Paediatrics & Child Health, 2018, 1–4
doi: 10.1093/pch/pxy056
Commentary

Commentary

Helping children and families to enrol in weight management: What can stakeholders do?

Arnaldo J. Perez PhD, Geoff D. C. Ball PhD RD

Department of Pediatrics, University of Alberta, Edmonton, Alberta

Correspondence: Geoff D. C. Ball, Department of Pediatrics, University of Alberta, 4–515 Edmonton Clinic Health Academy, 11405 – 87 Ave, Edmonton, Alberta T6G 1C7. Telephone 1-780-492-8727, fax 1-780-342-8464, e-mail geoff.ball@ualberta.ca

Institution where the work was originated: University of Alberta.

Ethics Board: Human Research Ethics Board of the University of Alberta.

Abstract

Many children and their families do not benefit from multidisciplinary clinical care (MCC) for paediatric weight management because they do not enrol in (initiate) treatment. The purpose of this report was to highlight practical recommendations to enhance the enrolment of Canadian children in MCC, which were drawn from multisite Canadian studies (quantitative and qualitative) that we completed recently. Recommendations to stakeholders, including primary care providers, MCC providers and decisions makers, were organized according to opportunities, motivation and barriers to enrol. Findings from our research suggested that enrolment in MCC can be improved by increasing opportunities and motivation to enrol as well as reducing the impact of enrolment barriers.

Keywords: *Children; Enrolment; Engagement; Obesity.*

Multidisciplinary clinical care (MCC) for paediatric weight management (PWM) is typically offered in clinical settings by a team of health professionals (e.g., paediatrician, psychologist, dietitian, fitness professional) with expertise in weight management (1). While children with obesity and their families can benefit from this care if they enrol in treatment, attend treatment sessions and adhere to goals, research has found that their enrolment (2) and retention (3) remain poor, which highlight the need for strategies to address these engagement issues. Recently, we published a series of papers on enrolment in MCC for PWM (4–7) that included qualitative data from families referred to four paediatric weight management clinics in Canada (8) as well as administrative referral and attendance data from Alberta Health Services (9). Based on this context-specific, multisite evidence, the objective of this commentary was to highlight practical recommendations to improve the enrolment of referred children and their families in MCC for PWM in Canada. Our recommendations relate to three conditions that we believe are necessary for enrolment: opportunity, motivation and absence of major barriers (see summary in Table 1).

OPPORTUNITY TO ENROL

Children with obesity usually need to be referred by a primary care provider (PCP) such as a physician or nurse practitioner to enrol in MCC. Kuhle and colleagues (10) estimated that only 1.3% of children with obesity in Canada are likely to be referred by their PCPs to specialized services for PWM. In our research, we found that some families were referred by PCPs only when they requested a referral, either because they perceived the need for specialized care or another health professional encouraged those families to ask their PCPs for a referral (6). Previous research has documented several physician-related factors preventing referral making, including physicians' lack of actual or perceived skill to discuss excess weight with families and perceptions of families' low readiness for treatment and motivation to make lifestyle changes (11). These factors highlight the

Table 1. Recommendations to improve enrolment in MCC for paediatric weight management

Stakeholders	Recommendations		
	Opportunity to enrol	Motivation to enrol	Barriers to Enrol
Primary Care Providers (PCP)	Become familiar with the eligibility criteria (e.g., BMI ≥85th percentile, presence of weight- related comorbidities) for referring children to MCC Refer eligible children to MCC if locally available, regardless of PCPs' subjective impressions of families' readiness to initiate and adhere to treatment	Counsel all eligible families, including children, about the opportunity to enrol in and potential benefits of weight management Use sensitive words and language when discussing weight management with families Assess families' level of readiness for treatment (e.g., whether the intention to enrol is formed) and act accordingly Use motivational interviewing techniques to elicit the values, expectations, and concerns that may motivate families to enrol Emphasize the value and characteristics of MCC, including comprehensive care, family-oriented approach, and design to facilitate lifestyle and behavioural changes Highlight the comparative advantages of MCC (e.g., comprehensive physical and psychosocial assessment, family and mental health support) over alternative options (e.g., self-management)	Assess and discuss the barriers that families may face to enrol in treatment Inform families about resources (e.g., passes for public transit, distant support via video-conferencing) that MCC providers may have to enhance accessibility Stress that MCC is family-oriented and options may exist to choose treatment modality (e.g., one-on-one and/or group-based care) and appointment frequency (e.g., weekly and/or monthly) to fit their expectations and circumstances Advise parents that MCC providers are trained to enhance children's motivation for treatment if this issue has been identified as a potential barrier to enrolment Address potential misperceptions (e.g., specific diet or exercise plan, one-size-fits-all model of care) that families may have about delivery of MCC
Multidisciplinary Clinical Care (MCC) Providers	Inform the public and PCPs about available services using different strategies (e.g., brochures, websites, local media, health care organizations) Support the enrolment of families who schedule initial appointments for MCC (e.g., complete reminder phone calls, re-schedule initial clinical appointments if missed)	Advertise available services in ways that appeal to families (e.g., emphasize that program is designed to facilitate behavioural change) Highlight the benefits of MCC for families during orientation sessions (if provided) Reduce the duration and complexity of the enrolment process	Inform PCPs and families about available strategies and resources that MCC providers may have to enhance accessibility to care (e.g., passes for public transit, distant support via video-conferencing)
Decision-Makers	Allow other health professionals (e.g., dietitians, psychologists, public health nurses) to refer families for MCC, especially those who have frequent contact with families	Reduce the duration and complexity of the enrolment process	Provide resources not only to support treatment delivery, but also families' enrolment Support MCC providers' training in paediatric obesity, especially regarding discussing weight management with families and motivating them to enrol in treatment (e.g., motivational interviewing)

need for training PCPs in managing paediatric obesity, which includes raising the weight issue with families, making a referral (if necessary) and motivating families to follow through with referrals. Further, although we did not explore whether PCPs were aware of locally-available specialized services for PWM (another potential barrier to referral making), the parents we interviewed stated that PCPs appeared to be ill-informed about existing PWM services (5,6). They reported that PCPs were not aware of the specific services to which they wanted their children to be referred or if they knew the name of the clinic, they lacked important details about the type and nature of services that were available.

Aside from increasing enrolment opportunities by increasing the number of referrals and giving families the option of self-referral, in one of our qualitative studies, parents also recommended to support the enrolment of families who seem to be interested in MCC, including those who scheduled an initial clinical appointment (5). Specifically, they suggested making reminder phone calls and re-scheduling missed appointments.

MOTIVATION TO ENROL

Our data on reasons for enrolment and nonenrolment and facilitators of enrolment (6,7) showed that families were at different levels of readiness for treatment initiation, which included those who could be considered as *ready intenders* (those who were ready to enrol in treatment), *impeded intenders* (those who formed the intention to enrol, but could not act on their intention due to enrolment barriers such as scheduling issues) and *nonintenders* (those who did not form the intention to enrol). Among nonintenders, we identified three subgroups including those who (i) did not perceive a weight problem, (ii) did not intend to take further action and (iii) perceived the services to be unsuitable. We also learned that some PCPs and MCC providers (during orientation sessions) improved families' readiness for treatment by highlighting the need for MCC and the advantages of this level of care compared to alternative options, including self-management (6).

Interviewed parents suggested a number of strategies to (i) enhance families' motivation for treatment including sharing successful stories of past participants and making weight management services more appealing to families and (ii) avoid discouraging families during the enrolment process (5). According to parents, appealing features of weight management services included marketing services as *lifestyle interventions* rather than *obesity programs*, focusing on behaviuoral changes in lieu of delivering education alone, and providing comprehensive, family-centred care to improve physical and mental health. To avoid discouragement, parents recommended that PCPs discuss weight and health in a sensitive manner, make the enrolment process shorter, and avoid using scare tactics to motivate families to make lifestyle changes, the latter being a well-established, ineffective strategy to promote heathy changes (12). Using sensitive terms and language (e.g., *weight* or *unhealthy weight* rather than *obese*) is recommended strongly when discussing weight-related issues with families since shame and stigma are often experienced by families with obesity (13). Our qualitative (5) and quantitative data (4) were consistent with previous research (14) showing that longer enrolment times negatively affect treatment initiation; that is, the longer the duration of the enrolment, the lower the likelihood that families enrol in treatment. Particularly, our quantitative data (4) is in line with cross-sectional evidence (15) showing that sociodemographic and anthropometric factors did not predict treatment enrolment in health services for PWM, which seems to suggest that no sociodemographic or anthropometric group is necessarily more or less likely to enrol in treatment than others.

BARRIERS TO ENROL

The parents we interviewed referred to several internal (e.g., personal health problems) and external (e.g., scheduling issues, children's lack of motivation) enrolment barriers (7). However, no parents reported that enrolment barriers (or strategies to overcome them) were discussed with their PCPs or MCC providers during the enrolment process. Only parents whose children enrolled in care indicated that they received support (e.g., bus tickets, clinical appointments at convenient times) for continued attendance (6).

Although an absence of or ability to overcome barriers facilitated treatment initiation (6), many parents did not feel capable to overcome the enrolment barriers they faced. Consistent with previous research (16), we found that conflicting schedules due to families' competing demands and interests, transportation challenges and children's lack of interest in the recommended care were common enrolment barriers (7). Parents made several recommendations to address these barriers, including offering multiple options for appointment times, more programming options (e.g., community programs), home visits, distance support (e.g., video-conferencing), support for transportation (e.g., parking passes) and interventions that varied in duration (5). We also found that including children in conversations about the need for and value of MCC for PWM facilitated enrolment (6).

In anecdotal conversations, clinical leaders and co-investigators across our study sites mentioned that, upon review, many parents' recommendations were either fully or partially implemented in their clinics. These observations highlighted the importance of considering the subjective dimension of barriers (perceived barriers) and the imperative for clear, consistent and ongoing communication about the resources and strategies that are available to families to support accessibility to care.

CONCLUSION

Although MCC for PWM remains in limited supply in Canada, our research showed that even when available, the enrolment of children and their families is suboptimal (4). Consequently, there is a need for designing, implementing and evaluating strategies to enhance enrolment at this level of care. Based on our data, improving families' motivation for treatment, enhancing enrolment opportunities and ameliorating the impact of accessibility barriers are three general strategies that PCPs and MCC providers can apply to optimize the likelihood that families enrol in and benefit from MCC for PWM. Additional strategies can be also derived from the existing literature on enrolment in PWM interventions as long as they relate to similar contexts, populations, type of care and settings.

Acknowledgements

The authors wish to thank all of the families who participated in their research over the years. In addition, they wish to acknowledge the clinical, academic and practical contributions of their colleagues who helped to plan, conduct and publish the studies that informed the recommendations included in this commentary. Our studies were funded by research grants from the Canadian Institutes of Health Research (Nominated Principal Applicant: GDCB; Funding Reference Numbers: 138774 and 106648).

Conflict of Interest

No conflict of interest with the study sponsor (Canadian Institutes of Health Research) regarding synthesis of the data, the writing of the report and the decision to submit the paper for publication.

References

1. Barlow SE; Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics 2007;120(Suppl 4):S164–92.
2. Shaffer LA, Brothers KB, Burkhead TA, Yeager R, Myers JA, Sweeney B. Factors associated with attendance after referral to a pediatric weight management program. J Pediatr 2016;172:35–9.
3. Dhaliwal J, Perez AJ, Holt NL, et al. Why do parents discontinue health services for managing paediatric obesity? A multi-centre, qualitative study. Obes Res Clin Pract 2017;11(3):335–43.
4. Perez A, Kebbe M, Maximova K, et al. Do children and adolescents referred to multidisciplinary care for weight management in Alberta enroll in treatment? A preliminary analysis". Abstract presented at The 5th Canadian Obesity Summit; Banff, AB.
5. Perez AJ, Kebbe M, Holt NL, et al. Parent recommendations to enhance enrollment in multidisciplinary clinical care for pediatric weight management. J Pediatr 2018;192:122–9.
6. Perez AJ, Avis JL, Holt NL, et al. Why do families enrol in paediatric weight management? A parental perspective of reasons and facilitators. Child Care Health Dev 2016;42(2):278–87.
7. Perez A, Holt N, Gokiert R, et al. Why don't families initiate treatment? A qualitative multicentre study investigating parents' reasons for declining paediatric weight management. Paediatr Child Health 2015;20(4):179–84.
8. Ball GD, Perez Garcia A, Chanoine JP, et al. Should I stay or should I go? Understanding families' decisions regarding initiating, continuing, and terminating health services for managing pediatric obesity: The protocol for a multi-center, qualitative study. BMC Health Serv Res 2012;12:486.
9. Team ABC3. The Team to Address Bariatric Care in Canadian Children (Team ABC3): Team Grant Research Proposal. *BMC Res Notes* 2017;10:301.
10. Kuhle S, Doucette R, Piccinini-Vallis H, Kirk SF. Successful childhood obesity management in primary care in Canada: What are the odds? Peerj 2015;3:e1327.
11. Gerards SM, Dagnelie PC, Jansen MW, De Vries NK, Kremers SP. Barriers to successful recruitment of parents of overweight children for an obesity prevention intervention: A qualitative study among youth health care professionals. BMC Fam Pract 2012;13:37.
12. Bandura A. Health promotion by social cognitive means. Health Educ Behav 2004;31(2):143–64.
13. Puhl RM, Peterson JL, Luedicke J. Parental perceptions of weight terminology that providers use with youth. Pediatrics 2011;128(4):e786–93.
14. Hampl S, Paves H, Laubscher K, Eneli I. Patient engagement and attrition in pediatric obesity clinics and programs: Results and recommendations. Pediatrics 2011;128(Suppl 2):S59–64.
15. Cheng JK, Wen X, Coletti KD, Cox JE, Taveras EM. 2-year BMI changes of children referred for multidisciplinary weight management. Int J Pediatr 2014;2014:152586.
16. Grow HM, Hsu C, Liu LL, et al. Understanding family motivations and barriers to participation in community-based programs for overweight youth: One program model does not fit all. J Public Health Manag Pract 2013;19(4):E1–E10.