HAS
HAUTE AUTORITÉ DE SANTÉ

SÉCURITÉ SOCIALE l'Assurance Maladie

RECOMMENDING BEST PRACTICES

TOOLKIT GUIDE

Overweight and obesity in children and adolescents: 10 key messages to improve practices

Validated by the HAS Board on 3 February 2022

Updated on Feb 2023

This guide updates the good practice guidelines "Overweight and obesity in children and adolescents" published in 2011.

When providing care and support for overweight and obese children and adolescents it is necessary to take into account their overall individual and family situation, without overlooking the influence of their living environment, social norms, advertising and the media.

It is essential to combat and prevent stigmatisation: through their attitude and choice of words, every professional working in a care and support, living, schooling or leisure setting must contribute to this. Families must be made aware of the issues and supported.

Early identification, along with a lifestyle assessment, a multi-component and, if necessary, multidisciplinary assessment, from the time of diagnosis and delivery of the diagnosis of overweight or obesity, along with coordination of care and support are priorities to ensure the feasibility of the care pathway.

The ten key messages

1. Measure BMI throughout childhood and adolescence in order to identify and diagnose overweight or obesity early on.

2. Limit the laboratory workup to targeted tests. Systematically investigate for type 2 diabetes in the presence of one or more risk factors.

3. Draw on a multi-component assessment whenever overweight or obesity is diagnosed and the diagnosis delivered.

4. Scale and adapt care and support based on the complexity of the situation.

5. Propose care and support from the time of diagnosis of overweight or obesity.

6. Losing weight is not a priority goal except in the event of complications.

7. If necessary, supplement with a stay in a follow-on care and rehabilitation unit in complex situations.

8. Ensure continuity of the care pathway: prepare the transition to adulthood from the start of adolescence.

9. Support children and adolescents with disabilities, and their parents: common points and specificities.

10. Encourage the involvement of users' representatives.

STRATÉGIE DE TRANSFORMATION DU SYSTÈME DE SANTÉ

STSS
Construction du parcours

1. Measure BMI throughout childhood/adolescence in order to identify and diagnose overweight or obesity early on

- **Analyse the growth curve history and trajectory together**
  - Measure the body mass index (BMI) and monitor its evolution based on the reference growth charts in the health record: AFPA – CRESS/INSERM (before the age of 2 years) and IOTF curves (beyond the age of 2 years)[1].
  - Systematically record the BMI in the health record and plot the curve in the chart.
- **Support parents:** understanding of and compliance with follow-up frequency, encouragement to move towards the established age-based benchmarks for lifestyle.
- **Regularly monitor BMI, and its evolution, in all children and adolescents throughout childhood and adolescence**, including in medico-social facilities.
- **In the event of identification of warning signs** (continuous increase in BMI trajectory since birth; early adiposity rebound; rapid upwards change in BMI centile; early and severe obesity): **implement more frequent follow-up.**
- **In the event of overweight or obesity, confirm and deliver the diagnosis** and propose a multi-component assessment of the situation, mobilising professional expertise.

2. Limit the laboratory workup to targeted tests. Systematically investigate for type 2 diabetes in the presence of one or more risk factors.

- **In situations of overweight with no clinical signs suggestive of complications:** no laboratory tests are required.
- **From the age of 10 years or after the start of puberty, in young people with overweight or obesity**, investigation for type 2 diabetes should be systematically performed in the presence of one or more risk factors: maternal diabetes or gestational diabetes for the young person concerned, first or second-degree family history of type 2 diabetes, signs of insulin resistance, or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidaemia, polycystic ovarian syndrome, or born small for gestational age)[2]:
  - if the results are normal, repeat the tests at least every three years, or more frequently if the BMI increases;
  - if a type 2 diabetes diagnosis is confirmed, a pancreatic assessment must be performed to rule out the possibility of autoimmune type 1 diabetes.
- **In a situation of obesity (BMI > IOTF 30)** and on the basis of family history, growth curve history and trajectory and clinical history: a non-urgent laboratory workup should be performed.

[1] Child's health record. Version in force on 1 April 2018. https://solidarites-sante.gouv.fr/IMG/pdf/carnet_de_sante-num-.pdf

[2] American Diabetes Association. Children and adolescent standards of medical care in diabetes 14. Children and Adolescents: Standards of Medical Care in Diabetes—2022 | Diabetes Care | American Diabetes Association (diabetesjournals.org)

3. Conduct a multi-component assessment immediately following a diagnosis of overweight or obesity and delivery of the diagnosis

It is essential to go beyond the measurement of BMI to identify the problems, needs and expectations of the child/adolescent and their parents, and to address them.

- ➔ **Call on the services of local professionals or a specialised obesity facility if the situation is complex,** to supplement the assessment on a health, social and medico-social level if necessary. Use the regional operational repository of resources (ROR).
- ➔ **Assess and provide early support**:
  - rebalancing the diet, reducing sedentary behaviour and, in particular, screen time, initiation or resumption of regular physical activity;
  - psychological difficulties, mental illnesses, risky situations;
  - dietary problems or eating disorders;
  - any form of social vulnerability;
  - any problem linked to a risk of danger to the child or adolescent: lack of parental guidance, neglect, physical, psychological or sexual maltreatment (abuse, incest);
  - any difficulties in the school setting (drop-out, bullying).
- ➔ **Put together a tailored care and support package jointly** with the child/adolescent, in consultation with their parents. Encourage mutual agreement between them.

4. Scale and adapt care and support based on the complexity of the situation

- ➔ **Scale care and support, mobilising the different professional skills** and resources required to address individual and family needs, taking into account two situations:
  - **a situation of overweight or obesity considered to be non-complex** in the event of a BMI of between IOTF 25 and 30 or a BMI > IOTF 30 without complications or the accumulation of factors contributing to or resulting from obesity. For example, an associated social, psychological or school problem does not necessarily lead to complexity if accessible local solutions can be found.
  - **a situation of obesity considered to be complex** due to the severity of the obesity (BMI > IOTF 30) and the accumulation of associated factors: associated physical or psychiatric, individual or family complications or comorbidities; obesity with a rare cause (either genetic or lesion-related); situation of disability, deficiency, history of failed obesity treatment; significant impact on daily life and quality of life; eating disorders associated with mental illnesses, social, family or school problems.
- ➔ **Organise time for coordination of interventions and consultation of players**, use shared tools for the coordination of all professionals (health, social and medico-social). Ensure the consistency of messages, avoid the juxtaposition of interventions.
- ➔ **Appoint a local coordinator** within the care team, to address the need for additional coordination in liaison with the child/adolescent's own physician and to support the engagement of the child/adolescent and their parents in the care pathway:

- this person must be clearly identified by the child/adolescent, their parents and all professionals involved in their care. If possible, the coordinator should be chosen with the family from among the professionals involved in the care pathway.
- this person serves as an intermediary for the child/adolescent and their parents. This person ensures the consistency of interventions, liaising with the child's own physician and between the professionals involved and the family. This person takes the initiative to contact families who have stopped attending consultations.
- this person organises and monitors the implementation of care and support, with the assistance of a coordination tool shared by all professionals (health, social and medico-social). This person manages priorities and, if necessary, triggers reassessment of the situation before the scheduled date.

➔ **Then scale care and support based on the evolution of the individual and family situation and attainment of goals:** continue, adapt and/or supplement care and support, continue investigations and/or tests if necessary.

5. Propose care and support from the time of diagnosis of overweight or obesity

➔ **Propose individual and/or group patient education sessions** to the parents of young children or to the child/adolescent **to support progressive lifestyle changes and the creation of an environment that is conducive to these changes.**

- Any professional supporting lifestyle changes should base their action on an educational approach and empathetic listening, going beyond simply providing information or advice and supporting the development of skills and motivation, even if the professional is not involved in the delivery of patient education sessions.
- The format proposed for patient education sessions (frequency, methods, duration, educational follow-up between sessions, continuation) depends on the complexity of the situation. The format must be flexible in order to encourage the adherence and regular attendance of the child/adolescent and their parents and respect their capabilities, and be coordinated, particularly if several professionals are involved in the pathway.

➔ **Support the young person's relationship with their body,** and if necessary the functional and aesthetic impacts, in both girls and boys.

➔ **Propose adaptations if necessary** to facilitate activities of daily living, including schooling.

➔ **Ensure overall and regular medical follow-up over several years,** adapting the frequency to the complexity of the situation **in order to scale care and support.**

6. Losing weight is not a priority goal except in the event of complications

➔ **Irrespective of BMI, promoting health and well-being while progressively supporting lifestyle changes is essential.**

➔ **In growing children**: slow down weight gain (levelling out of the BMI curve) while growth continues.

➔ **In adolescents at the end of growth**: stabilise weight. Although a reduction in BMI is a desirable outcome, it must be progressive and supported. Beware of excessively rapid weight loss.

- **In the event of severe complications**: weight loss, even slight, is beneficial. It must be very gradual. Weight regain should be prevented, as should any yo-yo phenomena.

7. If necessary, supplement with a stay in a follow-on care and rehabilitation unit in complex situations

Short stays in a follow-on care and rehabilitation unit lead to a dynamic of change and the greater engagement of parents, who must be systematically supported after the stay. Long stays are reserved for adolescents and are rarely proposed for children under the age of 12. Repeated short stays may be considered as an alternative to long stays.

- **The risk/benefit ratio of any long or repeated short stays must be assessed** at a multidisciplinary team meeting organised by the specialised obesity facility in liaison with the adolescent's own physician and with the participation of all the professionals involved.

  Adolescents and their parents must then agree to the conditions of the stay.
- **Preparation for the stay, as well as for the return home, is essential** to guarantee continuity of care, be it medical, social and/or educational, and to thus ensure the effectiveness of the required stay.
- **The repetition or prolongation of a stay is discussed on the same basis.**

8. Ensure continuity of the care pathway: prepare the transition to adulthood from the start of adolescence

The transition prepares adolescents as they approach adulthood thanks to the development of their capacities to look after themselves and their health as autonomously as possible. The aim is to encourage young adults to continue to make lifestyle changes a priority.

The transition from paediatric to adult care implies a change of physician or care team and the maintenance of good communication between the care settings and with the young person's own physician. In some situations the move from paediatric care to adult care can be made after the age of 18.

- **As in any chronic disease, this approach makes it possible to ensure continuity of care and support and avoid any disruption to the care pathway.**

9. Support children and adolescents with disabilities and their parents: common points and specificities

Children and adolescents with disabilities should benefit from:

- **the same multi-component assessment** as any other person but with additional vigilance depending on the disability;
- **prevention from a very young age** of the development of overweight or obesity related to the young person's condition or drug treatments, **systematically involving parents and professionals from medico-social services and facilities where appropriate**;
- **care and support integrated into the life plan**;
- **accessible patient education** (adapted educational techniques and tools) to support progressive lifestyle changes, and the creation or adjustment of a family, school and social environment that is conducive to and consistent with the implementation of these changes and their

maintenance over time: children, adolescents, parents and/or professionals from social and medico-social facilities and services.

10. Encourage the involvement of users' representatives

- **Support parents in their journey by providing accessible information and peer support.**
- **Make better use of the experience of parents and older adolescents or young adults**: experience-sharing, preparation of the transition to adulthood, design and co-leadership of patient education sessions.

Developed jointly with professionals and health system users, these short messages aim to encourage healthcare professionals to engage in a dialogue with patients about the most appropriate tests, treatments and interventions and to identify those that are not necessary. Professionals and users chose the themes and the messages, which were developed based on existing guidelines.

This document presents the main pointsof the publication: Overweight and obesity in children and adolescents: 10 key messages to improve practices - Method, **February 2022**
Update February 2023 All our publications can be downloaded at www.has-sante.fr

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