Supporting adolescents with type 1 diabetes during the transition from child to adult services: A literature review

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Abstract

This literature review considers the personal and practice implications of type 1 diabetes amongst adolescents. The review is part of a wider Post Graduate study and here 25 largely qualitative articles are critically considered. The selection process and thematic review lead to the identification of the themes: 'social and emotional transition' and 'service related transition'. Social and emotional transition relates to the experiences of adolescents diagnosed with type 1 diabetes. These included increased risk of anxiety, depression and eating disorders which were exacerbated during the challenging adolescent period. The service related transition refers to this vulnerable group not fitting well into child or adult services and the added pressures of managing the move from one to another. This included expectation of increased autonomy and problems of poor self-management. There are some examples of positive practice found in this review largely grounded in improved personal and service transition. The review considers problems encountered and informs professionals of gaps in practice, encompassing the distinct difficulties adolescents with type 1 diabetes may experience.

Introduction

This review will examine the social and emotional implications of living with type 1 diabetes (T1) during adolescence and the significance of this for primary care services. T1 is an autoimmune response affecting insulin production (Diabetes UK, 2015). T1 most often arises in childhood or adolescence, though the exact cause is unknown (Rankin et al, 2014a; Juvenile Diabetes Research Foundation (JDRF), 2018). Whilst T1 only accounts for 10% of all cases of diabetes, it represents 96% of diabetes diagnosis in children and young people (Diabetes UK, 2016). T1, therefore, is one of the most common chronic childhood conditions; affecting 29,000 children in the UK (JDRF, 2018). This highlights the significance of the provision of high-quality primary care services as young people progress into adulthood.

Adolescence was specifically identified as the focus of this article due to it being recognized by the World Health Organization (WHO) as a period of significant life change requiring special attention (WHO, 2014). According to the National Institute for Health and Care Excellence (NICE, 2016a) the adolescent years are also linked with increased incidences of mental health issues; and in adolescents with T1 this risk is higher. Living with T1 also creates additional pressures for adolescents including anxiety, through simultaneously being different and facing additional health risks (Ellis and Jayarajah, 2016). Therefore, this review considers the additional demand of living with T1 during this period and the ways in which primary care services can facilitate the transition through adolescence, into adulthood.

The risk of poor glycaemic control is heightened during adolescence as competing interests and psychological changes lead to non-adherence to treatment (Lostein et al., 2013; Merrick, et al., 2015; Campbell et al., 2016; Los et al., 2016). T1 during adolescence creates a pressure on both families and supporting professionals, with only around 1/3 of this group achieving target blood glucose levels (Diabetes UK, 2016). Consequently, this increases the risk of poorer long-term outcomes which
generates interest from primary care practitioners as they seek to ensure positive results for young people at this critical time (WHO, 2014).

As this review will explore the specific experiences of adolescent’s, it is important to briefly define the term adolescence. This unique period is widely recognised as socially constructed by Western society and based on economic opportunity (Goble and Bye-Brooks, 2016; Packer, 2017). Lerner and Steinberg (2004) define it as the second decade of life, whilst UNICEF (2011) identify adolescence more specifically as the age of 10–19 years. But whilst age can be a useful way to define adolescence, there is a general lack of consensus around its context. Individual experiences of adolescence mean that social and emotional development and maturity varies, which influences the ability of each individual to manage a long term condition.

During the complex transition from adolescent to young adult, and therefore children’s services to adult services, primary care providers can struggle to meet individual needs, as adolescents are still maturing both cognitively and emotionally (Burke & Dowling, 2007). Lack of continuity of care and the changes in dynamics of primary care delivery can be problematic for adolescents and their families. This may be due to the focus on greater autonomy, independence, and expectations of better self-management, even though the adolescent will not necessarily be a fully independent adult.

Aim:

To critically explore the impact of living with T1 during adolescence and consider the implications for primary care during transition from child to adult services

Research Objective 1:
To consider the social and emotional impact of T1 during adolescence.

Research Objective 2:
To consider the importance of the transition from child to adult services, including the implications for Primary care.

Methodology

The aim and objectives of this review were addressed through a review of literature, which has been modified from a post-graduate library-based dissertation. Thematic analysis was used to evaluate the findings, and as part of the larger study there were several themes identified. However, the focus of this review, through further refinement, will consider two of those themes; social and emotional transition and service related transition. The methodology was underpinned by social constructionism to acknowledge the contention surrounding adolescence, and the majority of the literature was of a qualitative nature. Burr (2015) asserts that Social Constructionism provides a way to question assumptions about social structures which can be taken for granted. Consequently, social processes and interactions can be considered qualitatively, questioning understanding of life and, in the case of adolescence, a distinct identifiable period (Owuegbizie and Frels, 2016). This review considers T1 holistically, exploring care from a physical, emotional and educational perspective.

The keywords chosen were Adolescence; Type 1 diabetes; Impact of diagnosis; Social; Emotional; Psychological (see table 1). These were adapted and refined to advance the search appropriately. ‘Transition’ was added as a keyword later to address an identified gap. The initial search began with the University of Bolton’s academic database, Discover@bolton which incorporates the Royal College of Nursing, ScienceDirect, ProQuest and Ebso databases and CINAHL amongst many others (University of Bolton, 2018). The search was then broadened to incorporate other relevant databases.
and specialist websites. The search strategy can be found in table 2. The total initial number of articles in the larger study was 51 which were reduced to 25 for this study through further refinement. Critical appraisal proved essential in making both reductions in and reviewing the remaining articles, enabling the assessment of the quality, reliability and credibility of the studies included (Coughlan et al. 2013). This evaluation was made possible using Critical Appraisal Skills Programme (CASP, 2017). This ensured the method, participant group and ethics could be measured, reviewing the authenticity of research. Thematic analysis was then carried out to establish the relevant themes within the literature, allowing the flexible consideration of qualitative research (Wood et al. 2009).

It is suggested that a framework is used to form the basis of a thematic analysis (Braun and Clarke, 2006). This included stages of reading and analysis with groupings of literature identified as they shared similar themes. For this review this resulted in a focus upon social and emotional and implications of T1 and transition. The broader study had identified further themes including: Factors directly affecting the adolescent / Factors affecting the Family Unit and Managing T1 in adolescence. Table 3 shows a summary of the literature review, identifying the evidence base incorporated into this article. This highlights the different methods and the variation in research approaches, and the total number of participants included across the review. Collated from all studies were an approximate total of 1652 adolescents, 20 professionals, 871 parents and 29 Trusts/providers. Hence the literature review incorporates participants from a range of experience with noticeable focus upon the experiences of young people, followed by their parents and less so professionals. This is related to considering the evidence from the perspective of young people using services and experiencing living with the condition.

Much of the literature relied upon case studies, interviews, focus groups or self-reporting questionnaires, which provided rich findings and interpretations from varying perspectives. Arguments against such qualitative approaches tend to focus upon subjectivity yet gaining understanding from the lived experience has its own credibility (Coughlan et al. 2013). Qualitative researchers accept and celebrate the subjectivity of knowledge and seek to understand participants’ voices and experiences rather than generalising a sample population (Coughlan et al., 2013). Limitations do exist within this review as in most research, although rigor and reliability were based on the use of CASP to identify and evaluate the journals.

Table 1: Keywords

<table>
<thead>
<tr>
<th>Keywords used</th>
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<tbody>
<tr>
<td>Adolescence; Type 1 diabetes; Impact, diagnosis; Social; Emotional; Psychological; Transition.</td>
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</table>

Table 2: Search Strategy

<table>
<thead>
<tr>
<th>Database/source</th>
<th>Keywords used</th>
<th>Refine/Inclusion/Exclusion</th>
<th>“Hits”</th>
<th>Selected</th>
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</thead>
</table>
| Discover@bolton | ‘Impact type 1 diabetes diagnosis’ AND ‘adolescence’ | Inclusion:  
• 2007-2017  
• Full text  
• Scholarly & peer reviewed  
• Journal articles only | 1106 | 13 |
<table>
<thead>
<tr>
<th>Author/Year/</th>
<th>Title</th>
<th>Type of Study/Sample size</th>
<th>Main theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babler &amp; Strickland (2015)</td>
<td>Normalizing: Adolescent Experiences living with Type 1 Diabetes</td>
<td>Qualitative - Grounded theory, 15 interviews conducted</td>
<td>Social and emotional impact</td>
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<tr>
<td>Bermudez et al. (2009)</td>
<td>Inpatient Management of Eating Disorders in Type 1 Diabetes</td>
<td>Review</td>
<td>Social and emotional impact</td>
</tr>
<tr>
<td>Burke &amp; Dowling (2007)</td>
<td>Living with Diabetes: Adolescents’ Perspectives.</td>
<td>Qualitative study - descriptive phenomenological approach, 5 participants</td>
<td>Social and emotional impact</td>
</tr>
<tr>
<td>Cammarata et al. (2009)</td>
<td>Psychosocial issues that Affect Youth with Diabetes</td>
<td>Research article</td>
<td>Social and emotional impact</td>
</tr>
<tr>
<td>Campbell (2016)</td>
<td>Transition of care for adolescents from paediatric services to adult health services (review)</td>
<td>Systematic Review, 4 studies (n = 238 participants)</td>
<td>Transition</td>
</tr>
<tr>
<td>Chao et al. (2014)</td>
<td>Self-management in early adolescence and differences by age at diagnosis and duration of type 1 diabetes</td>
<td>Quantitative, Cross sectional design, 320 adolescents.</td>
<td>Transition</td>
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<tr>
<td>Ellis &amp; Jayarajah (2016)</td>
<td>Adolescents’ views and experiences of living with type 1 diabetes</td>
<td>Systematic review</td>
<td>Transition</td>
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<tr>
<td>Hynes et al. (2015)</td>
<td>‘It makes a difference coming here’: A qualitative exploration of clinic attendance among young adults with type 1 diabetes</td>
<td>Qualitative study - grounded theory, 29 participants</td>
<td>Transition</td>
</tr>
<tr>
<td>Kay (2009)</td>
<td>An exploration of the experiences of young women living with type 1 diabetes</td>
<td>Qualitative, 9 participants</td>
<td>Social and emotional impact</td>
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<tr>
<td>Reference</td>
<td>Title</td>
<td>Methodology</td>
<td>Population Description</td>
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<tr>
<td>Kime (2014)</td>
<td>Young People with type 1 diabetes and their transition to adult services</td>
<td>Report on a Longitudinal study (3 years) multisite study (9 NHS trusts)</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Logan et al. (2008)</td>
<td>Smoothing the transition from paediatric to adult services in type 1 diabetes</td>
<td>Qualitative, 93 participants</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
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<tr>
<td>Los et al. (2016)</td>
<td>Technology Use in Transition-Age Patients with Type 1 Diabetes: Reality and promises.</td>
<td>Review</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
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<tr>
<td>Lostein et al. (2013)</td>
<td>Transition from pediatric to adult care for youth diagnosed with type 1 diabetes in adolescence</td>
<td>Quantitative, longitudinal study (185 participants)</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
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<tr>
<td>Merrick et al. (2015)</td>
<td>Characteristics of young people with long term conditions close to transfer to adult health services</td>
<td>Longitudinal study, 374 adolescents plus 1 of their parents/carers</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
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<tr>
<td>Palmer et al. (2009)</td>
<td>Mothers’, Fathers’, and Children’s Perceptions of Parental Responsibility in Adolescence: Examining the Roles of Age, Pubertal Status, and Efficacy</td>
<td>Quantitative, The first of a 3-year longitudinal study. 185 adolescents 185 mothers 145 fathers</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Rankin et al. (2011)</td>
<td>Understanding information and education gaps among people with type 1 diabetes: a qualitative investigation</td>
<td>Qualitative, Semi-structured interviews, 30 participants</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Rasmussen et al., (2011)</td>
<td>Young adult’s management of type 1 diabetes during life transitions</td>
<td>Qualitative, interpretive enquiry 20 young adults with T1 diabetes</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Simms &amp; Monaghan (2016)</td>
<td>The initial impact of a diabetes diagnosis on mental health in young people and families.</td>
<td>Literature review, Not specified</td>
<td>Social and emotional impact</td>
</tr>
<tr>
<td>Sonneveld (2012)</td>
<td>Gaps in transitional care: what are the perceptions of adolescents, parents and providers?</td>
<td>Quantitative study 127 adolescents, 166 parents, 19 providers.</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Spencer et al. (2013)</td>
<td>Type 1 Diabetes in Young People: The Impact of Social Environments on Self-Management Issues from Young People’s and Parents’ Perspectives</td>
<td>Qualitative study, 20 participants.</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
<tr>
<td>Winocour (2014)</td>
<td>Care of adolescents and young adults with diabetes – much more than transitional care: a personal view.</td>
<td>Personal Review</td>
<td>Transition through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services.</td>
</tr>
</tbody>
</table>

**Literature Review**

As identified, adolescence is a life transition which is notorious for reduced compliance with treatment, particularly with long term conditions (Palmer et al., 2009; Los et al., 2016). Burke & Dowling (2007) identified it as being a period where young people are still maturing emotionally and cognitively and it is associated with independence, new experiences and testing of boundaries. Rasmussen et al. (2011) noted two significant life transitions that impact diabetes self-care among adolescents with T1. The first was the fundamental life transitions associated with the period of adolescence, including social and emotional factors. The other was a diabetes related transition, which involves moving through the initial diagnosis, acceptance of the condition (psychosocial transition), and transition through services. This mirrored the two main themes for this article, filtered from the larger study as explained earlier. Therefore, the below themes will be the focus of this literature review:

- Social and emotional transition
- Service related transition
Social and Emotional Transition

Cammarata et al. (2009) identified that the initial acceptance and adjustment to the diagnosis of T1 impacts greatly on self-management ability and adherence to a treatment regime. The clinical presentation of the young person, and whether they were in a critical condition when first diagnosed was key (Spencer et al., 2013). Simms & Monaghan (2016) agree that illness severity at the time of diagnosis can contribute to the initial adjustment and overall acceptance of the condition. However, in relation to the emotional response to the diagnosis, it remains unclear why some adolescents adjust relatively well, and others suffer significant emotional distress (Robinson, 2015). Cammarata et al. (2009), Bermudez et al (2009) and Ashraff et al (2013) all discuss the negative impact on adolescent mental health after a diagnosis of T1. This can include anxiety, depression and eating disorders, which may help to explain why there is a higher rate of psychological disorders in adolescents with T1 (Kay, 2009). Therefore, services should consider this when delivering primary care, ensuring appropriate psychological support is in place.

Along with physical state at the time of diagnosis, age at diagnosis should be considered. Rankin et al. (2011) propose that those diagnosed during adolescence may display different levels of acceptance and adjustment, and therefore self-management, to those diagnosed as younger children. Additionally, those diagnosed during adolescence may have a more premature expectation put upon them to be more independent and play a more active role in self-management. Those who were diagnosed with T1 during the adolescent years may indeed have different needs to those diagnosed in childhood who have had more time to develop self-management skills (Lostein et al., 2013). Chao et al. (2014) however found no significant difference in self-management by age at diagnosis, but rather duration of diagnosis. Buchbinder (2009) also highlights that adolescents are often expected to be autonomous at certain times, for example during problem identification, but then expected to defer to the parent at other times. This can be restricting and create contradictory messages leading to lack of engagement, which for primary care is a significant concern to be considered in the delivery of appropriate services. Regardless of age or duration of diagnosis, flexible collaborative primary care is required and to do this effectively, health professionals need to negotiate with, not for, adolescents. Buchbinder (2009) and Babler and Strickland (2015) advise that professionals’ attitudes should be positive and focus upon supporting wellness and the maintenance of a normal life.

Service Related Transition

Transition to adult services is an inevitable process through which all adolescents must navigate, and Spencer et al. (2013) states this is daunting for adolescents and their families. Children’s services are notably individualised to adjust to the young person’s developing level of autonomy, through the formation of trustworthy and friendly relationships (Thynne et al. 2014). Merrick et al. (2015) propose that the transition from child to adult services is a wider concern that needs to be considered fully when designing and delivering services, as it is more than a simple transfer from one care provider to another. Edge (2015) and Ellis and Jayarajah (2016) agree and found non-adherence to treatment during adolescence increases during times of personal change, including within service provision. Therefore, it is vital primary care gains an understanding of this transition to aid improved outcomes.

The consequence of this reduction in effective diabetes management and engagement with services during adolescence is directly associated with a deterioration in health (Lostein et al., 2013; Merrick, et al., 2015; Campbell et al., 2016; Los et al., 2016). Thynne et al. (2014) agree that the transition to adult services is a difficult time, and professionals working in primary care should aim to ease transition for adolescents to improve responsiveness to increase autonomy, independence and responsibility. Kime (2014) identified that one of the main issues in relation to the transfer of young
people to adult services was a lack of continuity and psychological support. This is an area for significant consideration when designing and delivering care packages within primary care for adolescents and supporting positive future outcomes.

Sonneveld et al. (2012) highlight that some of the barriers to clinic attendance within the transition period include a negative perceptions of diabetes self-management and a lack of value in attending, and they stress the importance of services providers being able to cater for these. Winocour (2014) adds that some healthcare settings report having transition arrangements but on closer inspection it appears that they simply transfer the adolescent to adult services with no focus on empowerment of individuals or carers; this is in fact transfer not transition. Transition therefore should be a process rather than a finite event and when considering the care package required during transition, Thynne et al. (2014) suggest interventions such as joint and group sessions are beneficial, alongside one to one appointments. They also highlight the use of modern methods such as social media focus groups, text messaging and emails so that adolescents can seek advice and education without being judged. Hynes et al. (2015) found that collaborative relationships between young adults and service providers increased the perceived value of engagement with services, helping adolescents overcome barriers to engagement and access.

There were several areas of good practice identified in the literature review (Winocour, 2014; Logan et al. 2008), although Logan et al. (2008) argue that some of the existing models and concepts surrounding transition to adult services are non-specific to T1 diabetes. One example of this is the ‘Ready, Steady, Go’ (RSG) concept. RSG has been successful in transition for diabetes and other long-term conditions (Winocour, 2014). This framework is adopted by some NHS Trusts, but was introduced by Southampton NHS Foundation Trust in 2014. It is aimed at families with children over the age of 11 years old with long-term conditions and aims to educate them around managing their condition to improve long term outcomes and improve confidence, before fully moving to adult services (University Hospital Southampton NHS Foundation Trust, 2014). Although this model was not specific to T1, many of the considerations required during the process of transition are applicable to primary care for all long-term conditions.

Los et al. (2016) additionally explored the use of devices such as insulin pumps and continuous glucose monitoring along with decision-making software, mobile phone apps, text messaging and social networking. They found that although the adolescent period is deemed to be very ‘tech savvy’, they have a unique relationship with diabetes devices that is not present in younger or older patients and this can lead to barriers with its use. For example, NICE (2016b) state that continuous glucose monitoring (CGM) and insulin pump therapy provide safety features such as alarms which could help overcome poor management; however, this involves being permanently ‘attached’ to a monitor, which can lead to issues around body image (Bleakly, 2011). Therefore, there are complex challenges for adolescents with T1, which require professional recognition to allow for optimum control and prevention of complications.

**Discussion**

Despite the increase in evidence and improvements in diabetes care and technology, the process of transition to adult care is still not at a satisfactory level in many areas of the UK. Diabetes UK (2017) reiterates these findings and suggests that transition is often abrupt, fragmented or even non-existent. As identified, adolescence is a period of vulnerability which is notorious for reduced compliance with treatment, particularly in relation to long term conditions (Palmer et al., 2009; Los et al., 2016). Additionally, it is associated with increased incidences of mental health issues, which is a heightened risk for adolescents with T1 (NICE, 2016a). Bermudez et al. (2009), Lostein et al. (2013) and Ashraff et
al. (2015) all identified that a diagnosis of T1 had a significant impact on the psychological and emotional health and well-being of adolescents. NICE (2016a) identify that adolescents with T1 are more likely to have mental health and behavioural issues requiring referral to child and adolescent mental health services (CAMHS) than those who are non T1. Therefore, this transition from child to adult services is an area in need of immediate and significant improvement.

Unlike the adult clinic setting, paediatric care was more tailored towards the child’s unique and complex needs through a generally warmer and more familiar environment (Thynne et al. 2014). Loevin et al. (2013) suggest it is difficult to have a prescriptive policy to recommend transition at a certain age. For example, adolescents diagnosed during their teenage years may have different needs to those diagnosed at an earlier age, as the later have had more time to develop self-management skills and prepare for transition. Gill et al. (2014) support the use of a structured framework for transition as consultations alter from being complex and parent-led, to shortened and purpose driven appointments led by the professional.

The importance of a person centred and holistic approach to long term conditions was well founded and proved critical to this literature review. However, a key point that emerged was that even though T1 is known to cause emotional and behavioural problems in adolescence, this is often overlooked in favour of clinical factors. Recognition of the complex demands, and emotional needs of adolescents proved significant; stress affects BG levels and metabolism both directly and indirectly, through the release of hormones or interference with self-care (Ashraff et al., 2013). Stress was created through concern with wanting a ‘normal’ life, as symptoms of hypoglycaemia and hyperglycaemia were found to impact on all activities (Robinson, 2015). Ashraff et al. (2013) identified frustration amongst adolescents as they showed good adherence to the complex regime, but still had sub-optimal BG. This could create further emotional pressure and a sense of pointlessness at a time of vulnerability. They also found optimal control was often only partially effective in addressing immediate and future complications, which added to feelings of failure and contributed to the list of stressors.

Jain and Aravamudhan (2016) recommend the use of technology to encourage adolescents to be more self-reliant during the transitional period. Diabetes UK (2017) also promote the use of technology during adolescence and particularly prior to beginning transition to adult services. They advocate the use of social media such as Facebook and Twitter to make services more appealing and approachable for adolescents. This method along with other contemporary approaches such as text messaging and the use of mobile phone ‘apps’ improves education, engagement and attendance in this group of patients. Dr Partha Kar, a consultant diabetologist at Portsmouth Hospitals NHS Trust support this and highly commends the use of social media as a tool to help improve patient engagement and the development and delivery of services. Kar was one of the individuals named Social Media Pioneers across the NHS (Maier and Middleton, 2014) and he identifies that this is how society now communicates. Therefore, this should be embraced and implemented in to primary care delivery (Cooper and Kar, 2014).

Rea (2014) proposes that a national registry of transition services should exist. Very few interventions have been evaluated, which makes effectiveness and quality of care difficult to measure. Numerous guidelines and policy statements have highlighted the importance of good transition services to reduce the risk of future complications. For example, NICE (2016c) guidance on the process of transition supports many of the points raised throughout the literature review, such as ensuring that transitional care is developmentally appropriate, strengths based, and person centred. They also reiterate the importance of professionals from children’s and adult’s services working together to ensure a smooth and seamless transition. NHS England (2016) and the Care Quality Commission (CQC,
set similar expectations. Therefore, the fact that the process of transition is so inconsistent, and may be negatively perceived, raises professional issues and highlights a need for change.

**Conclusion and Recommendations**

This article has explored the key terms and concepts in relation to adolescence and the management of T1. The overall aim was to critically explore the social and emotional impact of T1 during adolescence and the relevance of this for primary care during transition from child to adult services. The study confirms that T1 is a complex condition that requires a demanding self-management routine. Adolescents often experience negativity as they try to navigate physical, psychosocial and societal demands. Several gaps and potential areas for improvement to current transition provision were identified (see table 4). These could potentially influence current practice to improve service provision for this unique group of patients. Most of the recommendations drawn from the literature review suggest that transition from child to adult services is an area in need of immediate and significant improvement. However, despite this recognition there seems at times little progress evident. National policy and guidelines on the process of transition also highlight the importance of ensuring that transitional care is developmentally appropriate, strengths based, and person centred. They also reiterate the importance of professionals from children’s and adult’s services working together to ensure a smooth, seamless transition. However transitional care remains less than satisfactory in many areas. Professionals facilitating transition therefore need to be aware of the holistic requirements of adolescents, to ensure that services are developmentally suitable. The fact that the process of transition remains so inconsistent and negatively perceived raises professional issues and highlights an urgent need for change.

**Table 4: Recommendations for Practice**

<table>
<thead>
<tr>
<th>Recommendations for practice</th>
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<tbody>
<tr>
<td>• Greater collaboration between professionals and more sharing of information between services to ensure smooth transition of care for adolescents.</td>
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<tr>
<td>• Services need to be more accessible and developmentally appropriate for adolescents to encourage better engagement and improved long-term outcomes.</td>
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<tr>
<td>• Transition needs to be targeted more specifically towards the holistic needs of the adolescent and their family to ensure a smooth transfer of care</td>
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</tbody>
</table>
References


Chao, A., Whittemore, R., Minges, K.E., Murphy, K.M. and Grey, M. (2014) Self-Management in Early Adolescence and Differences by Age at Diagnosis and Duration of Type 1 Diabetes. The Diabetes Educator, 40 (2), pp. 167-177.


Hynes, L., Byrne, M., Casey, D., Dinneen, S.F. and O'Hara, M.C. (2015) It Makes a Difference Coming Here: A Qualitative Exploration of Clinic Attendance among Young Adults with Type 1 Diabetes. British Journal of Health Psychology, 2015 (20), pp 847-858.


