Transition: a rheumatology perspective

This article reviews the evidence regarding the process of transition which young people experience when moving from paediatric to adult care. Rheumatology has championed this process and this article prioritizes the perspective of adult physicians.

Young people with chronic diseases have additional challenges in negotiating the complexities of their adolescence by virtue of their medical needs. Much of the literature exploring this is from a paediatric perspective to date but transition, by definition, involves both paediatric and adult health-care providers (in addition to the young person and his/her family). This article aims to redress the balance by asking what evidence is available to adult providers to enable them to meet and look after young people who are ready to leave paediatric care. This is not simply a matter of a transfer between two systems but part of a holistic developmental process involving young people and their families. In particular there is a need to bridge the cultural gaps between adult medicine (which assumes the patient is a fully autonomous individual) and paediatric medicine which focuses on the dependent child in the family unit and prioritizes psychosocial and educational or vocational issues (*Table 1*). Adult health-care providers (including physicians, nurses and professionals allied to medicine) need to do much more than 'receive' the young person into their care. Proactive involvement in both the event of transfer and the wider process of transition is needed.

Data from the USA suggest transition remains a pressing issue for adult health-care providers as there is persisting suboptimal provision for young people with cystic fibrosis (McLaughlin et al, 2008), congenital heart disease (Moons et al, 2009) and renal medicine (Bell, 2007).

This article reviews the available evidence regarding transition particularly from the perspective of the adult rheumatology team. It also contextualizes the discussion in the evolving specialty of adolescent medicine in which both paediatric and adult health-care providers by definition have an interest.

What is adolescence?

The World Health Organization (2010) regards young people between 10 and 19 years of age as being in adolescence, growing from dependent children to independent adults. In the UK and other western health-care systems, there is an organizational 'cut-off' between paediatric and adult services at around the age of 16 years. Health needs of adolescents are therefore an issue for adult and paediatric health-care professionals alike and can be approached by both groups under the umbrella of the discipline of adolescent medicine (Kennedy and Sawyer, 2008).

Adolescence involves key tasks in physical, social, vocational and psychological domains. For example there needs to be biological and sexual maturation, the development of personal identity and autonomy, experimentation and exploration of risky behaviours, and involvement in a new world of intimate relationships. Successfully negotiating these tasks occurs at different times for different young people and marks the entry to adulthood. Late adolescence and early adulthood are distinct developmental stages which merge in industrialized countries where a demographic shift is prolonging the time between which young people leave their childhood and fully accept the enduring responsibilities of adulthood. This 'emerging adulthood' is a time of exploration, a crucial part of growing up, and as such remains a time of continued vulnerability (Arnett, 2000). This stage is of increasing interest to psychological research in this area (Dovey-Pearce et al, 2005; Luyckx et al, 2008) and adult physicians are uniquely placed to develop this area of clinical service and research.

Alongside, and integral to, the social and psychological aspects of adolescence, and running parallel with physical

Table 1. Differences between adult-centred and paediatric care

Adult care	Paediatric care
Dyadic or individual consultation	Triadic or family consultation
Limited multidisciplinary team (often with less access to psychosocial support)	More likely to have multidisciplinary team and psychosocial support
Payment for medications	Usually medication free while in education
Larger patient numbers	Smaller numbers of patients
Consultation less likely to include vocational aspects – less support mechanisms for workplace issues	Educational and vocational aspects key to consultation – usually access to support mechanisms for school or college
Shorter consultation time	Longer consultation time
Procedural pain management – less sedation or general anaesthetic use	Procedural pain management – more sedation or general anaesthetic use
Less tolerance of immaturity	Greater tolerance of immaturity
Less chasing of patients who fail to attend appointments	Greater chasing of families who fail to attend appointments
Less direct supervision of trainees in clinics	Greater direct supervision of trainees in clinics
Less likely to see same doctor at consecutive visits	More likely to see same doctor at consecutive visits

Dr Rachel Tattersall *is Consultant in Adolescent Rheumatology, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield S10 2JF and* **Dr Janet E McDonagh** *is Clinical Senior Lecturer in Paediatric and Adolescent Rheumatology, University of Birmingham and Birmingham Children's Hospital NHS Foundation Trust*

Correspondence to: Dr R Tattersall

maturation, is a recently improved understanding of the developing adolescent brain. It is thought that the core of adolescent cognitive development (what might be described as the attainment of the 'self-directed mind') is a result of the assembly of an 'executive suite' of cognitive capabilities. There is extensive and continued change in the brain into the third decade of life, particularly by significant and localized synaptic pruning in the frontal areas crucial to executive functioning and in the pre-frontal cortex which affects the ways in which individuals evaluate and respond to risk and reward (Steinberg, 2005). These findings are jigsaw pieces of information not yet fully fitted into the puzzle of adolescent development but they do serve to remind that adolescence (and late adolescence especially) is a period of intense brain development and therefore a time of potential vulnerability. This has huge implications for adult-centred health care and supports the need for training in adolescent health for adult health-care providers along with dedicated young adult services (which are covered later).

Transitional care: what is it and why is it necessary?

The multidimensional, multidisciplinary, multiagency, dynamic nature and conceptual philosophy of transitional care has been presented in detail elsewhere (Chira and Sandborg, 2004; Tucker and Cabral, 2005; McDonagh, 2008). In brief, transition is the young person-centred process of addressing the medical, psychosocial, educational and vocational issues as young people with chronic conditions move from child- to adult-centred care (Department of Health, 2006). Adolescents with chronic conditions and/or disability face additional challenges both in managing their day-to-day health needs but also in negotiating the systems of health care within which their health professionals operate. Juvenile idiopathic arthritis can affect young people by delaying growth and/or puberty, have psychosocial effects in terms of body image and coping strategies, and time off school can lead to difficulties in achieving educational or vocational potential. A study of adults with juvenile idiopathic arthritis showed they were less likely to be in work than controls and that juvenile idiopathic arthritis had had significant effects on other markers of quality of life (Foster et al, 2003); there are similar data in the paediatric rheumatology literature (Duffy, 2005).

Self management, adherence, health literacy and the promotion of autonomy are core to transitional care and a knowledge and skills framework to address these is integral to any transitional care programme (McDonagh, 2008; Stinson et al, 2008), the implementation of which is a key task for all rheumatology team members and is reviewed elsewhere (Sawyer and Aroni, 2005; Rapoff, 2006). The potential of modern technologies in self management has been identified by several authors (Shaw et al, 2004a; Stinson et al, 2008) and is currently being developed by rheumatology centres such as Utrecht. Addressing the transitional care needs of the parents is also important (Shaw et al, 2004a) and rheumatology team members should seek to involve parents in the skills training and developmentally appropriate promotion of autonomy for their son or daughter.

Experimentation and health risk behaviours are hallmarks of adolescence but may come with a higher price for young people with chronic disease – think of the adolescent with lupus who smokes and the effect on her cardiovascular risk or the adolescent with juvenile idiopathic arthritis on methotrexate who practices unsafe sex or drinks alcohol (Sawyer et al, 2007). There is evidence that health risk behaviours tend to be clustered together so that, for example, young people who smoke are more likely also to binge drink or engage in unsafe sexual practices. In a Swiss analysis of a nationally representative survey of 16–20-year-olds, those with chronic illness were significantly more likely to engage in risky behaviour in general and to cluster several risk factors together when compared with their healthy peers (Suris et al, 2008). This is important because health risk behaviours are associated with non-adherence with medical therapy (Lurie et al, 2000) and conversely lack of substance misuse has been reported to be significantly correlated with successful transition to adult care in young people with congenital heart disease (Stilley et al, 2006).

Screening for such behaviours is therefore important and there is a need for age-appropriate transitional care to be run in such a way that young people have time and opportunity to discuss such behaviours. In turn this requires that health professionals have the required skills to elicit and act with this information. A survey of paediatric trainees showed that less than half had received any training in adolescent health at all and that when considering substance misuse, while 78% of respondents felt that detection was of high importance 48% deemed their skills in detection were low or very low (Dieppe et al, 2008). This mirrors a similar survey which identified unmet training needs in key health professionals involved in implementing transitional care for young people with juvenile idiopathic arthritis (Shaw et al, 2004b).

Transition in rheumatology: words into action?

There are several policies (Royal College of Nursing, 2004; Department of Health, 2006; Department of Children, Schools and Families, 2007; Royal College of Physicians of Edinburgh, 2008; Chief Medical Officer, 2008) reviewing the evidence of benefit of good quality transitional care and setting out best practice models. These policies share a core set of principles where transition starts early and is a future-focussed, active process. It is young person-centred and inclusive of family, carers and kinship groups. It is a multidisciplinary approach involving at least the paediatric service, adult service and GP but should extend to other agencies including education, social and youth services, always with excellent communication and documentation. For the young person it should be an age-appropriate, developmentally appropriate, culturally appropriate, flexible process equipping him/her with skills in communication, decision making, assertiveness, self care and self management. The ultimate aim is to enable adolescents to take control of their health-care needs and emerge into adulthood with maximal function and potential.

Acknowledging the evidence to support transitional care in other conditions, in rheumatology the evidence to support transition is summarized in *Table 2*.

So far the most important viewpoint of the challenges of transition has been underplayed here – that of young people. Focus groups of young people identified important themes which they felt should define quality transitional care – it should be coordinated between professionals with early referral being important. Being able to trust the professionals responsible for transitional care was key as was a developmentally- and age-appropriate programme of care – one size definitely doesn't fit all. Adolescent-focused information and the encouragement of young people to manage their own health care emerged as further themes (Shaw et al, 2004a).

Similar issues came to the fore when a consensus document was produced after discussion with key stakeholders in rheumatology transition including young people themselves (Shaw et al, 2004b). The same group then went on to test the effect of a coordinated, structured, multidisciplinary, evidence-based, transitional care programme on the quality of life of adolescents with juvenile idiopathic arthritis. They showed objective data to support the immediate potential impact of such a programme reflected in scores of health care quality of life, adolescent and parental knowledge and satisfaction, and pre-vocational readiness markers (McDonagh et al, 2007).

First, this evidence confirms what the policy documents and core philosophies outlined above state, and reminds us to consider to what extent young people themselves were consulted with in the writing of those documents. Second, adult health providers need, on both policy and face-to-face clinical level, to constantly check with young people that what they provide is what young people want. Third the available evidence about transition from user group perspectives is situated in the paediatric health-care arena and there is not the corresponding work published by adult providers. The onus is on this group to evaluate their services in a similar way.

Moving forward

Despite the evidence base in rheumatology in particular and medicine in general, evidence of suboptimal provision of transitional services persists. In the USA when transitional care for young people with arthritis was evaluated there were some positive findings – nearly three quarters of young people (according to parent proxy reports) were encouraged to take responsibility for their health-care needs and around half were encouraged to look forward to how their health-care needs might change in adulthood (Scal et al, 2009). However, the need for transfer of care to adult physicians was only discussed with around one in five and this is the kind of gap that adult providers could and should be seeking to fill in collaboration with their paediatric colleagues. This will necessitate ensuring that both paediatric and adult health providers have a mutual awareness of each other's service and are comfortable with and skilled in managing their interactions with young people. There is a clear unmet need in training that must be addressed to move transitional care forwards. Uniting under an umbrella of adolescent health will encourage all health providers engaging with young people to address their own interest in and abilities with regards to adolescents and drive forward a process of research and service evaluation which must intimately involve young people themselves.

So what should rheumatologists providing adult services actually do? The first practical point is to make a real-time assessment of current local provision and need for a transitional service. It may be that there are some parts of a service already running which simply need better linkage or there may be no service at all. Other disciplines locally may have transitional structures which work well and developing links often means that the 'wheel doesn't have to be reinvented' as their strategies can be adopted (which can be particularly important if funding of the service is an issue). Whatever the current state of play, the critical step is to engage a group of interested team members from adult and paediatric services to agree, plan and implement the new service. The team needs to be both multidisciplinary and preferably have direct input from young people themselves. This article has concentrated on the role of the adult rheumatology team and *Table 3* lists the key aspects of transitional care in the peri-transfer and post-transfer periods to consider and resolve.

Table 2. Evidence to support transitional care in the rheumatology literature

An early start, e.g. at the age of 11 years	Shaw et al (2004a); McDonagh et al (2007)
Opportunity for young person to be seen independently	Shaw et al (2004b); McDonagh et al (2007)
Individualized transition planning	McDonagh et al (2006)
Young people prefer to meet adult team members before transfer	Shaw et al (2004a)
Improved patient satisfaction	Shaw et al (2007)
Improved parent satisfaction	Shaw et al (2007)
Improved documentation of adolescent issues	Robertson et al (2006)
Improved health-related quality of life	McDonagh et al (2007)
Improved disease knowledge	McDonagh et al (2007)
Improved vocational readiness	McDonagh et al (2007)
Improved adherence to appointments	Rettig and Athreya (1991)

Demonstrating that local protocols for young people with rheumatic disease are established between local adult and paediatric rheumatology services assures those young people that there is consensus and collaboration between services and that they will have early and regular meetings with the adult team. Concentrating on the period around transfer, ensuring particularly frequent clinic visits at this time and an ‘open door’ policy in the face of problems, helps the process (Dugueperoux et al, 2008). Another key role of the adult team is facilitating tracking mechanisms of transferred patients as advocated by policy documents. In practice this might mean a letter from the adult rheumatologist to the paediatric team confirming attendance at a second appointment in adult care thereby confirming successful transfer (Department of Health, 2006).

Further steps might include auditing the adult service against quality criteria such as those of You’re Welcome (Department of Health, 2007) or looking to modify models of health care. One such possibility is the provision of combined clinics with paediatric and adult rheumatologists and the extended multidisciplinary team. A second possibility is the young adult clinic model – again running a combined approach but extending into the period of emerging adulthood identified earlier as an area of unrecognized need and under-provision (Tucker and Cabral, 2005). There is as yet no evidence that one model is better than another although Bent et al (2002) reported that a young adult team approach was just as cost effective as ad-hoc services for young people with disability and furthermore the former was associated with better participation in society. What must be avoided at all costs is transitional care being considered satisfactory as a one-page letter from paediatric to adult physician.

Table 3. Key aspects to consider in planning local transitional services – adult team perspective

Meet regularly with the paediatric team members involved in transitional care	
Develop a transitional care policy with the paediatric team to ensure consensus	
Develop informational resources to help the paediatric team to prepare young people for transfer to a particular service	
Set up the service so that young people always meet with a member of the adult rheumatology team before transfer	
Ensure the adult service for such young people meets the ‘You’re Welcome’ quality criteria for young person-friendly health services	
Train all new and existing staff involved with young people transferring from the paediatric service, to address staff knowledge, skills and attitudes in adolescent and young adult health issues	
Support tracking mechanisms to avoid transferred patients getting ‘lost’, e.g. sending letters from the first and second appointments of young people recently transferred to adult care to their paediatric team	
Consider potential of the following models:	Combined transitional clinic with paediatric team in either the paediatric or adult setting
	Young adult rheumatology service for 16–25 year olds in the adult setting
	A jointly funded post of an adolescent transitional care coordinator to specifically address transitional care issues in both the paediatric and adult units

Important in all of the above will be the involvement of young people themselves both in research and service evaluation and development as advocated by the You’re Welcome quality criteria (Department of Health, 2007). The Youth Health Talk (www.youthhealthtalk.org) initiative is an example of an innovative initiative to directly involve young people, enabling their actual voice to be heard including several young people with rheumatic disease. A chapter written by young people in a textbook of adolescent rheumatology (Abrams et al, 2008) received special mention in a review by Lazarus (2008).

Conclusions

There has never been a better time for development in adolescent health and transition. There is a first ‘wave’ of young people who are now adults and who have experienced current models of transition. Assessing what has worked and what hasn’t will be important. Rheumatology is also in a strong position to push transitional excellence forwards with joint initiatives to develop training for health-care professionals such as the Adolescent Health Project – an online learning package aimed at all professionals providing care for young people, which includes transition and chronic illness modules (www.e-lfh.org.uk/projects/ah/index.html). Britto et al (2000) reported improvement in adolescent health practices in rheumatology clinics with an educational intervention. Rheumatology was one of the first adult specialties in the UK to include adolescent rheumatology in the adult curriculum.

The gauntlet of transition has been thrown down and it is up to adult health-care providers to take up the challenge. **BJHM**

Conflict of interest: none.

Abrams A, Lewis D, Neufille T, Rahman A, Clarke H (2008) Young people have the last word. In: McDonagh JE, White PH, eds. *Adolescent Rheumatology*. Informa Health Care, New York

Arnett J (2000) Emerging adulthood: a theory of development from the late teens through the twenties. *Am Psychol* **55:** 469–80

Bell L (2007) Adolescents with renal disease in an adult world: meeting the challenge of transition of care. *Nephrol Dial Transplant* **22**(4): 988–91

Bent N, Tennant A, Swift T, Posnett J, Scuffham P, Chamberlain M (2002) Team approach versus ad hoc health services for young people with physical disabilities: a retrospective cohort study. *Lancet* **360:** 1280–6

Britto M, Rosenthal S, Taylor J, Passo M (2000) Improving rheumatologists' screening for alcohol use and sexual activity. *Arch Pediatr Adolesc Med* **154:** 478–83

Chief Medical Officer (2008) Under their skins- tackling the teenage nation. In: *Chief Medical Officer’s Annual Report 2007 - 'Tackling the Teenage Nation'*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_086176 (accessed 14 May 2010)

Chira P, Sandborg C (2004) Adolescent rheumatology transitional care: steps to bringing health policy into practice. *Rheumatology (Oxford)* **43**(6): 687–9

Department of Children, Schools and Families (2007) *A Transition guide for all services. Key information for professionals about the transition process for disabled young people.* www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00322/ (accessed 14 May 2010)

Department of Health (2006) *Transition: Getting it right for young people.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications

PolicyAndGuidance/DH_4132145 (accessed 14 May 2010)

Department of Health (2007) *You're Welcome Quality Criteria. Making Health Services Young people friendly.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586 (accessed 14 May 2010)

Dieppe C, Kumar M, Crome I (2008) Adolescent exploratory behaviour- what do trainees know? *J Adolesc Health* **45**(5): 520–2

Dovey-Pearce G, Hurrell R, May C, Walker C, Doherty Y (2005) Young adults' (16-25) suggestions for providing developmentally appropriate diabetes services: a qualitative study. *Health Soc Care Community* **13:** 409–19

Duffy C (2005) Measurement of Health Status, functional status and quality of life in children with juvenile idiopathic arthritis: clinical science for the paediatrician. *Pediatr Clin North Am* **52**(2): 359–72

Dugueperoux I, Tamalet A, Sermet-Gaudelus I, Le Bourgeois M, Gerardin M, Desmazes-Dufeu N, Hubert D (2008) Clinical changes of patients with cystic fibrosis during transition from pediatric to adult care. *J Adolesc Health* **43:** 459–65

Foster H, Marshall N, Myers A, Dunkley P, Griffiths I (2003) Outcome in adults with juvenile idiopathic arthritis: A quality of life study. *Arthritis Rheum* **48**(3): 767

Kennedy A, Sawyer S (2008) Transition from pediatric to adult services: are we getting it right? *Curr Opin Pediatr* **20**(4): 403–9

Lazarus H (2008) Adolescent rheumatology. *N Engl J Med* **359:** 12

Lurie S, Shemesh E, Sheiner PA, Emre S, Tindle H, Melchionna L, Schneider BL (2000) Non-adherence in pediatric liver transplant recipients - an assessment of risk factors and natural history. *Pediatr Transp* **4**(3): 200–6

Luyckx K, Schwartz S, Goossens L, Pollock S (2008) Employment, sense of coherence and identity formation. Contextual and psychological processes on the pathway to sense of adulthood. *J Adolesc Res* **23:** 566–91

McDonagh JE (2008) Young people first - JIA second. *Arthritis Care Res* **59:** 1162–70

McDonagh JE, White PH, eds (2008) *Adolescent Rheumatology.* Informa Healthcare, New York

McDonagh JE, Shaw K, Southwood T (2006) Growing up and moving on in rheumatology: development and preliminary evaluation of a transitional care programme for a multicentre cohort of adolescents with juvenile idiopathic arthritis. *J Child Health Care* **2006**(10): 22–42

McDonagh JE, Southwood T, Shaw K on behalf of the British Society of Paediatric and Adolescent Rheumatology (2007) The impact of a coordinated transitional care programme on adolescents with juvenile idiopathic arthritis. *Rheumatology* **46:** 161–8

McLaughlin S, Diener-West M, Indurkhya A, Rubin H, Heckmann R, Boyle MP (2008) Improving transition froom paediatric to adult cystic fibrosis care: lessons from a national survey of current practice. *Pediatrics* **121:** e1160-e1166

Moons P, Pinxten S, Dedroog D, Van Deyk K, Gewillig M, Hilderson D, Budts W (2009) Expectations and experiences of adolescents with congenital heart disease on being transferred from pediatric cardiology to an adult congenital heart disease programme. *J Adolesc Health* **44**(4): 316–22

Rapoff M (2006) Management of adherence and chronic rheumatic disease in children and adolescents. *Best Pract Res Clin Rheumatol* **20:** 301–14

Rettig P, Athreya B (1991) Adolescents with chronic disease. Transition to adult health care. *Arthritis Rheum* **4**(4): 174–80

Robertson L, McDonagh JE, Southwood T, Shaw KL on behalf of the British Society of Paediatric and Adolescent Rheumatology (2006) Growing up and moving on: a multicentre UK audit of the transfer of adolescents with juvenile idiopathic arthritis JIA form paediatric to adult centred care. *Ann Rheum Dis* **65:** 74–80

Royal College of Nursing (2004) *Adolescent transition care: guidance for nursing staff.* Royal College of Nursing, London (www.rcn.org.uk/development/publications/publicationsA-Z accessed 14 May 2010)

Royal College of Physicians of Edinburgh (2008) *Think Transition. Developing the essential link between paediatric and adult care.* www.rcpe.ac.uk/clinical-standards/documents/transition.pdf (accessed 7 May 2010)

Sawyer S, Aroni R (2005) Self-management in adolescents with chronic illness. *Med J Aust* **183**(8): 405–9

Sawyer S, Drew S, Yeo M, Britto M (2007) Adolescents with a chronic condition: challenges living, challenges treating. *Lancet* **369:** 1481–9

Scal P, Horvath K, Garwick A (2009) Preparing for adulthood: health care transition counseling for youth with arthritis. *Arthritis Rheum* **61**(1): 52–7

Shaw KL, Southwood T, McDonagh JE on behalf of the British Society of Paediatric and Adolescent Rheumatology (2007) Young people's satisfaction of transitional care in adolescent rheumatology in the UK. *Child Care Health Dev* **33**(4): 368–79

Shaw KL, Southwood T, McDonagh JE on behalf of the British Paediatric Rheumatology Group (2004a) User perspectives of transitional care for adolescents with juvenile idiopathic arthritis. *Rheumatology* **43:** 770–8

Shaw KL, Southwood T, McDonagh JE on behalf of the British Paediatric Rheumatology Group (2004b) Transitional care for adolescents with juvenile idiopathic arthritis: a Delphi stiudy. *Rheumatology* **43**: 1000–6

Steinberg L (2005) Cognitive and affective development in adolescence. *Trends Cogn Sci* **9**(2): 69–74

Stilley C, Lawrence K, Bender A, Olshansky E, Webber SA, Dew MA (2006) Maturity and adherence in adolescent and young adult heart transplant recipients. *Pediatr Transp* **10**(3): 323–30

Stinson J, Toomey P, Stevens BJ et al (2008) Asking the experts: exploring the self management needs of adolescents with arthritis. *Arthritis Rheum* **59:** 65–72

Suris J-C, Michaud P-A, Akre C, Sawyer SM (2008) Health risk behaviours in adolescents with chronic conditions. *Pediatrics* **122**(5): e1113–e1118

Tucker L, Cabral D (2005) Transition of the adolescent patient with rheumatic disease: issues to consider. *Pediatr Clin North Am* **52**(2): 641–52

World Health Organization (2010) Adolescent health. www.who.int/topics/adolescent_health/en/ (accessed 14 May 2010)

Further information

Transition in rheumatology	www.bspar.org.uk	Includes transition plans
	www.dreamteam-uk.org	Includes informational resources, transition plans, transition policy template and audit tools
Training resources	e-lfh.org.uk/projects/ah/index.html	Includes modules on transition and chronic illness
	www.euteach.com	Includes teaching resources for a chronic illness module including transition
	www.youthhealthtalk.org	Long-term conditions section has several young people with rheumatic conditions talking about their experiences
	DVD: Nothing About Us Without Us	Available from Dr McDonagh, developed by young people with rheumatic conditions to teach health professionals how to communicate with them
	Textbook: *Adolescent Rheumatology* (McDonagh and White, 2008)	Addresses generic adolescent health aspects of rheumatology
Organizations	www.yphsig.org.uk	
	www.youngpeopleshealth.org.uk	

KEY POINTS

- Adult and paediatric health-care teams need to work together in the interests of young people to achieve smooth and effective transition between services.
- Training in generic principles of adolescent medicine for those providing transitional services is essential.
- Designing local services to fit local populations and sharing skills across specialities helps make effective transfer and transition a reality.
- Young people's input into service design and evaluation is critical in ensuring those services are fit for purpose.