

Best practice guidelines for health professionals

for the effective transition of young people with
diabetes from paediatric to adult care

1.0 Introduction

1.1 Background

In 2002, a clinical audit was undertaken on behalf of Queensland Health to identify clinical management practices for young people with diabetes and to collect prevalence data on diabetes-related complications.¹ Data was collected on 968 children and adolescents with diabetes who represented 66% of those registered with the National Diabetes Supply Scheme (NDSS). When comparing age group data with the NDSS Register it was found that only 48% of adolescents in the 15-17 age group were captured compared to 75% in the under 15 years age group. This figure was worrying. It was thought that these young people were either being seen less frequently than recommended (3 monthly) or were seeking care outside specialist diabetes services.^{2,3} It seems likely that they were 'lost to follow-up' during transfer from paediatric to adult care.

An audit conducted in mid 2007 by the Mater Children's Hospital in Brisbane showed that approximately 35% of patients transitioned from their paediatric service were lost to specialist diabetes follow-up.⁴ Considering that the paediatric and adults clinics at the Mater Hospital are held in the same location (on different days) this result is very concerning.

1.2 Why are these guidelines required in Queensland?

There is evidence that these young people who 'drop out' of specialist diabetes care then re-present in early adult life with preventable diabetes related complications as a result of poor diabetes control.⁵ These complications may have been avoided had they had continued surveillance by a diabetes specialist. The 'drop out' from specialist diabetes care results in preventable morbidity, a potential reduction in both productivity and life expectancy and additional long term costs to the health system.

Paediatric and adult out-patient services frequently fail to meet the needs of young people with chronic illness. These patients sit poorly between the family-centred paediatric paradigm, which frequently ignores the growing independence of the adolescent, and the adult medical model which acknowledges patient autonomy but often neglects growth and development and psychological concerns of the adolescent.⁶

In the absence of Best Practice Guidelines transition to adult care may be an unplanned process that will increase the chance of the young person 'dropping out' of care.

1.3 'Sweet' - The Diabetes Transition Program

In 2006, Queensland Health provided funds to the Mater Children's Hospital to develop an effective state-wide model for transitioning young people with diabetes from paediatric to adult care. This program is now known as '**Sweet**' The Diabetes Transition Program actively engages young people to participate in the transition

process while taking into account the wide geographical distribution of health services for this age group across the state.

The aims of 'Sweet' The Diabetes Transition Program are to:

- develop strategies and resources to effectively engage young people in the transition process
- develop an appropriate model of care for effective transition of young people to adult care
- ensure that national and international guidelines on complication screening for this patient group are being met regardless of where care is accessed.

1.4 The Aim of this Document

These *Best Practice Guidelines* are intended to provide a framework to assist health professionals deliver effective care during the transition period based on the individual needs of the young person and within the availability of current resources.

The Guidelines are not designed to educate health professionals on clinical management of young people with diabetes but to emphasise the need for an individual approach based on a non-judgemental philosophy of care.

2.0 Transition from Paediatric to Adult Care

2.1 Definition

The concept of simply transferring a patient from paediatric to adult care in a single step at a point in time has been replaced with the concept of 'transition', emphasising the need for the change to be guided, educational and therapeutic rather than an administrative event.⁷

The most useful definition for transition comes from the American Society for Adolescent Medicine, where it is described as:

'the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-orientated health care systems'.⁶

2.2 Key Elements of Transitional Care

As well as dealing with the medical issues of the young person, transitional care also needs to include:

- skills training, including diabetes self management, self-advocacy and the ability to independently negotiate services
- education about general adolescent health issues such as drug taking, alcohol use, mental and sexual health issues
- educational and vocational issues, particularly career, work experience and disclosure.⁸

The key elements of '*Sweet*' the Diabetes Transition Program are:

- **Flexible Timing of Transfer:** There is no 'set' (right) time for transition. Each person is an individual and consideration should be given to what is happening in the young person's life. Young people should never be transferred to a new service or clinic at a time when they are experiencing major life changes or are in 'crisis'.
- **Flexibility in Provision of Health Services:** Delivery of health services designed to suit the needs of young people e.g. evening clinics, Young Adult clinics.
- **A Key Worker for Each Individual:** Assignment of a 'key worker' or 'case manager' to each young person who is in the transition process provides continuity and an opportunity to assess the effectiveness of the 'transfer' to the adult diabetes service.
- **A Preparation Period:** Young people need to develop the necessary knowledge and skills to enable them to cope with the responsibilities of taking charge of their diabetes care.
- **A Choice of Adult Provider:** Where possible young people should be given a choice of adult care provider and be reassured that they may need to try more than one until they find someone that they feel comfortable with. These options may include private care.
- **A Co-ordinated Transfer:** Young people should be given an anticipated transfer date or age of transfer. Prior to transfer there should be at least one joint visit with the adult diabetes service/clinic. Ideally, this works best if the adult diabetes service attends the paediatric service/clinic.
- **Accessible Medical Summary:** A comprehensive medical history and treatment summary needs to be provided when the young person is transferred to the adult diabetes service. The young person's consent needs to be obtained for the release of this information.
- **Transfer to an Interested and Capable Adult Diabetes Service:** A successful transition program requires active participation and interest from an adult diabetes service or clinic (public or private) and a willingness by the health professionals to participate in the transition process. Where this does not exist, the paediatric team **should** work proactively to create linkages with an adult diabetes service.

(Adapted from Viner R.,1999)⁹

3.0 Changes and Challenges for All

The transition process involves change for each of the parties involved:

- for the young person with diabetes it means learning about their diabetes and beginning the journey towards self-management of their diabetes
- for the parent/s of the young person, it means beginning to "let go" and allowing the young person to begin independent decision making about their diabetes, *and*
- for the health care professionals in the diabetes care team it means accepting the young person's growing autonomy and starting to interact directly with the young person during visits rather than exclusively through their parent(s).

4.0 Transition Process

Because Transition should be a planned and purposeful process, there is a need for an over-arching structured program which guides the process as the young person matures.

Table 1 outlines the recommended steps in the transition process

Table 1

The Transition Process	
Step 1	At 12-13 years , introduce the Transition Program to the parents and young person.
Step 2	At 12-13 years , assess diabetes knowledge and provide appropriate diabetes education.
Step 3	At 15 years , provide education on specific issues that confront young people and the additional impact of diabetes. Start seeing the young person alone for some of the consultation.
Step 4	Around 16-17 years , assigning a transition case manager.
Step 5	By 16-17 years the young person should be fully self-managing their diabetes.
Step 6	Transfer to adult care. Ensuring the young person has up-to-date knowledge and skills on diabetes and other life issues prior to transfer.
Step 7	Maintaining contact after transfer to ensure the young person is continuing in specialist care and is not lost to follow-up

4.1 The Transition Journey Begins

The transition journey begins when the young person reaches 12-13 years of age, dependent on their level of maturity. At this age, parents are typically (and appropriately) still actively involved in the young person's diabetes management.

Information brochures for young people and parents and carers on Transition have been developed and are available on the sweet.org.au website. A

Step 1:

The first step in the transition process begins with explaining the process of transition and the Transition Program to the parents of a young person with diabetes and to the young person themselves.

Step 2:

The second step is to assess the diabetes knowledge level of the young person. Depending on the age at diagnosis of their diabetes, the young person may have never received primary education about their diabetes and their knowledge is likely restricted to what they have acquired from their parents and information secondarily acquired through attendance at diabetes clinic's or camps.

Based on this assessment diabetes education should be provided to the young person so that they have the knowledge base to become progressively more involved in their diabetes management.

It is not expected that they will begin to immediately self-manage their diabetes without parental input. Rather, the process is about providing them with basic information so they better understand their diabetes and its management so they can begin to actively participate in their diabetes care with their parents. The ultimate goal is for them to be able to self-manage their diabetes. Young people will achieve self-management at varying ages depending on their level of maturity and independence. The journey to complete self-management usually takes several years.

The Diabetes Education program for Step 2 is aimed specifically at the young person. The modules of education that should be offered mirror that provided to the parent of a newly diagnosed patient. Key modules include:-

- About diabetes
- Diabetes Control
- Insulin Therapy & Adjustment
- Management of 'Hypo's'
- Exercise
- 'Sick Day' Management
- Effects of Hormones on Diabetes
- School issues (including school camps when appropriate)
- Diabetes Complication Screening

A guide for these education modules is included as Appendix 1 of these Best Practice Guidelines. A review by a dietitian should also be arranged at this time.

It is strongly recommended that the modules are delivered over several clinic visits or in special half-day sessions to avoid information over-load. There is too much information to be provided in the course of one clinic visit. In larger clinics, depending on the number of young people in this age range, there would be some efficiencies to be gained by delivering group education sessions, provided these remain flexible enough to accommodate the learning needs of individuals. There is the additional potential benefit that this group could, over the full course of the Transition Program, become mutually self-supporting.

4.2 Continuing the Journey

Step 3:

By approximately **15 years of age**, the young person should be actively involved in their diabetes care and beginning to take more responsibility. At clinic visits, the diabetes care team should begin to acknowledge the young person's growing autonomy by seeing them alone for part of the consultation. Their parents can be included towards the end of the consultation so they are able to contribute to the consultation and also be kept informed of any treatment changes or concerns. This is an essential part of the transition process and requires discipline on the part of the care team as the consultations may take longer when conducted in this way.

A key step in this process is to explain to the young person that the confidentiality of any information they provide will be respected.

Basic diabetes knowledge and skills continue to be reinforced with the young person during these clinic visits and consultations (refer to Appendix 1).

By this age, the young person needs to be provided with education on some of the additional challenges that being a young person with diabetes brings. These include:-

- Alcohol & Related Issues
- Drugs & Smoking
- Sexuality & Diabetes
- Feelings and Emotions - Burnout
- National Diabetes Supply Scheme (NDSS) & Government Allowances
- Confidentiality

While many of these issues are common to all young people, it is the impact on their diabetes that must be emphasised in the education process. To assist with this education Fact Sheets on these topics for young people are included on the transition website: www.sweet.org.au

A guide for this education is included as Appendix 2 to these Best Practice Guidelines.

At this stage, it is also important to begin discussing with the young person as to what they should expect from a clinic visit or medical consultation.

Step 4: Assigning a Transition Case Manager

At around **16-17 years of age**, the young person should be assigned a Transition Case Manager from within the diabetes care team. For most areas in Queensland this does not need to be a separate position as the number of patients in this age group being transitioned at any time is likely to be small. However, in large Regional or Tertiary Hospitals where there are large numbers of young people undergoing transition a Case Manager position may be warranted.

The role of the Transition Case Manager is to:

- ensure the overall Transition Program is being followed
- monitor the young person's progress through the transition process and ensure their needs are being met
- support and guide the parents/carers through the transition process, *and*
- maintain contact with the young person after they transition to ensure that the transition has been effective.

The Diabetes Team and the Case Manager need to educate the young person about how to access reliable information and resources on diabetes. They must also be taught how to actively participate in a medical consultation or clinic visit so that their needs are met.

4.3 Still on the Journey

Step 5:

By **16-17 years** of age the young person should be taking full responsibility for their diabetes management. However, some young people will continue to require support and guidance from their parents but all should be working towards total independence. By this age most young people should be seen by the diabetes team without their parents being present. Parents should only be provided with information if the young person consents.

4.3.1 Dedicated Diabetes Transition Clinics

Some diabetes clinics have sufficient patients that they are able to provide specific Diabetes Transition Clinics. These clinics are usually offered once a month or every few months and involve having joint consultations with the paediatric and adult diabetes teams. Where possible these combined consultations should occur for some time prior to the young person being transferred to an adult diabetes service. Advantages of having a dedicated Diabetes Transition clinic include:

- Allows the young person to experience the differences of approach between paediatric and adult care while remaining in a supportive and familiar environment.

- Offers the young person an opportunity to get to know the adult care team before transfer.
- Having a blend of paediatric and adult care strengthens the level of expertise amongst staff and provides the young person with a greater depth of specialised care during these years.
- Provides the opportunity for adult and paediatric health care providers to work together on a regular basis which breaks down barriers and promotes collegiality between the different sectors.
- The opportunity to attract extra health disciplines to the service when a larger joint clinic is held. eg. psychology, dietetics and social work.³

Step 5 Continued:

Diabetes education is a continuous process that requires reinforcement for it to be effective. During this time (**16-17 years of age**), it may be necessary to reassess knowledge base and, when required, repeat elements of the education previously given to the young person e.g:

- Alcohol & Related Issues
- Drugs & Smoking
- Sexuality and Diabetes
- Getting a Drivers Licence
- Feelings and Emotions - Burnout
- National Diabetes Supply Scheme (NDSS)
& Government Allowances

(Refer to Appendix 2 of these Guidelines)

Additional education on the management of diabetes during 'Schoolies' Week should also be provided at this time. A guide for this education is included in Appendix 3 of these Best Practice Guidelines. Discussions regarding tertiary studies and employment should also occur at this stage.

Specific resources to assist in this education process have also been developed and are available on the *Sweet* website: www.sweet.org.au

4.4 A New Beginning

Step 6: Transfer

The age that the young person finally transfers to an adult diabetes service or clinic will depend on their individual needs and whether there is an adult diabetes service available in the area. Some places transfer young people when they turn 18 years or when they finish school whereas others, where there is limited adult diabetes services available locally, may not transfer the young person until early adulthood.

Where there is not a well developed local adult diabetes service, the paediatric team will be well served in the long run by trying to improve services locally.

This could be achieved through dialogue with local adult medical services, attempting to establish an outreach service or inviting a local general practitioner to join the care team for a period to be up-skilled in diabetes management.

In adult diabetes services, young people with Type 1 diabetes are out-numbered by older adults with Type 2 diabetes. This may be a disincentive for them remaining with the adult diabetes service. To assist the transition process and increase the retention rate, it may be possible for the paediatric service to negotiate with the adult diabetes service to hold either separate clinics for patients with Type 1 diabetes or 'Young People' only clinics.

4.4.1 Other Models of Care

While these best practice guidelines are principally focussed on young people attending hospital-based clinics, it must be recognised that there are other models of care. Regardless of their health insurance status, families can elect for their child/young person to be treated by a paediatrician or paediatric endocrinologist in private practice. The strength of this model is continuity of care from the same specialist. The down-side is that the care is not multi-disciplinary. Ideally, in this model the young person should be reviewed periodically by a multi-disciplinary team either at a diabetes clinic or be referred to health professionals in private practice.

The same steps (Steps 1-6) should be followed in private practice. When further education is required the family and young person should be referred to a diabetes educator and dietitian. The growing autonomy of the young person should be respected in consultations.

When the time comes to formally transfer the young person to adult care, the paediatrician or clinic has a responsibility to ensure that the young person is:-

- prepared for the transfer
- given a choice of adult provider
- followed-up to ensure that the process has been successful

4.4.2 When There is No Local Adult Diabetes Service

Not all areas in Queensland have an adult diabetes service or clinic that the young person can be transitioned to. While not ideal, this reflects the geography of the state and distribution of specialist diabetes services. In this situation, the paediatric diabetes care team must give careful consideration as to how the young person's care is transferred. The local care team is best placed to make these decisions based on their knowledge of the resources available within the local community or in the local referral hub. It may be necessary for a local General Practitioner (GP) to become the primary service provider with periodic support from a visiting diabetes specialty outreach service or by referring the young person annually for assessment to either a diabetes clinic or private diabetes specialist.

The general practitioner must be informed of the required complication screening program by the paediatric care team at the time of transfer.

Specific guidelines for complications screening have been developed on behalf of Queensland Health and can be found on the 'Sweet' website www.sweet.org.au.

The transfer period can be gradual e.g. alternating visits between the paediatric service and the general practitioner. This also allows effective transfer of information to the general practitioner.

4.5 Beyond Transition

Step 7. Maintaining Contact

By the time the young person transfers to an adult diabetes service or clinic, they should be fully self-managing their diabetes with support from their diabetes care team and if required support from their parents.

Because of the high percentage of young people who are currently lost to diabetes specialist care after transfer to adult care, it is strongly recommended that the Transition Case Manager in the paediatric care team maintain contact with the young person to ensure that needs are being met within the adult diabetes service. If they are not, they should return to the paediatric clinic while an alternative arrangement is sought.

It is important that young people are supported to find an adult care provider that they feel comfortable with. This may not be the first adult provider that they meet with. By supporting them to 'keep looking' until they find someone that meets their needs we can assist them to remain in specialist diabetes care.

5.0 The Role of the General Practitioner

The general practitioner has an important role as a partner in the management of all young people with diabetes.

The general practitioner should be the primary point of contact for the young person and their family for day to day health issues such as minor intercurrent illnesses, injuries and immunisations.

The paediatric diabetes care team for their part, has a responsibility to identify the young person's general practitioner, update this information periodically and keep the general practitioner informed of the young person's progress and current treatment.

In the absence of a suitable adult diabetes service, the general practitioner will become responsible for the young person's diabetes management after the transition from paediatric care. This role involves much more than just providing prescriptions for insulin.

At each visit with the general practitioner, the following issues must be addressed:-

- review of blood glucose results, frequency of hypoglycaemic episodes, recent HbA1c results
- current state of health and well-being including life circumstances that may impact on diabetes control
- self-initiated changes to insulin dosage since last visit and results of these
- review diabetes complication screening status, *when required*
- order appropriate tests to screen for diabetes complications
- confirming supplies of insulin, glucagon (check expiry date), and supply of ketone strips for blood or urine.
- initiate referral to diabetes educator and other allied health when required.

(Adapted from Diabetes Best Practice Guidelines, 2002)¹⁰

It is essential that the general practitioner also continue complication screening (Appendix 2). Immediate referral to a diabetes specialty service should occur in the following situations:

- If there are **any** abnormal findings on the annual Diabetes Complication Screen
- If the HbA1c is > 9% on two or more occasions in one year
- If there is continued and significant weight loss
- BMI <18kg/m² or >25kg/m²
- If the young person is experiencing difficulty adhering to the treatment regimen (or is non-compliant)
- If the young person is pregnant or is considering becoming pregnant
- If there has been an admission to hospital for a diabetes related conditions e.g. ketoacidosis, severe hypoglycaemia
- Diagnosis of co-existing diseases
- If there are any mental health issues

6.0 Optimising Services for Young Adults

Keeping young adults engaged in specialised diabetes care is a challenge. They are a group who are particularly busy with other priorities such as work, education and social activities. They are a generation who are increasingly intolerant and won't continue to see health professionals where no benefit is perceived from the service. Historically little has been done to meet the unique needs of this group. Busy clinics comprised predominantly of older adults can alienate young people with diabetes.⁶

In 2005, Dovey-Pearce et. al. surveyed young people to identify what young people want from an adult diabetes service.¹¹

Given the high proportion of young people with diabetes that ‘drop out’ of conventional adult diabetes services, it is appropriate that adult diabetes services should consider adopting these practices in order to meet the specific needs of young adults.

A summary of these practices include:

Improving Clinic Organisation	
<ul style="list-style-type: none"> • Seeing the same staff at clinic visits • Specific clinics for young adults with Type 1 diabetes • Definite appointment times 	<ul style="list-style-type: none"> • Capacity for “drop in” visits • Clinics held out of working hours (including weekends)
Improving Consultations	
<ul style="list-style-type: none"> • Staff knowing the patient and their history • Meeting the individual’s needs • Respecting emotional needs 	<ul style="list-style-type: none"> • Encouraging questions during consultations • Taking an interest in the patient as a person
Providing Appropriate Information	
<ul style="list-style-type: none"> • Information provided should be relevant to the young person • Regular up-dates e.g. newsletter • Telephone, email, contact with Staff • SMS reminders for clinic appointment 	<ul style="list-style-type: none"> • Provide resources e.g. list of appropriate websites, booklets, video etc • Notice board at clinic with information for young people
Providing Extra Services	
<ul style="list-style-type: none"> • Providing diabetes counsellors • Patient feedback process 	<ul style="list-style-type: none"> • Providing a Mentor System

7.0 References

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Appendix 1:

This education can be delivered either as individual teaching or in small groups.

Table 1: Education for Young People with Diabetes

Topic	Content
About Diabetes	<ul style="list-style-type: none"> • deliver a detailed explanation of the disease process including: <ul style="list-style-type: none"> - epidemiology, <i>and</i> - current research • discuss management goals
Diabetes Control	<ul style="list-style-type: none"> • discuss the role of blood glucose levels (BGL's) in overall diabetes management • discuss target range for BGL's • discuss HbA_{1c} target range
Insulin Therapy & Adjustment	<ul style="list-style-type: none"> • explain the action of the different insulin regimens • discuss principles of adjusting insulin doses • discuss principles of matching insulin, food and exercise
Management of Hypoglycaemia	<ul style="list-style-type: none"> • review hypoglycaemia management • discuss individuals signs and symptoms • discuss treatment strategies • discuss prevention strategies
Exercise	<ul style="list-style-type: none"> • discuss importance of regular exercise • review management hypoglycaemia related to exercise • discuss 'hypo' prevention strategies
Sick Day Management	<ul style="list-style-type: none"> • explain how to adjust insulin doses during illness • discuss principles of prevention of Ketoacidosis

Appendix 1 continued:

Topic	Content
<i>School Issues</i>	<ul style="list-style-type: none">• discuss differences between primary and high school• principles of managing diabetes at school, and, when appropriate school camps• discuss strategies for managing diabetes during school examinations
<i>Diabetes Complication Screening</i>	<ul style="list-style-type: none">• discuss micro and macro-vascular complications related to diabetes, <i>and</i>• strategies for their prevention• explain the complication screening process

Note: A dietary review should also occur at this stage of the transition process.

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Appendix 2:

Table 2: Additional Education for Young People with Diabetes

Topic	Content
<i>Alcohol and Diabetes</i>	<ul style="list-style-type: none"> • explain the effects of alcohol on the brain & liver • explain the impact alcohol has on diabetes control • explain the relationship between alcohol and hypoglycaemia • discuss strategies to minimise the impact of drinking alcohol on diabetes control specifically prevention of hypoglycaemia
<i>'Hangovers' & Diabetes</i>	<ul style="list-style-type: none"> • discuss strategies to manage diabetes if 'hung over' • discuss 'sick day' action plan
<i>Drug Taking & Diabetes</i>	<ul style="list-style-type: none"> • explain the effects of casual drug taking on diabetes control • explain the long-term implications if taking drugs regularly
<i>Smoking & Diabetes</i>	<ul style="list-style-type: none"> • explain the effects of smoking on diabetes control • explain the long-term implications of smoking on general health and diabetes complications
<i>Sexuality & Diabetes</i>	<p>Note: It is not the primary responsibility of a diabetes health professional to educate teenagers on sexual issues. However, it is not practical to disregard these issues and their potential impact on diabetes control and the risk of a sexually transmitted disease or unplanned pregnancy.</p> <ul style="list-style-type: none"> • discuss the implications of unprotected sex • explain the need for pre-pregnancy counselling • explain the importance of tight glycaemic control prior to and during pregnancy • discuss the relationship between sexual activity (increased physical activity) and hypoglycaemia during sex (particularly for males) • strategies to prevent hypoglycaemia during sexual activity e.g. take extra CHO • discuss the effects of poor glycaemic control and sexual dysfunction in males <p>The advice provided to each teenager must be individualised according to their specific circumstances.</p>

Appendix 2 Continued:

Topic	Content
<p><i>Getting a Driver's Licence</i></p>	<ul style="list-style-type: none"> • explain the specific requirements to obtain a drivers licence • discuss current restrictions and regulations
<p><i>Feelings and Emotions - Burnout</i></p> <p>Additional Information</p>	
<p><i>National Diabetes Supply Scheme (NDSS) & Government Allowances</i></p>	<ul style="list-style-type: none"> • discuss the process for obtaining diabetes supplies • discuss availability of Government allowances and the process for applying
<p><i>Confidentiality</i></p>	<ul style="list-style-type: none"> • explain the issue of confidentially • explain how information they provide will be managed

Note: A dietary review should also occur at this stage of the transition process.

Appendix 3:

Table 3: Education on the Management of Diabetes at ‘Schoolies’ Week

Topic	Content
<i>Alcohol and Diabetes</i>	<ul style="list-style-type: none"> • explain the effects of alcohol on the brain & liver • explain the impact alcohol has on diabetes control • explain the relationship between alcohol and hypoglycaemia • discuss strategies to minimise the impact of drinking alcohol on diabetes control specifically prevention of hypoglycaemia
<i>‘Hangovers’ and Sleep Deprivation</i>	<ul style="list-style-type: none"> • discuss strategies to manage diabetes if ‘hung over’ • discuss ‘sick day’ action plan • explain the effects of sleep deprivation on diabetes control • discuss strategies to minimise the impact of sleep deprivation on diabetes control
<i>Drug Taking and Diabetes</i>	<ul style="list-style-type: none"> • explain the effects of casual drug taking on diabetes control
<i>Alcohol and Sex</i>	<p>Note: It is not the primary responsibility of a diabetes health professional to educate teenagers on sexual issues. However, it is not practical to disregard these issues and their potential impact on diabetes control, acute complications such as hypoglycaemia and the risk of a sexually transmitted disease or unplanned pregnancy</p> <p>The advice provided to each teenager must be individualised according to their specific circumstances.</p>

Note: Ensure the teenager has a written plan (including a ‘Sick Day’ plan for managing their diabetes). Ensure the teenager has adequate diabetes supplies to take with them. Ensure the teenager’s friends know how to treat a ‘hypo’ and have an emergency plan in place for seeking medical care if needed.

Note: A dietary review should occur prior to transfer.

Appendix 4:

Glossary of Terms

Adult Diabetes Service or Clinic

Specialty service or clinic which provides medical services to adult patients with diabetes. This service is usually multidisciplinary with the medical officer being either an Endocrinologist or Physician with an interest in diabetes management. These services can either be provided publicly or privately.

Paediatric Diabetes Service or Clinic

Specialty service or clinic which provides medical services to children and adolescents with diabetes. This service should be multidisciplinary with the doctor being either a Paediatric Endocrinologist or Paediatrician with an interest in diabetes management. These services can either be provided publicly or privately.

Paediatric Diabetes Care Team

Specialty service or clinic which provides medical services to children and adolescents with diabetes. This service should be multidisciplinary with the doctor being either a Paediatric Endocrinologist or Paediatrician with an interest in diabetes management. These services can either be provided publicly or privately.

Dedicated Diabetes Transition Clinic

A speciality clinic that only sees young people with diabetes and who are about to transfer. Both paediatric and adult staff attend the clinic.