The NHMRC recently released Clinical Practice Guidelines for the Management of Overweight and Obesity for Adults, Adolescents and Children in Australia. Mark Harris, Director of COMPaRE-PHC, was a member of the guideline development groups. Dr Nighat Faruqi interviewed him about the guidelines. A summary of that interview is below:

Q: Compared to the last set of Australian guidelines on obesity, which came out in 2003, what's new in these guidelines for adults?

A: They are structured using the five As. This Is a pathway: assessment, providing brief advice and goal setting, and then going on to assist people further and follow up. For adults body mass index and waist circumference are the key assessments. The cover of the guidelines has got a tape measure on it for a good reason, and it's for the reason that weight circumference really is very important. This is because of the importance of central obesity especially in med. However we think that less than 10% of patients are getting their waist circumference measured in primary care in Australia. We're recognising that in terms of advice and assisting people, in addition to giving brief advice and goal setting, goal setting needs to be realistic, so the goal that we're suggesting that people aim for initially, particularly if they're having a lifestyle intervention, 5-10% of body weight, not 30% of body weight.

Q: A more realistic goal?

A: People can lose weight but then put it back on again, and that's a hassle. So I guess that's a slightly different emphasis in terms of goal setting. We know that multiple interventions are required, so we're suggesting that diet, and physical activity, and psychological interventions are all useful. And so for the majority of patients, those that support for making dietary and physical activity, a change, and the change in the way people think about themselves, and their
diet, and their physical activity, that that will require patients often to get something more intensive than a brief advice. Usually that will mean some kind of educational program. This might be run as a group program in the practice by the practice nurse. Or it might mean referral to another service or program, or even an evaluated private sector program.

Q: What should be the frequency of these kinds of interventions?

A: Probably six to ten sessions. And that there’s evidence that they need to be tailored towards giving people practical support, for example how to deal with hunger, and reducing portion size. The guidelines do not recommend a specific diet but it is important that there is an overall deficit in calories. Physical activity is particularly important in terms of prevention, and also in terms of maintenance of weight. For some people that won’t be enough, and they’ll need to undertake some very low energy diets under supervision.

Q: What about children and adolescents who are overweight or obese, what do the guidelines say?

A: The emphasis is on using BMI for age charts and maintenance of weight. As children grow, their BMI may reduce, just by virtue of them getting taller, and so we’re not usually aiming for children to lose weight. In late adolescence that might be a little different. The emphasis on physical activity is more important in children, because there’s good evidence that sedentary behaviour in children is reflected in obesity and chronic disease in later life. The other emphasis in the diet is on the composition of the diet, and establishing healthy eating patterns.

Q: To reach children, are you targeting the parents, or do you have interventions directly to them?

A: The evidence is that interventions that engage the whole family are more effective. In early childhood, the whole family’s at risk. For example in
women the trend towards being overweight and obese, begins in the postpartal period, where weight that’s gained during pregnancy isn’t lost again, and so you get this sort of trajectory between each pregnancy of increasing weight. And that can be hazardous for all sorts of reasons, including the risk of diabetes in pregnancy. It’s necessary often, to engage the whole family in order to have a chance of changing physical activity and weight, because these are things the family does together.

Q: In Australia, which populations are most at risk of developing obesity?

A: Everyone is at risk. The particular population groups that have high rates of obesity, and obesity related diseases, includes Aboriginal and Torres Strait Islander people and certain ethnic groups, particularly migrant groups who may have had fairly significant changes in their dietary patterns, and the levels of physical activity after migrating to Australia. There are many groups, and this makes it especially challenging to explain the consequences of being overweight, as well as the cultural differences in diet and physical activity.

Q: So what do you think are the main challenges for implementation of the guidelines in primary healthcare?

A: These are now the second evidence based guidelines produce by the NHMRC in the last decade. And it’s a decade when we’ve seen increase in obesity, overweight and obesity in the population. So this is an increasing problem, and it’s a problem that’s going to take up a lot more of your average primary care provider, average GP, or practice nurse’s time, in dealing with. So I think a big challenge is to identify some practical ways in which they can proceed. I think there are some pretty simple things, like waist circumference. Time is a big problem, and so education and advice is difficult to fit in, and that’s where having referral options is going to be important. And frankly, referral options aren’t available in all areas, for all the population, so I think it’s going to be particularly challenging for Medicare locals, to really develop those options.
There's been good programs that have demonstrated, for example, that you can deal with obesity and prevent diabetes and so on. But getting those to happen, not just as part of a special project, but to happen across the whole population, is very challenging. And this is not unique to Australia, the same challenges are being confronted in the US and Europe for example, but it's a big task ahead.

**Q:** Now what's the role of medications for reducing obesity?

**A:** Well we don't have a lot of choices really, at the moment in Australia. Really, the only medication that really we would recommend to be considered as a possibility, is Orlistat. This is expensive, and may have side effects.

**Q:** And what about surgical interventions, do they work in your opinion?

**A:** Oh certainly, surgical interventions have a high effectiveness rate. There's some differences between the surgical techniques, and we don't have really good trial evidence to make recommendations. It is important that people are physically and psychologically prepared for surgery. The guidelines have recommended that they can be considered in adults from BMIs of 30 up, who've got complications, and from people that really ought to be thought about for people from 35, BMIs of 35 up. However not everyone has access.

**Q:** What about other referral options to medical or allied health services?

**A:** They not available in all areas equally. There are barriers related to availability, cost, language and culture, how much knowledge and health literacy is required to participate. And we don't have the workforce to provide everyone with individualised support. There is some evidence that group programs provide peer support.