Childhood, Adolescent, and Teenage Obesity: Recommendations for Community Initiatives in Central Harlem

Michelle P. Maidenberg

Because of poverty, the high prevalence of obesity, and the lack of adequate supports, Central Harlem's children, adolescents, and teenagers are at risk for major physiological, psychological, and social issues. This article discusses the public health concerns related to this population, especially the prevalence of obesity. This article identifies the prevalence of illness and obesity in the inner city and stipulates the causes and consequences of obesity among children, adolescents, and teenagers. In addition, it reports on the appropriate community intervention, using a coalition and a community collaborative organization that serve as models to build support for Central Harlem. A proposal is offered for reducing obesity among youths in the community. The intervention outlines a logic model that identifies a multisystemic approach at the micro and macro level for community intervention and policy initiatives to advocate for fundamental change. Further research recommendations are described to reduce the prevalence of childhood, adolescent, and teenage obesity in urban communities.

KEY WORDS: *Central Harlem; childhood obesity; juvenile obesity; New York City; obesity prevention*

In June 2013, the American Medical Association formally classified obesity as a disease. Obesity is the most prevalent nutritional disease of children and adolescents in the United States (Dietz, 1993). As of 2012, more than one-third of the children and adolescents in this country were overweight or obese (Ogden, Carroll, Kit, & Flegal, 2014). Childhood obesity has more than doubled in children and tripled in adolescents in the past 30 years.

The percentage of children ages six through 11 years in the United States who were obese increased from 7 percent in 1980 to nearly 18 percent in 2010. The percentage of adolescents and teenagers ages 12 through 19 years who were obese increased from 5 percent to 18 percent over the same period (Ogden et al., 2014; National Center for Health Statistics, 2012). The numbers are even higher in African American and Hispanic communities, where nearly 40 percent of the children are overweight or obese (Ogden, Carroll, Kit, & Flegal, 2012).

Among American children ages two through 19, obesity rates vary by race or ethnic group. Among non-Hispanic white children, 17.5 percent of male and 14.7 percent of female children are obese. Among non-Hispanic black children, 22.6 percent of male and 24.8 percent of female children fit this category.

Among Mexican Americans, 28.9 percent of male and 18.6 percent of female children are obese (Ogden et al., 2012).

Because the problem often starts in childhood, and because the incidence is especially high in inner cities, society will greatly benefit with a reduction in urban juvenile obesity. In this article I discuss the prevalence of obesity, the root causes, the consequences of this disease, and methods to implementing community initiatives in Central Harlem by modeling a coalition structure and programs that already exist in other communities.

PREVALENCE OF ILLNESS AND OBESITY IN CENTRAL HARLEM

In general, residents of Central Harlem have a high rate of illness and mortality compared with residents of other districts (Karpati, Lu, Mostashari, Thorpe, & Frieden, 2003). The leading cause of hospitalization in Central Harlem in adults is heart disease. When comparing Central Harlem to New York City (NYC) as a whole, Central Harlem's rate of heart disease is higher by 35 percent (Karpati et al., 2003). More recent reporting continues to show that heart disease is the leading cause of death in Central Harlem. Also, the incidence of diabetes mellitus,

Table 1: Eight Major Causes of Death (rate per 100,000)			
Disease	Central Harlem ^a	New York City ^a	United States ^b
Heart disease	226.4	219.3	192.9
Malignant neoplasms	172.0	163.1	185.9
HIV	22.5	10.2	
Diabetes mellitus	32.8	20.9	22.3
Cerebrovascular disease	16.4	19.4	41.8
Pneumonia/influenza	30.2	30.1	16.2
Chronic lower respiratory disease	22.5	21.0	44.6
Accidents (unintentional injuries)	16.4	11.4	38.2

Notes: Obesity-related diseases are in bold. In the city data, Central Harlem is referred to as Community District 10.

^aThese data are from the New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics (2011), *Summary of Vital Statistics 2010: The City of New York*, retrieved from <http://www.nyc.gov/html/doh/downloads/pdf/vs/vs-population-and-mortality-report.pdf>

^bThese data are from S. L. Murphy, J. Xu, & K. D. Kochanek (2012), "Deaths: Preliminary Data for 2010," *National Vital Statistics Reports*, 60(4), 31. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

another disease that is directly associated with obesity, is greater in Central Harlem than elsewhere in NYC. This is noted in Table 1. Following this table, discussion will focus specifically on juvenile obesity and its prevalence in Central Harlem.

In Central Harlem, the obesity rate was 21.1 percent in 2011, 22.4 percent in 2010, and 23 percent in 2009. The Central Harlem district ranked 29th out of 33 community districts in terms of obesity rate (Furman Center, 2011). According to a report issued by the New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics (2011), more than four in 10 (42 percent) Head Start participants in East and Central Harlem are either obese (27 percent) or overweight (15 percent). Findings were similar among kindergartners and fifth graders attending public schools, where 46 percent are either obese (27 percent) or overweight (19 percent). Nearly one in three (32 percent) of high school students are either obese (14 percent) or overweight (18 percent).

These percentages are staggering and, as noted, continue to increase over time. To consider appropriate interventions, it is critical to understand what the root causes of the problem are and what factors may contribute to this growing epidemic.

THE CAUSES OF OBESITY AMONG CHILDREN, ADOLESCENTS, AND TEENAGERS

There are numerous factors contributing to juvenile obesity. A high caloric intake, a sedentary lifestyle

including excess television viewing, high-fat foods, and large portion sizes are all known contributors to juvenile obesity (Bassett & Perl, 2004). Many adolescents do not exercise regularly or eat the recommended amount of fruits and vegetables. One in three high school students does not exercise at least 20 minutes a day, three days per week. Nearly six in 10 watch television at least three hours per day. Also, more than eight in 10 adolescents say they eat fewer than five servings of fruits and vegetables per day (New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2011).

Moreover, the sedentary lifestyle caused by television, computer, and video game use promotes increased food consumption and reduced physical activity (Bouchard et al, 1990; Robinson & Killen, 2001). For a significant number of obese children, the problem is drinking rather than eating too much, as these children consume an abundance of full-fat milk, sugared soft drinks, and fruit juice (Dietz, 1993).

The media contributes to this epidemic by marketing unhealthful eating and drinking. Regarding drinks, beverage companies spent \$866 million to advertise unhealthful drinks in 2013 (Harris et al., 2014); that is four times as much as they spent advertising fruit juice and water. The number of ads for children's drinks on youth-targeted Web sites increased by 15 percent from 2010 to 2013 (Harris et al., 2014).

In addition to lifestyle and media, poverty is another factor that contributes to the prevalence rates of obesity. Central Harlem's poverty rates are another factor to consider when seeking to understand why the rate of obesity is so high in that community.

POVERTY AND OBESITY IN INNER-CITY NEIGHBORHOODS

Poverty is a major problem plaguing the Central Harlem community. Obesity is more prevalent in poor communities where there is a high crime rate and lack of adequate social supports, as many parents prohibit or restrict their children from being physically active outdoors. Moreover, when parents are obese, as is more likely to be the case in an impoverished neighborhood, parents may misinterpret their infant's cues for hunger and thirst. According to Dietz (1993), "Such parents will respond to an infant's restlessness or fretting by feeding, rather than comforting" (p. 283). Dietz (1993) noted that parents struggling with their own obesity, stress, and depression may consequently struggle to set limits

on their children's eating habits. Parents are more likely to struggle with these problems in inner-city communities.

In Central Harlem, with a total population of 115,723 in 2012, those living at or below the poverty rate included 30 percent of the population; in 2010 28.1 percent lived at that level. In 2012, there were a total of 47,956 Medicaid enrollees and 42,394 food stamp recipients in Central Harlem ([New York City Human Resources Administration, 2012](#)).

Poverty has a direct influence on residents' health behaviors. Healthy foods are not easily affordable or readily available in low-income neighborhoods. The lack of access to supermarkets, fresh food, and vegetables is the key reason for poor diets and obesity among the poor ([Sutton, 2005](#); [Zenk et al., 2005](#)).

Due to poverty, the high prevalence rates of obesity, and lack of adequate supports, Central Harlem's children, adolescents, and teenagers are at risk for major physiological, psychological, and social issues.

CONSEQUENCES OF JUVENILE OBESITY AND HOW IT AFFECTS CENTRAL HARLEM'S CHILDREN, ADOLESCENTS, AND TEENAGERS

There are serious and immediate physical and psychological effects due to being overweight and obese, such as prediabetes, bone and joint problems, social issues, and poor self-confidence, as well as acute long-term risks to our children. Heart disease, stroke, poor self-image and identity, and depression are some of the many problems that can persist from childhood through adulthood because of weight and health issues. The medical and economic toll of this problem remains huge. It is estimated that the obesity epidemic carries a \$117 billion medical price tag ([Wang, Li, Chiuve, Hu, & Willett, 2015](#)).

Unfortunately, juvenile obesity does not easily go into remission. According to [Figueroa-Colon, von Almen, and Suskind \(1993\)](#), "The percentage of obese children who become obese adults is 14% at age 6 months, 41% at age 7 years, and about 70% at 10 to 13 years of age" (p. 285).

In addition to the physical consequences, there are also psychological ones. These consequences include depression (for example, feelings of helplessness and hopelessness), low self-esteem (for example, feeling unattractive and inadequate), physical discomfort (for example, difficulty breathing when walking up a flight of stairs and being forced to wear tight clothing because clothing does not fit properly), compromised peer relationships (for example,

being left out and ridiculed), and weight discrimination (by family, peers, and others in the form of verbal teasing, relational victimization, or even physical assault).

Children, adolescents, and teenagers in Central Harlem are in considerable need of community initiatives to help them acquire and maintain healthier lifestyles that are meaningful and for the long term.

IMPLEMENTING COMMUNITY INITIATIVES New York Coalition for Healthy School Food

Fortunately, organizations have begun to address the problem of juvenile obesity. The New York Coalition for Healthy School Food, which once served Central Harlem, is a small coalition with 501(c)(3) nonprofit status. Its board of directors and advisory board consist of doctors, PTA representatives, other teachers and parents, public health professionals, lawyers, restaurant owners, chefs, registered dietitians, a yoga teacher, and two spouses of celebrities (personal communication, A. Hamlin, NYC Coalition for Healthy School Food, August 1, 2013).

This organization is financially supported by individual donations, income from a fall gala and other fundraising events, online auctions, private foundations, and wellness grants from NYC schools. As of yet, they have received no federal or state funding, although they have applied for it (personal communication, A. Hamlin, NYC Coalition for Healthy School Food, August 1, 2013).

They support public policies regarding food and exercise and encourage people to submit comments on the new U.S. Dietary Guidelines ([U.S. Department of Agriculture & U.S. Department of Health and Human Services, 2015](#)) and the 2015 update of the [Healthy, Hunger-Free Kids Act of 2010 \(P.L. 111-296\)](#). The coalition has also signed letters written by the National Alliance for Nutrition and Activity and other organizations that support public policies regarding healthy food and exercising.

They attempt to have school involvement and have done so in partnership with the NYC Office of School Food and the Ithaca City School District Child Nutrition Program. In NYC, they worked to get two schools to adopt a vegetarian menu and about 30 schools to adopt an alternate menu consisting of unprocessed foods and eliminating beef, pork, chicken nuggets, and mozzarella sticks.

These schools have also incorporated their Wellness Wakeup Call program: nutrition education in

the form of “easy to digest” sound bites read over the loudspeaker each day. The messages, which have a different topic each month, get sent home with the students so their parents can review them with their children. Families are also provided with healthful recipes. Children become invested in eating these healthy foods because they are actively involved in shopping for and preparing their meals. The Wellness Wakeup Call comes in two versions: kindergarten through grade 5, and grades 6 through 12. The K–5 version goes home with students, and both versions may be posted on the school’s Web site or included in PTA newsletters.

In the fall of 2013, the coalition’s curriculum, called Food UnEarthed: Uncovering the Truth About Food, was taught in four schools to over 400 students. In contrast to other curricula, it is based on the premise that nutrition is highly influenced by the food industry. It relies on critical thinking skills, encouraging kids to view themselves as detectives discovering the truth about the food industry and the impact it has on their eating. In addition to general nutrition, kids learn about the meaning of nutritional labels on foods, media literacy, food politics, food and the environment, and more. It is a yearlong curriculum, and each class includes a snack that exposes students to new foods.

To carry out its mission, the coalition has participated in health fairs at schools, at the NYC Green Festival, and in vegetarian festivals, such as the NYC Vegfest and Vegetarian Summerfest. It also holds a few Family Dinner Nights each year. These events consist of a free dinner, four or five hands-on learning activities, and a cooking demo. The coalition publicizes its events and markets itself primarily through its Web site, e-mail list, and social media.

Funding is a main concern and impedes this coalition from accessing technology that would allow for automated and open memberships. Currently there is no acquisition membership system in place to garner additional revenue. Additional revenue is necessary to enable the coalition to offer the services to more schools and hire more individuals to help carry out its mission.

Choosing Healthy and Active Lifestyles for Kids (CHALK)

Another model for the Central Harlem community is CHALK, a collaboration between NewYork-Presbyterian Hospital Ambulatory Care Network and Columbia University Medical Center Com-

munity Pediatrics. CHALK focuses its attention on its medical center, public schools, and the community at large. It began as a five-year grant funded by the New York State Department of Health in 2008, but it has continued to receive state funding since then. The goals of CHALK are

to reduce over time the prevalence of childhood obesity and its related morbidity in Northern Manhattan (in Washington Heights and Inwood, with a focus on school-aged children), and to promote a culture and create an environment in which healthy lifestyles are integral to the lives of all children. ([NewYork-Presbyterian Hospital Ambulatory Care Network & Columbia University Medical Center Community Pediatrics, n.d.-a](#))

CHALK spreads its health-promoting message in various settings, such as schools. CHALK’s focus is on nutrition, physical activity, and school staff wellness. CHALK works to ensure that partner schools have active School Wellness Councils that set and adhere to the health priorities.

CHALK’s obesity prevention initiatives are securing resources at New York-Presbyterian Hospital. Some key initiatives led to securing a hospital farmers market, launching a stair-walking promotion campaign, and working with medical providers to educate families about healthy habits.

CHALK and a task force sponsored by CHALK called Vive Tu Vida/Live Your Life “recognize that the environment, lack of physical activity, eating habits, genetics, sleep, mental well-being and access to resources (including education) all play a role in our children’s health” ([NewYork-Presbyterian Hospital Ambulatory Care Network & Columbia University Medical Center Community Pediatrics, n.d.-b](#)). Their message is delivered in both English and Spanish, targeting their predominantly Latino (74 percent) community. They promote healthy lifestyles within a family-based model.

The task force works on building the campaign and holds general monthly meetings at a local community center. If an individual is to invest in a membership pledge, he or she commits to campaign building tasks, like recruiting new participants, interviewing campaign participants, and attending general meetings. In addition, the individual commits to a community activism task that includes promoting the campaign.

BUILDING COMMUNITY SUPPORT IN CENTRAL HARLEM

Central Harlem and similar urban areas could use a coalition like the ones described in this article. Ideally either the New York Coalition for Healthy School Food would expand its services to once again include the Central Harlem community or CHALK would broaden its constituency to include this community. If that is not feasible and a new coalition is to be formed, to get things started, the coalition could seek private, local, and state funding. Funding is essential, because poverty is a substantial problem in the community. A lack of adequate financial resources discourages residents from purchasing healthier foods because of the high cost of these foods.

Another initial concern for the creation of a Central Harlem coalition would be to inform people of its existence. The coalition should make use of com-

munity resources that are already available in their local districts. For example, families could be informed through flyers (such as those printed by schools and hospitals) about community parks and recreation, community sports programs, and free or low-cost healthy family lifestyle programs geared specifically for families with children and adolescents. Press releases would be necessary. Most local television stations and radio shows offer free advertising for free local youth programs. Once the coalition is formed and the community is informed of its programming and services, the coalition would rely on a logic model for interventions as a plan for their specific target goals and objectives.

A Logic Model for Community Intervention

As presented in Figure 1, this model looks at making changes at both the micro (that is, individual) and

Figure 1: A Logic Model for Intervention: A Community Intervention

macro (that is, system) levels. It specifies a multi-systemic approach and earmarks particular activities, desired intermediate behaviors, and favored outcomes for the Central Harlem community.

The interventions would target some of the social problems underlying urban juvenile obesity. For example, nutritional education and support groups would combat the problem by providing support to parents who are feeling uninformed, too stressed to help their children, or feeling uncertain about how to comfort their children through some means other than food. The coalition would advertise and oversee a specialized health and fitness program for overweight and obese children, which would be held at a local community center such as the YMCA. The coalition would organize an annual community health fair to address health issues for the school district.

Other initiatives would include developing opportunities for minority parents to address their nutrition and physical activity concerns in their native languages at the health fair and throughout the school year to appropriate personnel at the school. At the educational level, schools would work to combat the problem by reducing school policy obstacles and further opening up access to fresh food and exercise.

Policy Initiatives

As Wallack (2005) observed, “Fundamental to media advocacy is knowing what policy goals you want to accomplish” (p. 423). The coalition would support the current bills that are up for consideration in the federal, state, and local governments that curtail student access to “junk food” and vending machines in schools. In addition, the coalition would make recommendations for implementing a mechanism to monitor schools’ compliance with these government regulations. The coalition would also support bill A07323 (New York State Assembly, 2011), which was proposed to create the New York state governor’s council on physical fitness, sports, and health; establish the membership of the council; and create the New York state governor’s council on physical fitness, sports, and health fund.

The coalition would also seek to develop additional school policies to reduce the prevalence of obesity for children. These include (a) a policy that requires the city’s elementary, middle, and high public schools to dedicate a section of the curriculum per quarter toward a tutorial for students on healthy eating habits and exercise (it would include contributing factors to health and weight, societal and

media influences, and so on); (b) a policy implemented throughout the city’s elementary, middle, and high public schools stipulating the hiring of a nutritionist to oversee all school-selected breakfasts and lunches; (c) a policy stipulating that the City Board of Education will hold an annual health and fitness workshop (a standardized curriculum) for the city’s elementary, middle, and high public school students’ parents; and (d) a policy stipulating that pediatricians and nurses take an approved workshop regarding obesity and disordered eating in children (similar to workshops on mandated reporting of child abuse).

The coalition would seek community support for these bills by holding rallies, spearheading a letter-writing campaign to legislators in support of these bills, having school classes make posters, and encouraging students to attend advocacy activities by providing transportation for them to attend (Feinberg, 1997). The goal would be to publicize these issues and inform community members about how these policies directly affect the health and wellness of their children.

Further Research

In this article I presented specific recommendations at the community and policy levels to reduce the prevalence of obesity among children, adolescents, and teenagers in the Central Harlem community. Given the numerous causes of juvenile obesity in urban areas, it is necessary to have a multilevel systemic approach involving parents and caretakers, the school, and the community. These recommendations can be equally useful and easily applied to any urban community where there is a prevalence of childhood, adolescent, and teenage obesity.

To sustain such changes and understand this problem further, experimental studies should be conducted measuring the success and limitations of multisystemic approaches. Additional research may shed more light on the root causes of obesity in specific communities (whether inner city, rural, and so on) and the need for interventions that take into consideration the whole child from a biological, psychological, and social perspective to facilitate long-term incremental change in the fight against this growing problem. **HSW**

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SOCIAL WORK PRACTICE IN CHILD WELFARE

THE INTERACTIONAL MODEL

Lawrence Shulman

Social Work Practice in Child Welfare: The Interactional Model integrates and illustrates practice theory and practice skills. It demonstrates how evidence-based practices can be integrated into a practice framework, consistent with a social worker's professional role, while avoiding overly prescriptive practices. The general practice model is presented, illustrated, and then applied to the different areas of social work in child welfare, including protection, family support, foster care, adoption, and residential care. Process recording examples drawn from child welfare practice are analyzed and then connected to the practice model. *Social Work Practice in Child Welfare: The Interactional Model* presents a paradigm shift from the current medical model to the emerging interactional model. This book is an excellent resource for those social workers and practitioners who work in the field of child welfare.

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— Andrew Malekoff, MSW, executive director and CEO,
North Shore Child and Family Guidance Center,
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