Appendix 2.

LEEDS
CITY COUNCIL

INTERNAL MEMORANDUM

Department of Social Services
Adoption & Fostering

To: Adoption & Fostering Staff

From: Val Hales
Team Manager
Tel: 0113 247 8675
Your Ref: Adoption & Fostering
Our Ref: VH/MW
Date: 11 August 2005

SUBJECT: Adoption & Fostering Assessments - Obesity

I am circulating for your information a BAAF article on Obesity and also a table outlining Body Mass Index.

Some workers maybe aware there have been a number of cases recently where the prospective carers weight became a significant issue in approval.

In discussing the matter with the Medical Adviser, Alison Share, she gives as a guide BMI levels indicating differing levels of concern for a person's health and longevity. Thus BMI between 20 – 25 is normal and of no concern. A BMI of 30 – 35 is of significant concern.

A BMI of over 40 is likely to indicate very serious concerns about a person's health and is unlikely to be approved, from a medical point of view.

Where there are concerns about a persons weight it should be flagged up at an early stage and discussed with the Medical Advisers. If necessary the matter can be brought to panel from a view whether to continue with an assessment, but this course of action should be a last resort. If in doubt discuss with your Team Manager.

Val Hales
Team Manager
Adoption & Fostering

Body Mass Index Table

for BMI greater than 35, go to Table 2

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.
Select the PDF version for better printing

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height (inches)	Body Weight (pounds)																
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

Go to Table 2

Please send us your feedback, comments, and questions
by using the appropriate link on the page, Contact the NHLBI.

Medical notes

Obesity: implications for the health of prospective carers

Dr Gabrielle Summerhays, Senior Clinical Medical Officer in Community Paediatrics, Havant, Hants, and Adoption Medical Adviser to Hampshire Social Services, prepared these notes

Obese individuals may suffer from social stigmatisation and discrimination and the relevance of obesity to the health assessment of prospective carers is inevitably controversial. Medical advisers are therefore required to make assessments of health risks based on sound evidence rather than prejudice. The impact of a sedentary lifestyle should not be underestimated for a child placed with prospective adopters; we should also be considering what risk factors there may be for the child's health in placement.

Obesity affects 16 per cent of men and 18 per cent of women in the UK. Around one per cent of the population are severely obese. Obesity is a health risk and raises the risk of illness from high blood pressure, raised blood lipids, type 2 diabetes, coronary heart disease, stroke, gall bladder disease and certain cancers (eg uterine, breast, prostate and colon). It can also cause or exacerbate osteoarthritis, breathlessness, heart burn, sleep apnoea, venous thromboembolism and psychological distress, particularly anxiety and depression (*Drugs and Therapeutics Bulletin*, 1998).

How is obesity determined?

The most practical method to assess obesity is using the Body Mass Index (BMI). This describes relative weight for height and is significantly correlated with total body fat content. It is calculated using weight (kilograms) divided by height (metres) squared. If your BMI is 25 or over you are overweight, if it's 30 or over you are obese and if it's 40 or over you are morbidly or severely obese (according to UK definitions).

Who is at risk of health complications?

Obese adults (BMI of greater than or equal to 30) are at increased risk of health problems. However, other factors are crucial in the assessment of health risk, as listed below.

1. Waist circumference

Waist circumference in relation to your total body fat is an independent predictor of morbidity risk. A waist measurement of more than 40 inches in a middle-aged man increases cardiovascular risk by 20-fold, even in the absence of high blood pressure, diabetes and high cholesterol (National Heart, Lung and Blood Institute, 1998).

A small group of 'high-risk' abdominally obese patients are recognised who also carry the 'atherogenic metabolic triad' of fasting hyperinsulinaemia, increased apolipoprotein B and increased proportion of small, dense, low density lipoproteins (Després *et al*, 2001).

2. Co-morbidity

Applicants with any of the following are classified as being at very high risk for disease complications and mortality (over 20 per cent five-year risk of cardiovascular disease):

- established coronary heart disease;
- type 2 diabetes;
- sleep apnoea;
- renal dysfunction;
- familial hypercholesterolaemia or other inherited dyslipidaemia.

3. Cardiovascular risk factors

Cigarette smoking multiplies the risk significantly, as does blood pressure greater or equal to 140/90 and taking anti-hypertensive medication. In addition, alcohol intake greater than 22 units per week increases the risk of serious cardiovascular events (moderate intake of less than 8 units might decrease the risk) (Lindsay, 2002). Tables for calculating risk factors are readily available (British Cardiac Society *et al*, 2000; Jackson R, 2000).

4. Family history

A history of premature cardiovascular heart disease (myocardial infarction or sudden death at or before 55 years of age in father or other male first degree relative or at or before 65 years of age in mother or other female first degree relative) is known to increase the risk by a factor of 1.5.

5. Age
Men of 45 years or over and women of 55 years and over or post-menopausal are at greater risk of cardiovascular disease.

6. Other obesity associated diseases
The following may indicate that the applicant is already suffering obesity-related problems:

- gynaecological abnormalities;
- osteoarthritis;
- gall stones and their complications;
- stress incontinence.

7. Metabolic abnormalities

- high risk – LDL: cholesterol (> or = to 160 mgs/decilitre);
- low risk – HDL: cholesterol (<35 mgs/decilitre);
- increased risk – high serum triglycerides (>200 mgs/decilitre);
- increased risk – impaired fasting glucose (110–125 mgs/decilitre).

Other risk factors include lifestyle issues. Regular exercise (20 minutes of exercise to increase the heart rate over 100 beats per minute, three times per week) reduces cardiovascular risk, but obese individuals may lead a highly sedentary lifestyle and need significant encouragement to change this.

Why lose weight?
Any discussion of risks must include positive advice about the benefits of weight loss. There is strong evidence that weight loss in overweight and obese individuals reduces risk factors for diabetes and cardiovascular disease and may prevent the onset of symptomatic osteoarthritis of the knee.

Treatment
Motivation
Successful weight loss depends very largely on motivation. An unmotivated applicant is unlikely to lose weight.

The following factors need to be evaluated:

- whether the applicant wants to lose weight;
- previous history of successful and unsuccessful weight loss attempts;
- family, friends and work site support;
- the applicant's understanding of the causes of obesity and how obesity contributes to several diseases;
- attitude to physical activity, both for themselves and any prospective adoptive children placed;
- capacity to engage in physical activity, both for themselves and for a prospective adoptive child placed;
- time availability for weight loss intervention;
- financial considerations;
- applicants' lifestyle and dietary habits – implications for any prospective child placed.

Treatment methods
- dietary changes (500 to 600 calories per day reduction from previous intake, with the emphasis on a healthy, well-balanced diet is desirable);
- increasing physical activity;
- behaviour modification:
  - alteration of meal frequency
  - changed pace of eating
  - avoiding situations that provide the temptation to over-eat
  - separation of eating from other activities
- slimming clubs/support groups, eg 'Weight Watchers';
- drug therapy, eg Phentermine or Orlistat for use after the above interventions have been tried and failed;
- surgery (gastroplasty or gastric bypass) for patients with a BMI of 40 and over, in whom other treatments have been tried and failed.

Control of cardiovascular risk factors by appropriate medication and treatment deserves equal emphasis as weight reduction therapy. Reduction of risk factors will lessen the risk of a cardiovascular disease, whether or not efforts at weight loss are successful (Jackson, 2000).

Issues for consideration by adoption medical advisers
The GP medical is an opportunity for a health review of a patient, not merely to

assess their medical suitability to be an adoptive parent. Where applicants are obese, attention must be drawn to this in the space for the medical advisers' comments, even if no mention of overweight or obesity has been made by the GP.

It is important that the social worker raises the issue of weight with the applicants and advises them that it would be an issue for the panel to consider. The treatment notes 'When and how to lose weight' (Consumers' Association, 1999) could be usefully sent or handed to applicants.

Unless an applicant is severely incapacitated by obesity, or is considered to be at extremely high risk such that chronic ill health and early mortality are extremely likely, obesity of itself should not be a major consideration in approval. It is a factor which must be weighed in the balance along with all other considerations. Information about dietary habits, lifestyle and exercise should be sought by the social worker, and it is reasonable to expect applicants to demonstrate an understanding that their health is being affected by their weight and for them to be motivated to lose weight.

BMI >30 <40

a) Applicants should be made aware by your comments that they have a problem with their weight and that their health is being put at risk.

b) You should be advising on an appropriate amount of weight to lose, and advising the applicant to discuss this further with the GP and seek the GP's advice.

c) Where the GP's examination reveals that there are risk factors other than 'merely' obesity, it is important to have the following information:

- blood pressure estimation;
- urine analysis;
- LDL – cholesterol;
- HDL – cholesterol;
- serum trigylcerides.

This will enable calculation of cardiovascular disease risk.

BMI > or = 40

When applicants are morbidly obese, it is important to obtain the following information before any comment can be made about their current health, and to predict their cardiovascular disease risk, in addition to comments a) and b) above:

- blood pressure;
- urine analysis;
- HDL/LDL ratio;
- serum triglycerides;
- abdominal girth measurement.

References

British Cardiac Society, British Hyperlipidaemia Association, British Hypertension Society and British Diabetic Association, 'Joint British recommendations on the prevention of coronary heart disease in clinical practice: summary', *British Medical Journal* 320, pp 705–08, 2000

Consumers' Association Treatment Notes No. 2, *When and How to Lose Weight*, January 1999

Després J-P, Lemieux I and Prud'homme D, 'Treatment of obesity: need to focus on high-risk abdominally obese patients', *British Medical Journal* 322, pp 716–20, 2001

Drug and Therapeutics Bulletin 36:12, 'Why and how should adults lose weight?', December 1998

Jackson R, 'Estimating cardiovascular risk and treatment benefit', source from *New Zealand Guidelines*, www.cebm.net/prognosis.asp

Jackson R, 'New Zealand cardiovascular disease risk benefit prediction guide', *British Medical Journal* 320, pp 709–10, 2000

Lindsay P, 'Objective assessment of vascular disease risk in prospective adoptive parents', *Adoption & Fostering* 26:1, pp 74–76, 2002

National Heart, Lung and Blood Institute (USA), *Clinical Guidelines on Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The evidence report*, USA: National Institutes of Health, September 1998