

Helping Without Harming: Exploring the Current State of External Child and Adolescent Wellness Programs

Caity Robinson, UW Nutritional Sciences Program, MPH-Nutrition Student & Dietetic Intern
Project Mentors: Alicia Dixon Docter, MS, RDN, Robyn Duran, ARNP, Lauren Rice, MPH, RDN, Yolanda Evans, MD, MPH

Funding provided by UW LEAH grant from the Maternal and Child Health Bureau

Background

- Wellness programs focused on diets and weight loss have an extremely low chance of sustained success; up to 95% of dieters regain the weight loss within 2 to 5 years and up to 67% regain more weight than they lost.
- Attempts to regulate or control what children and adolescents eat can lead to an increased risk of weight, body image, and eating-related issues.
- Weight management approaches intersecting with weight bias can cause the patient feelings of anxiety, depression, low self-esteem, guilt, shame, and fear.

(Mann et al., 2007, Birch et al., 1999, Puhl et al., 2010)

Objectives

Assess the current state of weight management approaches in child and adolescent wellness programs

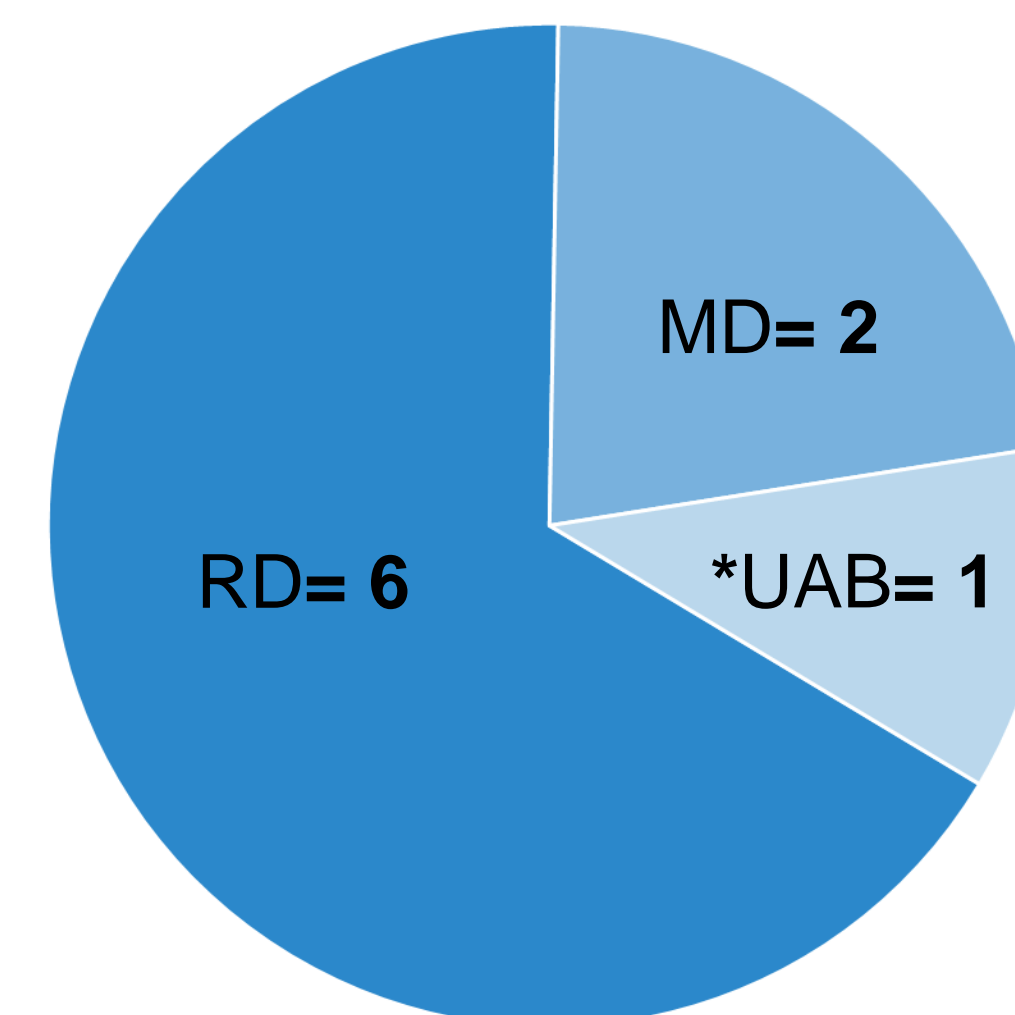
Conduct a literature review to inform recommendations for child and adolescent wellness programs

Please email robinsc8@uw.edu for full list of sources.

Methods and Results

The Child and Adolescent Clinical Weight Management Survey consisted of 12 open-ended questions. The survey was e-mailed to 81 individuals and 9 responses were received representing a total of 7 clinics.

Participant Disciplines and Locations



- UW-Madison University Health Services
- Lucile Packard Children's Hosp. - Stanford
- Mt. Washington Pediatric Hospital
- University of Alabama - Birmingham Hosp.
- University of Minnesota Medical Center
- Children's Hospital Los Angeles
- Boston Children's Hospital

*UAB provided a collaborative response with insight from multiple providers

Common Themes

- Most wellness patients are referred by a PCP
- All clinics report 2+ providers involved in care; common providers include (in order) MD, RD, PT or exercise physiologist, psych, SW
- 3 clinics reported having individual visits only; 1 clinic reported having group visits only. The other clinics were individualized
- 5 clinics reported offering bariatric surgery or partnering with an affiliate surgeon; minimum age ranged from 11+ to 16+ YO
- Commonly reported methods: the use of MI, cognitive behavioral techniques, family-based approach
- Commonly reported interventions: nutrition education (such as food groups, portion sizes, consistency with meals, label reading, or the traffic light diet) + physical activity education. Most clinics stated they avoid teaching calorie counting or doing full meal plans
- Clinic follow-up visits varied, ranging from every month to every 3 months or as needed

Considerations and Next Steps

- The survey had low participation which could have been due to several factors; lack of direct experience or knowledge of clinic's wellness program, feeling ill-equipped or uncomfortable filling out survey, short lead time, or feeling burdened by the length of the survey.
- Recommendations for adolescent programming is often extrapolated from studies done on adults or younger children. More evidence-based research should be considered in clinical programming for adolescents.
- There is still disagreement among healthcare professionals on the purpose and efficacy of weight management services. Overall, more research focused on wellness programming is needed for this population so that providers are able to align and better support children, adolescents, and their caregivers.

Evidence-Based Recommendations

Accept and respect the diversity of body shapes and sizes

Recognize that health and well-being are multi-dimensional

Promote all aspects of health and well-being for individuals of all sizes

Promote eating that balances individual nutrition needs, hunger, satiety, and pleasure

Promote individually appropriate, life-enhancing physical activity vs. exercise for weight loss

- Providers should examine their own biases related to weight and obesity
- Screen for common social determinants of health, including food insecurity, domestic issues, and transportation barriers
- Interventions should include promoting positive self-image, a strong sense of self-worth, and listening to innate signals for appetite, hunger, and satiety
- Encourage the consumption of nutrient rich foods through educational efforts but avoid stigmatizing language such as "bad", "unhealthy", or "junk" foods
- Include the whole family in behavioral change goals, as needed
- Programming should aim for ≥ 26 contact hours and ≥ 7 visits over 2-12 months