Holland Bloorview
Kids Rehabilitation Hospital

Evidence and *real-life learnings* from the heart of care

A Knowledge Translation Casebook for healthcare professionals

Introduction

A note from the team

There are many aspects that contribute to a person's health and wellness. Lifestyle behaviours, such as being physically active and eating well, can contribute to a healthy life. A person's weight may also play a part, especially in cases where higher weights increase the risk of developing other health conditions. However, because the majority of us have grown up in a society that celebrates smaller body-sizes and rejects larger bodies, many healthcare professionals worry that they will offend and alienate children and families by raising the topics of healthy lifestyles and weight management.[1,2] Meanwhile, families and children often assume that healthcare professionals will raise the topics if they have concerns.[3] As researchers who explore the best approaches to talking about weight, wellness and health, we wanted to develop a practical, evidence-based resource to support healthcare professionals to have positive conversations about healthy lifestyles and weight-management with children and their families. Note that throughout this resource when we refer to 'children' we mean those who access the paediatric healthcare system, which include children and youth.

To do this, we decided to create a Casebook, which is a knowledge translation (KT) product that helps to bridge the gap between what we know and what we do. Casebooks are used for sharing knowledge and raising awareness, with the hope of fostering changes in knowledge and practice.[4]

In this Casebook readers will find:

- **Call-out boxes with key information**
- Research Evidence
- Impact Stories
- Key Quotes
- Resources

A word about words

Throughout this Casebook, person-first language is used when referring to obesity, as recommended by Obesity Canada and the World Obesity Federation.

This KT Casebook (herein referred to as 'the Casebook') presents summaries of the research evidence where available, but also the experiences of practicing healthcare professionals, children and families (also known as 'impact stories'). This content is presented through videos, case studies, photographs and other practical resources.

The Casebook provides broad advice on how to talk about weight, health, healthy lifestyles and living well so that healthcare professionals feel well equipped and supported to have these conversations. The Casebook does not address how to treat obesity, how to provide care for those who are underweight, nor those with eating disorders or disordered eating. For further information on eating disorders, visit the Canadian Mental Health Association or National Eating Disorder Information Centre (NEDIC).

Who can benefit from this Casebook?

Many healthcare professionals may find this Casebook useful, including nurses, dietitians, physicians, occupational therapists, physiotherapists, psychologists, social workers and any other clinicians who work with children and their families.

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Guiding your conversations

The Casebook has been organized into five sections (see **Figure 1**). They are are based on five key questions that were created by a research advisory panel involved in a scoping review of best-practices in weight-related communication.[5] The questions are not intended to be all-encompassing, but represent a practical way to approach and facilitate positive conversations with children and families about weight, wellness, health and growth.

Figure 1. Key questions to help guide weight-related conversations

Don't forget to ASK

Always ask permission before initiating a conversation about lifestyle and weight.

Research Evidence

McPherson et al. recently conducted a scoping review of best-practices in weight-related communication literature (2005 to 2016) that focused on how healthcare professionals communicate about healthy weight, overweight, obesity or healthy living with children and families.[5] From 32 articles, 8 guiding principles were derived (see **Box 1**), supported by the best available evidence. While many recommendations in this Casebook are underpinned by published research, experiential and contextual evidence, it is important to note that more research is needed in this area.

Note: Not all of the guiding principles will be appropriate for every family. Throughout the Casebook, we provide examples of how they can be tailored to individual family contexts.

Box 1. Guiding principles for weight-related communication.[3]

- Approach the topic of weight in terms of growth and health
- Communicate trust and respect through active listening
- Explore family perspectives through open questions, being collaborative and solution-focused
- Explore with the family what terminology they prefer to use
- Start conversations early in a child's life and discuss regularly
- Involve all relevant stakeholders (child, parents, other family members where appropriate) in discussions
- Avoid idioms or euphemisms to describe overweight and obesity, and clarify meanings of any terms used
- Motivational interviewing techniques may be helpful in engaging children and parents

Who should participate in weight-related discussions?

There are many ways to involve children and families in weight-related conversations. Knowing who should be involved in the conversation early on and being respectful of their voices allows more meaningful conversations to take place.

Research Evidence

Consideration of the individual child should always be at the centre of discussions. Families should be consulted on who should be involved in the discussions. Some children may prefer discussions to occur initially with their families. Other children are happy to be included in weight-related discussions, especially as they near or enter adolescence.[6] Some families may benefit from inviting other members (e.g. grandparents) who provide regular care for the child to be part of the conversation. This approach can be helpful in creating home environments that will help to sustain healthy habits.[7,8] While the best available literature generally supports the inclusion of all of the key stakeholders in discussions,[5] healthcare professionals should explore with each family how best to provide personalized care within their particular family context.

A summary of who should be involved in conversations is provided in **Figure 2**. Although evidence supports the involvement of a familiar, trusted healthcare professional in weight-related conversations, this may not always be possible. The ability to establish rapport, use appropriate language and adopt a respectful approach can all support positive conversations in this situation, and is often more important than engaging with a particular provider discipline (e.g., physician, dietitian).

Research Evidence

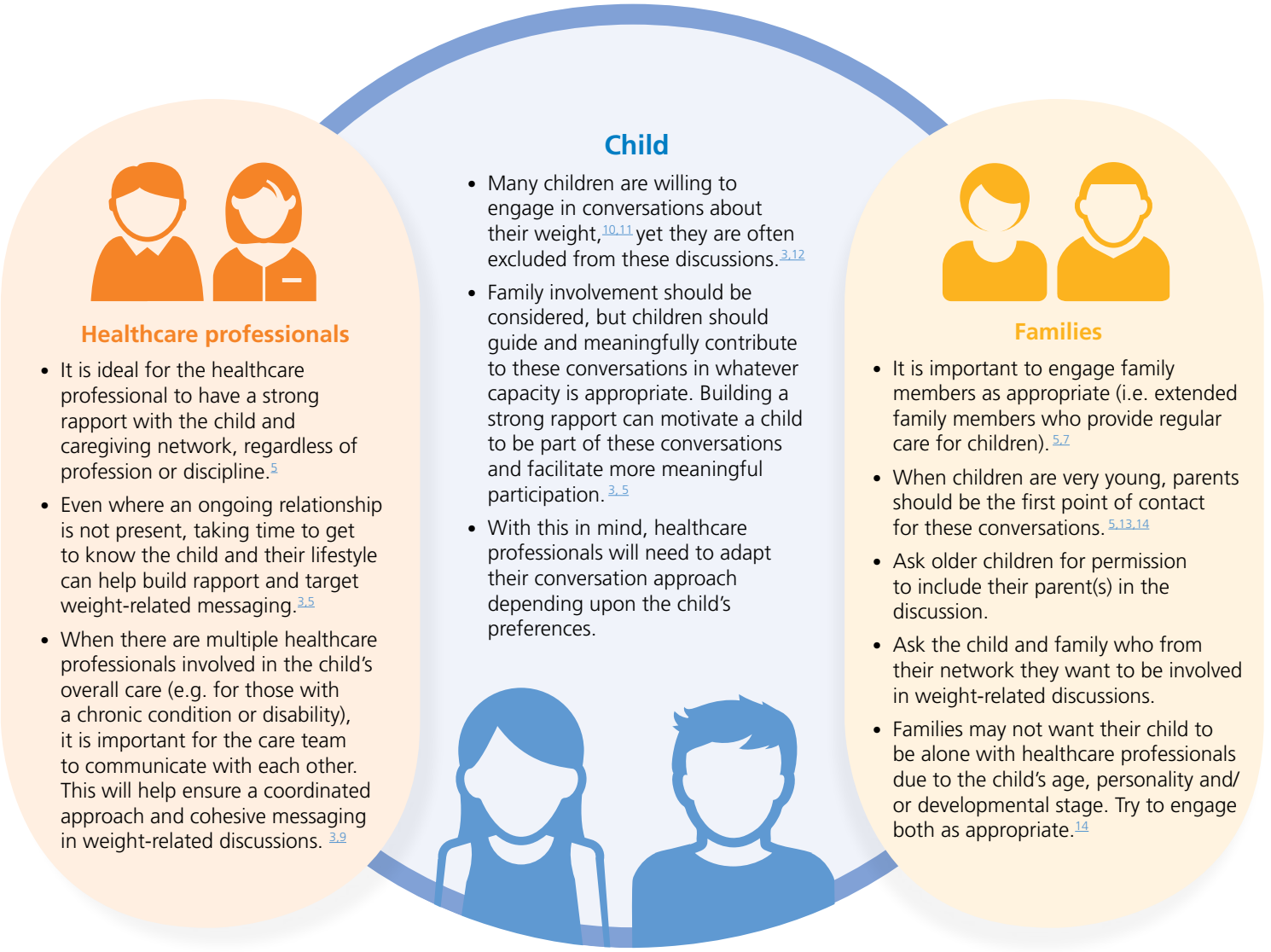


Figure 2. The 'who' of engaging in weight-related conversations

Resource

Who to engage in weight-related conversations

The Australian government established a set of guidelines[15] identifying the need to engage a number of healthcare professionals in weight-related conversations. Check out Table 3.1 of this resource.

CLICK HERE TO WATCH THIS VIDEO

Impact Story

Hear from Susan Cosgrove, a Family Leader at Holland Bloorview Kids Rehabilitation Hospital, about the importance of engaging family members in weight-related conversations.

> *The doctor now is much better because they treat me like a friend and helps me feel good about my body because they really understand me, my problems and my life.*
>
> – Charlotte, 11[16]

When and how should the topic be raised?

Healthcare professionals often don't know when and how to broach the topic of weight with children and their families. While these conversations can be difficult, it is important to create a safe environment for discussions to take place.

Research Evidence

When and how to raise the topic of weight can be complicated. Key considerations from the evidence include:

- Be sensitive to the individual's cultural values, belief systems and family circumstances (e.g. age of child, other children, access to food, parent weight status) [9]
- Don't expect to address all of the conversation elements in one discussion. Use a staged approach, sometimes over several visits, if necessary. [17]
- Discuss the importance of establishing **healthy behaviours** (instead of focusing upon weight itself)
  - Focus on growth and health, rather than weight and obesity [5]
  - Emphasize the wide-reaching benefits of healthy eating and physical activity [17,18]
  - Consider ways of getting the whole family involved to discuss strategies for healthy lifestyles. Consider a family's circumstances [3,9]
- Create an environment where there is mutual respect, trust and openness [5]
- Use a strengths-based approach to weight-related discussions [3]
  - Focus on a child's and family's strengths and celebrate any successes to promote therapeutic engagement and motivation
  - Be positive. When applied to paediatric weight management, children respond better to positively-framed messages than to scare-tactics and negatively-framed messages [19,20]

Consider a strengths-based approach

Strengths-based approaches focus on strengths rather than deficits, look for solutions and resources rather than what needs to be 'fixed', and emphasize what is working versus what is not.[21] Look at the techniques section for strengths-based resources.

Resource

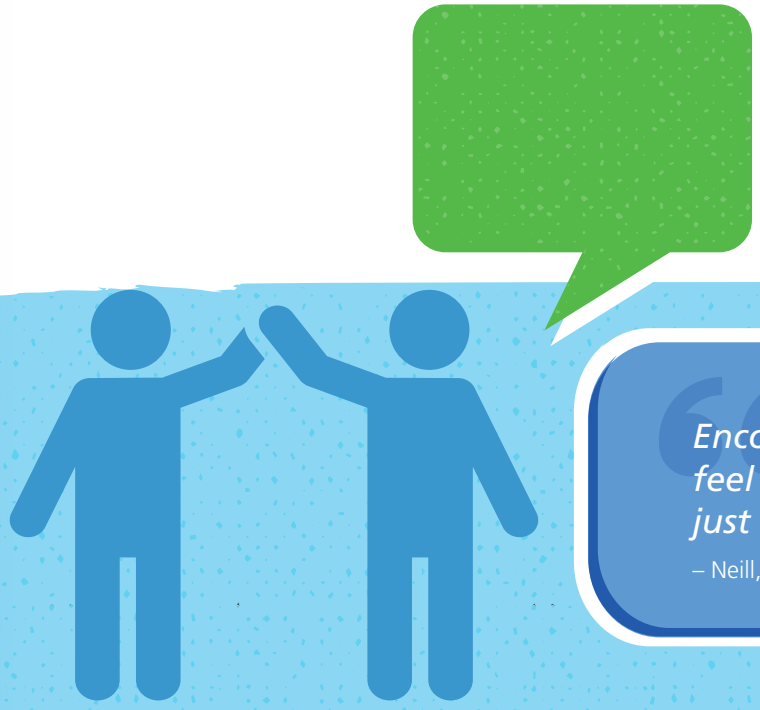
Planning weight-related discussions

Watch this video developed by The Hospital for Sick Children summarizing key considerations[5] when planning weight-related conversations.

CLICK HERE TO WATCH THIS VIDEO

Read this: American Academy of Pediatrics

The American Academy of Pediatrics promotes the optimal physical, mental and social health and well-being for children and youth. Read their policy statement on *Stigma Experienced by Children and Adolescents with Obesity* to learn about weight stigma in everyday life including healthcare.



Encourage them…not make them feel bad about themselves; that'll just make them want to do less.

– Neill, 15[20]

BEFORE YOU START THE CONVERSATION

Things to consider

To foster positive conversations about health behaviours and weight, it is important to create a safe environment where healthcare professionals, children and their families feel comfortable sharing openly. People with weight-related concerns may be reluctant to speak to their healthcare professional due to fear of judgement, scolding or humiliation.[25] Creating an atmosphere that demonstrates respect, understanding and openness will invite children and families to comfortably participate in conversations.

Here are key considerations to keep in mind:

1. Understand that obesity is not a personal choice

- Obesity is complex and attributed to a variety of different factors including environment, genetics, health behaviours, emotional health, medical issues and medications.[22]

2. Recognize your own biases

- Weight bias refers to negative weight-related attitudes, beliefs, assumptions and judgements toward individuals living with obesity[23] and is common everywhere, even in healthcare.
- Experiencing weight bias has many negative consequences, including feelings of shame and guilt, mental health issues (e.g. anxiety, depression), poor self-esteem and body dissatisfaction, as well as unhealthy weight-control practices, increased cortisol secretion and weight gain.[23, 24]
- Recognizing our own biases is a first important step in avoiding discriminating against people living with obesity.[25]
- Research shows that shaming, blaming, teasing and stigmatizing does not motivate positive behavior change; it promotes the opposite.[26-29]

3. Ensure the physical environment is private, quiet and comfortable

- Key considerations include: room arrangement, availability of appropriate equipment, comfortable seating for all body sizes and privacy.
- When having the conversation directly with the child, give them a few minutes alone before or after talking with families, where appropriate.

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BEFORE YOU START THE CONVERSATION

Things to consider

4. Allow for dedicated time to have discussions

- Talking about obesity and weight can be difficult. Set aside protected and dedicated time (across several visits if necessary) to ensure that these conversations are not rushed.

5. Be mindful of the words you choose and how the child and family responds to your wording

- Be aware that terminology may be received differently by children and families. Be prepared to explore with families what **their** acceptable terms are. Take a look at the section on "What should healthcare professionals say" for some ideas.
- Agree upon a cue that the child and family can give the healthcare professional to indicate that it is a 'safe time to talk'.

6. Prepare resources to support the child and family

- It is important not to overwhelm children and their families with information.
- Consider using resources that address varied ages, family circumstances, cultural believes and values, and that are in different formats such as binders, books, colouring sheets, etc. Many different resources are provided in this Casebook that may be helpful.

Resources

Weight bias

To learn more about weight bias and to access toolkits and resources, visit:

Rudd Center
http://uconnruddcenter.org/weight-bias-stigma

Obesity Canada
https://obesitycanada.ca/weight-bias/

Balanced View
https://balancedviewbc.ca/

Impact Story

Brenndon Goodman is a political science student at York University working towards an Honors Bachelor of Arts. He is a member of the public engagement committee for Obesity Canada and is a passionate voice for people living with obesity.

BRENNDON

What have been your past experiences of having conversations with healthcare professionals about your weight?

Every time I went to my doctor as a child, no matter the reason, I was bombarded with negative comments by my paediatrician about my obesity. By making every appointment related to my weight, I would dread going to the doctor. He would instill panic in my parents that caused them to put me on crash diets. By my teenage years, I stopped going to him altogether. Instead, I would go to walk-in clinics if I needed medical treatment.

> *I was once told that I would be dead before I reached 30 years. How would that help a 10 year old child?*

How did those encounters make you feel?

I felt horrible. I would be carted to dietitians and specialists around the city, many of whom would either try to scare the weight off me or have unrealistic dietary expectations for me on the first visit. I was once told that I would be dead before I reached 30 years. How would that help a 10 year old child? All of this culminated in a deep distrust of the medical system and its ability to deal with obese people in a productive and respectful manner. I would try and avoid medical help with my weight as much as possible.

How do you want to feel after discussing weight and wellness with your healthcare professionals?

I would like to feel empowered and confident that I can reach a healthier lifestyle myself and with the help of my doctor. I think that a person should leave a doctor's office in the right frame of mind and this is paramount for dealing with their situation. If the individual is not in the right place mentally and feeling good about themselves, it is highly unlikely that their weight loss journey will be a positive experience.

> *I would like to feel empowered and confident that I can reach a healthier lifestyle myself and with the help of my doctor.*

What advice do you have for healthcare professionals when having these conversations with children and/or families?

Children are not always ignorant to what is occurring to their body and their health. When I was 6 or 7 years old, I fully comprehended than I was much larger than the other kids and that it was unhealthy. I did not need to be reminded of this fact at every visit to the doctor and made to feel ashamed of myself. Ask the patient what lifestyle changes they are willing to make and which they believe that they will be able to follow through with - try not to tell them what changes they must make. Above all, don't try to scare a patient in an attempt to get them to change. Positive feedback always goes a long way when compared to negative scolding.

Impact Story (cont'd)

> *Ask the patient what lifestyle changes they are willing to make and which they believe that they will be able to follow through with – try not to tell them what changes they must make.*

What advice do you have for children and families when having weight-related conversations with healthcare professionals?

Do not be afraid to speak your mind when dealing with a healthcare professional that you feel is not communicating well or is making every visit about weight. You should speak up for yourself and challenge the healthcare professional if you are not comfortable with the advice or approach. You are entitled to feel as you do!

Finally, know that long lasting change will only occur when both sides of the conversation are willing to make changes. Listen and respect what the other is saying. This should be a team effort, including the family and healthcare professionals. When only one side is fully committed, any changes that occur will only be short term.

Thank you Brenndon.

WHEN GETTING THE CONVERSATION STARTED

Things to think about

DO

- Always ask permission to have the conversation. (e.g. see conversation starters for suggested wording).
- Use person-first language (e.g. "person with obesity").
- Make eye contact and talk to children and families equally.
- Ask children and families what is important to them to feel healthy and well.
- Listen.
- Affirm and acknowledge the child and family's responses, even if you don't agree with them. Seek common ground to move forward.
- Hold genuine interest in what children and families have to say.
- Make growth and healthy lifestyles a part of every consultation (as appropriate). This can help to de-stigmatize the topics.
- Talk about the benefits of healthy lifestyles and healthy home environments for children and the entire family.

DON'T

- Over-simplify the problem or solution (e.g. just move more, eat less, it's just a matter of will power).
- Assume the reasons for weight-related issues (e.g. they are not taking their health seriously).
- Assume that families are not already engaged in healthy behaviours.
- Be judgemental or use shame, blame or scare tactics.
- Leave a family without resources and next steps.
- Assume that families are ready, willing and able to make changes right away.

Resources

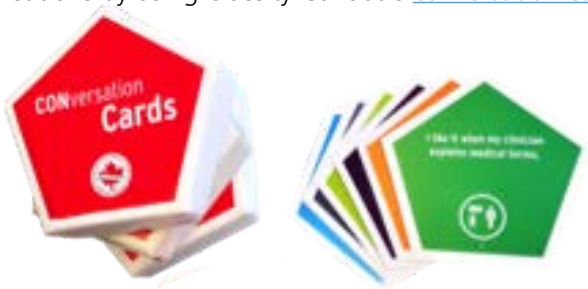
5As of pediatric obesity management

Asking for permission is the first 'A' of Obesity Canada's 5As of Pediatric Obesity Management resource.

This resource is free to Obesity Canada members. To become a member and access this resource, visit: https://obesitycanada.ca/5as-pediatrics/

Child and family priorities

Ask children and families about their priorities for weight-related conversations by using Obesity Canada's conversation cards:



Tip: Customize the CONcards to the needs of the child and family

Try this: Need some help getting the conversation going?

Try these conversation starters:

- *Would you be willing to spend a few minutes talking about ways to stay healthy and energized?*
- *Are you interested in knowing more about ways to stay healthy? How can I help?*
- *Can we take a few minutes to discuss your health and weight?*
- *Would it be alright if we discussed your (child's) weight?*

> *I feel like they assume just that I was sitting on the couch eating, like a bunch of chips… and that just wasn't me.*
>
> – Alexis, 15[8]

Try this: Put the family in charge!

There are many different times, places and ways that healthcare professionals, children and families talk about wellness and weight. If you are planning to have a dedicated conversation about a child's lifestyle and health as it relates to their weight, it may be useful to have a tool or strategy to engage them without compromising the therapeutic rapport or promoting feelings of blame and shame. One such technique is to allow the child and family to direct the agenda for the discussion so that the topics can be meaningful and relevant to their family context. This also allows the healthcare professional to learn how the family would like to be included in the future.

Try the following exercise:

Have children and families identify 5-10 meaningful items, such as goals, questions and ideas on blank cue cards at the start of a meeting. These should be topics that are important to them. Examples can include:

- I'm/my child (is) too shy to talk about weight with healthcare professionals
- I'm/my child (is) ready to make lifestyle changes
- It is important to me/my child to feel listened to in appointments
- I/my child like(s) when you explain what you are saying in plain language

Healthcare professionals then ask the child and/or family to divide the cards into two piles:

- Pile 1: Items that they want addressed today
- Pile 2: Items that can be addressed at another appointment

Have the child/family pick out 1 to 3 items from pile 1 that they are willing to talk about during the current session (depending on the length of the session).

Need more help to use this approach or some ideas?

There are products available to help guide these types of activities. Consider using a Motivational Interviewing Card Sort or using Obesity Canada's CONversation cards (available for purchase). Such pre-packaged cards can be reviewed and sorted for relevance and importance by the family, providing healthcare professionals with an understanding of what is important to children and families and setting the tone for the session.

Growth charts

Growth charts are often standard practice (especially for physicians, nurses and dietitians) for recording a child's growth, using their height and weight calculated as their body mass index (BMI). In children, BMI percentile or z score is frequently used. Growth charts indicate how the child's growth compares with that of other children, specific for age and gender (called 'norms' or 'normative data'), in order to classify their weight status (i.e. underweight, normal weight, overweight, obese). Both the World Health Organization and Centers for Disease Control and Prevention have specific cut-offs for overweight and obesity.

Research Evidence

Children, families and healthcare professionals have expressed support of growth charts if used as a non-judgemental way to facilitate conversations about a child's weight status.[1, 30-32] However, they can also be confusing for families. [33] Simplified visuals have been developed (e.g. the BMI ruler [33]), but empirical evaluations of such tools are sparse. The use of BMI has also been criticized, as it often fails to identify children at risk of obesity-related conditions.[34]

What are good things about using growth charts and BMI?

- Plotting growth over time to show a trajectory: A steeply increasing weight trajectory on a growth chart may indicate that proactive discussions of preventative strategies are warranted
- Helping healthcare professionals provide a rationale for the lifestyle changes that they are recommending
- Supporting discussions, especially when a healthcare professional is not fluent in the child/family's native language[35]

What are the drawbacks of growth charts and BMI?

- Growth charts may be used to shock and shame children and families (e.g. 'your child is off the chart!')
- Children and families may find them hard to interpret
- Plotting just one point in time does not provide useful information
- BMI provides no information about a child's body composition (e.g. extent and distribution of lean tissue)
- BMI provides no other contextual information (e.g. How is the child's metabolic and mental health? What is their lifestyle like?)
- No normative data exist for many children, including those with disabilities or with severe obesity

Remember: The impact of discussions based on growth charts can be considerable and lasting.

> *When I go home and they're like 'oh, she's not where she's supposed to be' [on a growth chart] it's like, great, that's another thing that I have to think about every single day*
> – Alexis, 15[8]

Try this: Building a broader clinical picture

The Edmonton Obesity Staging System for Paediatrics (EOSS-P) is an emerging approach for assessing the impact of a child's weight on their health.[34] It combines information about BMI with a comprehensive exploration of the mental, mechanical, metabolic and milieu drivers, complications and barriers to weight management. More information can be found within the 5As material.

What should healthcare professionals say?

Words matter. As healthcare professionals, it is important to think about what terms to use in order to communicate respect and caring, and develop a trusted relationship with children and families.

Research Evidence

Different stakeholders (e.g. children, families, healthcare professionals) have different preferences about the types of terms to use when having conversations. Preferences in terms differ based on who is asked. The terms *fat*, *extremely obese*, *chubby* and *obese* have been rated by families as least desirable, most stigmatizing and least motivating terms.[36] Adolescents with overweight or obesity have reported different acceptable terms that can vary by gender, but considered the word *fat* to be broadly undesirable.[37] If *overweight* and *obese* are used, healthcare professionals should explain what they mean in a non-judgemental manner. Taking a health promotion approach that emphasizes *wellness* and *healthy living* has been advocated by families.[3] Given the variation in preferences, ask first what terms families prefer. See **Figure 3** for practical tips.

> *I always think doctors and stuff should, like, always ask people, even if it says that THIS is the recommended word, still ask…'what words do you like'…*
>
> – Adele, 16[8]

Research Evidence

What to avoid

- Unclear language to describe overweight and obesity (e.g. idioms, euphemisms, medical jargon)
- Blaming language or focusing on what the child can't do or should stop doing
- Labelling children according to body type terminology (e.g. endomorphs, ectomorphs, apple, pear)
- Using growth charts to shock or shame children
- Solely focusing upon weight, size or BMI
- Comparing children with norms where little normative data exist (e.g. children with disabilities,[31] differing body compositions, severe obesity)

What to focus on

- Health and growth
- Overall wellness
- Terms and words that children and families prefer to use
- Clear communication and clarification of the meanings of any terms being used
- An optimistic, strengths-based approach
- Acknowledgement that both height and weight are the result of the interaction of genetics/ heredity and the environment
- Body diversity (i.e. people come in different shapes and sizes)

Considerations

- Think about using a script to help get the conversation started with terminology that everyone is comfortable with
- Highlight what children and families are doing well and can do
- Use growth charts to plot growth trajectories over time rather than at just one point
- Think about contextual information (culture, beliefs, gender, overall health conditions)
- Ask open-ended questions (e.g. What are your health goals? What is important to you health-wise?)

Figure 3. How to promote a positive weight-related conversation

According to the Porcupine Health Unit[38] a person with a healthy body weight:

- Feels good about what they are eating
- Enjoys eating a variety of foods
- Is active with friends and family
- Acknowledges that they are much more than just a body

Try this: Use a solution-focused approach when having a weight-related conversation

Instead of…	Try
Saying "but"	"And…" "What else?" "What do you think about that?"
Saying "What are your concerns?"	"How can I help?" "What is better?"
Thinking "he is so stubborn/resistant"	"He really knows what he wants"
Writing "She can't do…"	"She is able to do this with support"

Credit: Solution-focused cue cards, Thames Valley Children's Centre

For guidance on terms that may be more or less preferable to individuals, children and families, please see **Table 1**. Remember, explore with the child and family what terminology they prefer.

Table 1. Terminology for weight-related conversations

Preferred terminology and statements	Inappropriate terminology and statements
• Best weight for you	• Fat
• Healthy goals	• Lazy
• Healthy growth	• You're going to have a heart attack
• Optimize health	• You're going to get diabetes
• Growth and development	• You're going to die
• Continue doing…	• Just try
• How do you feel about…	• Eat less, move more
• What does healthy mean to you?	
• Eating patterns/habits	
• Let height catch up with weight	

Adapted from: *A Guide for Health Professionals: Assisting Parents and Guardians in Communicating with their Children about Body Weight*.[39]

What is meant by 'best weight'?

A person's 'best weight' has been described as "whatever weight a person achieves while living the healthiest lifestyle they truly enjoy."[40]

For more information on this definition of best weight, visit https://obesitycanada.ca/publications/best-weight-book/

Try this: Here is a script to consider when talking about weight:

"Most children are still growing in height and our goal is to slow [child's name] weight gain or maintain his/her weight."[41]

Remember: It's not about the number on the scale. The most important thing is having a healthy lifestyle.

Resource

Using the right words

Sometimes, families ask healthcare professionals for advice on the words to use with their child. Consider providing this Weigh in Guide as a resource. It may also help healthcare professionals answer some common queries families have.

How can healthcare professionals enhance family engagement?

It is important for healthcare professionals, children and families to work together. Establishing rapport and a strong therapeutic relationship with children and families is essential to having meaningful discussions.

Developing a good therapeutic relationship is key to engaging children and families in any healthcare discussion, but especially when communicating about weight-related issues. Figure 4 provides some considerations to help guide weight-related conversations.

> *Like we talk about other topics too, like what goes on at school and stuff, and then we get into the topic [weight]. But it's eased in. So it's not directly to that. It's kind of like gaining the person's interest sort of thing.*
>
> - Sarah, 16[3]

Figure 4. Getting ready to talk about weight

Rapport building

- Ensure there is an appropriate and safe space to start the conversation (see the section on "before you start the conversation" for examples of safe environment tips)
- Ask permission to open the conversation
  - Use active listening techniques [5]
  - Ask open questions and acknowledge the concerns brought forward by the child and family [5,39]
  - Talk about growth and health, rather than weight and obesity [5]
  - Understand which aspects of health and wellness are important to the child and family [3]

Ready to talk

Considerations:

- Who is in the room: age, independence/function, family dynamic, culture, history (social, medical), expectations (child, family, healthcare professional), readiness for change/motivation
- What they need: communication style, emotional support, resources

Approaches:

- Work with families to identify goals, barriers and drivers for them and their child in their context [14,42]
- Support families to suggest and initiate healthy changes [14]
- Consider examples in the child's and family's lives that provide natural opportunities for change [39]
- Ask (don't assume) how the child is feeling
- Ask them what support they would find helpful [39]
- Set SMART (Specific, Measurable, Attainable, Realistic, Timely) goals and support family-centred lifestyle modifications

Not ready to talk

Considerations:

- Families may be sensitive about any perceived criticism of their caregiving skills [39]
- They may be anxious or worried about their own weight or that of their child(ren) [39]
- They may not have felt 'heard' in the past

Approaches:

- Respect the child and family's wishes [39]
- Let them know the conversation can take place at any time [39]
- Emphasise that help will be available whenever they are ready
- Offer the opportunity to speak to another healthcare professional [39]

Now ready to talk

Still not ready to talk

- Try revisiting at another time
- Be patient

Maintain a safe, open, strengths-based approach
Plan for appropriate follow-up

Resource

Tracking and harnessing strengths

In the Toolkit Healthy Living... It's in Everyone: A guide to healthy living for families who have a child or youth living with mental health challenges, examples of how to track and harness strengths are provided.

Impact Story

Meet Alisa, RD

Alisa Bar-Dayan is a registered dietitian with 15 years of experience. She has been working in the SickKids Team Obesity Management Program (STOMP) since it began in 2010. In this capacity, she works with teens and families, providing clinical services to improve the health and well-being of children and youth living with obesity.

ALISA

> *Be real and put yourself in their shoes.*

What is your first step when working with children with obesity?

I find that relationship-building is an essential step for having conversations about weight. Taking time to build a relationship is important before getting into sensitive topics such as weight. The first few sessions might be very simple and basic … slow steps lead to more long-term success and positive relationship-building.

How do you start the conversation?

When working with teenagers, I always ask permission to discuss topics such as healthy eating and nutrition goals before diving in. From my experience, rushing or pushing clients to set goals or talk about weight when they don't want to, can result in the session becoming a failure.

How do you decide who should be involved in the discussion?

I always carefully consider if and how other family members, such as parents, should be involved in clinical conversations about weight. If I think that a teen's parent(s) might be a good support in helping to carry out the teen's goal, for example around nutrition, I ask teens for permission to involve parents, and explain the importance of including family members or other supports who can contribute to the conversation. When it comes to working with younger children (~<6 years), I usually work with the child's parent(s) to educate them about nutrition and how to implement changes in child and family daily routines. I have found Motivational Interviewing to be a particularly helpful technique when providing education to clients and working with them to set and achieve nutrition goals.

How do you engage with children and families?

In my experience, I find that conversations go well when the appropriate wording is used with no judgements. It is critical that clients feel comfortable talking about a subject that is typically difficult to talk about. Many of the teens I work with feel judged and shamed, and so I try to alleviate such feelings by explaining that I am there to support them and that parents shouldn't feel judged either or feel like they are being criticized for their parenting styles and techniques.

Do you have any advice for other healthcare professionals?

Be real and put yourself in their shoes. Empathy is so important when working with patients and families. Be sensitive and think about your word choices before speaking.

Thank you Alisa.

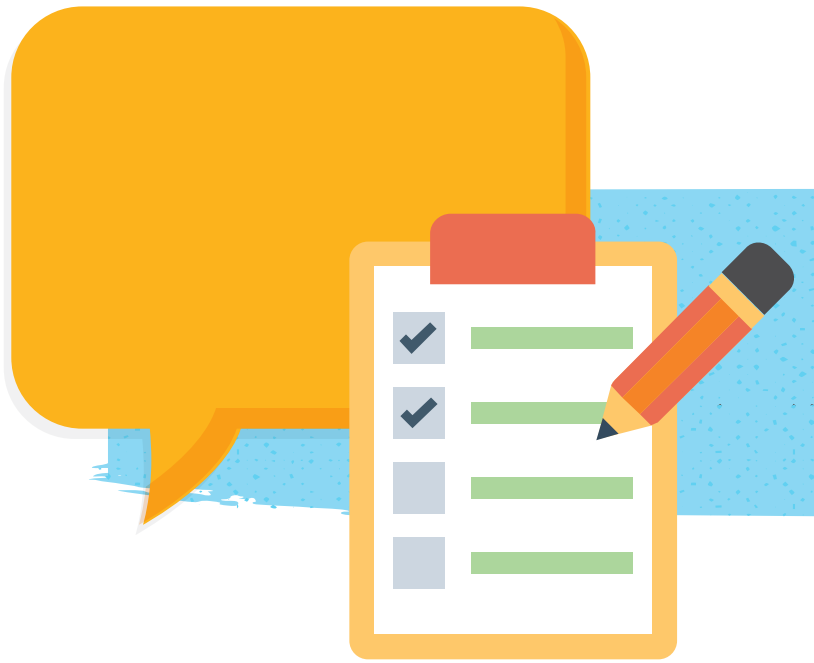
What techniques have been recommended?

Healthcare professionals are encouraged to use strengths-based approaches to facilitate positive and meaningful, client-centred weight-related conversations.

Both research and experiential evidence suggest that taking a strengths-based approach highlighting what the child **can** do, rather than what they cannot do or should stop doing has demonstrated benefits when promoting healthy lifestyles.[3, 5, 19, 20]

Strengths-based approaches can result in hope, motivation and action.[43] These approaches are also much briefer, and behaviour change is less costly using strengths-based approaches than problem-based approaches.[44]

Two strengths-based approaches are highlighted here: Motivational Interviewing (MI) and solution-focused coaching. In-depth instruction of either approach is beyond the scope of this Casebook, but key principles are outlined, as well as resources to support healthcare professionals to use MI and/or solution-focused coaching approaches when having weight-related conversations.



Motivational Interviewing

MI aims to foster collaboration using goal-oriented communication.[4,5] MI uses non-judgemental questions and reflective listening to uncover beliefs and values. This approach avoids the defensiveness created by a more directive style.[7]

Research Evidence

A significant body of work has looked at the use of MI in paediatric weight communication. However, there is variation between studies in the target populations, persons delivering the MI intervention, delivery mode, purpose and dose of MI.[5] MI appears to be helpful in engaging children and families, and may be particularly helpful when combined with other approaches. Combining MI with family involvement, for example, has shown to lead to enhanced nutrition, activity, health, psychosocial and anthropometric outcomes.[46] However, more work is still needed to determine its exact mechanisms of change.

Resources

MI infographic

Check out this infographic developed by the American Council on Exercise highlighting key MI techniques.

Using MI in obesity prevention

Barlow[7] discusses how to use MI through an example of an obesity prevention protocol. To review this protocol, see Table 4 of Barlow's open access paper.

MI App

The American Academy of Pediatrics Institute for Healthy Childhood Weight has a web and mobile app called "Change Talk: Childhood Obesity." This uses an interactive virtual practice environment to train paediatricians about the basics of MI.

Solution-focused coaching with children

Solution-focused coaching is where healthcare professionals act as a coach and use strategic questions to help children identify personally meaningful goals and develop practical solutions using their own available strengths and resources.[47] Children are empowered to assume ownership over their goals and develop self-regulation. Using active listening, empathy and affirmative language helps develop a trusting relationship whereby the child can achieve their goals. It can also be customized to children and families' resources, environmental settings, child's age and developmental stage.

CLICK HERE TO WATCH THIS VIDEO

Watch a short video that explains the difference between solution-focused coaching and traditional problem-based approaches.

Research Evidence

Coaching has been used to improve and sustain a range of health habits in children.[48] There is some evidence to support solution-focused coaching for weight management. Research has shown telephone coaching of children and their families to be beneficial in fostering dietary improvements and increased fitness.[49] Children with obesity have also reduced their BMI in response to a group-based coaching intervention.[50]

Resource

Key principles of solution-focused coaching

Organization Development by Mike Cardus identifies key tenets of solution-focused coaching. To learn more, download the "Major Tenets of Solution-Focused Coaching" information sheet.

DOWNLOAD

Try this: Solution-focused coaching sample conversation about weight and healthy lifestyles

Key aspects of the solution-focused coaching conversation	Example of the solution-focused coaching conversation	How it helps the client
Contracting: The coach and client come to an agreement about what they will discuss, based on the client's priorities	**Coach:** I'm glad you came in to see me today and I understand you have some concerns about your son. What will be most useful for you in our conversation today? **Client:** I'm worried about my son. He's already jumped 2 sizes this year and my mom had diabetes, and I'm not sure what to do about it. **Coach:** It sounds like you are concerned about your son's health. What needs to happen in our conversation that will make it worthwhile for you coming in today? **Client:** Maybe if I knew how to help him have a bit more of a healthier lifestyle. **Coach:** Ok. So, if after this conversation you had some ideas for how to help your son live a healthier lifestyle, would that be helpful? **Client:** Yes, very.	• The client can articulate what is important to them and what they want to change. • Coach and client have an agreed-upon starting point for their conversation, based on what is important to the client.
Exploring the preferred future: The coach asks questions to support the client to envision what will be different when things are closer to what they want	**Coach:** Suppose tomorrow you knew what to do to help your son have a healthier lifestyle, what would be different? **Client:** I would know exactly what changes to make. **Coach:** And what difference would that make? **Client:** Well, he would be eating better and be more active. **Coach:** OK so 2 things would be different. He would be eating better and he would be more active. Which one do you want to start with first? **Client:** I guess eating better. **Coach:** Ok. So suppose your son was eating better, what difference would that make? **Client:** He would have more energy.	• The client generates their own vision of what they want to be different in the future, based on their own values, priorities and life. • It supports the client to envision a time when things are better and increases their ability to see that positive change is possible.

Solution-focused coaching sample conversation about weight and healthy lifestyles (cont'd)

Key aspects of the solution-focused coaching conversation	Example of the solution-focused coaching conversation	How it helps the client
Exploring the preferred future: (cont'd)	**Coach:** What else? **Client:** If he was more active I think he would feel better about himself. **Coach:** Who else would notice a difference? **Client:** I think his sister would notice. **Coach:** What would she notice? **Client:** Maybe he would have the energy to play outside with her more.	
Exploring precursors: The coach asks questions to support the client to identify past successes, when things were already a bit closer to what they want	**Coach:** Okay, so on a scale of 1 to 10, where 10 is you know how to support your son so that he is eating really well and he has more energy and he's playing with his sister more, and 1 is the opposite, where are you now? **Client:** Maybe a 3. **Coach:** How did you manage to get to a 3? **Client:** I've stopped buying so many treats when I grocery shop and I try to pack him a healthy lunch for school every day. **Coach:** That's great! What else? **Client:** Sometimes we snack on veggies and dip instead of chips when we watch TV or movies. **Coach:** Fantastic. What else? **Client:** I can't think of anything else. He's a picky eater so he only eats the stuff he wants to and he leaves the healthy stuff.	• Client identifies their existing strengths, resources and ideas. • Ideas and strategies that have worked in the past begin to emerge. Ideas are relevant to the client's lived experience.

Solution-focused coaching sample conversation about weight and healthy lifestyles (cont'd)

Key aspects of the solution-focused coaching conversation	Example of the solution-focused coaching conversation	How it helps the client
Progress clues: The coach asks questions that support the client to think about small, realistic steps that can get them closer to what they want	**Coach:** And what would be different if you were one point higher on that scale? **Client:** We would be eating less fast food. It's just that I know he likes it and it's so much easier than fighting with him to eat the food I cook him. **Coach:** So he'll be eating the food you cook for him. Have there been times when he does eat what you cook? **Client:** Yeah, when he gets to pick, like his birthday or whatever. Maybe I could get him to help pick foods that he likes every week so I can cook them at home. **Coach:** That's an interesting idea. What are your ideas about how to do that? **Client:** Maybe he could pick one night a week what he wants to eat, as long as it's healthy, and I could make that for the family. **Coach:** I think that's a great idea. So after this conversation today, what will be a small sign that you are making progress? **Client:** I can talk to him about healthy meals and we could look online to find healthy dishes that I could cook. **Coach:** I am so impressed with this idea you have come up with. It's clear to me that your son's health is really important to you. On a scale of 1 to 10, how confident are you that you will do this? **Client:** About a 5. **Coach:** What could make you a 6? **Client:** I don't know what websites to look at. **Coach:** Would it be helpful if I gave you a list of a few good websites to help you with healthy food choices? **Coach:** Yes that would be helpful.	• The client begins to develop a plan that is tailored to their own life and is realistic for them. • The client has a sense of ownership over the steps they will take. • The coach can offer technical knowledge or supports to help the client move forward, but the plan remains the client's.

Children with Disabilities

Children with disabilities live in the same environment that has led to increased levels of obesity in typically developing children.[51] There are also a number of other factors that further increase the chances of children with disabilities developing higher weights.[52] These can include things such as mobility impairments, medication and sensory issues.[53,54]

Children with disabilities experience the same physical consequences associated with childhood obesity as typically developing children, but these can be intensified and result in conditions such as pressure ulcers, muscle loss, pain and further mobility limitations. These changes in turn can affect everyday functioning, independence and quality of life. [55, 56]

This section of the Casebook builds on the general principles detailed previously and highlights some of the physical, psychosocial and cognitive issues many children with disabilities experience that add a layer of complexity to discussions about weight. To do this, we have used two examples: a life-long physical disability (spina bifida) and a neurodevelopmental disability (autism spectrum disorder).

Spina Bifida

What is it?

Spina bifida is a neural tube defect affecting approximately 1 in 1000 live births in North America.[57] It affects the spine and can damage the spinal cord and nerves. Depending upon the level of spinal damage, children with spina bifida may walk unaided or with support, and/or may use a wheelchair. Spina bifida is now a non-progressive, life-long condition,[58] making long-term health a particularly important part of clinical care. Obesity is approximately twice as common in young people with spina bifida compared with typically developing peers.[59]

Considerations for weight management in spina bifida

- Children with spina bifida have less calorie burning tissue (lean body mass) and a lower rate of burning calories (metabolic rate).[59, 60]
- Children with spina bifida may experience a number of challenges to engaging in healthy lifestyles, including restricted mobility, cognitive impairments (making planning and multitasking difficult) and concerns about incontinence.[59, 61]
- Chiari brain malformation is common and can cause problems with swallowing and gagging, as well as limiting food intake to specific tastes or textures (e.g. simple carbohydrates such as white bread and pasta).
- Children with spina bifida often experience issues with urinary and/or fecal continence, which can be embarrassing and intrude on everyday life. Maintaining bowel and bladder function may therefore be more of a priority to a child than overall nutritional status.[62]
- BMI is not an accurate measure in people with spina bifida[18] and no normative data are available.

> *It needs to be discussed but maybe the professionals, the doctors and also whoever is involved has to really recognize that no parent wants his or her child [with spina bifida] to gain weight. So they have to have that in the back of their mind when they're talking to parents.*
>
> – Father of a 10 year old child with spina bifida[3]

When discussing weight and healthy lifestyles with children with spina bifida and their families:

- Communicate clearly with other members of the team to ensure that weight-related issues are not inadvertently overlooked or repeatedly raised by team members.[63]
- Provide regular opportunities for families to discuss any concerns with their child's weight, growth, activities and/or eating behaviours.[14]
- Acknowledge the significant challenges experienced by children with spina bifida when engaging in healthy lifestyles.[3]
- Identify children's/families' priorities and negotiate goals that meet these priorities, as well as clinician goals.[64]
- Show, if appropriate, the trajectory of a child's weight/height (or other measures of growth/adiposity) to families on a growth chart as a visual aid, **without** referring to growth cut-offs developed for typically developing children.[65] A steeply increasing trajectory would indicate that overweight or obesity may be a concern.[3]
- Avoid the use of scare tactics, but discuss potential consequences of higher weights for children/families with spina bifida, as it relates to their circumstances:
  - Moving and transferring may become more difficult, which may also reduce a child's independence and self-care.[59]
  - There can be increased pressure on skin, which may be more vulnerable to pressure ulcers if a person is seated for long periods of time (e.g. in a wheelchair).[66]
- Celebrate any successes (e.g. drinking more water, introducing a new fruit or vegetable, reduction in sugary drinks, regular meal times). Focus upon the strengths of the family.[18]
- Educate families on the importance of consuming a balanced diet on the whole body.

Small successes can grow!
Whatever changes the family has made, however small, are cause for celebration. Here are some examples:

- I picked out a new vegetable at the grocery store to try
- We changed our schedules so we could eat together as a family last Wednesday
- We decided to make Tuesdays a pop-free day
- We turned the TV off earlier than usual and played a game outside
- We brainstormed a list of activities that we can do as a family
- We looked at the Parks and Recreation website to find a different park to visit next weekend
- I asked a friend to try a new activity with me
- I looked online to find accessible activity groups I could join
- We played catch during TV commercial breaks
- I drank an extra glass of water today
- We walked to school once last week
- I took my lunch to school twice last week

Resource

A series of simulations have been developed to highlight communication practices when discussing weight management in a range of disability clinical contexts.

To watch these simulations, send an email to conversations@hollandbloorview.ca for immediate access

As you watch the simulation videos, think of these questions:

1. How do you think each of the individuals felt in the situation? Why do you think they felt like that?
2. How successful was the approach used by the healthcare professional? Why?
3. What could have been done differently?
4. What strengths did the family have?
5. What are the main messages you will take away from this scenario?

*For pragmatic reasons, some of the videos do not show children participating in the conversation. This does not necessarily reflect best practices. Please see the section on 'Who should participate in weight-related discussions?'.

Simulation scenario	Objectives	Brief
Andrew's parents meet with the physiotherapist at their annual appointment at the spina bifida clinic	• Discuss the benefits of healthy lifestyles and how they impact participation in life. • Demonstrate how to elicit family/client priorities around healthy lifestyles.	Andrew is an 11 year old boy with spina bifida. His weight has been steeply increasing and he has been finding it difficult to walk long distances. The physiotherapist wants to talk to Andrew's parents about how weight loss and more physical activity could help Andrew maintain his independence.
Amanda's mother meets with a nurse at their annual appointment at the spina bifida clinic	• Engage in weight-related discussions with the family while demonstrating dignity and respect.	Amanda is a 7-year old girl with spina bifida. Her mother, Mary, has always struggled with her weight. Discussing weight is difficult for Mary, as she does not want Amanda to feel badly about her body.
Danielle and her mother meet with an occupational therapist at their annual appointment at the spina bifida clinic	• Collaborate with the family around healthy lifestyle strategies in everyday living situations.	Danielle is a 14-year old girl with spina bifida, who uses a walker to get around. She enjoys coming home after school and playing video games until she goes to bed. Danielle's mother, Diane, has many stressors in her life.

Resource (cont'd)

A series of simulations have been developed to highlight communication practices when discussing weight management in a range of disability clinical contexts.

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As you watch the simulation videos, think of these questions:

1. How do you think each of the individuals felt in the situation? Why do you think they felt like that?
2. How successful was the approach used by the healthcare professional? Why?
3. What could have been done differently?
4. What strengths did the family have?
5. What are the main messages you will take away from this scenario?

*For pragmatic reasons, some of the videos do not show children participating in the conversation. This does not necessarily reflect best practices. Please see the section on 'Who should participate in weight-related discussions?'.

Simulation scenario	Objectives	Brief
Salma's father meets with a paediatrician at their annual appointment at the spina bifida clinic	• Demonstrate the use of a growth chart to facilitate information-sharing about weight trajectories.	Salma is an 11-year old girl with spina bifida. A recent assessment shows that her body weight has sharply increased. Salma's father is meeting with the paediatrician.
Sam's mother meets with a physician who wants to talk about Sam's weight during their next visit to the Autism Spectrum Disorder (ASD) clinic	• Appreciate how to engage a family in a conversation about weight, without stigma • Recognize how to identify, acknowledge and integrate a family's strengths into a conversation about weight.	Sam is a 12-year old boy with ASD. His mother, Donna is meeting with Sam's physician. The physician wants to have a conversation with the Donna about the risks associated with higher weights.
Jackson's father meets with a respirologist who wants to discuss the impact of higher weights on obstructive sleep apnea in kids with Duchenne muscular dystrophy (DMD)	• Identify strategies that will enhance collaboration with the family- ensure child/ family have opportunity for feedback. • Appreciate how to direct the conversation towards healthy lifestyles for the whole family.	Jackson is a 13 year old boy with DMD. His father, Mr. Smith, is meeting with a respirologist for the first time to receive results from Jackson's sleep study. Following the sleep study, the respirologist has concerns about Jackson's current weight because of its impact on obstructive sleep apnea.

Impact Story

As a physiotherapist working in the spina bifida clinic at Holland Bloorview Kids Rehabilitation Hospital, weight is a topic that Kelly Brewer has discussed with children and their families. Kelly often brings up the topic as part of her clinical assessment, with a lens towards exercise and the benefits of living an active lifestyle; not how much the child weighs or goals to lose weight:

KELLY

"I approach weight around the importance of everyone keeping active and watching their weight… It is important for everyone to try to keep their weight healthy. I also discuss it in relation to the fact that if they are too heavy, their walking may become more tiring (if they are able to walk) or their transfers (if they are a full time wheelchair user) may be more challenging, because the heavier you are, the more weight your weaker muscles have to carry around and lift. The effect on function often resonates with them."

As a physiotherapist within a large multi-disciplinary team, Kelly's particular interactions are largely based on physical aspects of the child's condition or disability. In her experiences, children and their families are receptive to talking about healthy lifestyles, including opportunities for physical activity and recreation.

But there have been times when the conversation has been challenging:

"I have had a few conversations when the parents indicate that they don't have the financial means to take their child to recreational activities. This is always the hardest time for me, as I don't really know what to say. Finding resources to allow you [to go] to a gym is next to impossible, so in those situations, I feel very uncomfortable."

While these topics can be difficult to address, Kelly says that *"hopefully you open the door for families to have these conversations. Weight gain is hard to discuss and knowing that your function could be affected as you age if you continue to gain weight is hard for everyone."*

For Kelly, at the end of the day, having conversations about wellness is about empowering the child and making a difference in their lives to help them on their pathway towards living a healthy lifestyle: *"I would like them to feel like they could do something about it. I want to feel like I have made a difference for the child."*

Thank you Kelly.

Autism Spectrum Disorder

What is it?

Children with Autism Spectrum Disorder (ASD) experience ongoing challenges communicating with others, reading non-verbal communication and understanding relationships.[67] ASD now affects 1 in 68 US children and young people.[68] Recent figures showed that 33.6% of children with ASD were classified as overweight (greater than 85th percentile) and 18% were classified as obese (greater than 95th percentile).[69]

Considerations for weight management in ASD

- Poor coordination and other motor difficulties can make physical activity challenging.[70]
- Challenges communicating with others can limit group physical activity and may result in high levels of sedentary activities.[60]
- Avoiding extreme child distress ('Meltdowns') may be prioritized when making lifestyle decisions[60] in order for the family to function.
- Many behaviour management techniques for children with ASD use food as a reward for good behaviour.[71]
- Many children with ASD have unusual eating patterns:[60]
  - Oral sensitivity can mean the child sticks to specific tastes and textures. This often leads to eating low nutrition, energy-dense foods (e.g. white bread, few fruits and vegetables)
  - Rigid rules can limit the foods they will eat (e.g. all foods must be white)
  - Fixating on eating may lead to children constantly thinking about and seeking food
  - Children may use food as a form of self-stimulation
  - Staying in one place to eat (especially with other people) may be extremely difficult for some children with ASD
- Medication to help anxiety and aggression are frequently prescribed. Side-effects include considerable weight gain, especially with atypical antipsychotic medication.[72,73]
- Agreeing to medication to treat a child's irritability/aggression while knowing that weight gain is a side-effect can lead to profound guilt from both parents and healthcare professionals.

When discussing weight and healthy lifestyles with children with ASD and their family:

- Explore a child's willingness/ability to participate in the discussions. Do not assume that children with ASD do not understand discussions about weight, even when they are not engaging with the healthcare professional directly.
- Provide concrete examples and short-term goals.
- Consider talking about weight-related topics as a regular part of consultations. This may provide consistency for the child and avoid surprises. Explore with families whether this would be useful for their child.
- Discuss non-food related rewards for good child behaviour, understanding that this may be daunting for the family. Use strengths-based, coaching approaches for reinforcing healthy lifestyle behaviours, allowing for a tailored approach to the complexity of children with ASD.

> *He's put on 30 pounds because of the medication, and it's hard seeing him like that. But if he wasn't on the meds, he'd be stuck with his behaviour where he gets agitated incredibly easily. You negotiate the health risks of obesity, but then look at your situation … It's not an easy decision but I was desperate to make his life better. That was it. I didn't care how it happened. It was just what's going to make him happier and make his life better the fastest. He was a suicidal kid.*
>
> – Leah, parent of a child with ASD[16]

Even though I don't like talking about my weight, at least if I know it's coming, I can prepare for it. There is nothing worse than learning something new about your body and not expecting it. It would also help if [healthcare professionals] could mention some of the things I am doing well and not only always tell me the things I am not doing, and the things I should be doing. It also helps when they show me what I need to do and not just tell me what I need to do. I usually forget what they tell me to do by the time I leave the hospital. Oh and it's helpful if they ask me how I feel about my body…

– Lars, 14, youth with ASD [16]

Impact Story

Meet Isabelle & Geoffrey

Isabelle is an amazing 15 year old girl who is a bit of a mystery … she has an undiagnosed condition. Communication can sometimes be challenging, as Isabelle is non-verbal, severely deaf and developmentally delayed. BUT Isabelle's challenges don't stop her from living life to the fullest and maintaining a social, interactive and healthy lifestyle. Dancing, swimming, arts and crafts, among other activities, play an important role in her health and well-being.

While great efforts are being taken to ensure Isabelle is happy and healthy, an area of particular focus right now for Isabelle's father, Geoffrey, is her weight. Conversations around Isabelle's weight have been raised by a doctor she sees in a nutrition outpatient clinic. Working with the dietitian to find ways to include more vegetables and fibre in Isabelle's diet have been extremely helpful. But for Geoffrey, Isabelle's weight is still a concern:

"[Her] height is not going up as much as her weight. I am not sure what to change in her diet other than to reduce the quantity, but she is always hungry… but I do not want to starve her. It is such a delicate balance being a teenager, not being as mobile as other teens and being just as hungry."

"My daughter is the most important part of my life and I will always do my best for her and cannot do more than my best. I want to keep her happy and to enjoy life as best she can and I will try to keep her height to weight ratio the best ratio I can without getting so stressed as to be sick myself with worry."
- Geoffrey Feldman

ISABELLE & GEOFFREY

As a parent of a child with a developmental disability, Geoffrey does his best to listen to healthcare professionals and to follow their instructions, but also recognizes that the challenges are immense. For him, sharing his stresses and challenges in following instructions is all part of the weight-related conversation.

His advice to healthcare professionals is to *"keep up the conversation, but to also realize the pressures of the primary family trying hard to maintain a proper balance of food intake vs outtake, height vs weight, health vs sickness, exercise vs mobility, and…daily medications."*

Thank you Isabelle & Geoffrey.

Conclusion

The aim of this Casebook was to present summaries of currently available research combined with experiences of practicing healthcare professionals and guidance from children, young adults and families regarding weight-related discussions. Topics related to weight and healthy lifestyles can be difficult to discuss with children and families, so we hope that this Casebook provides practical support that is applicable to everyday clinical practice. We view the content of the Casebook as providing guiding principles rather than unequivocal recommendations. No one approach or specific terminology will be appropriate for every child and family. We therefore strongly urge healthcare professionals to take these guiding principles and work collaboratively with children and families to identify the most appropriate approach for their particular family context. This is especially important when additional complexities are present, for example when working with children with disabilities. The skilled nature of this work highlights the importance of having knowledgeable healthcare professionals supported by up-to-date, evidence-based resources to promote positive conversations for all.

KT Casebook Development Process and Information

Development process

This Casebook was developed with an interdisciplinary team and in consultation with key stakeholders with expertise in the area of weight-management and healthy lifestyles. The Casebook creation involved: (1) preparation of the evidence; (2) stakeholder consultation and workshops; and (3) content development and review.

1. Preparation of the evidence

The interdisciplinary team of healthcare professionals, researchers and families solidified the vision and mission of the Casebook, prepared the evidence and explored how to engage stakeholders to provide meaningful input.

The Casebook incorporated research evidence and best practices from key stakeholders and included the following:

- Research evidence on weight-related conversations in healthcare contexts;
- Tools and techniques available to healthcare professionals in undertaking weight-related conversations; and
- Consultation with clinical, research and community experts and families, youth and advocates with experience in the field.

An integrated knowledge translation approach[74] was taken to create the Casebook by bringing together key stakeholders via workshops.

2. Stakeholder consultation and workshops

Two workshops were held with the aims of exploring, evaluating and refining ideas, concepts and communication strategies for the Casebook. Twenty-two stakeholders representing varied clinical, research and experiential expertise participated. The workshops integrated evidence, stakeholder perspectives and collaborative creativity to co-create content for the Casebook.

Design approach

A co-creation framework shown to foster innovation was used to guide the Casebook creation process:[75]

Stage 1: Contextual knowledge and information

Stage 2: Collaborative network of experts and partners

Stage 3: Integrating methodologies and tools

Stage 4: Engaging events and experiences

Stage 5: Integrated and co-created platform

Workshop 1

Workshop 1 provided contextual knowledge and information (stage 1).The format of the workshop included:

- An overview of the topic of weight-related conversations in healthcare
- An introduction to Casebooks as KT products
- Capturing participants' thoughts, feelings and hopes for weight-related conversations
- An overview of evidence and best practices
- Discussions of stakeholder experiences as they related to the evidence

Evolving the strategy

Bringing together the experiences, thoughts and expertise of the various stakeholders fostered a *collaborative network of experts and partners* (stage 2), which set the foundation for workshop 2. The aim of workshop 2 was to create materials and resources that would support evidence-based practice.

Workshop 2

Workshop 2 used hands-on activities to allow stakeholders to *explore integrating methodologies and tools* (stage 3) by using *engaging events and experiences* (stage 4). Stakeholders discussed optimal ways of communicating key issues identified at workshop 1 and created and designed materials to build the collective vision. By having the stakeholders create materials that would be helpful in clinical practice, the Casebook remains an *integrated and co-created platform* (stage 5). The format of the second workshop included:

- A review of the purpose of the two workshops and Casebook
- Small-group creation of products and tools
- Presentations of each group's created product(s)
- Concluding remarks and future steps

3. Content development and review

The research, experiential and contextual evidence identified through the workshops was synthesized and used to create the Casebook. Feedback from targeted stakeholders and subject matter experts (including healthcare professionals, children and families) was obtained to ensure various perspectives and high quality evidence were integrated.

KT Casebook development team

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This Casebook was jointly produced by researchers, healthcare professionals, knowledge translation experts, young adults and family members in the Greater Toronto Area through consultation and workshop participation. The KT Casebook team would like to acknowledge the following workshop participants: Shafeeq Armstrong (Program Developer, Health, Special Olympics Ontario, ON), Alisa Bar-Dayan (Registered Dietitian, The Hospital for Sick Children, ON), Sanjukta Basak (Physician, Rouge Valley Health System, ON), Julie Bernard-Genest (Pediatrician, Centre Mère-Enfant Soleil du CHU de Québec, QC), Catherine Birken (Physician, The Hospital for Sick Children, ON), Kelly Brewer (Physiotherapist, Holland Bloorview Kids Rehabilitation Hospital, ON), Lorry Chen (Registered Dietitian, Holland Bloorview Kids Rehabilitation Hospital, ON), Liam Cosgrove (Youth, Holland Bloorview Kids Rehabilitation Hospital, ON), Elizabeth Dettmer (Registered Psychologist, The Hospital for Sick Children, ON), Geoffrey Feldman (Family Leader, Holland Bloorview Kids Rehabilitation Hospital, ON), Kelsey Gallagher (Registered Dietitian, The Hospital for Sick Children, ON), Brenndon Goodman (STOMP Program Alumni at The Hospital for Sick Children & Obesity Canada), Brooke Halpert (Child Psychologist, Trillium Health Partners, ON), Amy Illingworth (Family Leader, Holland Bloorview Kids Rehabilitation Hospital, ON), Julia Khayat (Family Leader, Holland Bloorview Kids Rehabilitation Hospital, ON), Tara Joy Knibbe (Manager, Research and Program Evaluation, Abilities Centre, ON), Rebecca Noseworthy (Registered Dietitian,The Hospital for Sick Children, ON), Melanie Penner (Developmental Pediatrician, Holland Bloorview Kids Rehabilitation Hospital, ON), Catherine Petta (Registered Nurse, Holland Bloorview Kids Rehabilitation Hospital, ON), Janice Shepard (Executive Committee, Obesity Canada-YYZ, ON), Jonah Strub (Research Student, The Hospital for Sick Children, ON), Joseph Telch (Physician, Holland Bloorview Kids Rehabilitation Hospital, ON), Carla Ulloa (Registered Nurse, Trillium Health Partners, ON). The team would also like to acknowledge the external reviewers for providing valuable feedback on the Casebook and Sarah Keenan (Life Skills Coach, Holland Bloorview Kids Rehabilitation Hospital, ON) for providing solution-focused coaching resources.

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KT Casebook information

Conflict of interest declaration

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User consideration

This Casebook is a compilation of best available evidence and practices to assist healthcare professionals in fostering positive weight-related conversations with children and their families. This Casebook was developed for healthcare professionals to use as a practical guide to approach and manage weight-related conversations, but does not constitute professional clinical advice. While every effort has been made to ensure the accuracy of the content of the Casebook at the time of publication, the completeness or accuracy of the information contained cannot be guaranteed. Healthcare professionals are required to exercise their own clinical judgement in using the Casebook and the application of any information contained in this Casebook should be based on an individual child's needs, relevant circumstances and local context.

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ProFILE lab

Holland Bloorview

Holland Bloorview Kids Rehabilitation Hospital is Canada's largest children's rehabilitation hospital dedicated to improving the lives of children with disabilities. As a fully affiliated hospital with the University of Toronto, we are home to the Bloorview Research Institute and the Teaching and Learning Institute, allowing us to conduct transformational research and train the next generation of experts in childhood disability. For more information please visit www.hollandbloorview.ca

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