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HALDIMAND-NORFOLK HEALTH UNIT

PHYSICIANS' NEWSLETTER

Family Physicians and the Early Identification of Communication Difficulties in Children

Approximately 7-10% of preschool children in Canada have a specific speech and language disorder (Beitchman, Nair, Clegg, & Patel, 1986). Why should this concern us? There are at least three well-documented reasons (Warr-Leeper, 1996):

1. Language is our main method of establishing and maintaining social relationships. Psychiatric disorders are more common in language-disordered than normal language-learning children (Cantwell & Baker, 1991; Waller, Sollad, Sander & Kunkicki, 1983). It is clear that poorly developed language skills are strongly associated with life-long difficulties in psycho-social development (Weiner, 1985).
2. Language constitutes a principal means of organizing behaviour and is central to the normal acquisition of many cognitive and academic skills, particularly literacy. Language is the medium of instruction in the classroom (Berlin, Blank & Rose, 1980). Problems in the comprehension and expression of oral and written language result in academic difficulties that are not alleviated over time (Weiner, 1985).
3. As the language-delayed child ages, the gap between himself/herself and his/her peers widens (Wiig & Semel, 1984). Thus, the longer the child remains without intervention, the more pronounced the delay becomes and the more pervasive the impact.

In addition to these concerns, there is growing evidence that an "optimal" period for language learning exists and that it occurs earlier in life than we previously believed (Mustard, 1999; LaMorelle 2001). Children identified as "late talkers" showed continued

weaknesses in narrative, social language use and teacher-child discourse at the age of five (Girolametto et al, 2001). Only 42% of children who showed language delay at 18 months of age will "catch up" without intervention by age 30 months (Dionne 2005).

There are, then, compelling reasons for early identification of communication difficulties and referral to speech-language pathology services. Family practitioners are in an ideal position to identify speech and language delays in children at the 18-month immunization visit. Tools to assist in this screening include:

- The Communication Checklist, available from the Haldimand-Norfolk Preschool Speech and Language Program through the Haldimand-Norfolk Health Unit, 519-426-6170 Ext. 3243;
- The Nipissing District Developmental Screen (NDDS), which can be ordered on-line at www.ndds.ca.

Any child showing even mild communication concerns at the 18-month visit should be referred to the Haldimand-Norfolk Preschool Speech and Language Program through the Parent Info Line, 1-866-463-2759. For children who show concerns in more than one area of development, staff of Haldimand-Norfolk R.E.A.C.H. hold regular developmental screening clinic throughout the two counties. Contact the Parent Info Line, 1-866-463-2759, for upcoming dates.

At the Preschool Speech and Language Program, our motto is "No child is too young." Early identification and early intervention are critical to a child's optimal development. *(Continued on page 4.)*

SAVE THIS DATE

The Haldimand-Norfolk Health Unit in partnership with Women's SPACE is pleased to present an exciting one-day conference:

Understanding Women's Drug Use & What it Takes to Change

Friday, Nov. 16, 2007
Laurier University, Brantford Campus

Look for more details and registration information in the fall Physicians' Newsletter.

Talking about Weight

The Haldimand-Norfolk Health Unit has created **Healthy Weights Key Messages** to assist in communicating **consistent evidence-based messages** to the public regarding eating healthy, being active and accepting yourself and others. The messages focus on health and health-enhancing behaviours to achieve and maintain a healthy weight, rather than focusing on weight itself.

Words are powerful

It may seem unimportant to use particular words and terms. However, messaging in other health areas has reflected the importance of words. As an example, injury prevention experts promote the use of the word "collision" instead of "accident" to relay the sense of responsibility for actions and consequences.

The term "disability" has been replaced by "*differently*-abled" or "physically challenged" to encourage more positive attitudes and behaviour change. Similarly, the terms "healthy eating" (instead of "diet") and "physical activity" (instead of exercise) are used to convey a positive, health-focussed approach to body weight and lifestyle choices.

Health messages addressing weight **must contain the three elements of healthy eating, physical activity and self-esteem** as critical components for achieving and maintaining health and a healthy weight This balanced approach acknowledges the psycho-social aspects of weight, in addition to healthy eating and activity behaviours.

BALANCED APPROACH vs. WEIGHT-LOSS-CENTRED APPROACH

	Balanced VITALITY approach	Weight-loss-centered approach
Eat well ~~Diet~~	Healthy eating	Dieting
	Take pleasure in eating.	Follow a restrictive, boring diet plan.
	Follow variety and portion sizes in Canada's Food Guide.	Eliminate foods.
	Eat when hungry; stop when full.	Ignore hunger and satiety.
Be active ~~Exercise~~	Participate in activity for the fun of it.	Focus on exercise to change your weight or shape.
	Be active your way, every day. Choose activities you like. Follow the activity guidelines in Canada's Physical Activity Guides to Healthy Active Living.	Feel like you "have to" do certain exercises – "no pain, no gain."
	Value the many health benefits of being active – mental and physical.	Quit when there is no visible weight loss or change in ability.
Feel good about yourself ~~Fat is bad, thin is good~~	Accept that weight is a result of many different factors, some of which cannot be changed; weight is not an indication of personality traits, such as "laziness" or "lack of self-control." Muscularity or thinness alone is not an indication of success or happiness.	Discriminate against overweight people, "fat phobia."
	Accept that healthy bodies come in many weights, shapes and sizes, with some genetic basis for this diversity.	Believe that your body weight is entirely within your control.
		Believe that self-esteeem and happiness come from weight loss.

Submitted by Kathy Page, Dietitian 519-426-6170 Ext. 3247 and Michele Crowley, Health Promoter, 519-426-6170 Ext. 3239.

Summary of Healthy Weights Key Messages

Eat well

- Follow Canada's Food Guide by eating the recommended amount and type of food each day.
- Enjoy a variety of foods from the four food groups of Canada's Food Guide.
- Eat vegetables and fruit at all meals and as snacks.
- Eat regularly throughout the day, starting with breakfast.
- Eat together as a family whenever possible.
- Parents/caregivers are responsible for what foods are served, when and where meals and snacks are served. The child is responsible for how much and whether or not to eat.
- Breast milk is the best food for all infants. Health Canada recommends exclusive breastfeeding for the first six months.
- Dieting doesn't work. Eating well, being active and feeling good about yourself are important steps towards better health and a healthy body weight.

Be active

- Follow Canada's Physical Activity Guide to Healthy Active Living and be active everyday.
- Build activity into your daily routine.
- Choose activities that you enjoy.
- Physical activity can be fun for the whole family.
- Limit screen time and sitting for long periods of time.

Accept yourself and others

- Healthy people come in a variety of weights, shapes and sizes.
- Appreciate the positive qualities in yourself and others.

The key messages are recommended for use with children, youth and adults, and contain general public health lifestyle messages. It is hoped that these messages will also support other health issues, such as stress management and addictions. If there is a health reason for individuals to lose weight, they would benefit from an individualized assessment and plan from an outpatient or private practice Dietitian. Individuals can also be encouraged to contact local recreation organizations for opportunities to be active.

Waist Circumference Measurement - A new vital sign

The new Canadian guidelines on the management and prevention of obesity "recommend waist circumference measurement in all adults and adolescents as a **new vital sign** and an integral component of client assessment for global cardiometabolic risks."

Waist circumference provides a measure of visceral (abdominal) fat, which has been shown to increase a person's risk of heart disease and death independent of body weight or body mass index (BMI). A 2006 study by researchers at Queen's University showed that visceral fat is an independent predictor of all-cause mortality (Kuk et al., Obesity Research 14:336-341, 2006). The study showed that a 0.4 kg increase in visceral fat is associated with an 81% higher mortality rate.

Further, the new Canadian guidelines for the clinical management of obesity recommend measuring "body mass index **and waist circumference** in all adults and adolescents to determine the degree **and distribution** of body fat" (CMAJ April 10, 2007, Vol. 176, Issue 8). With or without weight loss, waist circumference is the best measure of change in visceral fat. It should therefore be monitored regularly as part of routine clinical assessment.

The enclosed Obesity Management Kit includes a MyoTape™ measuring tape for measuring waist circumference and an instructional video developed by leading obesity researcher, Dr. Robert Ross, of the Centre for Obesity Research and Education at Queen's University.

Dr. Robert Ross, PhD, is a leading, international expert in the area of obesity, physical activity and metabolism. He has published more than 90 manuscripts and book chapters in these topics and related areas. Dr. Ross's research focuses on the development of lifestyle-based strategies designed to prevent and reduce obesity.

Obesity During Pregnancy... What are the risks?

Obesity rates among pregnant women have jumped substantially in the past several years. Results from an examination of data on 370,000 Ontario women who underwent maternal serum screening between 1994 and 2000 showed that the percentage of overweight mothers rose 37% over the seven years; the rate of obese women went up 70%; and the proportion of severely obese jumped 80%, to three out of every 200 women.[1]

Even with maternal obesity increasing a woman's and fetus's risk of complications, dieting (caloric restriction) during a pregnancy is not recommended. A certain amount of weight gain during pregnancy is desirable. Eating according to Canada's Food Guide and maintaining a certain amount of exercise is imperative for a healthy pregnancy.

Ideal Weight Gain During Pregnancy

BMI < 20..... 12.5-18.0 kg (28-40 lb)
BMI 20-27..... 11.5-16.0 kg (25-35 lb)
BMI >27..... 7.0-11.5 kg (15-25 lb)

Health Canada in 1999 adopted the following chart for ideal weight gain during pregnancy.

Studies have shown that there are many risks associated with overweight and obese women during pregnancy and delivery.[2, 3] There can be fetal complications as well.

Some of these risks are:

Pregnancy risks for women with a BMI > 30:

- 3X risk of Gestational Diabetes.
- 2X risk of preeclampsia.
- 1.5X risk of pulmonary embolism.
- 1.5X risk of prolonged hospitalization.

Intrapartum risks for women with a BMI > 30:

- 1.8X risk of emergency CS.
- 1.7X risk of induction of labour.
- 1.7X risk of elective CS.
- 1.4X risk of major post partum haemorrhage.
- 2X risk of wound infection.

Infants born to women with BMI > 30:

- 2.4X risk of birth weight > 90 %ile.
- 1.4X risk of stillbirth.
- 1.4X risk of low Apgar score.
- 1.3Xrisk of admission to NICU.

It is important to remember that each person is unique and weight gain during pregnancy is dependent on activity and healthy eating. However, being overweight before becoming pregnant and carrying that extra weight into a pregnancy can increase the risks for problems during the pregnancy, during labour and with the newborn.

Obesity is a modifiable risk factor for adverse pregnancy outcome. Modifications should come before conception not during the pregnancy. Preconception is the time to discuss optimal BMI with the patient and to encourage some weight loss.

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Early Identification of Communication Difficulties

(Cont'd from page 1.)

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