

## STUDENT WORKS

### CHILDHOOD OBESITY AND STATE INTERVENTION: A CALL TO ORDER!

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*“[M]ankind owes to the child the best it has to give.”*<sup>1</sup>

#### I. INTRODUCTION

##### A. Please Meet Jane

The teacher wrote the day’s journal assignment on the blackboard: “Write a paragraph about yourself; make sure to use descriptive adjectives.” That night, while grading the journal entries, the teacher found one that stood out from the rest:

My name is Jane, but kids do not call me by my name. They call me fatso, hippo, piggy-wiggy, blimp, heifer, and two-ton. Mostly, they whisper in front of me and laugh at me. I do not have any friends. I’m embarrassed to go to school or to even be seen in public. That is why I’m absent from school a lot. I want to find a hiding place and never come out. I don’t have any brothers or sisters. I love my mom and dad more than anything else. I guess my best friend is my dog, Snowball. I love her too. She is the only one that sees me cry. I feel like crying all day, every day. I wish that I were not overweight. I weigh 200 pounds. Mom and Dad are overweight too. All of

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1. Declaration of the Rights of the Child, UN, GA Res. 1386 (XIV) (1959).

us are trying very hard to lose weight. If I don't lose weight, I will be taken away from Mom, Dad, and Snowball. I'm so scared. The more I try to lose weight, the more I seem to gain. I don't know what to do. Mom and Dad are scared too. They try not to show it, but I can tell by their faces that they are scared. Every night I hug Snowball, close my eyes, and pray that everything will be alright.

Jane's journal entry brought the teacher to tears.<sup>2</sup> The next day, Jane did not attend school, and the principal delivered sad news. Jane would not be returning to school. The State had removed Jane from her home and placed her in a foster home that was located in another school district. The reality of the situation left the teacher grief-stricken. How could the child welfare system tear a child away from her home and loved ones? How could this be considered a rational and healthy solution to childhood obesity? One thought remained prominently in the forefront of the teacher's mind. There must be a better solution.

### B. A Call to Order

There is a better solution. In childhood-obesity cases that require government intervention, states must take action to prevent the removal of children from their families and homes.<sup>3</sup> This Article proposes a specific course of action by which states can effectively answer this call to order.

First, states should fund the development of mental-health counseling programs that utilize a family-systems approach and target neglect generally and childhood obesity specifically.<sup>4</sup>

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2. Jane is a fictitious character whom the Author created for purposes of introducing the reader to state intervention in cases of childhood obesity.

3. *Infra* pt. III (summarizing the legal framework for the concept of state intervention in cases of childhood obesity).

4. The development of mental-health counseling programs that utilize a family-systems approach would fall under the umbrella of family-preservation services and, therefore, would help states to comply with the reasonable-efforts requirement of the Adoption Assistance and Child Welfare Act (AACWA). Susan L. Brooks, *A Family Systems Paradigm for Legal Decision Making Affecting Child Custody*, 6 Cornell J.L. & Pub. Policy 1, 8–9 (1996); see *infra* nn. 65–69 and accompanying text (discussing the AACWA's reasonable-efforts requirement and the emergence of family-preservation services). Importantly, support exists for including mental-health counseling as a form of family-preservation services. K. Edward Greene, *Mental Health Care for Children: Before and During State Custody*, 13 Campbell L. Rev. 1, 31 (Winter 1990).

Second, states should mandate family-systems therapy for the entire nuclear family<sup>5</sup> in cases involving childhood obesity.<sup>6</sup>

Third, states should mandate the assignment of a Parent Coordinator to cases involving childhood obesity. The Parent Coordinator's responsibilities should include the following:

- researching available family-preservation services;
- maintaining readily available information on these services;
- providing information on these services to interested parties;
- gathering interested party input regarding choice-of-service provisions;
- offering opinions on the services to be included in parenting plans;
- documenting services to be utilized by the parents/child;
- providing follow-up on the utilization of services by the parents/child;
- promoting service utilization by the parents/child; and
- reporting on service utilization to all interested parties.<sup>7</sup>

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5. For purposes of this Article, "nuclear family" refers to the obese child's caregiver(s).

6. The family-systems approach to mental-health counseling emerged during the second half of the twentieth century and correlated with a shift in paradigm "from an 'individual' orientation to a 'systems' orientation. . . . Family systems theory has influenced mental health scholars and practitioners throughout [the United States]." Brooks, *supra* n. 4, at 3.

7. Many judicial circuits in Florida utilize Parent Coordinators in dissolution cases. Fla. Sen., Interim Project Rpt. 2005-145, Comm. on Jud., *Parenting Coordinators and Domestic Violence 2* (Nov. 2004) (available at [http://www.flsenate.gov/data/Publications/2005/Senate/reports/interim\\_reports/pdf/2005-145ju.pdf](http://www.flsenate.gov/data/Publications/2005/Senate/reports/interim_reports/pdf/2005-145ju.pdf)). In addition to Florida, other states are utilizing Parent Coordinators. *Id.* at 4. As of November 2004, these states included Oregon, Idaho, Oklahoma, Arizona, California, Kentucky, Massachusetts, North Carolina, Ohio, and Vermont. *Id.* The Association of Family and Conciliation Courts (AFCC) held its 44th Annual Conference entitled *Children of Separation and Divorce: The*

Fourth, states should both empower their courts to order mediation in cases that involve neglect and mandate their courts to order mediation in childhood-obesity cases.<sup>8</sup>

### C. Charting the Specific Course of Action

The remainder of this Article provides the detailed information that is necessary for a thorough understanding of the proposed four-step course of action. Part II describes the problem of childhood obesity, including the associated causal factors and the current use of ineffective remedies. Part III summarizes the legal framework for the concept of state intervention in cases of childhood obesity. Part IV argues that the current approach to state intervention in cases of childhood obesity is both deficient and damaging. Part V proposes a better approach to state intervention in cases of childhood obesity and offers the rationale that supports such a method. Part VI explains how to implement the new approach to state intervention in cases of childhood obesity. Part VII concludes with some final thoughts on childhood obesity and the states' Call to Order.

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*Politics of Policy, Practice, and Parenting* in Washington, D.C. from May 30, 2007 to June 2, 2007. *Annual Conference Program* vol. 44, No.1 (AFCC 2007) (available at <http://www.afccnet.org/pdfs/2007%20AFCC%Washington%20DC%20Program.pdf>). "AFCC is an interdisciplinary and international association of professionals dedicated to improving the lives of children and families through the resolution of family conflict." *Id.* at Cover. One of the Pre-Conference Institutes as well as several Conference Workshops addressed Parent Coordination. *Id.* at 4, 8, 10, 12. This Article advocates for the expansion of the Parent Coordinator's role and the utilization of Parent Coordinators in cases of childhood obesity. *Infra* pt. V(C).

8. New York State passed legislation that allows judges to order mediation in cases of neglect. N.Y. Fam. Ct. Act § 1018 (McKinney Supp. 2008). The New York Society for the Prevention of Cruelty to Children (NYSPPC) has partnered with the New York City Family Court, the New York State Unified Court System, and the New York State Office of Children and Family Services to provide the Permanency Mediation Program for use during the permanency phase of child abuse and neglect cases. NYSPCC, *Programs*, [http://www.nyspcc.org/programs/index\\_programs.htm](http://www.nyspcc.org/programs/index_programs.htm), *select* Child Permanency Mediation (accessed Dec. 3, 2008). The goal of the Permanency Mediation Program is to prevent extended litigation and limit the child's stay in foster care through the use of mediation, a form of alternative dispute resolution (ADR), so that all interested parties can effectively and efficiently come to an agreement about whether the child should return to her family or undergo adoption. *Id.* Interested parties include but are not limited to parents, family members, and social service agencies. *Id.* This Article advocates use of mediation in childhood-obesity cases at the beginning of neglect proceedings and with additional interested party involvement to include a Parent Coordinator. *Infra* pt. V(C) and pt. V(D). Notably, NYSPCC, founded in 1875, "was the first child protective agency in the world." NYSPCC, *History*, [http://www.nyspcc.org/beta\\_history/index\\_history.htm](http://www.nyspcc.org/beta_history/index_history.htm) (accessed Dec. 6, 2008).

## II. OBESITY: PROBLEM, CAUSE, INEFFECTIVE REMEDIES

### A. Obesity: The Prevalence

The prevalence of adult obesity in the United States doubled from 1980 to 2002.<sup>9</sup> The results of a recent study indicate that the adult prevalence of obesity was at 32.2% in 2003–2004.<sup>10</sup> Additionally, the prevalence of obesity in men increased from 27.5% in 1999–2000 to 31.1% in 2003–2004, whereas obesity in women remained about the same with only a slight decrease from 33.4% in 1999–2000 to 33.2% in 2003–2004.<sup>11</sup> Further, this study revealed differences in the prevalence of adult obesity across three age ranges: 28.5% of the twenty to thirty-nine-year-old participants were obese compared to 36.8% of the forty to fifty-nine-year-old participants and 31.0% of the sixty-year-old or older participants.<sup>12</sup>

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9. Cynthia L. Ogden, Margaret D. Carroll, Lester R. Curtin, Margaret A. McDowell, Carolyn J. Tabak & Katherine M. Flegal, *Prevalence of Overweight and Obesity in the United States, 1999–2004*, 295 JAMA 1549, 1549 (2006). The term “adult” referred to people who were twenty years of age or older. *Id.*

10. *Id.* The study utilized the National Health and Nutrition Examination Survey (NHANES), which is comprised of data gathered from “a complex, multistage probability sample of the US civilian, noninstitutionalized population.” *Id.* Researchers gathered data during 1999–2000, 2001–2002, and 2003–2004. *Id.* Specifically, the survey participants underwent physical examinations that measured height and weight. *Id.* Thereafter, the researchers calculated Body Mass Index (BMI) by dividing the participant’s weight in kilograms by the square of her height in meters and rounding this quotient to the nearest tenth. *Id.* The study compared the BMI percentages from 1999–2000 and 2001–2002, with those from 2003–2004. *Id.*

11. *Id.*

12. *Id.*

Sadly, the prevalence of overweight<sup>13</sup> children and adolescents in the United States tripled from 1980 to 2002. Study results indicate that the prevalence of overweight children and adolescents was 17.1% in 2003–2004.<sup>14</sup> Significantly, the prevalence of overweight children and adolescents increased across the sexes from 1999–2000 to 2003–2004. Overweight female children and adolescents increased from 13.8% to 16.0%, and overweight male children and adolescents increased from 14.0% to 18.2%.<sup>15</sup>

### B. Obesity: A Problem

The scientific data on prevalence substantiates the media's recent focus on obesity. Whether watching television, reading the newspaper, surfing the internet, or listening to the radio, a person will come across media coverage of obesity.<sup>16</sup> Also, whether or not

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13. The scientific community in the United States uses the term “overweight” instead of “obese” when referring to the childhood and adolescent population. P.K. Newby, *Are Dietary Intakes and Eating Behaviors Related to Childhood Obesity? A Comprehensive Review of the Evidence*, 35 J.L., Med. & Ethics 35, 35 n. 1 (Spring 2007). Aside from the use of the term “overweight” in Part II(A) of this Article, the Author utilizes the term “obese” when referring to the childhood and adolescent population. The Centers for Disease Control and Prevention (CDC) utilizes weight status categories to interpret BMI for adults as well as for children and adolescents. CDC, *BMI—Body Mass Index*, <http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm> (last updated June 20, 2008). The adult weight-status categories include Underweight, Normal, Overweight, and Obese, whereas the children and adolescent weight-status categories include Underweight, Healthy Weight, At Risk of Overweight, and Overweight. *Id.* at *select* About BMI for Adults, *select* About BMI for Children and Teens. BMI is calculated the same for adults as it is for children and adolescents. *Id.* at *select* About BMI for Children and Teens. However, the weight-status categories for children and adolescents are age and sex specific as compared to the adult weight-status categories, which are the same across age and sex. *Id.* The CDC considers a child and/or adolescent overweight if her BMI falls at or above the 95th percentile. *Id.*

14. Ogden, Carroll, Curtin, McDowell, Tabak & Flegal, *supra* n. 9, at 1549. The category of children and adolescents referred to people who were between two and nineteen years of age. *Id.* The researchers used the NHANES instrument and BMI calculation in studying the children and adolescent population. *Id.*; *supra* n. 10 (explaining the NHANES instrument and BMI calculation).

15. Ogden, Carroll, Curtin, McDowell, Tabak & Flegal, *supra* n. 9, at 1549.

16. See Rehema Ellis, MSNBC, *Nightly News*, <http://www.msnbc.msn.com/id/17951505/> (last updated Apr. 5, 2007) (reporting that childhood obesity has reached unprecedented levels with “[a] third of America’s 74 million children [being] considered dangerously overweight or obese” and characterizing childhood obesity as “a public health problem of epidemic proportions”); Merrill Lynch & Thomson Financial, *Fat Profits from Fighting Obesity*, *Buff. Evening News D8* (June 8, 2007) (reporting that 400 million people are obese worldwide and that, in 1998, obesity related expenditures totaled 47.5 billion dollars and obesity accounted for 5.5% of total healthcare spending); Natl. Pub. Radio, *Surgeon General Nominee Vows to Uphold Science* (July 12, 2007) (radio broadcast) (avail-

the media coverage specifically characterizes obesity as a problem, the person will likely conclude for herself that obesity is a problem in today's society.

While people may indeed conclude that childhood obesity is a problem, the conclusion, without more, lacks substance. Substance for the conclusion rests in the numerous consequences that result from being obese. Obese children face immediate and long-lasting health effects that are not only physical but also psychosocial in nature.<sup>17</sup> A plethora of physical risks is associated with childhood obesity and includes but is not limited to high cholesterol, high blood pressure, type-two diabetes, cancer, orthopedic problems,<sup>18</sup> abnormal glucose tolerance, asthma, hepatic steatosis (fatty degeneration of the liver), and sleep apnea.<sup>19</sup> Obese children must also deal with debilitating psychosocial risks: “[t]he most immediate consequence of children being overweight is how they perceive themselves and the fear and reality of the social discrimination that they will encounter.”<sup>20</sup> In addition to obesity, these children may also suffer from low self-esteem, depression, anxiety, and obsessive-compulsive disorder (OCD).<sup>21</sup> The multitude of physical and psychosocial risks facing obese children not

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able at <http://www.npr.org/templates/story/story.php?storyId=11926702> (reporting that the presidential nominee for surgeon general, Dr. James Holsinger, Jr., “pushed” childhood obesity as one of his agenda points before a Senate committee on Thursday, July 12, 2007).

17. Newby, *supra* n. 13, at 35. Newby notes that there is a correlation between being obese as a child and being obese as an adolescent and as an adult. *Id.*

18. Lisa Smith & Bryan A. Liang, *Childhood Obesity: A Public Health Problem Requiring A Policy Solution*, 9 *J. Med. & L.* 37, 45 (Winter 2005).

19. CDC, *Overweight and Obesity, Childhood Overweight, Consequences*, <http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/consequences.htm> (last updated Nov. 25, 2008). Note that high cholesterol, high blood pressure, and abnormal glucose tolerance are considered risk factors associated with cardiovascular disease (CVD). *Id.* A CDC “study found that obesity caused 400,000 deaths in 2000, which was an astounding 33 percent increase from the year 1990. More dramatically, these numbers narrow the gap tremendously between the number of deaths caused by obesity and the 435,000 deaths in 2000 that were due to tobacco use, which had less than a 9 percent increase since 1990.” Smith & Liang, *supra* n. 18, at 38.

20. Smith & Liang, *supra* n. 18, at 45; see Elizabeth E. Theran, “Free to Be Arbitrary and . . . Capricious”: *Weight-Based Discrimination and the Logic of American Antidiscrimination Law*, 11 *Cornell J.L. & Pub. Policy* 113, 170–171 (Fall 2001) (arguing that antidiscrimination law in the United States fails to protect against weight-based discrimination and, as illustration of this failure to protect, pointing to the fact that “childhood obesity is sometimes viewed as per se evidence of poor or neglectful parenting, and it has been used to remove children from their parents’ custody or to subject some aspect of their lives to ongoing control by a court or agency”).

21. Smith & Liang, *supra* n. 18, at 45.

only justifies the conclusion that childhood obesity is a problem, but also justifies the characterization of childhood obesity as an epidemic.<sup>22</sup>

### C. Obesity: Causal Factor(s)

Society seeks solutions to problems, and in the quest for solutions, it devotes time and energy to causation. This focus on causation is understandable because causation provides the insight necessary to solve problems. Therefore, unsurprisingly, society has devoted time and energy in an attempt to identify the cause of childhood obesity.<sup>23</sup>

On a basic scientific level, the cause of obesity is straightforward. Obesity is caused by an imbalance between the body's caloric intake and energy output.<sup>24</sup> Specifically, caloric intake exceeds energy output.<sup>25</sup> Importantly though, at the complex and interdisciplinary level, childhood obesity can result from a multitude of causal factors.<sup>26</sup> Just as important, "these factors are not mutually exclusive and may be combined to result in a likelihood and manifestation of obesity."<sup>27</sup>

Nevertheless, the multitude of causal factors can be placed into one of three categories—genetic, behavioral, or environmental.<sup>28</sup> The interplay between the various causal factors holds the explanation for why only certain people become obese.<sup>29</sup> A group of expert psychologists noted:

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22. Marlene B. Schwartz & Kelly D. Brownell, *Actions Necessary to Prevent Childhood Obesity: Creating the Climate for Change*, 35 J.L., Med. & Ethics 78, 78 (Spring 2007). Society also uses the terms "crisis" and "emergency" to characterize the problem of childhood obesity and the phrase "war on obesity" to characterize the efforts that are aimed at remedying the problem. *Id.*

23. Jess Alderman, Jason A. Smith, Ellen J. Fried & Richard A. Daynard, *Application of Law to the Childhood Obesity Epidemic*, 35 J.L., Med. & Ethics 90, 91 (Spring 2007).

24. *Id.*; Smith & Liang, *supra* n. 18, at 39; Newby, *supra* n. 13, at 35–36.

25. Smith & Liang, *supra* n. 18, at 39.

26. Alderman, Smith, Fried & Daynard, *supra* n. 23, at 91. Alderman, Smith, Fried, and Daynard explain that "[o]besity is not a simple disease relying on traditional models, where a particular agent causes a disease or condition. . . . The notion of a direct relationship between a potential cause and an illness made it difficult to understand or to control effectively complex diseases and illnesses that were not associated with a singular proximate cause." *Id.*

27. Smith & Liang, *supra* n. 18, at 41.

28. Adam Benforado, Jon Hanson & David Yosifon, *Broken Scales: Obesity and Justice in America*, 53 Emory L.J. 1645, 1652 (Fall 2004).

29. Alderman, Smith, Fried & Daynard, *supra* n. 23, at 91; see also Newby, *supra*



Only recently have scientists begun to sort through the genetic, behavioral, and environmental factors that have a direct impact on body weight. Although the evidence remains hotly contested, especially by fast food companies facing potential tort liability, the emerging consensus among public health experts is that obesity is largely a product of a “toxic environment.”<sup>30</sup> As our diet has been taken over by high-calorie, low-nutrition foods and mega servings, we have also become increasingly sedentary with greater reliance on the car, less time for exercise, and more of our day in front of televisions and computers.<sup>31</sup>

Because the debate about obesity’s cause will undoubtedly continue into the future, society must fashion and implement remedies for the epidemic of obesity.<sup>32</sup>

#### D. Obesity: Individualistic Remedies

Currently, remedies for childhood obesity are fashioned on an individualistic model that focuses on the child.<sup>33</sup> These remedies are usually implemented via school-based interventions<sup>34</sup> or individual-based counseling.<sup>35</sup> Additionally, individual-based counsel-

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n. 13, at 35 (noting that the rapid rise in percentages of obese children suggests that environmental causal factors outweigh genetic causal factors).

30. Benforado, Hanson & Yosifon, *supra* n. 28, at 1652 n. 12 (citing E. Katherine Battle & Kelly D. Brownell, *Confronting a Rising Tide of Eating Disorders and Obesity: Treatment vs. Prevention and Policy*, 21 *Addictive Behaviors* 755, 761–763 (1996)); see also Schwartz & Brownell, *supra* n. 22, at 79 (using the concept of “toxic environment” to frame the issue of obesity).

31. Benforado, Hanson & Yosifon, *supra* n. 28, at 1652.

32. *Id.* at 1652–1653. Benforado, Hanson, and Yosifon suggest that while causal research is important, it “seems to miss something central about why we are fat and why it is so appealing and so commonsensical to blame the ‘lard asses’ for their condition.” *Id.* at 1652. They argue that society is using “broken scales” in its effort “to infer causation and assign responsibility.” *Id.* Rather than blaming a person’s obesity on personal choice, they urge society to start looking at the environment in which the obese person finds herself. *Id.* at 1653. Importantly, they conclude that “[i]f we are calibrating our prescription devices based on incorrect measurements, we have little hope of solving the obesity epidemic.” *Id.*

33. Schwartz & Brownell, *supra* n. 22, at 79. Schwartz and Brownell note that society’s remedy for obesity is fashioned upon the assumption that obesity is caused by a personal failure to make responsible choices and, therefore, focuses on the individual. *Id.* at 79. Interestingly, this assumption favors behavioral-type causal factors. *Supra* pt. II(C).

34. Karen E. Peterson & Mary Kay Fox, *Addressing the Epidemic of Childhood Obesity through School-Based Interventions: What Has Been Done and Where Do We Go from Here?* 35 *J.L., Med. & Ethics* 113, 113 (Spring 2007).

35. Robert I. Berkowitz, Thomas A. Wadden, Andrew M. Tershakovec & Joanna L.

ing generally consists of some combination of caloric restriction, exercise promotion, and behavior therapy.<sup>36</sup>

Schools offer a powerful forum in which to implement childhood-obesity remedies because they have “continuous and intensive contact with children during their first two decades of life.”<sup>37</sup> Current school-based programs include nutritional education and physical activity, which have been statistically shown to correlate with decreases in children’s body mass index (BMI).<sup>38</sup> Nevertheless, the population of obese children has continued to rise over the last decade.<sup>39</sup>

Nutritional counseling provides the obese child with advice about food choices.<sup>40</sup> The nutritional counselor advocates a high-nutrient and low-energy dense diet that incorporates only necessary amounts of appropriate high-energy dense fat.<sup>41</sup> This type of diet includes seafood, dairy, fruits, vegetables, olive oil, and nuts.<sup>42</sup> Unfortunately, eating healthy can be an expensive endeavor that simply may not be affordable for everyone.<sup>43</sup>

Behavior therapy aims to modify the eating behaviors of the obese child through self-monitoring, nutritional education, stimulus control, physical activity, reinforcements, and rewards.<sup>44</sup> And while behavior therapy is the favored treatment approach for childhood obesity, little research has been conducted on its effectiveness.<sup>45</sup> Amidst this limited research, studies have revealed that behavior therapy, as applied to obese adolescents, has poor outcomes. Participants generally remain obese by the conclusion

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Cronquist, *Behavior Therapy and Sibutramine for the Treatment of Adolescent Obesity, A Randomized Controlled Trial*, 289 JAMA 1805, 1805 (2003); Angela Fowler-Brown & Leila C. Kahwati, *Prevention and Treatment of Overweight in Children and Adolescents*, 69 Am. Fam. Phys. 2591, 2594–2597 (2004); Rebecca Moran, *Evaluation and Treatment of Childhood Obesity*, 59 Am. Fam. Phys. 861, 861–877 (1999); Newby, *supra* n. 13, at 36, 52.

36. Fowler-Brown & Kahwati, *supra* n. 35, at 2594.

37. Peterson & Fox, *supra* n. 34, at 113.

38. *Id.* at 114–115.

39. *Supra* pt. II(A).

40. Newby, *supra* n. 13, at 52.

41. *Id.*

42. *Id.*

43. *Id.* Newby notes that nutritional counseling raises ethical issues since not all people can afford to purchase the recommended foods. *Id.* Further, she suggests that the nutritional advice “may even be considered elitist.” *Id.*

44. Moran, *supra* n. 35, at 861–877.

45. Berkowitz, Wadden, Tershakovec & Cronquist, *supra* n. 35, at 1805; Fowler-Brown & Kahwati, *supra* n. 35, at 2594.

of therapy, with decreases in weight of only one to four kilograms.<sup>46</sup>

### E. Obesity: The Failure of Individualistic Remedies

Society's perception about the cause of obesity is what determines its views towards obese children and obesity remedies.<sup>47</sup> Importantly, any disparity between the perceived and actual cause can lead to weight bias and ineffective remedies.<sup>48</sup> The current perception of cause is based on the idea of personal responsibility, and this perception has resulted in remedies that are individualistically modeled to focus on the obese child.<sup>49</sup> However, as discussed earlier, childhood obesity results from the complex interaction of a multitude of causal factors.<sup>50</sup> Clearly, there exists a disparity between society's perceived cause and the actual cause. This disparity assists in explaining why current remedies have failed to effectively address the epidemic of childhood obesity.<sup>51</sup> Individualistic remedies must give way to systemic remedies.

## III. THE ROAD TO STATE INTERVENTION

### A. Constitutionality

The failure to remedy the epidemic of childhood obesity through interventions such as school-based programs, nutritional counseling, and behavior therapy can result in a drastic form of intervention—state intervention.<sup>52</sup> State intervention in childhood-obesity cases is a controversial topic because it necessarily implicates parents' fundamental liberty interest; parents have a general right to raise their children free from interference.<sup>53</sup> Nev-

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46. Berkowitz, Wadden, Tershakovec & Cronquist, *supra* n. 35, at 1805.

47. Schwartz & Brownell, *supra* n. 22, at 79.

48. *Id.*

49. *Id.*; *supra* nn. 32–33.

50. *Supra* pt. II(C).

51. *Supra* pt. II(D).

52. Shireen Arani, *State Intervention in Cases of Obesity-Related Medical Neglect*, 82 B.U. L. Rev. 875, 875–876, 879 (2002). Arani describes how state officials from New Mexico removed a morbidly obese three-year-old child from her home. *Id.*

53. *Id.*; James A. Cosby, *How Parents and Children 'Disappear' in Our Courts—And Why It Need Not Ever Happen Again*, 53 Clev. St. L. Rev. 285, 287–288 (2005–2006); James A. Cosby, *Re-examining the Parent-Child-State Relationship*, 11 Kan. J.L. & Pub. Policy 723, 723 (2002).

ertheless, state intervention is permissible when it is necessary to protect the physical and emotional health of a child.<sup>54</sup> Because obesity threatens the physical and emotional health of children,<sup>55</sup> states must determine when and how to intervene. However, “current jurisprudence limits intervention to situations where there is a compelling interest in preventing harm to the child.”<sup>56</sup> In cases of morbid childhood obesity, there is clearly such a compelling interest because the “child’s life is in imminent danger.”<sup>57</sup> Less clear are cases of childhood obesity where the obese child would benefit from intervention but whose life is not in imminent danger. In those cases, perhaps intervention could prolong the child’s longevity or improve the child’s quality of life.<sup>58</sup>

### B. The Means—Neglect Statutes—The Carrot-and-Stick Approach

Neglect statutes prescribe how and when the state can intervene in cases of childhood obesity.<sup>59</sup> Most states’ neglect statutes allow for intervention that includes removal from the home where the parents have failed to provide the child with a “necessary” level of care.<sup>60</sup> This “necessary” level of care requires that parents

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54. Arani, *supra* n. 52, at 876, 879.

55. *Supra* pt. II(B).

56. Arani, *supra* n. 52, at 881.

57. *Id.* at 893; *see supra* pt. II(B) (discussing the grave consequences of morbid childhood obesity).

58. Arani, *supra* n. 52, at 893. Arani explores the difficulties inherent to state intervention in cases of childhood obesity. *Id.* at 887–894. She advocates for a case-by-case determination of the nature of the child’s obesity where the treatment that will result from state intervention is categorized as “life-saving,’ ‘life-prolonging,’ and ‘quality-of-life enhancing.’” *Id.* at 887. She argues that this categorization is not a clear-cut process and can only be done by looking at case-specific facts. *Id.* at 888. However, she adamantly states that genetics should not be considered in determining whether to intervene in cases of childhood obesity. *Id.* at 891, 893. Ultimately, she concludes that state intervention holds strong justification only where the resulting treatment is to save the child’s life or help the child lead a normal life. *Id.* at 893.

59. *Id.* at 876.

60. *Id.* at 882. Iowa, Kentucky, New Mexico, Pennsylvania, and Texas have utilized their neglect statutes to remove morbidly obese children from the home. *In re L.T.*, 494 N.W.2d 450 (Iowa App. 1992) (affirming the trial court’s placement of the obese child in the custody of the department of human services); *A.U. v. Commonwealth*, 2006 WL 203538 (Ky. App. Jan. 27, 2006) (affirming the Jefferson Family Court’s order that terminated the parents’ rights to the obese child and transferred the child’s custody to the Cabinet for Health and Family Services); *In re D.K.*, 58 Pa. D. & C.4th 353 (Pa. Com. Pl. 2002) (finding that the parent did not provide proper care for the obese child and placing custody

act in a manner that fosters their child's well-being. Parents must act in a manner that promotes the physical as well as emotional health of their child.<sup>61</sup>

While states are responsible for providing child welfare services, the federal government makes funds available to states for child welfare, foster care, and adoption through the Social Secu-

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of the child with the Northumberland County Children and Youth Services); *In re G.C.*, 66 S.W.3d 517 (Tex. App. Forth Worth Dist. 2002) (affirming the Parker County Court at Law's order that terminated the parent's rights to the obese child); Arani, *supra* n. 52, at 877–878 (discussing the New Mexico Children, Youth, and Families Department's removal of an obese child from her parents' custody and the court's subsequent order that the child remain in foster care). Also, recent caselaw in New York illustrates an attempt to use New York's neglect statute similarly. *In re Brittany T.*, 835 N.Y.S.2d 829 (N.Y. Fam. Ct. 2007) (finding the parents in willful violation of a dispositional order and placing the obese child in the custody of the Chemung County Department of Social Services), *rev'd*, 852 N.Y.S.2d 475 (N.Y. App. Div. 3d Dept. 2008) (finding that the Chemung County Family Court erred by finding the parents in willful violation because the Chemung County Department of Social Services did not establish willful violation by clear and convincing evidence).

61. Arani, *supra* n. 52, at 876; see Iowa Code § 232.2(6)(e), (g) (2006) (defining a “child in need of assistance” to mean “an unmarried child . . . [w]ho is in need of medical treatment to cure, alleviate, or prevent serious physical injury or illness and whose parent, guardian, or custodian is unwilling or unable to provide such treatment . . . [w]hose parent, guardian or custodian fails to exercise a minimal degree of care in supplying the child with adequate food, clothing or shelter and refuses other means made available to provide such essentials”); Ky. Rev. Stat. Ann. § 600.020(1)(h) (West 2006) (defining “neglected child” to mean “a child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child . . . [d]oes not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being”); N.M. Stat. § 32A-4-2(E)(2) (2006) (defining “neglected child” to mean a child . . . “who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of the faults or habits of the child's parent, guardian or custodian or the failure or refusal of the parent, guardian, or custodian, when able to do so, to provide them”); N.Y. Fam. Ct. Act Law § 1012(f) (McKinney 2006) (defining “[n]eglected child” as “a child less than eighteen years of age (i) whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent . . . to exercise a minimum degree of care (A) in supplying the child with . . . education . . . or medical . . . care, though financially able to do so or offered financial or other reasonable means to do so”); 23 Pa. Consol. Stat. Ann. § 6303(b)(1)(iv) (2006) (defining “child abuse” to include “[s]erious physical neglect by a perpetrator constituting prolonged or repeated lack of supervision or the failure to provide essentials of life, including adequate medical care, which endangers a child's life or development or impairs the child's functioning”); Tex. Fam. Code Ann. § 261.001(4) (2006) (defining “[n]eglect” to include: “(ii) failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child; (iii) the failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability unless relief services had been offered and refused”).

urity Act.<sup>62</sup> In order to receive these federal funds, states must comply with specific requirements and guidelines.<sup>63</sup> Therefore, state legislation (i.e. neglect statutes), regulations, and policy not only reflect compliance with federal requirements and guidelines, but also share similarities with other states' legislation, regulations, and policy.<sup>64</sup>

Prior to 1980, state legislatures and social-service agencies most often responded to cases of child abuse and neglect by removing the children from their homes.<sup>65</sup> However, Congress enacted the Adoption Assistance and Child Welfare Act (AACWA) in 1980, which amended the Social Security Act and provided that state social-service agencies must "make 'reasonable efforts' to maintain a child with her family or, if removal is necessary, to return the child safely to the family or arrange another permanent home."<sup>66</sup> Despite this "reasonable efforts" requirement, states have been slow to move away from the removal-based standard that is grounded in a rescue philosophy.<sup>67</sup> The idea of reasonable efforts is a cornerstone tenet of a philosophy known as family preservation.<sup>68</sup> Therefore, "reasonable efforts" gave birth to family-preservation services that are aimed at assisting at-risk families so that the children can remain safely in the home.<sup>69</sup>

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62. 42 U.S.C. §§ 601–679 (2006); Child Welfare Information Gateway, *Major Federal Legislation Concerned with Child Protection, Child Welfare, and Adoption 2*, <http://www.childwelfare.gov/pubs/otherpubs/majorfedlegis.cfm> (last updated Nov. 14, 2008). These funds are provided under Title IV-B Child Welfare Services and Promoting Safe and Stable Families (previously titled Family Preservation), Title IV-E Foster Care Program, Title IV-E Adoption Assistance Program, Title IV-E Foster Care Independence Program, and Title XX Social Services Block Grant (SSBG) Program. *Id.*

63. *Id.*

64. *Id.*

65. Margaret Beyer, *Too Little, Too Late: Designing Family Support to Succeed*, 22 N.Y.U. Rev. L. & Soc. Change 311, 311 (1996).

66. *Id.* at 311–312 (quoting Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (1980)). The AACWA amended Title IV-B and Title IV-A of the Social Security Act. Child Welfare Information Gateway, *supra* n. 62, n. 1.

67. Beyer, *supra* n. 65, at 313. Beyer argues that "the needs of many children are best served when they are permitted to remain with their families." *Id.* at 311.

68. *Id.* at 313.

69. Jeanine L. English & Michael R. Tritz, *In Support of the Family: Family Preservation as an Alternative to Foster Care*, 4 Stan. L. & Policy Rev. 183, 188 (Winter 1992/1993). English and Tritz argue that family preservation is an effective alternative to removing children from their homes because it "remove[s] the problems from the homes" while, at the same time, supporting the family. *Id.* at 183, 189.

Once a state has received federal funds, the federal government continues to assert influence through Child and Family Services Reviews (CFSRs).<sup>70</sup> The federal government utilizes CFSRs to review states' child welfare performance, and the review covers performance within both the executive and judicial branches of state government.<sup>71</sup> Program Improvement Plans (PIPs) are the end product of CFSRs and include steps that states must take to improve their child-welfare performance.<sup>72</sup>

While the federal government utilizes CFSRs to assist states in implementing their child-welfare services, it utilizes the Court Improvement Program (CIP) to improve state court proceedings in abuse and neglect cases.<sup>73</sup> Title IV-B of the Social Security Act provides funds for CIP in the form of grants, and these grants are given to and distributed by the highest court in each state.<sup>74</sup> The amount of an individual state grant begins at \$85,000 and is de-

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70. Mark Hardin, *Court Improvement for Child Abuse and Neglect Litigation: What Next?* 6 (ABA 2003) (available at [http://www.abanet.org/child/rcj/cj\\_article.pdf](http://www.abanet.org/child/rcj/cj_article.pdf)) (accessed Dec. 6, 2008) [hereinafter Hardin, *Court Improvement*]; Mark Hardin, *Child and Family Services Reviews (CFSRs): How Judges, Court Administrators, and Attorneys Should Be Involved* 1 (ABA 2002) (available at <http://www.abanet.org/child/rcj/cfsr1.pdf>) (accessed Dec. 6, 2008) [hereinafter Hardin, *CFSRs*].

71. Hardin, *Court Improvement*, *supra* n. 70, at 6. Three questions drive CFSRs: "(1) whether the state is adequately keeping abused and neglected children safe, (2) whether the state is achieving timely permanency for foster children, and (3) whether the state is maintaining the well being of children in foster care." Hardin, *CFSRs*, *supra* n. 70, at 2. Quantitative and qualitative measures, including "statistical analysis, case file review, individual and group interviews, and the examination of state policies," gauge seven outcomes that fall under one of the three driving questions:

*Safety* 1. Children are, first and foremost, protected from abuse and neglect. 2. Children are safely maintained in their homes whenever possible and appropriate. *Permanency* 3. Children have permanency and stability in their living situations. 4. The continuity of family relationships is preserved for children. *Well-Being* 5. Families have enhanced capacity to provide for their children's needs. 6. Children receive appropriate services to meet their educational needs. 7. Children receive adequate services to meet their physical and mental health needs.

*Id.* at 2–3. Additionally, CFSRs assess the operational components of the child-protective system. *Id.* at 3. The federal government completes CFSRs in four stages that are identified by either an activity or product. *Id.* These stages include (1) statewide assessment, (2) onsite review, (3) final report, and (4) Program Improvement Plan (PIP). *Id.*

72. Hardin, *Court Improvement*, *supra* n. 70, at 6; Hardin, *CFSRs*, *supra* n. 70, at 7.

73. Hardin, *Court Improvement*, *supra* n. 70, at 1; Hardin, *CFSRs*, *supra* n. 70, at 7. The federal government advocates for state courts to participate in PIPs and to utilize CFSR findings in the development of their strategic plans. Hardin, *Court Improvement*, *supra* n. 70, at 6.

74. 42 U.S.C. §§ 629f–629h; Hardin, *Court Improvement*, *supra* n. 70, at 1.

pendant upon the number of children in the state.<sup>75</sup> Further, the grants must be used to improve court proceedings, and CIP requires both a strategic plan and self-assessment.<sup>76</sup> Through the Social Security Act, CFSRs, and CIP, the federal government can wield powerful influence on states. Essentially, this powerful influence is an intricate version of the carrot-and-stick approach.

### C. Caselaw—State Intervention in Action

There exists a relatively recent and small body of caselaw from a limited number of states that involves state intervention and childhood obesity.<sup>77</sup> Unfortunately, this caselaw reflects a pattern of state intervention in which the end-result has been removal of the obese child from the home.<sup>78</sup> Just as unfortunate, the reasoning employed in this body of caselaw is likely to spread rapidly among many more states, especially as childhood obesity has reached unprecedented levels in the United States.<sup>79</sup> This pattern should not increase and spread, and, more importantly, it must change so that obese children are not removed from the home during state intervention. Before analyzing the rationale and means for stopping the increase and for changing the pattern, it is important to examine specific examples of the current body of caselaw.

#### 1. *In re D.K.—Removal in Pennsylvania*

In April 2002, D.K., a sixteen-year-old male, had attained five feet, three inches in height and 451 pounds in weight.<sup>80</sup> D.K. had gained one hundred of those pounds in the preceding year.<sup>81</sup> His mother was single and was herself approximately 600 pounds in weight.<sup>82</sup> Further, D.K.'s father had died of a heart attack when he was thirty-seven years old.<sup>83</sup>

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75. 42 U.S.C. § 629h; Hardin, *Court Improvement*, *supra* n. 70, at 1.

76. *Id.*

77. A summary of this caselaw is introduced *supra* n. 60.

78. *Id.*; *infra* pt. III(C)(1).

79. *Supra* pt. II(A).

80. *In re D.K.*, 58 Pa. D. & C.4th 353, 354 (Pa. Com. Pl. 2002).

81. *Id.* at 355.

82. *Id.* at 354, n. 1.

83. *Id.*



School concern about performance and absenteeism led to an evaluation of D.K. by Geisinger Medical Center.<sup>84</sup> Thereafter, D.K. was referred to the Northumberland County Children and Youth Services (CYS) by his evaluating physician at Geisinger Medical Center who had determined that he suffered from life-threatening morbid obesity as well as depression and social isolation.<sup>85</sup> CYS obtained voluntary consent from D.K.'s mother to place him in its custody, and subsequently placed D.K. in a foster home where he was put on a diet and exercise regimen.<sup>86</sup> While in the foster home, he lost fifty pounds.<sup>87</sup>

On June 2, 2002, the Northumberland County Court of Common Pleas in Pennsylvania held a hearing in which both D.K. and his mother voiced a desire to have D.K. returned home.<sup>88</sup> Additionally, a board-certified nutritionist gave testimony.<sup>89</sup> Thereafter, the court looked at the Juvenile Act and interpretive case-law to determine whether D.K. should be declared a dependent child, whether D.K.'s mother had provided the minimum standard of care, and to what extent family preservation should impact the court's decision.<sup>90</sup>

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84. *Id.* at 355.

85. *Id.* The physician noted that D.K.'s morbid obesity manifested the following six complications: "(1) An enlarged liver as a precursor to cirrhosis of the liver; (2) Hypertension; (3) Respiratory problems to the extent that he required oxygen at night; (4) Insulin resistance that places him at a high risk for diabetes; (5) Sleep apnea; and, (6) Knee pain." *Id.* These complications were among the physical risks noted in Part II(B). *Supra* pt. II(B). Interestingly, the court references a Dr. Cochran in its opinion. *In re D.K.*, 58 Pa. D. & C.4th at 362. This Dr. Cochran referenced is most likely the board-certified nutritionist who gave testimony before the court as well as the same Dr. Cochran that served an integral role in *In re Brittany T.*, 835 N.Y.S.2d 829 (N.Y. Fam. Ct. 2007), *rev'd*, 852 N.Y.S.2d 475 (N.Y. App. Div. 3d Dept. 2008), which is discussed *infra* Part III(C)(2).

86. *In re D.K.*, 58 Pa. D. & C.4th at 355–356.

87. *Id.* at 356.

88. *Id.* D.K. expressed his belief that "he could now shop and prepare his meals, with some assistance of his mother" and his hope that he would "be reunited with friends at his former school." *Id.* D.K.'s mother "stated that she would keep him on his diet." *Id.*

89. *Id.* The board-certified nutritionist expressed that "he did not believe that the mother here with her limitations . . . would provide the necessary help and support the minor needs in order to avert a return to his former lifestyle, and if this occurs, the minor then has a 'guarantee' of a short life span of only reaching his 30s." *Id.* Is it not remarkable that a board-certified nutritionist, presumably a person with a strong foundation in science, used the term "guarantee"?

90. *Id.* at 357–359 (quoting 42 Pa. Consol. Stat. Ann. § 6302(1) (2006); *In re Yeager*, 309 Pa. Super. 491, 496 (Pa. Super. 1983); *In re Pernishek*, 268 Pa. Super. 447, 458 (Pa. Super. 1979); *In re Whittle*, 263 Pa. Super. 312, 316 (Pa. Super. 1979)).

The court found that D.K.'s mother was incapable of providing the minimum standard of care and, further, that she was not in a position to receive skill instruction while D.K. remained in the home.<sup>91</sup> Based upon these findings, the Court adjudicated D.K. dependent, removed him from his home, and placed him in the physical custody of CYS.<sup>92</sup>

## 2. *In re Brittany T.—Removal Spreads to New York's Doorstep*

Brittany T., an obese female child, irregularly attended school and had numerous tardy arrivals.<sup>93</sup> Her mother was obese and had weighed 436 pounds at one point, and her father was confined to a wheelchair due to cardiomyopathy, muscular dystrophy, arthritis, and scoliosis.<sup>94</sup> On August 4, 2003, the Chemung County Family Court in New York gave an Order of Disposition involving Brittany T., which provided in part that her parents "ensure that [she] attend school on a regular basis and on time; . . . take [her] at least two to three times per week to the gym; . . . actively and honestly attend and participate in a nutrition and education program; . . . cooperate with the referred programs; and . . . sign necessary releases of information."<sup>95</sup> Over the course of roughly two years, the court twice temporarily removed Brittany T. from her home, both times placing her in foster care.<sup>96</sup>

During Brittany T.'s second stay in foster care, Dr. William J. Cochran at Geisinger Health Systems evaluated Brittany T. and diagnosed her as morbidly obese.<sup>97</sup> However, he ruled out "genetic

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91. *In re D.K.*, 58 Pa. D. & C.4th at 359–360. Did not the court essentially place the cart before the horse when it found that D.K.'s mother was not in a position to improve through skill instruction? The court also stated that "[s]ince [D.K.'s mother] did not go to the hospital during his six days as an inpatient there, it is unlikely that she fully appreciates her son's situation at this time." *Id.* at 359. Notably, in the sentence preceding this statement, the court had stated that D.K.'s mother was homebound. *Id.* Is it not a better conclusion that D.K.'s mother was unable to visit the hospital because she had been homebound at the time?

92. *Id.* at 361–363. The court order included additional directives. *Id.*

93. 835 N.Y.S.2d at 832–833.

94. *Id.* at 835.

95. *Id.* at 831–832. The Order of Disposition gave the Chemung County Department of Social Services (CCDSS) authority to approve the required nutrition and education programs. *Id.* at 833. Also, CCDSS made the referrals to additional programs. *Id.* at 832.

96. *Id.* at 831.

97. *Id.* at 833. The court noted that Dr. Cochran "is a Board certified pediatric gastroenterologist and nutritionist" who is "the director of the pediatric weight management

and psychiatric disease syndrome” as causal factors.<sup>98</sup> Instead, he named “excessive caloric intake and a sedentary lifestyle” as the causes of Brittany T.’s obesity.<sup>99</sup> Under the care and direction of Dr. Cochran, Brittany T. participated in a treatment program characterized as a “multi-disciplinary one . . . consist[ing] of 15 sessions, and involv[ing] behavior modification, lifestyle changes, dietary assistance, and exercise therapy.”<sup>100</sup> Unfortunately, Dr. Cochran ultimately found that his work with Brittany T. and her parents was not effective in treating Brittany T.’s obesity.<sup>101</sup>

On March 23, 2006, the Chemung County Department of Social Services (CCDSS) petitioned the court on grounds that Brittany T.’s parents had willfully violated the Order of Disposition.<sup>102</sup> The court heard testimony from numerous individuals including Brittany T.’s parents, Dr. Cochran, and the CCDSS caseworker.<sup>103</sup> While the individuals’ testimony conflicted to a certain

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program and vice-chairman of the department of pediatrics at Geisinger Health Systems” in Danville, Pennsylvania. *Id.* This Dr. Cochran is likely the same Dr. Cochran that was referenced by the *In re D.K.* court as well as the board-certified nutritionist that gave testimony before the *In re D.K.* court. *Supra* n. 89. Additionally, the court noted that Dr. Cochran had written a book about childhood obesity. *In re Brittany T.*, 835 N.Y.S.2d at 833. A quick search will reveal that Dr. Cochran is the author of *Weight Management: Childhood and Adolescence FAQs* (BC Decker Inc. 2007). See [http://www.amazon.com/Weight-Management-Children-Adolescence-FAQs/dp/1550093436/ref=sr\\_1\\_1?ie=UTF8&s=books&qid=1227295835&sr=1-1](http://www.amazon.com/Weight-Management-Children-Adolescence-FAQs/dp/1550093436/ref=sr_1_1?ie=UTF8&s=books&qid=1227295835&sr=1-1) (accessed Nov. 21, 2008) (providing an editorial review of the book).

98. *In re Brittany T.*, 835 N.Y.S.2d at 833. Given the interaction of complex-level causal factors in childhood obesity as well as the fact that Brittany T.’s mother was obese and her father was suffering from multiple health conditions, is it not striking that Dr. Cochran definitively ruled out “genetic and psychiatric disease syndromes” as causal factors? *Id.* at 833, 835; *supra* pt. II(C).

99. *In re Brittany T.*, 835 N.Y.S.2d at 833. Naming “excessive caloric intake and a sedentary lifestyle” as the causes of Brittany T.’s obesity addresses causation on a basic level rather than a complex level. *Id.*; *supra* pt. II(C).

100. *In re Brittany T.*, 835 N.Y.S.2d at 834. The treatment program that Dr. Cochran utilized with Brittany T. clearly represents an individualistic remedy. *Supra* pt. II(D).

101. *In re Brittany T.*, 835 N.Y.S.2d at 834. Brittany T.’s participation in the treatment program was not continuous since she left the program in the fall of 2005 and reentered it in February of 2006. *Id.* However, given the poor outcomes associated with individualistic remedies and the fact that Dr. Cochran’s treatment program is an individualistic remedy, it is unsurprising that Dr. Cochran experienced poor outcomes with Brittany T. *Id.*; *supra* pt. II(E).

102. *In re Brittany T.*, 835 N.Y.S.2d at 831.

103. *Id.* at 832–836. In addition to the testimony of Brittany T.’s parents, Dr. Cochran, and the CCDSS caseworker, the court heard testimony from a school official, the Director of the Elmira Fitness Center, the Director and a nutritionist from the Nutrition Clinic of Elmira, and Brittany T.’s family physician at Southern Tier Pediatrics. *Id.*

extent, the parents did not dispute that strict adherence to the Order of Disposition had proved problematic.<sup>104</sup> Ultimately, they testified that “they had tried their best.”<sup>105</sup>

The court began its analysis by looking at the terms of the Order of Disposition.<sup>106</sup> Not only did it find that the terms were unambiguous, it also found that there was clear and convincing evidence that Brittany T.’s parents had willfully and without just cause violated the Order of Disposition<sup>107</sup> by “fail[ing] to regularly attend and meaningfully participate in programs.”<sup>108</sup>

Next, the court examined the options available in the aftermath of its finding.<sup>109</sup> While there had been no similar cases in New York to date, the court noted the case’s similarity to *In re D.K.*<sup>110</sup> Further, it noted that courts in several other states had “recognized morbid obesity as an actionable issue.”<sup>111</sup> In deciding whether to remove Brittany T. from her home and to terminate the parents’ custody, the court recognized that the new Order of Disposition must be in Brittany T.’s best interest and be determined based upon “all relevant facts and circumstances” that are “supported by a sound and substantial basis in the record.”<sup>112</sup>

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104. *Id.* at 836.

105. *Id.*

106. *Id.*

107. *Id.* (quoting N.Y. Fam. Ct. Act Law § 1072 (McKinney 2006); *In re L.M.*, 824 N.Y.S.2d 768 (N.Y. Fam. Ct. 2006)).

108. *Id.* (citing *In re Marquise EE*, 257 A.D.2d 699 (N.Y. App. Div. 3d Dept. 1999)).

109. *Id.* at 838–839. Specifically, the court looked at provisions of the Family Court Act, including the neglect statute. *Id.* (quoting N.Y. Fam. Ct. Act Law §§ 1012(f), 1052(a), 1072); *see supra* n. 61 (providing the statutory definition for “neglected child”).

110. *In re Brittany T.*, 835 N.Y.S.2d at 838; *supra* pt. III(C)(1).

111. *In re Brittany T.*, 835 N.Y.S.2d at 838 (citing Deena Patel, Student Author, *Super-Sized Kids: Using the Law to Combat Morbid Obesity in Children*, 43 Fam. Ct. Rev. 164 (2005)). Is it not notable that the court cited to a student-written article as authority for the fact that courts in other states have addressed actions involving morbid childhood obesity? Patel strongly advocates removal from the home in cases where a child suffers from life-threatening obesity. Patel, 43 Fam. Ct. Rev. at 164, 173. Additionally, she states that “[m]orbid obesity presents fatal risks to the child’s physical health and those risks need to be addressed *before emotional health concerns* in order to prevent irreparable damage that might be caused from the excess weight.” *Id.* at 172 (emphasis added). Contrary to this position, a strong argument can be made that the state is obligated to provide mental-health care once the child-protective agency “is advised and determines that the welfare of the child is threatened and it is possible that the child may be removed from her home.” Greene, *supra* n. 4, at 54.

112. *In re Brittany T.*, 835 N.Y.S.2d at 838 (citing *In re Alaina E.*, 33 A.D.3d 1084, 1087 (N.Y. App. Div. 3d Dept. 2006)).

Further, it recognized that parental ability to provide adequate shelter is not the only relevant fact and circumstance.<sup>113</sup>

Taking all the facts and circumstances into consideration, the court found that Brittany T.'s parents had neglected her and that the state had made every effort to keep Brittany T. in her home.<sup>114</sup> Therefore, the court ordered Brittany T. removed from the home and placed in CCDSS's custody.<sup>115</sup>

Brittany T.'s parents appealed to New York's Supreme Court, Appellate Division, Third Judicial Department, which reversed the order and dismissed CCDSS's petition.<sup>116</sup> The Third Judicial Department found that the Chemung County Family Court had erred in finding Brittany T.'s parents in willful violation of the Order of Disposition because CCDSS had failed to establish willful violation by clear and convincing evidence.<sup>117</sup>

#### IV. CURRENT STATE INTERVENTION— DEFICIENT & DAMAGING

##### A. Deficient: Prescriptions for Failure

*In re D.K.* and *In re Brittany T.* exemplify the deficient nature of state intervention as it currently exists in cases of childhood obesity.<sup>118</sup> Both cases prescribed individualistic remedies.<sup>119</sup> CYS placed D.K. on a diet and exercise regimen while he resided in foster care,<sup>120</sup> and CCDSS recommended and approved services for Brittany T. that included exercise at Elmira Fitness Center, nutritional counseling at the Nutrition Clinic of Elmira, and behavior therapy under the supervision of Dr. Cochran at Geisinger

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113. *Id.* (citing *Matter of Megan G.*, 291 A.D.2d 636, 737 (N.Y. App. Div. 3d Dept. 2002); *In re Harriet U. v. Sullivan Co. Dept. of Soc. Serv.* 224 A.D.2d 910, 911 (N.Y. App. Div. 3d Dept. 1996); *In re Belinda B.*, 114 A.D.2d 70 (N.Y. App. Div. 4th Dept. 1986)).

114. *Id.* at 839.

115. *Id.* The court made additional orders. *Id.* at 839–840.

116. *In re Brittany T.*, 852 N.Y.S.2d 475, 480 (N.Y. App. Div. 3d Dept. 2008).

117. *Id.* at 478–480. While the Third Judicial Department reversed the Chemung County Family Court's removal order, this does not bar future attempts to use New York's neglect statute to remove obese children from the home in situations where there is clear and convincing evidence that parents have willfully violated an order of disposition. *In re Brittany T.*, 835 N.Y.S.2d 829; *In re Brittany T.*, 852 N.Y.S.2d 475.

118. *Supra* pt. III(C)(1) and III(C)(2).

119. *Supra* pt. II(D).

120. *In re D.K.*, 58 Pa. D. & C.4th at 356.

Health Systems.<sup>121</sup> These individualistic remedies are prescriptions for failure because they reflect a presumption of cause that is based on the idea of personal responsibility.<sup>122</sup> Thus, the remedies focus on the obese child and fail to address the interaction of complex-level causal factors.<sup>123</sup>

Additionally, in both cases, the child-protective agencies unilaterally coordinated the provision of services. CYS presented D.K.'s mother with a service plan that included foster care with a diet and exercise regimen,<sup>124</sup> and CCDSS recommended and approved Brittany T.'s exercise, nutritional, and behavior-therapy service plans.<sup>125</sup> The unilateral coordination of services does not allow for parental input and can undoubtedly lead to parental animosity toward the child protective agency.<sup>126</sup>

### B. Damaging: The Stark Reality

Not only is current state intervention deficient, it is also damaging for the obese child and her parents. Intervention through state-neglect statutes carries a large and misplaced stigma because these statutes are utilized to intervene in a broad array of situations, including but not limited to, situations where parents completely disregard the daily needs of their children.<sup>127</sup> Further, state intervention in cases of childhood obesity often results in removal from the home. The Northumberland County Court of Common Pleas removed D.K. from his home,<sup>128</sup> and the Chemung County Family Court repeatedly removed Brittany T. from her home.<sup>129</sup> Sadly, state intervention results in a stark reality for the

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121. *In re Brittany T.*, 835 N.Y.S.2d at 831–834.

122. *Supra* pt. II(E).

123. *Id.*

124. *In re D.K.*, 58 Pa. D. & C.4th at 356.

125. *In re Brittany T.*, 835 N.Y.S.2d at 833.

126. See Ann Moynihan, Mary Ann Forgey & Debra Harris, *Symposium, Fordham Interdisciplinary Conference Achieving Justice: Parents and the Child Welfare System*, FOREWORD, 70 *Fordham L. Rev.* 287, 289 (2001) (describing how the interaction between the New York City child-protective agency and parents reflects a lack of partnership).

127. See Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes between Parents and the State*, 58 *N.Y.U. L. Rev.* 157, 202 (1983) (advocating the creation of a separate and less stigmatizing neglect statute for use in cases of medical neglect). Childhood obesity has been characterized as a form of medical neglect. Arani, *supra* n. 52, at 876.

128. *In re D.K.*, 58 Pa. D. & C.4th at 361.

129. *In re Brittany T.*, 835 N.Y.S.2d at 831, 839.

obese child—it exponentially compounds her problem. She not only continues to face the issues associated with obesity due to the deficient nature of an individualistic remedy but she also faces issues associated with the separation from and stigmatization of her family. One scholar notes the unintended consequences of state intervention:

[O]ur legal system purports to care about children. . . . Yet, in our efforts to help children, we often condemn their parents. . . . What we fail to recognize is that by these same actions, we deprive children of something they also cherish and need—their families.<sup>130</sup>

Clearly, there exists a Call to Order regarding the current method of state intervention in cases of childhood obesity.

## V. REVAMPING STATE INTERVENTION: WHAT & WHY

### A. Step One—Fund a Family-Systems Approach

In answering this Call to Order, states must first fund the development of mental-health counseling programs that utilize a family-systems approach to treat neglect generally and childhood obesity specifically.<sup>131</sup> Unlike individualistic remedies that focus on the child's personal responsibility for her obesity,<sup>132</sup> family-systems theory focuses on the “dynamics of [the child's] interpersonal relationships and their contexts” in addressing her obesity.<sup>133</sup> Family-systems theory views cause and effect as a mutual interaction instead of a “linear” interaction in which cause leads to effect.<sup>134</sup> Rather than promoting the idea of personal responsi-

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130. Brooks, *supra* n. 4, at 22.

131. *See id.* at 3–4 (describing a “judicial lag” in shifting to a family-systems paradigm despite the fact that the mental-health field has made the shift by developing family-systems theory, and current policy has made the shift by advocating family preservation).

132. *Supra* pt. II(E).

133. Brooks, *supra* n. 4, at 4–5. Brooks states that “[a]ccording to family systems theory, the only way to understand a person fully is to look at that individual in the context of her family and to understand the family's interaction.” *Id.* at 5.

134. *Id.* *In re D.K.* and *In re Brittany T.* both involved service provisions that reflected a behavior theory of therapy. *Supra* pt. III(C)(1), pt. III(C)(2), and pt. II(D). Unfortunately, behavior therapy represents an individualistic remedy that promotes the idea that personal choice causes childhood obesity. *Supra* pt. II(E).

bility,<sup>135</sup> this view of mutual interaction promotes the idea of shared responsibility.<sup>136</sup> Therefore, the whole family shares responsibility for the child's obesity.<sup>137</sup> Essentially, the successful treatment of a child's obesity requires an understanding of the child from "the outside in" instead of from "the inside out" and relies upon the principle that the obese child "is a part of the [family] whole, not simply a whole unto herself."<sup>138</sup> Further, family-systems therapy represents a positive and forward-thinking approach that strives to identify "a family's strengths rather than its pathology."<sup>139</sup> The family-systems approach holds great potential for the treatment of childhood obesity because it supports the view that childhood obesity results from the interaction of complex-level causal factors.<sup>140</sup>

#### B. Step Two—Mandate a Family-Systems Approach

The second step in answering the Call to Order requires that states mandate family-systems therapy for the entire nuclear family when they intervene in cases involving childhood obesity.<sup>141</sup> States must firmly mandate family-systems therapy to combat society's tendency to cleave to the concepts of linear causation and personal responsibility that both rely upon judgmental blame-framing.<sup>142</sup> By mandating family-systems therapy, states will assist society to grasp an empowering approach that "reflect[s] the larger scope of current professional knowledge about

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135. *Supra* pt. II(E).

136. Brooks, *supra* n. 4, at 5.

137. *Id.*

138. *Id.*

139. *Id.* at 8.

140. *Id.* at 5; *supra* pt. II(C).

141. Brooks, *supra* n. 4, at 4. Brooks advocates use of a family-systems approach in custody determination cases. *Id.* at 12. Under a family-systems approach, she argues that "the true 'best interests' of the child [ ] cannot be determined apart from determining the best interests of the family system." *Id.* at 13.

142. *Id.* at 5. Brooks explains that the judicial system has lagged behind in transitioning to a family-systems approach because of its emphasis on "individual rights and remedies," provision "for individual representation," and reliance on "the traditional [individual-based] medical model." *Id.* at 3–4. The judicial system's emphasis on individual rights disserves children because the resolution of family problems necessarily involves both the child and parent. Clare Huntington, *Rights Myopia in Child Welfare*, 53 UCLA L. Rev. 637, 672 n. 176 (2006).



children and families.”<sup>143</sup> By embracing a family-systems approach, obese children and their families will be able to hold onto the hope for a positive outcome.<sup>144</sup>

### C. Step Three—Mandate Assignment of a Parent Coordinator

States must continue in answering the Call to Order by taking a third step; they should mandate the assignment of a Parent Coordinator to all childhood-obesity cases.<sup>145</sup> A Parent Coordinator

assist[s] high conflict parents to implement their parenting plan, to monitor compliance with the details of the plan, to resolve conflicts regarding their children and the parenting plan in a timely manner, and to protect and sustain safe, healthy and meaningful parent-child relationships. Parenting [C]oordination is a quasi-legal, mental health, alternative dispute resolution (ADR) process that combines assessment, education, case management, conflict management and sometimes decision-making functions.<sup>146</sup>

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143. Brooks, *supra* n. 4, at 4.

144. If the Northumberland County Court of Common Pleas and the Chemung County Family Court had mandated family-systems therapy in cases involving childhood obesity, *In re D.K.* and *In re Brittany T.* could have resulted in more positive outcomes. *Supra* pt. III(C)(1) and pt. III(C)(2).

145. Several states already utilize Parent Coordinators in dissolution cases. *Supra* n. 7.

146. *Guidelines for Parenting Coordination 2* (AFCC 2005) (available at <http://www.afccnet.org/pdfs/AFCC2GuidelinesforParentingcoordination2.pdf>). In May 2005, the Association of Family and Conciliation Courts (AFCC) Board of Directors approved the *Guidelines for Parenting Coordination*, which was a product of the Interdisciplinary Task Force on Parenting Coordination that had been reconstructed by the Honorable George Czutrin, the AFCC's 2003–2004 President, and charged with developing “standards of practice for parenting coordination for North America.” *Id.* at 1. Recognizing Parenting Coordination as a new field, the Interdisciplinary Task Force on Parenting Coordination chose to entitle its work-product as *Guidelines* rather than “standards.” *Id.* The Florida Chapter of AFCC (FLAFCC) serves the “role [of] convener to encourage multi-disciplinary collaboration in the development of Parenting Coordination throughout the [S]tate [of Florida].” FLAFCC, *Parenting Coordination*, <http://www.flafcc.org/parenting.cfm> (accessed Dec. 6, 2008). The FLAFCC posts information to its Website that tracks the development of Parenting Coordination in the State. *Id.* The State has vested much time and effort into developing Parenting Coordination, which was reflected when the legislature passed Senate Bill 2640 during the 2004 Legislative Session. The Florida Senate, *supra* n. 7, at 1. Senate Bill 2640 “would have expressly authorized the practice of parenting coordination and created uniform qualifications, training, and standards for its use throughout the [S]tate.” *Id.* Unfortunately, Governor Bush vetoed the Bill due to concerns about cost and its use in domestic

While Parenting Coordination is currently geared towards assisting “high conflict” parents,<sup>147</sup> it holds great potential for application in cases involving childhood obesity. Through a slight expansion in role, a Parent Coordinator could also assist in dealing with the high level of conflict that can develop among the child protective agency, the obese child, and the parents.<sup>148</sup>

States should proactively mandate the assignment of a Parent Coordinator at the outset of intervention in order to prevent conflict rather than wait until conflict develops during the intervention process.<sup>149</sup> Further, the Parent Coordinator’s responsibilities should be expanded in cases of childhood obesity. Additional responsibilities should include the following:

- researching available family-preservation services;
- maintaining readily available information on these services;
- providing information on these services to interested parties;
- gathering interested party input regarding choice-of-service provisions;

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violence cases. *Id.* Nevertheless, he voiced his support should the Legislature choose to revise the Bill. *Id.* Recently, the FLAFCC PC Task Force drafted *Ethical Guidelines for Parenting Coordinators in Florida. Ethical Guidelines for Parenting Coordinators* (FLAFCC, Oct. 6, 2008) (available at [http://www.flafcc.org/Documents/FLAFCC\\_PC\\_Taskforce\\_on\\_Ethical\\_Guidelines\\_Draft\\_5-4-07.doc](http://www.flafcc.org/Documents/FLAFCC_PC_Taskforce_on_Ethical_Guidelines_Draft_5-4-07.doc)). Additionally, the Chief Justice of the Florida Supreme Court, Barbara J. Pariente, appointed the Florida Supreme Court Parenting Coordination Workgroup in September of 2004 to draft a model administrative order for Parenting Coordination. Parenting Coordination Workgroup, *Report of the Parenting Coordination Workgroup: Model Parenting Coordination Administrative Order* (Mar. 9, 2005) (available at <http://www.flafcc.org/documents/PCCoordFinalDraft.pdf>). The Florida Supreme Court Parenting Coordination Workgroup submitted its proposed *Model Parenting Coordination Administrative Order* on March 9, 2005. *Id.* (final draft available at [http://www.flafcc.org/documents/PC\\_FinalAdminOrder.pdf](http://www.flafcc.org/documents/PC_FinalAdminOrder.pdf)).

147. *Guidelines for Parenting Coordination*, *supra* n. 146, at 2.

148. *Supra* pt. IV(A).

149. *Report of the Parenting Coordination Workgroup*, *supra* n. 146. In its *Model Parenting Coordination Administrative Order*, the Florida Supreme Court Parenting Coordination Workgroup proposed that assignment of a Parenting Coordinator should require, among other things, that “[t]he parties have failed to adequately implement their parenting plan in relation to the child(ren) who are subject(s) of the proceedings.” *Id.* at 7. This requirement does not reflect a conflict-preventative course of action. Assignment of a Parent Coordinator at the outset of a childhood-obesity case would represent a course of action aimed at preventing conflict.

- offering opinions on the services to be included in parenting plans;
- documenting services to be utilized by the parents/child;
- providing follow-up on the utilization of services by the parents/child;
- promoting service utilization by the parents/child; and
- reporting on service utilization to all interested parties.

This expansion of responsibility would foster three positive outcomes. First, it would provide the opportunity for the child and parents to give input in the choice-of-service provisions. Second, the opportunity for input would, in turn, increase both the child's and the parents' reception of service provisions. Third, the involvement of the Parent Coordinator would serve a checks-and-balance function for the child protective agency and the family. Ultimately, the child-protective agency would no longer unilaterally coordinate service provisions.<sup>150</sup>

#### D. Step Four—Mandate Mediation

The fourth and final step in answering the Call to Order requires that states empower their courts to order mediation in cases that involve neglect and mandate courts to order mediation in cases that involve childhood obesity.<sup>151</sup> Mediation must be mandatory rather than discretionary in cases of childhood obesity not only because it will foster more positive outcomes, but also be-

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150. *Supra* pt. IV(A). If the Northumberland County Court of Common Pleas and the Chemung County Family Court had mandated the immediate assignment of a Parent Coordinator in cases involving childhood obesity, *In re D.K.* and *In re Brittany T.* could have resulted in these three positive outcomes. *Supra* pt. III(C)(1) and pt. III(C)(2).

151. New York State Statute Section 1018 provides that:

[i]n any proceeding initiated pursuant to this article, the court may, at its discretion, authorize the use of conferencing or mediation at any point in the proceedings to further a plan for the child that fosters the child's health, safety, and well-being. Such conferencing or mediation may involve interested relatives or other adults who are significant in the life of the child.

N.Y. Fam. Ct. Act § 1018.

cause courts have been slow to embrace a family-systems approach.<sup>152</sup> Importantly, states must order a family-systems model of mediation that is grounded in the premise that a child's obesity does not result from an inadequacy of the child.<sup>153</sup> Effective use of a family-systems model of mediation would result in a clear family structure with collaborative patterns of interaction so that the family system is better able to respond to "situational stressors and developmental change."<sup>154</sup>

The mediator's role would be to facilitate the creation of a parenting plan that is agreed to by all of the interested parties. The interested parties would necessarily include the obese child, the obese child's parents or guardians, the child-protective agency, and the Parent Coordinator. During mediation, the interested parties would be able to address the need for and appropriate choice-of-service provisions.<sup>155</sup>

#### VI. HOW TO REVAMP: A TRICKLE-DOWN APPROACH

Simply proposing the four steps that states must take in answering the Call to Order does not give impetus for states to actually take the four steps. Something more is needed to encourage these steps—a trickle-down approach.

Congress must take the lead by amending Title IV-B of the Social Security Act.<sup>156</sup> The amendment should provide that:

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152. *Supra* pt. V(B). Despite the fact that the Chemung County Family Court could have chosen to authorize mediation under New York State Statute Section 1018, it did not do so in the case of *In re Brittany T.* *Supra* pt. III(C)(2).

153. *Cf.* Richard D. Mathis & Lynelle C. Yingling, *Family Modes: A Measure of Family Interaction and Organization*, 36 *Fam. & Conciliation Cts. Rev.* 246, 247 (1998) (advocating and describing the use of a family-systems model of mediation in dissolution).

154. *Id.* at 247–248 (noting the indicators of successful dissolution mediation under a family-systems model).

155. Mediation would provide the Parent Coordinator with a convenient forum in which to execute the responsibilities of her role since all interested parties would be present at the mediation session(s). *Supra* pt. V(C). While NYSPCC implements mediation during the permanency phase of child abuse and neglect cases, this Article advocates implementation of mediation in childhood-obesity cases at the beginning of neglect proceedings and with additional interested party involvement to include a Parent Coordinator. NYSPCC, *supra* n. 8, at *Programs*.

156. Congress has regularly amended the Social Security Act to reflect new developments in policy. 42 U.S.C. §§ 601–679; Child Welfare Information Gateway, *supra* n. 62, at 1–2. The Child Information Gateway provides a concise listing of the various amendments to the Social Security Act since 1974. Child Welfare Information Gateway, *supra* n. 62, at 3. Since Dr. James Holsinger Jr., the presidential nominee for surgeon general, "pushed"

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- Childhood obesity is a unique and multi-faceted problem that falls under the umbrella of neglect.
- Prevention and family-preservation programs must reflect the unique and multi-faceted nature of the problem.
  - A family-systems approach to mental-health counseling and mediation reflects this nature.
  - Parent Coordination reflects this nature.
- Funds will be provided to states that mandate
  - family-systems therapy,
  - family-systems mediation, and
  - Parent Coordination
  - when intervening in cases of childhood obesity.
- These funds will be provided specifically and exclusively for the development of prevention and family-preservation programs that
  - utilize a family-systems approach for mental-health counseling and mediation; and
  - utilize Parent Coordination.

Such an amendment would provide the necessary impetus because states would be encouraged to enact legislation, develop polices and regulations, and implement programs—actions inherent to taking the proposed four steps.<sup>157</sup> Therefore, states would answer the Call to Order through a trickle-down approach.

Long-term success in addressing childhood obesity depends upon how effectively the states take each of the required four steps. Therefore, the need arises for assessment. Fortunately, the federal government has two assessment programs in place that can be utilized to monitor the states' progress in addressing childhood obesity. CFSRs can be utilized to assess how effectively

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childhood obesity as an agenda point before a Senate committee on July 12, 2007, it is not difficult to envision the passage of an amendment to Title IV-B of the Social Security Act to reflect a governmental policy aimed at addressing the “epidemic” of childhood obesity. Natl. Pub. Radio, *supra* n. 16; Ellis, *supra* n. 16.

157. Child Welfare Information Gateway, *supra* n. 62, at 1–2.

the state executive branch meets the federal requirements for funds that are provided under the Title IV-B amendment, and CIP can be utilized to assess how effectively the state-judicial branch has improved court proceedings.<sup>158</sup> A Title IV-B amendment, CFSRs, and CIP provide the tools necessary to ensure that states achieve long-term success in answering the Call to Order.

## VII. CONCLUSION

### A. Let's Revisit Jane

The teacher wrote the day's journal assignment on the blackboard: "Write a paragraph about yourself; make sure to use descriptive adjectives." That night, while grading the journal entries, the teacher found one that stood out from the rest:

My name is Jane, but some kids call me fatso, hippo, piggy-wiggly, blimp, heifer, and two-ton. Mostly, they whisper in front of me and laugh at me. My counselor is helping me to ignore these kids. I'm beginning to feel more comfortable at school and no longer beg my parents to stay home. I love Mom and Dad more than anything else. I love my dog, Snowball, very much too. I still consider Snowball my best friend. However, I do have a new friend at school. We have lots of fun together. I've noticed that I don't cry as much about my weight. But I still wish that I were not overweight. Mom and Dad are overweight too. Since we have been going to counseling together, we have all lost weight. A few months ago, my parents and I got really scared when we thought that I might have to leave my family. We stopped worrying after we met with a bunch of people. Shortly after that meeting, my family started going to see my counselor. Ever since then, things have started to look up for me. Every night, I hug Snowball, close my eyes, and say a prayer of thanks.

Jane's journal entry brought the teacher to tears.<sup>159</sup> The next morning the teacher found Jane sitting in her seat with a smile on her face. This brought a smile to the teacher's face.

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158. *Supra* pt. III(B).

159. Jane is a fictitious character whom the Author created for purposes of reinforcing the proposals presented in this Article.

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### B. A Resounding Call to Order

D.K. and Brittany T.<sup>160</sup> deserved different outcomes; their outcomes should have brought smiles to their faces. Instead, they experienced heart-wrenching separation from their loved-ones.<sup>161</sup> Society desperately failed them. Childhood obesity demands a resounding Call to Order. States must not hesitate in answering this Call. The time is right for change.

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160. *Supra* pt. III(C)(1) and pt. III(C)(2).

161. *Id.*