, codes, summary of findings and points for further consideration. Illustrative quotations were identified under each code. At a collective meeting the final analytic framework was agreed and data charted on to a matrix. The matrix was then collectively reviewed, alongside the analytic memos, and subsequent discussion, sought to interpret the data. The intention was to develop themes which offered some explanations for what was being presented in the data. The process was informed by the original research aims alongside concepts generated inductively from the data.

Table 3 Thematic Framework

Categories	Code	Sub Themes
Obesity	Professional understanding of causes, Professional understanding of consequences Personal and professional experiences shape professional response, Assessment and identification Social factors	Parental behaviour Parental skills Physical - short term - long term Psychosocial - short term - long term Assessment - guidelines - awareness training Poverty - culture
Thresholds	Ambiguity Personal Referrer's agency Perceived Actual Legal Multi-agency	Significant harm Child in need
Child Protection	Obesity is not a child protection concern Obesity is a child protection concern Obesity and neglect Intervention levels Prevalence	Universal services Prevention and early help Legal (statutory) intervention
Viner Framework	Awareness Agree Disagree Ambiguous	Knowledge Standalone child protection concern - is - is not
Good Practice	Multi-agency approach Holistic understanding Direct work	Whole family approach

	Parental education Service user involvement Preventative work	
Challenges for Practice	Multi-agency working Lack of support Barriers to accepting support Problematic direct work	Lack of information Non statutory working with agreements Thresholds for multi-agency support Lack of funding Practitioners beliefs about weight Identification
Suggestions for Future	Training Provide guidance, procedures and Framework Outcome research	Practice ideas Dissemination

Case Study

To further illustrate the findings this case study demonstrates how the categories and themes identified in the findings interact together in a specific piece of practical work with service users. As part of the data collection interviewees and focus group participants were asked about current and previous professional experiences of working with families where child obesity was an element in child protection cases. The following case is chosen from the range of experiences shared. The case study is specific to the individual social worker identified and uses the respondent's words to tell the story of how a case progressed under child protection. This is followed by the author's commentary on the case study which moves the findings into a wider discussion.

Case Study

D was a six year old girl weighing 12 stone (76 kilos) and was referred to social care by school nurses. Health visiting services had been monitoring her before she was five at which point she was passed over to the school nursing team. Health visitors had passed on their concerns:

"And they felt that, you know, action had to be taken in regards to not allowing her to put on more weight"

A core assessment was undertaken which identified issues around the parent's understanding of the concerns and their ability to work with services to reduce her weight. A child protection conference took place specifically around the child being obese and overweight. D was placed on a child protection plan for neglect.

"Which was quite interesting because she was sort of, in every other area she was the opposite to being neglected. She was very much the princess of the house, only child. So the parents in their view felt that, you know, she had absolutely everything that she needed and wanted, down to whatever she demanded she got – which was part of the problem, yeah. So they wouldn't accept the concerns at all"

The child gained more weight between the first conference and the three month conference. The lack of engagement led to social services "*going into PLO*" (When social services are very concerned about the welfare of a child, the social worker may wish to consider taking the case to court so they can make orders to protect the child. PLO stands for 'Public Law Outline', a set of rules which tells social workers how to deal with these sorts of cases.) At this stage the family appeared to engage but this was described as tokenistic. Direct

work was undertaken with the child at school and role play in the kitchen area of the classroom indicated

"She would like a big pile of chips and that kind of thing. So that's sort of evidence that they weren't really working with her"

Child D also had dietician and paediatrician appointments. Mum refused to work with the paediatrician because they shared the social work concerns and was *quite stern* around mum and dad needing to take action.

"But the dietician was working with them and (D) started to sort of lose weight very steadily, but the dietician said that she would want her to not lose any more than one to two pound a week. And then mum became very focused on that and was saying, you know, she can't lose weight fast because the dietician has said that she can only lose, and we've said well that's maybe a minimum guide. But she wouldn't have that, it was, you know, that's what they've said and she's not losing any more than that"

The case then became "*a bit stagnant really - she would lose a pound, put another one back on.*" The case is described as "*quite frustrating really because we were in PLO but we weren't going to remove her. We didn't really know where to go with it. Legal were saying, you know, we can't remove her on that base, if we go to court and say we want to remove her, the court isn't going to agree to that …*"

The health service are then seen as retracting their original strong views and not providing evidence of impact

on health that would persuade a court to order the removal of the child:

"Because she was doing things, she was joining in at school. And she was getting out of breath and she couldn't manage things that the other children could manage, but they were saying that she wasn't at a sort of immediate risk in regards to her health and that she could have some longer term issues if she didn't lose weight over time. But they also said, you know, she's going to grow in height and things like that. So it was a bit like we didn't have the evidence to back up the harm really"

The PLO ended and work continued with the family on the basis of a child protection plan. Slow progress was made. Child D attended a local initiative of a before and after school sports club. Intended as a 6-12 week programme this was rolled forward as the child and mother seemed to be engaging. Social services paid for swimming lessons to which mum took her and:

"Parents were told they had to walk to and from school. They were doing that most of the time. Apart from if it was raining because mum then argued that it would cause her a health issue because she'd get a cold"

The potential impact of emotional harm was acknowledged:

"And a lot of work was done with her about how she saw herself, because we wanted to know what impact it was having on her emotionally. But because parents were very nurturing, very loving and things like that, it didn't appear to be having that much of an impact. She would describe herself as beautiful and things like that because that was the message that they were giving to her; whereas, you know, if the parents weren't like that

I think it would've been quite different for her"

The social worker thought that in this case childhood obesity alone is a child protection issue. They were also frustrated by the realities of working with other professions.

"I mean that one was really frustrating because we didn't, even though the initial concerns were health and they were sort of jumping up and down saying you need to do something with this child, they didn't then help us with the evidence to prove that it was harm…But I suppose it's where their thresholds lie as well."

Author Commentary

- The case demonstrates the 'messiness' of practice and the frustrations of working with parents who are seen as not engaging. Direct work is required with the child and family but working from within a child protection framework is not a panacea for success.
- Initial concerns were highlighted by health services and pressure for action was applied by health services but evidence to prove that the harm to the child and the causal link with obesity constituted significant harm was seen by the social workers as not forthcoming from health services.
- In this case the concept of threshold impacted on the case, not on initial referral by health services or on progression from assessment to child protection plan to proposed legal proceedings by social workers, but as regards to the assumed threshold for the court to take action on the part of local authority solicitors and in the changing judgement of health care professionals as the case progressed.

- There is an agreement between health and social care professionals that the child's health and wellbeing is impaired as a result of her obesity but an apparent lack of congruence in respect of threshold judgments as to whether the impairment constitutes significant harm.