

EULAR recommendations for patient education for people with inflammatory arthritis

Authors: Heidi A. Zangi¹, Mwidimi Ndosi², Jo Adams³, Lena Andersen⁴, Christina Bode⁵, Carina Boström⁶, Yvonne van Eijk-Hustings⁷, Laure Gossec⁸, Jana Korandova⁹, Gabriel Mendes¹⁰, Karin Niedermann¹¹, Jette Primdahl¹², Michaela Stoffer¹³, Marieke Voshaar¹⁴, Astrid van Tubergen¹⁵

Institution affiliations

¹ National Advisory Unit on Rehabilitation in Rheumatology, Department of rheumatology, Diakonhjemmet Hospital, Oslo, Norway

² School of Healthcare, University of Leeds, Leeds, UK

³ Centre for Innovation and Leadership in Health Faculty of Health Sciences University of Southampton Highfield, Southampton, UK

⁴ Nyborg, Denmark

⁵ University of Twente, Department of Psychology, Health & Technology, Enschede, The Netherlands

⁶ Division of physiotherapy, Department of Neurobiology, care sciences and society, Karolinska Institutet, Stockholm, Sweden

⁷ Dept. of Patient & Care/ Dept. of Rheumatology, Maastricht University Medical Center, and CAPHRI, School for Public Health and Primary Care, University of Maastricht, Maastricht, the Netherlands

⁸ Sorbonne Universités, Institut Pierre Louis d'Epidémiologie et de Santé Publique; AP-HP, Pitié Salpêtrière Hospital, Department of rheumatology, Paris, France

⁹ Institute of Rheumatology, Prague, Czech Republic

¹⁰ Portuguese Cycling Federation, Department of National Team, Lisbon, Portugal

¹¹ Institute of Physiotherapy, School of Health Professions, Zurich University of Applied Sciences, Winterthur, Switzerland

¹² Institute for Regional Health Research, University of Southern Denmark, Odense, Denmark, Hospital of Southern Jutland, Aabenraa, Denmark and King Christian X's Hospital for Rheumatic Diseases, Graasten, Denmark

¹³ Division of Rheumatology, Department of Medicine 3, Medical University of Vienna, Vienna, Austria

¹⁴ Department of Psychology, Health and Technology, University of Twente, Enschede, the Netherlands

¹⁵ Department of Medicine, Division of Rheumatology, Maastricht University Medical Center, Maastricht, The Netherlands and CAPHRI, School for Public Health and Primary Care, University of Maastricht, Maastricht, The Netherlands.

Key words: Patient education, inflammatory arthritis, recommendations

Corresponding author: Heidi A. Zangi, National Advisory Unit on Rehabilitation in Rheumatology, Department of rheumatology, Diakonhjemmet Hospital, PO Box 23 Vinderen, 0319 Oslo Norway, e-mail: heidi.zangi@diakonsyk.no

ABSTRACT

Objectives The task force aimed to: (i) develop evidence-based recommendations for patient education (PE) for people with inflammatory arthritis, (ii) identify the need for further research on PE and (iii) determine health professionals' educational needs in order to provide evidence-based PE.

Methods A multidisciplinary task force, representing 10 European countries, formulated a definition for PE and 10 research questions that guided a systematic literature review (SLR). The results from the SLR were discussed and used as a basis for developing the recommendations, a research agenda and an educational agenda. The recommendations were categorised according to level and strength of evidence graded from A (highest) to D (lowest). Task force members rated their agreement with each recommendation from 0 (total disagreement) to 10 (total agreement).

Results Based on the SLR and expert opinions, eight recommendations were developed, four with strength A evidence. The recommendations addressed when and by whom PE should be offered, modes and methods of delivery, theoretical framework, outcomes and evaluation. A high level of agreement was achieved for all recommendations (mean range 9.4 - 9.8). The task force proposed a research agenda and an educational agenda.

Conclusion The eight evidence-based and expert opinion-based recommendations for PE for people with inflammatory arthritis are intended to provide a core framework for the delivery of PE and training for HPs in delivering PE across Europe.

Word count: Abstract 224, main text: 3730

INTRODUCTION

Patient education (PE) is recommended as an integral part in established recommendations for the management of early arthritis and ankylosing spondylitis.^{1, 2} PE comprises all educational activities provided for patients, including aspects of therapeutic education, health education and health promotion.³ Previous systematic reviews on various PE interventions in patients with rheumatoid arthritis documented significant short-term improvements in knowledge, coping behaviour, pain, disability and depression, but long-term effects were inconsistent.⁴⁻⁷

During the last decades there has been an ongoing development within health care, moving away from the view of health professionals (HPs) as the only experts and providers of knowledge and patients as passive recipients towards a more collaborative approach. Patients have been recognized as active agents in managing their illness and own health care.⁸ The principle of “shared decision making” allowing patients and their providers to make health care decisions together, based on the best scientific evidence available, as well as the patient’s values and preferences, is increasingly accepted.⁹ The primary goal of PE is no longer only knowledge transfer and disease control, but also to enable patients to manage their illness, adjust to their condition and maintain quality of life.^{10, 11}

Moreover, PE has been influenced by scientific developments and changes in society. Biomedical advancements, new pharmacological treatment options, and better knowledge about the risk for developing co-morbidities require new approaches to communicate with patients in a timely and meaningful way.^{12, 13} In several countries, larger health care teams with more specialised HPs have been established to meet the complexity of the rheumatology patients' health care needs.^{14, 15} Furthermore, the development of e-health and the use of mobile tele-health platforms have introduced new possibilities for communication and delivery of information, which are increasingly applied in PE. Finally, the increase in immigration and cultural diversity in many European countries is challenging for planning and facilitating effective PE for all patients.⁸

Informal discussions amongst multidisciplinary health professionals at the European League Against Rheumatism (EULAR) annual congress in 2012 and succeeding e-mail correspondences revealed that great variety exists in the content and modes of delivery of PE across European countries. In some countries PE is still limited to providing knowledge in

order to improve patients' adherence to treatment. Additionally, there seems to be a large variation in HPs' involvement in PE.¹⁵ To what extent different HPs participate in PE is likely to depend on their competency, availability and education, as well as the organisation of the health care system.¹⁶ Based on these initial discussions, a EULAR task force was convened with the following objectives: (i) to develop a set of recommendations for PE for people with inflammatory arthritis (IA) (ii) to identify the need for further research and (iii) to define HPs' educational needs for providing evidence-based PE. The recommendations would allow standardisation and improvement of PE for people with IA across Europe. The target groups for the recommendations are HPs, including rheumatologists, working in rheumatology, patients with IA, policy makers and patient and professional organisations.

METHODS

The EULAR standardised operation procedures (SOPs) for the elaboration, evaluation, dissemination, and implementation of recommendations¹⁷ were followed.

The task force

The multidisciplinary task force comprised 15 experts including three patients, five nurses, two occupational therapists (OTs), two physiotherapists (PTs), a psychologist and two rheumatologists / epidemiologists with clinical experience and/or academic knowledge in the field of PE. They represented ten European countries (Austria, Czech Republic, Denmark, France, the Netherlands, Norway, Portugal, Sweden, Switzerland, and United Kingdom). People who had taken part in the initial discussions, but were not included in the task force, were invited to participate in a "consultation group". This group comprised 20 HPs, such as OTs, PTs, nurses and rheumatologists, but no patients were included.

Before the first task force meeting in 2013 one of the members was tasked with reviewing the literature of existing PE definitions. An overview was presented and thoroughly discussed during the meeting. Common elements in the definitions were identified and the following definition was formulated, based on consensus among the task force members: "PE is a planned interactive learning process designed to support and enable people to manage their life with IA and optimise their health and wellbeing". This interactive learning process includes a wide range of educational activities, such as provision of knowledge,

written material, e-health, self-management programmes (SMP), cognitive behavioural therapy (CBT), mindfulness, stress management, individual consultations with HPs, sharing experiences among patients, motivational discussions, exercise counselling, lifestyle change interventions and self-help courses. Moreover, the task force agreed that the recommendations should be based on the principle of shared decision making.⁹ Following this consensus process, the task force formulated ten research questions to guide the systematic literature review (SLR) (online supplementary file 1).

Systematic literature review

An extensive systematic literature search in Medline, Embase, PsycINFO, Cochrane Library and CINAHL from January 2003 up to September 2013 of publications in English, German, French or Spanish describing any kind of PE activities, was conducted (details provided in online supplementary file 2). No limitations regarding study type or research design was applied. The inclusion criteria were IA, confined to rheumatoid arthritis (RA), ankylosing spondylitis (AS) and psoriatic arthritis (PsA) and adults (age ≥ 18). All abstracts were independently read by two reviewers, and by a third reviewer in case of disagreement. The papers of the included abstracts were reviewed in full-text. Papers were excluded if they did not include any formal PE intervention (as defined above) or did not address the patient perspective on PE. The task force members were asked to review the final list of included papers and could add studies that were not captured by the SLR.

Developing the recommendations

The results of the SLR were presented and discussed during the second task force meeting in 2014 and eight recommendations were developed. The strength of each recommendation was based on the categories of evidence defined by the EULAR SOPs, graded from A (highest) to D (lowest)¹⁷ (online supplementary file 3). The recommendations were e-mailed to each task force member for final independent voting and approval. The level of agreement was recorded on a 0-10 point scale (0=no agreement at all; 10=full agreement, Table 1). In addition to the task force, the consultation group was invited to independently rate their level of agreement with each recommendation to obtain an indication of the agreement among people who are supposed to use the recommendations in clinical practice.

RESULTS

Figure 1 shows the flow chart of the SLR. In total, 115 publications were included, comprising 11 systematic reviews/meta-analyses, 36 randomised controlled trials (RCTs) (reported in 44 papers), 7 controlled clinical trials (CCTs), 9 pre-post-test studies, 23 cross-sectional surveys and 21 qualitative studies. The majority of patients in the included studies was female (58% - 100%), diagnosed with RA (82%) and had relatively long disease duration (mean 6–16 years). Ten studies included patients with AS and/or PsA and five studies included only patients with early disease duration (<2 years).

Recommendations

Two overarching principles and eight evidence-based and expert-opinion based recommendations were developed, four of which achieved strength A. A high level of agreement was achieved for all recommendations; mean range 9.4-9.8 in the task force and 8.2-9.2 in the consultation group (Table 1).

Table 1 Recommendations for patient education for people with inflammatory arthritis

Overarching principles				
1. Patient education is a planned interactive learning process designed to support and enable people to manage their life with inflammatory arthritis and optimise their health and well being				
2. Communication and shared decision making between people with inflammatory arthritis and their health care professionals are essential for effective patient education				
Recommendations	Category of evidence	Strength of recommendation	Level of agreement mean (SD)	
			Task force	Consultation group
1. Patient education should be provided for people with inflammatory arthritis as an integral part of standard care in order to increase patient involvement in disease management and health promotion	1A - 2B	A - C	9.6 (0.8)	9.2 (1.8)
2. All people with inflammatory arthritis should have access to and be offered patient education throughout the course of their disease including as a minimum; at diagnosis, at pharmacological treatment change and when required by the patient's physical or psychological condition	3 - 4	C - D	9.6 (0.7)	9.1 (1.8)
3. The content and delivery of patient education should be individually tailored and needs-based for people with inflammatory arthritis	1B	A	9.8 (0.6)	9.1 (2.3)
4. Patient education in inflammatory arthritis should include individual and/or group sessions, which can be provided through face-to-face or online interactions, and supplemented by phone	1A - B	A	9.5 (0.7)	8.9 (2.4)

calls, written or multimedia material

5.	Patient education programmes in inflammatory arthritis should have a theoretical framework and be evidence-based, such as self-management, cognitive behavioural therapy, or stress-management	1A - B	A	9.5 (0.9)	8.8 (2.2)
6.	The effectiveness of patient education in inflammatory arthritis should be evaluated and outcomes used must reflect the objectives of the patient education programme	4	D	9.6 (0.8)	8.3 (1.8)
7.	Patient education in inflammatory arthritis should be delivered by competent health professionals and/or by trained patients, if appropriate, in a multidisciplinary team	3	C	9.5 (0.8)	8.4 (2.0)
8.	Providers of patient education in inflammatory arthritis should have access to and undertake specific training in order to obtain and maintain knowledge and skills	3 - 4	C - D	9.4 (0.8)	8.2 (1.6)

Recommendation 1: Patient education as an integral part of standard care

The task force agreed that PE should be an integral part of standard care for people with IA. Category I evidence showed that various individual and group educational interventions had beneficial short-term effects in patients with RA.^{3, 7} Three RCTs¹⁸⁻²⁰ and one CCT²¹ showed that individual or group PE enhanced adherence with pharmacological treatment and knowledge of medication side effects. Moreover, one meta-analysis and four RCTs concluded that group educational programmes significantly improved disease knowledge, coping skills and physical and psychological health status.²²⁻²⁵ Several RCTs²⁶⁻³¹ and CCTs^{32, 33} demonstrated that PE supplementary to physical therapy or joint protection exercises had positive influence on physical function and activity, and reduced pain. Furthermore, consistent evidence showed that CBT and stress management programmes improved psychological health after intervention and at follow-up (4 to 18 months).³⁴⁻⁴²

Finally, there was consensus in the task force that PE would increase patients' involvement in their disease management, but this was only supported by one cross-sectional study,⁴³ in which high levels of perceived knowledge of the disease were positively associated with involvement in health care.

Recommendation 2: Patient education throughout the course of the disease

The task force emphasised the importance of offering timely PE. Individual patients' educational needs may vary, related to their disease stage and to fluctuations in their physical and psychological health condition. Educational needs may be identified by the patients themselves as well as by HPs and should be regularly monitored. Educational and

support needs may be most salient at times when patients are more likely to be experiencing change or pressure, such as in the early stages of their disease, when new pharmacological treatment is initiated and when their everyday life is affected.^{44, 45} Differing educational needs may also appear when patients experience flares, worsening or co-morbidities, and when the disease interferes with daily activities, life events and family roles.⁴⁶⁻⁴⁸

Recommendation 3: Tailored and needs-based patient education

The task force stated that PE should be tailored to the individual patient's needs. Several RCTs supported that individual counselling with a competent HP, either in one-by-one consultations or in combination with group sessions had beneficial health effects.^{19, 29, 37, 49-51} Cross-sectional and qualitative studies exploring patients' needs and expectations described a wide range of educational needs, such as knowledge and management of the disease, knowledge of side-effects and risk factors, non-pharmacological treatment, pain control and self-help methods, as well as activity regulation, physical exercises and behaviour change.^{44, 47, 52-60} In general, patients' levels of knowledge about the disease were low to moderate and patients expressed they had received insufficient information.^{47, 61, 62} Patients with IA wanted to be recognised as more than their disease, to be enabled to use their own resources and to re-engage in previously abandoned activities.^{55, 57, 63-65} Moreover, PE should include discussion on emotional issues and support from HPs in coping with emotional distress.⁶⁴⁻⁶⁶

Recommendation 4: Modes of delivery of patient education

The SLR showed that PE is provided in various modes; individual face-to-face-meetings,^{19, 20, 23, 26, 30, 37, 42, 67-73} groups,^{24, 25, 28, 34-36, 38-41, 74-79} a combination of the two,^{27, 29, 49, 50, 80} and online.⁸¹⁻⁸³ Category I evidence was found for individual counselling. Interactive individual education by rheumatologists improved adherence to medication regimen.^{19, 20} Individual counselling by OTs and PTs led to increased use of self-management strategies, such as hand exercises, joint protection and activity regulation.^{26, 71, 72} Individual counselling by psychologists reduced depression, anxiety, and total use of health care.^{37, 42, 69} Individual counselling supplementary to physical exercise improved health status, adherence with exercise programs and physical activity recommendations.^{29, 50, 51, 80, 84} Individual counselling

by nurses, supplementary to group education improved disease knowledge, wellbeing, pain and self-management behaviours.^{27, 49}

Various group interventions focussing on active coping with emotional distress and daily life stressors improved functional and emotional health status, patients' coping strategies^{28, 31, 34-36, 38-41, 74, 76} and perceived social support.⁸⁵ Finally, two RCTs^{80, 82} and one pre-post-test study⁸³ demonstrated that interactive online programmes contributed to improvement in health status, pain, physical limitations and levels of physical activity.

Recommendation 5: Theoretical framework and evidence for patient education

The task force agreed that PE should be based on a theoretical framework and be evidence-based. Four categories of PE interventions were described in the included studies: educational programmes (32 studies),^{18-21, 23-33, 49, 50, 70, 71, 73, 76-78, 80, 83, 86-91} SMP (7 studies),^{74, 75, 82, 92-95} CBT (9 studies)^{34-39, 42, 68, 96} and stress management programmes (6 studies).^{34, 40, 41, 69, 97, 98} The educational programmes mainly aimed to enhance knowledge, adherence to treatment, performance of physical function, joint protection and healthy lifestyle. The methods used were primarily didactic, instructions, counselling and practical exercises. These programmes were typically based on clinical experience and knowledge and were not underpinned by a theoretical framework. In contrast, the SMP and CBT interventions were based on frameworks derived from social cognitive theory⁹⁹ and cognitive behavioural theories.¹⁰⁰ In addition to provision of knowledge; these programmes were targeted at improving coping and psychological health status, facilitating behaviour change and adoption of health promoting behaviours. Participants were actively involved in goal-setting, problem-solving, group discussions and in preparing action plans. Furthermore, CBT interventions focussed on cognitive restructuring of beliefs.^{100, 101} The stress management programmes were mainly adapted from ancient Buddhist practices including yoga and breathing exercises, training of mindfulness meditation and acceptance.¹⁰² The main aims of these programmes were to enhance wellbeing by improving stress management skills, alleviate emotional distress^{34, 40, 41, 69} and promote a constructive relationship with both positive and negative emotions.¹⁰²

Recent systematic reviews have concluded that various group programmes (SMP, CBT, and stress management) demonstrated small, but positive impact on self-reported physical

activity levels, pain, disability, depressive symptoms, anxiety^{22, 103} and fatigue¹⁰⁴ at follow-up (4 to 18 months).

Recommendation 6: Outcomes of patient education

The task force agreed that in order to provide evidence-based PE, the various PE programmes need to be evaluated. To ensure valid evaluation the outcomes must reflect the programme objectives. The SLR revealed a great variation in evaluation criteria and use of outcome measures in the included studies. The specific educational objectives of the programmes were not always clear, making it difficult to judge whether the reported outcomes were matched to the educational objectives. For example, some studies reported DAS-28 and joint counts, which are unlikely to be directly influenced by PE.^{25, 74, 75}

Many of the PE programmes can be characterised as complex interventions, which intend to influence various aspects of the disease impact on life. It is challenging to find the outcome measure(s) that best capture these aspects and the outcome measures need to be carefully reviewed before evaluation studies are conducted.

Recommendation 7: Competency in delivery of patient education

The task force agreed that PE should be delivered by competent HPs and patients. The majority of the studies included, comprised PE interventions delivered by HPs within a health care context. However, PE may also be delivered by trained patients and in community settings.⁹² Sixteen of the PE programmes were delivered by multidisciplinary HPs,^{25, 28, 31, 33, 38, 41, 76-78, 88-90, 93, 95, 96, 98} and ten programmes were delivered by two different professionals, i.e. OT and PT (3 studies),^{26, 30, 50} nurse and rheumatologist (1 study),²¹ OT and rheumatologist (1 study),²⁴ psychologist and nurse (1 study),³⁹ psychologist and OT (1 study),³⁶ pharmacist and nurse (1 study)⁹¹ and nutritionist and OT (1 study).⁷⁹ Trained patients were involved in, or delivered two SMPs,^{75, 82} two online programmes^{82, 83} and one patient-led interactive workshop.⁸⁹ The remaining interventions were provided by one HP.^{18-20, 23, 27, 29, 34, 35, 37, 40, 42, 49, 67-71, 74, 80, 86, 87, 97} Which professionals should be involved, and how many, will depend on the aim, the topic and the context for the education. For example, physical exercise programmes provided by physiotherapists may be combined with group educational sessions by other HPs, as appropriate^{50, 76} and some CBT programmes are provided by psychologists only.^{34, 37, 42, 67, 68} Other programmes are independent of

profession, but require specific training in methods, such as CBT techniques^{36, 38} and mindfulness.^{40, 41}

Recommendation 8: Training competency for delivering Patient Education

The task force agreed that teaching competence is necessary alongside clinical expertise to deliver high quality PE. Only a few studies reported what skills and training providers of PE need. Qualitative studies exploring patients' perspectives on PE indicated requirements for knowledge and skills by educators. For example, patients wanted to receive clear explanation about test results, medication and self-management techniques.¹⁰⁵ HPs should have the ability to provide emotional support^{59, 64} and to focus on acceptance of the patient's illness and its consequences.¹⁰⁶ Moreover, patients experienced that the use of creative learning methods, such as guided discovery, metaphors, poetry, music and visual materials in groups facilitated their emotional and behavioural change processes^{57, 65} and they wanted to have the possibility to exchange knowledge and experiences with other patients.^{56, 65} HPs, on the other hand, perceived that their delivery of knowledge and advice was influenced by their own attitudes and their abilities to interact with the patients.¹⁰⁷

Research and educational agendas

Table 2 presents the research agenda proposed by the task force, based on areas with only weak or limited evidence for PE. The two overarching principles (see Table 1) should be applied when addressing each of these topics.

Table 2 Research agenda for patient education (PE)

-
- To evaluate, harmonize and/or further develop existing patient education outcomes, such as educational needs, goal attainment, etc., and if needed develop new outcomes, such as outcomes reflecting health literacy, health promotion, activity pacing, patients' needs, etc.
 - To develop guidelines on how to conduct and report studies in patient education
 - To investigate which modes of delivery are best suited to meet which objectives of patient education, including the time point (in the disease trajectory) at which patient education is likely to produce maximum effects
 - To study PE in other rheumatic conditions than rheumatoid arthritis
 - To investigate educational needs in specific subgroups (i.e, males, patients with minority ethnic backgrounds and patients with lower literacy levels)
 - To develop and evaluate PE for significant others (partners, spouses, family and carers)
 - To conduct economic evaluations of patient education (PE) interventions (using PE-sensitive outcomes and effects in relation to healthcare resource use).
-

-
- To investigate the long term effects and cost-effectiveness of PE
 - To gain insight into the working principles of PE – i.e. the mechanism by which PE produces its effects; whether directly, or by modifying or mediating its effects through other outcomes.
 - To investigate how to best provide online/e-health PE programmes
 - To investigate cross-cultural acceptability of PE programmes/modes of delivery across Europe
 - To define training requirements for PE provider
-

Table 3 presents the educational agenda, which encourages the development of training programmes to enhance and support HP's opportunities to improve their educational competencies.

Table 3 Educational agenda for providers of patient education (PE)

1. Increase health professionals' knowledge on the process and practicalities of delivering and evaluating effective PE
 2. Regular updating of PE skills/training is necessary to ensure provision of state of the art effective PE
 3. Develop training programmes for health professionals within the European League Against Rheumatism (EULAR)
-

DISCUSSION

Eight recommendations for PE for people with IA were developed based on a SLR and expert opinions. The recommendations were formulated to be practical and feasible for providing evidence-based PE across all European countries. The strength of evidence supporting the recommendations varies and a research agenda is proposed for areas with lack of evidence. A high level of expert agreement was achieved for all recommendations. An educational agenda was also formulated to support the development of competencies of HP's providing PE.

The included studies showed a trend towards greater inclusion of behavioural, cognitive and emotional aspects in the PE programmes during the last decade. This trend is reflected in the PE definition that the task force formulated as an overarching principle, stating that PE should enable people to manage their *life with IA* and *optimise their health and wellbeing* rather than be limited to the disease. Some previous PE definitions have stated that PE is designed to improve patients' health behaviours. However, the patient representatives in the task force felt that this was rather patronising and therefore it was not included in the

consensus definition. The definition emphasises that PE is an *interactive learning process*, not a one-way delivery of knowledge. Substantial evidence has shown that interactive counselling, either in combination with group sessions or in one-by-one consultations with a competent HP, has beneficial effects in terms of adherence to treatment regimens, behavioural change, use of self-management strategies and wellbeing.^{19, 37, 49, 72, 108} In order to ensure the application of shared decision-making, HPs need to develop their communication skills, and patient representatives should be involved in all phases of designing, implementing and evaluating the interventions.

Surprisingly, the SLR included only a limited number of studies on online PE programmes, but these showed promising results on health status and levels of physical activity.^{82, 84} In our rapid growing digital world, one may foresee that face-to-face-meetings will be more frequently replaced by online programmes, the impact of which will need evaluation.

A limitation to the generalizability of the recommendations is that the majority of patients who participated in the included studies was female, diagnosed with RA and had relatively long disease duration. The task force recognises that at present there is limited evidence for patients with AS and PsA. It is therefore suggested that the recommendations should be regarded as "points to consider" for this population. Furthermore, little is known about special educational needs for men, patients with minority ethnic backgrounds and patients with lower literacy levels, which needs attention in future research. A great diversity in the type of educational programmes was observed, varying from interventions with a primary focus on increasing knowledge and improving performance, to more therapeutic oriented interventions aiming at behavioural change and improving mental health status.^{3, 5, 103} Also, a wide range of outcome measures was used and most studies reported multiple outcomes, limiting comparison of the effectiveness of the programmes. To be able to evaluate the programmes more stringently and to compare relevant interventions, the task force recommends harmonisation of outcomes, tailored to the programme goals and content and to the patients needs. Furthermore, the task force has proposed that existing outcomes should be evaluated, and new outcome measures should be developed, if needed. The task force was not aware of any unpublished studies with negative results. Nevertheless, due to publication bias some positive effects of PE may potentially have been overestimated.

A methodological limitation of the SLR is that the task force decided to include all types of studies that could give insight in PE, resulting in a great methodological variety. Consequently, it was not possible to use one formal quality scoring system. Four recommendations were of strength A and the remaining four were of strength C to D, i.e. based on qualitative and cross-sectional studies or expert opinions. However, the qualitative studies may provide valuable insight into the individual patient's needs and expectations, which should be regarded as the core of PE programmes.

The use of a multidisciplinary task force, including patients, is one of the strengths of this study. Ideally, the task force should also have included a dietician and a pharmacist as the educational activities comprise life-style changes and adherence to medication. However, we believe that these issues have been addressed by the comprehensive SLR. Another strength is the high level of agreement with the recommendations among the members of the task force and the consultation group. However, the level of agreement will have to be further evaluated in a wider population of patients and HPs with interest and expertise in this field during the dissemination and evaluation of the recommendations.

The task force agreed on a research agenda to gain further insight in the qualitative and quantitative aspects of PE, including working mechanisms of PE, developing and harmonising PE outcomes, economic evaluations and cross-cultural acceptability of PE programmes across European countries. The educational agenda states that providers of PE need regular updates of their skills in order to deliver effective PE. The task force proposes that training of educational skills should be integrated in EULAR courses for HPs and rheumatologists.

Effective dissemination, implementation and evaluation of these recommendations across European countries demand a clear implementation strategy. Barriers and facilitators for implementation of PE as an integral part of standard care for all people with IA must be assessed within each country and appropriate support and education must be provided. This strategy will need further support from EULAR.

In conclusion, eight evidence-based and expert-opinion-based recommendations for PE for people with IA were developed. The dissemination and application of the recommendations should allow establishment of core standards for PE across Europe. Further evaluation will be necessary to ensure relevance and effective application.

Acknowledgements

The authors thank Kari Matre (medical librarian, Diakonhjemmet Hospital Library) for her contribution to the systematic literature review. The authors also wish to thank the members of the consultation group for their involvement in the early conception of this project and for rating the recommendations. The consultation group consisted of Adewale Adebajo, Michael Backhouse, Ulrika Bergsten, Tricia Cornell, Jenny de la Torre-Aboki, Silvia Garcia Diaz, Ricardo Ferreira, Kjersti Gronning, Bernadette Hardware, Agnes Kocher, Marja Leena Kukkurainen, Ingrid Larsson, Azucena Pedraz Marcos, Andrea Marques, Jorit Meesters, Sue Oliver, David Pickles, Birgit Prodinger, Sarah Ryan and Karen Vinall

Contributors HAZ was the research fellow for the project, undertaking the SLR; MN and AvT were the project convenors, AvT being the epidemiologist directing the SLR. All authors have contributed substantially by participating in the development of the recommendations, revising the manuscript critically for important intellectual content and approved the final version for submission.

Funding This study was supported by European League Against Rheumatism (EULAR), Grant reference: HPR024

Competing interests

All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: all authors had financial support from EULAR for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

REFERENCES

1. Combe B, Landewé R, Lukas C, et al. EULAR recommendations for the management of early arthritis: report of a task force of the European Standing Committee for International Clinical Studies Including Therapeutics (ESCISIT). *Ann Rheum Dis* 2007; **66**(1): 34-45.
2. Zochling J, van der Heijde D, Burgos-Vargas R, et al. ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis* 2006; **65**(4): 442-52.
3. Albano MG, Giraudet-Le Quintrec JS, Crozet C, et al. Characteristics and development of therapeutic patient education in rheumatoid arthritis: analysis of the 2003-2008 literature. *Joint Bone Spine* 2010; **77**(5): 405-10.
4. Riemsma RP, Taal E, Kirwan JR, et al. Systematic review of rheumatoid arthritis patient education. *Arthritis Rheum* 2004; **51**(6): 1045-59.
5. Niedermann K, Fransen J, Knols R, et al. Gap between short- and long-term effects of patient education in rheumatoid arthritis patients: A systematic review. *Arthritis Care Res* 2004; **51**(3): 388-98.
6. Astin JA, Beckner W, Soeken K, et al. Psychological interventions for rheumatoid arthritis: a meta-analysis of randomized controlled trials. *Arthritis Rheum* 2002; **47**(3): 291-302.
7. Christie A, Jamtvedt G, Dahm KT, et al. Effectiveness of nonpharmacological and nonsurgical interventions for patients with rheumatoid arthritis: an overview of systematic reviews. *Phys Ther* 2007; **87**(12): 1697-715.
8. Hoving C, Visser A, Mullen PD, et al. A history of patient education by health professionals in Europe and North America: from authority to shared decision making education. *Patient Educ Couns* 2010; **78**(3): 275-81.
9. Chewning B, Bylund CL, Shah B, et al. Patient preferences for shared decisions: a systematic review. *Patient Educ Couns* 2012; **86**(1): 9-18.
10. Newman S, Steed L, Mulligan K. Self-management interventions for chronic illness. *Lancet* 2004; **364**(9444): 1523-37.
11. de Ridder D, Geenen R, Kuijer R, et al. Psychological adjustment to chronic disease. *Lancet* 2008; **372**(9634): 246-55.
12. Klarenbeek NB, Kerstens PJ, Huizinga TW, et al. Recent advances in the management of rheumatoid arthritis. *BMJ* 2010; **341**: c6942.
13. John H, Hale ED, Treharne GJ, et al. Patient education on cardiovascular aspects of rheumatoid disease: an unmet need. *Rheumatology (Oxford)* 2007; **46**(10): 1513-6.

14. Vliet Vlieland TP, Hazes JM. Efficacy of multidisciplinary team care programs in rheumatoid arthritis. *Semin Arthritis Rheum* 1997; **27**(2): 110-22.
15. Stamm T, Hill J. Extended roles of non-physician health professionals and innovative models of care within Europe: results from a web-based survey. *Musculoskeletal Care* 2011; **9**(2): 93-101.
16. Visser A, Deccache A, Bensing J. Patient education in Europe: united differences. *Patient Educ Couns* 2001; **44**(1): 1-5.
17. Dougados M, Betteridge N, Burmester GR, et al. EULAR standardised operating procedures for the elaboration, evaluation, dissemination, and implementation of recommendations endorsed by the EULAR standing committees. *Ann Rheum Dis* 2004; **63**(9): 1172-6.
18. Homer D, Nightingale P, Jobanputra P. Providing patients with information about disease-modifying anti-rheumatic drugs: Individually or in groups? A pilot randomized controlled trial comparing adherence and satisfaction. *Musculoskeletal Care* 2009; **7**(2): 78-92.
19. El Miedany Y, El Gaafary M, El Arousy N, et al. Arthritis education: the integration of patient-reported outcome measures and patient self-management. *Clin Exp Rheumatol* 2011; **30**(6): 899-904.
20. Ravindran V, Jadhav R. The effect of rheumatoid arthritis disease education on adherence to medications and followup in Kerala, India. *J Rheumatol* 2013; **40**(8): 1460-1.
21. Mohammad A, Kilcoyne A, Bond U, et al. Methotrexate information booklet study 2008. *Clin Exp Rheumatol* 2009; **27**(4): 649-50.
22. Knittle K, Maes S, de Gucht V. Psychological interventions for rheumatoid arthritis: examining the role of self-regulation with a systematic review and meta-analysis of randomized controlled trials. *Arthritis Care Res (Hoboken)* 2010; **62**(10): 1460-72.
23. Rudd RE, Blanch DC, Gall V, et al. A randomized controlled trial of an intervention to reduce low literacy barriers in inflammatory arthritis management. *Patient Educ Couns* 2009; **75**(3): 334-9.
24. Neto BEL, Jennings F, Ohashi CB, et al. Evaluation of the efficacy of an educational program for rheumatoid arthritis patients. *Clin Exp Rheumatol* 2009; **27**(1): 28-34.
25. Giraudet-Le Quintrec JS, Mayoux-Benhamou A, Ravaud P, et al. Effect of a collective educational program for patients with rheumatoid arthritis: a prospective 12-month randomized controlled trial. *J Rheumatol* 2007; **34**(8): 1684-91.
26. O'Brien AV, Jones P, Mullis R, et al. Conservative hand therapy treatments in rheumatoid arthritis--a randomized controlled trial. *Rheumatology (Oxford)* 2006; **45**(5): 577-83.
27. Nunez M, Nunez E, Yoldi C, et al. Health-related quality of life in rheumatoid arthritis: therapeutic education plus pharmacological treatment versus pharmacological treatment only. *Rheumatol Int* 2006; **26**(8): 752-7.

28. Masiero S, Boniolo A, Wassermann L, et al. Effects of an educational-behavioral joint protection program on people with moderate to severe rheumatoid arthritis: a randomized controlled trial. *Clin Rheumatol* 2007; **26**(12): 2043-50.
29. Brodin N, Eurenus E, Jensen I, et al. Coaching patients with early rheumatoid arthritis to healthy physical activity: a multicenter, randomized, controlled study. *Arthritis Rheum* 2008; **59**(3): 325-31.
30. Hammond A, Bryan J, Hardy A. Effects of a modular behavioural arthritis education programme: a pragmatic parallel-group randomized controlled trial. *Rheumatology (Oxford)* 2008; **47**(11): 1712-8.
31. Mathieux R, Marotte H, Battistini L, et al. Early occupational therapy programme increases hand grip strength at 3 months: results from a randomised, blind, controlled study in early rheumatoid arthritis. *Ann Rheum Dis* 2009; **68**(3): 400-3.
32. Oh H, Seo W. Decreasing pain and depression in a health promotion program for people with rheumatoid arthritis. *J Nurs Scholarsh* 2003; **35**(2): 127-32.
33. Abourazzak F, El Mansouri L, Huchet D, et al. Long-term effects of therapeutic education for patients with rheumatoid arthritis. *Joint Bone Spine* 2009; **76**(6): 648-53.
34. Zautra AJ, Davis MC, Reich JW, et al. Comparison of cognitive behavioral and mindfulness meditation interventions on adaptation to rheumatoid arthritis for patients with and without history of recurrent depression. *J Consult Clin Psychol* 2008; **76**(3): 408-21.
35. Barsky AJ, Ahern DK, Orav EJ, et al. A randomized trial of three psychosocial treatments for the symptoms of rheumatoid arthritis. *Semin Arthritis Rheum* 2010; **40**(3): 222-32.
36. Hewlett S, Ambler N, Almeida C, et al. Self-management of fatigue in rheumatoid arthritis: a randomised controlled trial of group cognitive-behavioural therapy. *Ann Rheum Dis* 2011; **70**(6): 1060-7.
37. Sharpe L, Schrieber L. A blind randomized controlled trial of cognitive versus behavioral versus cognitive-behavioral therapy for patients with rheumatoid arthritis. *Psychother Psychosom* 2012; **81**(3): 145-52.
38. van Lankveld W, van Helmond T, Naring G, et al. Partner participation in cognitive-behavioral self-management group treatment for patients with rheumatoid arthritis. *J Rheumatol* 2004; **31**(9): 1738-45.
39. Carson JW, Keefe FJ, Affleck G, et al. A comparison of conventional pain coping skills training and pain coping skills training with a maintenance training component: a daily diary analysis of short- and long-term treatment effects. *J Pain* 2006; **7**(9): 615-25.
40. Pradhan EK, Baumgarten M, Langenberg P, et al. Effect of Mindfulness-Based Stress Reduction in rheumatoid arthritis patients. *Arthritis Rheum* 2007; **57**(7): 1134-42.

41. Zangi HA, Mowinckel P, Finset A, et al. A mindfulness-based group intervention to reduce psychological distress and fatigue in patients with inflammatory rheumatic joint diseases: a randomised controlled trial. *Ann Rheum Dis* 2012; **71**(6): 911-7.
42. Sharpe L, Sensky T, Timberlake N, et al. Long-term efficacy of a cognitive behavioural treatment from a randomized controlled trial for patients recently diagnosed with rheumatoid arthritis. *Rheumatology (Oxford)* 2003; **42**(3): 435-41.
43. Leung YY, Tam LS, Lee KW, et al. Involvement, satisfaction and unmet health care needs in patients with psoriatic arthritis. *Rheumatology (Oxford)* 2009; **48**(1): 53-6.
44. Kristiansen TM, Primdahl J, Antoft R, et al. Everyday life with rheumatoid arthritis and implications for patient education and clinical practice: a Focus Group Study. *Musculoskeletal care* 2012; **10**(1): 29-38.
45. Ørnbjerg LM, Andersen HB, Kryger P, et al. What do patients in rheumatologic care know about the risks of NSAIDs? *J Clin Rheumatol* 2008; **14**(2): 69-73.
46. Bode C, Taal E, Emons PAA, et al. Limited results of group self-management education for rheumatoid arthritis patients and their partners: explanations from the patient perspective. *Clin Rheumatol* 2008; **27**(12): 1523-8.
47. Meesters JIL, Vlieland TPMV, Hill J, et al. Measuring educational needs among patients with rheumatoid arthritis using the Dutch version of the Educational Needs Assessment Tool (DENAT). *Clin Rheumatol* 2009; **28**(9): 1073-7.
48. Mitton DL, Treharne GJ, Hale ED, et al. The health and life experiences of mothers with rheumatoid arthritis: a phenomenological study. *Musculoskeletal Care* 2007; **5**(4): 191-205.
49. Gronning K, Skomsvoll JF, Rannestad T, et al. The effect of an educational programme consisting of group and individual arthritis education for patients with polyarthritis--a randomised controlled trial. *Patient Educ Couns* 2012; **88**(1): 113-20.
50. Mayoux-Benhamou A, Giraudet-Le Quintrec JS, Ravaud P, et al. Influence of patient education on exercise compliance in rheumatoid arthritis: a prospective 12-month randomized controlled trial. *J Rheumatol* 2008; **35**(2): 216-23.
51. Sjoquist ES, Brodin N, Lampa J, et al. Physical activity coaching of patients with rheumatoid arthritis in everyday practice: a long-term follow-up. *Musculoskeletal Care* 2011; **9**(2): 75-85.
52. Schildmann J, Grunke M, Kalden JR, et al. Information and participation in decision-making about treatment: a qualitative study of the perceptions and preferences of patients with rheumatoid arthritis. *J Med Ethics* 2008; **34**(11): 775-9.
53. Hirsh D, Clerehan R, Staples M, et al. Patient assessment of medication information leaflets and validation of the Evaluative Linguistic Framework (ELF). *Patient Educ Couns* 2009; **77**(2): 248-54.

54. Brand C, Claydon-Platt K, McColl G, et al. Meeting the needs of people diagnosed with rheumatoid arthritis: an analysis of patient-reported experience. *J Nurs Healthc Chronic Illn* 2010; **2**(1): 75-83.
55. Bergsten U, Bergman S, Fridlund B, et al. "Striving for a good life" - the management of rheumatoid arthritis as experienced by patients. *Open Nurs J* 2011; **5**: 95-101.
56. Primdahl J, Wagner L, Hørslev-Petersen K. Being an outpatient with rheumatoid arthritis—a focus group study on patients' self-efficacy and experiences from participation in a short course and one of three different outpatient settings. *Scand J Caring Sci* 2011; **25**(2): 394-403.
57. Dures E, Kitchen K, Almeida C, et al. "They didn't tell us, they made us work it out ourselves": Patient perspectives of a cognitive-behavioral program for rheumatoid arthritis fatigue. *Arthritis Care Res* 2012; **64**(4): 494-501.
58. Zwikker H, van den Bemt B, van den Ende C, et al. Development and content of a group-based intervention to improve medication adherence in non-adherent patients with rheumatoid arthritis. *Patient Educ Couns* 2012; **89**(1): 143-51.
59. Ryan S, Lillie K, Thwaites C, et al. 'What I want clinicians to know'—experiences of people with arthritis. *Br J Nurs* 2013; **22**(14): 808-12.
60. Werner AM, Kaliski S, Salazar K, et al. Knowledge about their disease and treatment among patients with rheumatoid arthritis. [Spanish]. *Rev Med Chil* 2006; **134**(12): 1500-6.
61. Adab P, Rankin E, Witney A, et al. Use of a corporate needs assessment to define the information requirements of an arthritis resource centre in Birmingham: comparison of patients' and professionals' views. *Rheumatology (Oxford)* 2004; **43**(12): 1513-8.
62. Claudepierre P, Flipo RM, Sibilia J, et al. Patient knowledge of their disease: a French multicenter study in ankylosing spondylitis. *Joint Bone Spine* 2004; **71**(6): 550-6.
63. Ahlmen M, Nordenskiöld U, Archenholtz B, et al. Rheumatology outcomes: the patient's perspective. A multicentre focus group interview study of Swedish rheumatoid arthritis patients. *Rheumatology (Oxford)* 2005; **44**(1): 105-10.
64. Radford S, Carr M, Hehir M, et al. 'It's quite hard to grasp the enormity of it': Perceived needs of people upon diagnosis of rheumatoid arthritis. *Musculoskeletal care* 2008; **6**(3): 155-67.
65. Zangi HA, Hauge MI, Steen E, et al. "I am not only a disease, I am so much more". Patients with rheumatic diseases' experiences of an emotion-focused group intervention. *Patient Educ Couns* 2011; **85**(3): 419-24.
66. Cumming J, Hull RG. The information and support needs of people living with rheumatoid arthritis [abstract]. *Rheumatology (Oxford)* 2012; **51**(Suppl 3): iii159.

67. Sharpe L, Allard S, Sensky T. Five-year followup of a cognitive-behavioral intervention for patients with recently-diagnosed rheumatoid arthritis: effects on health care utilization. *Arthritis Rheum* 2008; **59**(3): 311-6.
68. Parker JC, Smarr KL, Slaughter JR, et al. Management of depression in rheumatoid arthritis: a combined pharmacologic and cognitive-behavioral approach. *Arthritis Rheum* 2003; **49**(6): 766-77.
69. de Brouwer SJ, Kraaimaat FW, Sweep FC, et al. Psychophysiological responses to stress after stress management training in patients with rheumatoid arthritis. *PLoS One* 2011; **6**(12): e27432.
70. Hammond A, Freeman K. The long-term outcomes from a randomized controlled trial of an educational-behavioural joint protection programme for people with rheumatoid arthritis. *Clin Rehabil* 2004; **18**(5): 520-8.
71. Hammond A, Young A, Kidao R. A randomised controlled trial of occupational therapy for people with early rheumatoid arthritis. *Ann Rheum Dis* 2004; **63**(1): 23-30.
72. Niedermann K, Buchi S, Ciurea A, et al. Six and 12 months' effects of individual joint protection education in people with rheumatoid arthritis: a randomized controlled trial. *Scand J Occup Ther* 2012; **19**(4): 360-9.
73. Walker D, Adebajo A, Heslop P, et al. Patient education in rheumatoid arthritis: the effectiveness of the ARC booklet and the mind map. *Rheumatology (Oxford)* 2007; **46**(10): 1593-6.
74. Bearne LM, Manning VL, Scott DL, et al. A Brief Exercise and Self Management Programme Improves Upper Limb Disability in People with Early Rheumatoid Arthritis. [abstract]. *Arthritis Rheum* 2012; **64**(Suppl10): 2439.
75. Conn DL, Pan Y, Easley KA, et al. The effect of the Arthritis Self-Management Program on outcome in African Americans with rheumatoid arthritis served by a public hospital. *Clin Rheumatol* 2013; **32**(1): 49-59.
76. Breedland I, van Scheppingen C, Leijnsma M, et al. Effects of a group-based exercise and educational program on physical performance and disease self-management in rheumatoid arthritis: a randomized controlled study. *Phys Ther* 2011; **91**(6): 879-93.
77. Masiero S, Bonaldo L, Pigatto M, et al. Rehabilitation treatment in patients with ankylosing spondylitis stabilized with tumor necrosis factor inhibitor therapy: a randomized controlled trial. *J Rheumatol* 2011; **38**(7): 1335-42.
78. Krauth C, Rieger J, Bonisch A, et al. [Costs and benefits of an education program for patients with ankylosing spondylitis as part of an inpatient rehabilitation programs-study design and first results]. *Z Rheumatol* 2003; **62**(Suppl 2): II14-6.
79. McKellar G, Morrison E, McEntegart A, et al. A pilot study of a Mediterranean-type diet intervention in female patients with rheumatoid arthritis living in areas of social deprivation in Glasgow. *Ann Rheum Dis* 2007; **66**(9): 1239-43.

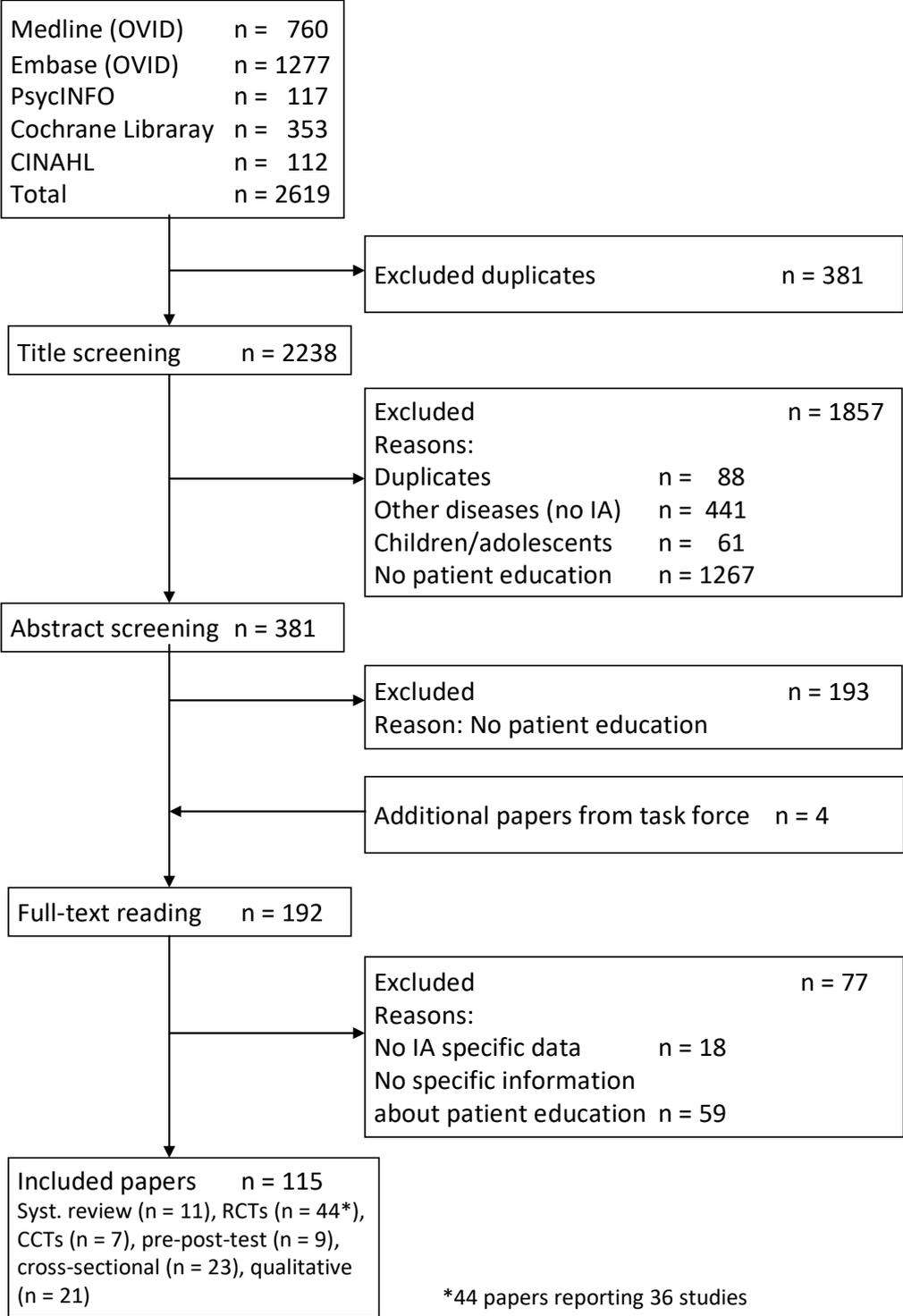
80. Van den Berg M, Ronday H, Peeters A, et al. Using internet technology to deliver a home-based physical activity intervention for patients with rheumatoid arthritis: A randomized controlled trial. *Arthritis Care Res* 2006; **55**(6): 935-45.
81. van den Berg MH, Ronday HK, Peeters AJ, et al. Engagement and satisfaction with an Internet-based physical activity intervention in patients with rheumatoid arthritis. *Rheumatology (Oxford)* 2007; **46**(3): 545-52.
82. Lorig KR, Ritter PL, Laurent DD, et al. The internet-based arthritis self-management program: a one-year randomized trial for patients with arthritis or fibromyalgia. *Arthritis Rheum* 2008; **59**(7): 1009-17.
83. Meesters JJ, de Boer IG, van den Berg MH, et al. Evaluation of a website providing information on regional health care services for patients with rheumatoid arthritis: an observational study. *Clin Rheumatol* 2012; **31**(4): 637-45.
84. Hurkmans EJ, van den Berg MH, Ronday KH, et al. Maintenance of physical activity after Internet-based physical activity interventions in patients with rheumatoid arthritis. *Rheumatology (Oxford)* 2010; **49**(1): 167-72.
85. Savelkoul M, de Witte L, Post M. Stimulating active coping in patients with rheumatic diseases: a systematic review of controlled group intervention studies. *Patient Educ Couns* 2003; **50**(2): 133-43.
86. Niedermann K, de Bie RA, Kubli R, et al. Effectiveness of individual resource-oriented joint protection education in people with rheumatoid arthritis. A randomized controlled trial. *Patient Educ Couns* 2011; **82**(1): 42-8.
87. Johansson K, Katajisto J, Salanterä S. Pre-admission education in surgical rheumatology nursing: towards greater patient empowerment. *J Clin Nurs* 2010; **19**(21-22): 2980-8.
88. Kennedy CA, Beaton DE, Warmington K, et al. Prescription for education: development, evaluation, and implementation of a successful interprofessional education program for adults with inflammatory arthritis. *The Journal of rheumatology* 2011; **38**(10): 2247-57.
89. Brosseau L, Lineker S, Bell M, et al. People getting a grip on arthritis: A knowledge transfer strategy to empower patients with rheumatoid arthritis and osteoarthritis. *Health Educ J* 2010; 0017896910387317.
90. Sudre A, Figueredo IT, Lukas C, et al. On the impact of a dedicated educational program for ankylosing spondylitis: effect on patient satisfaction, disease knowledge and spinal mobility, a pilot study. *Joint Bone Spine* 2012; **79**(1): 99-100.
91. Stockl KM, Shin JS, Lew HC, et al. Outcomes of a Rheumatoid Arthritis Disease Therapy Management Program Focusing on Medication Adherence. *J Manag Care Pharm* 2010; **16**(8): 593-604.
92. Chui D, Lau J, Yau I. An outcome evaluation study of the rheumatoid arthritis self-management programme in Hong Kong. *Psychol Health Med* 2004; **9**(3): 286-92.

93. Siu AM, Chui DY. Evaluation of a community rehabilitation service for people with rheumatoid arthritis. *Patient Educ Couns* 2004; **55**(1): 62-9.
94. Lacaille D, White MA, Rogers PA, et al. A proof-of-concept study of the “employment and arthritis: Making it work” program. *Arthritis Care Res* 2008; **59**(11): 1647-55.
95. O’Gorman A, Nolan M, Doyle C, et al. R.A.I.S.A. (Rheumatoid Arthritis Information, Support and Education): a four week multidisciplinary education programme [abstract]. *Phys Ther Rev* 2008; **13**: 119-20.
96. Vriezolkolk JE, Eijsbouts AM, van Lankveld WG, et al. An acceptance-oriented cognitive-behavioral therapy in multimodal rehabilitation: a pre-post test evaluation in highly distressed patients with rheumatic diseases. *Patient Educ Couns* 2013; **91**(3): 357-63.
97. Bagheri-Nesami M, Mohseni-Bandpei MA, Shayesteh-Azar M. The effect of Benson Relaxation Technique on rheumatoid arthritis patients: extended report. *Int J Nurs Pract* 2006; **12**(4): 214-9.
98. Zangi HA, Finset A, Steen E, et al. The effects of a vitality training programme on psychological distress in patients with inflammatory rheumatic diseases and fibromyalgia: a 1-year follow-up. *Scand J Rheumatol* 2009; **38**(3): 231-2.
99. Bandura A. *Self-efficacy: The exercise of control*. New York: Freeman; 1997.
100. Sharpe L, Curran L. Understanding the process of adjustment to illness. *Soc Sci Med* 2006; **62**(5): 1153-66.
101. Lorig KR, Holman H. Self-management education: history, definition, outcomes, and mechanisms. *Ann Behav Med* 2003; **26**(1): 1-7.
102. Hofmann SG, Asmundson GJ. Acceptance and mindfulness-based therapy: new wave or old hat? *Clin Psychol Rev* 2008; **28**(1): 1-16.
103. Dissanayake RK, Bertouch JV. Psychosocial interventions as adjunct therapy for patients with rheumatoid arthritis: a systematic review. *Int J Rheum Dis* 2010; **13**(4): 324-34.
104. Cramp F, Hewlett S, Almeida C, et al. Non-pharmacological interventions for fatigue in rheumatoid arthritis. *Cochrane Database Syst Rev* 2013; **8**: CD008322.
105. Ward V, Hill J, Hale C, et al. Patient priorities of care in rheumatology outpatient clinics: a qualitative study. *Musculoskeletal Care* 2007; **5**(4): 216-28.
106. Hamnes B, Hauge MI, Kjekken I, et al. ‘I have come here to learn how to cope with my illness, not to be cured’: A Qualitative Study of Patient Expectations Prior to a One-Week Self-Management Programme. *Musculoskeletal care* 2011; **9**(4): 200-10.

107. Bergsten U, Bergman S, Fridlund B, et al. "Delivering knowledge and advice": Healthcare providers' experiences of their interaction with patients' management of rheumatoid arthritis. *International journal of qualitative studies on health and well-being* 2011; **6**(4).

108. Sjoquist ES, Almqvist L, Asenlof P, et al. Physical-activity coaching and health status in rheumatoid arthritis: a person-oriented approach. *Disabil Rehabil* 2010; **32**(10): 816-25.

Figure 1: Flow chart of the systematic literature review



IA = inflammatory arthritis; RCT = randomised controlled trial; CCT = clinical controlled trial

Online supplementary file 1 Definition of patient education and research questions for the systematic literature review

Definition of patient education:

Patient education is a planned interactive learning process designed to support and enable people to manage their life with inflammatory arthritis and optimise their health and well being

Research questions:

1. How is PE organized in published studies from 2003 – to date? (availability, accessibility, frequency, duration, by whom)
 2. What content is used in PE programs? (If any, which theories and models are used?)
 3. What are the learning goals for PE described in the literature?
 4. Which techniques are used in PE? (i.e. self-help courses, books, e-health, SMP, CBT, mindfulness, goal management, stress management, individual consultations with HPs, peer contacts, role models, motivational (interview) discussions, exercise therapy, lifestyle changes)
 5. Which modes and methods of delivery are used for PE? (Individual, group, e-health, face-to-face education, etc.)
 6. Who (professionals, lay persons, organisations) deliver what type of PE (see question 1) and what skills or qualifications (in the subjects and pedagogics) do they have?
 7. Which patients have participated in PE studies? (demographics, disease characteristics, health literacy)
 8. Which outcomes are reported for evaluation of PE? (including cost-effectiveness)
 9. What are the effects of PE on knowledge, skills, attitudes and coping abilities?
 10. What are the patients' needs/expectations/preferences for PE?
-

PE = patient education, SMP = self management program, CBT = cognitive behavioural therapy, HP = health professional

Online supplementary file 2: Systematic literature search

The systematic literature search was conducted by the research fellow (HAZ) and a medical librarian, guided by an epidemiologist (AvT). The following databases were searched: Ovid Medline, EMBASE, Cochrane Library, PsycInfo and CINAHL. Relevant keywords, free text words and terms were selected and defined for a search strategy combining patient education (PE) AND patients with inflammatory arthritis (IA). The search was limited to studies on adults (age ≥ 18), published between January 2003 and September 2013 (date of search), written in English, German, French or Spanish. No limitations regarding geographical area was applied

Systematic reviews and meta-analyses

A separate search was conducted for systematic reviews and meta-analyses in the databases Ovid Medline and EMBASE. The same search terms were applied as well as the limitations regarding languages and years of publication. However, the studies were not limited to adults because relevant studies may be indexed without age-specifications.

Medline search strategy. (The same strategy, with an adjustment to the correct thesaurus, was used in searching the other databases)

1. exp Behavior Therapy/
2. self management.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
3. exp Health Behavior/
4. cognitive behavioural therapy.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
5. behaviour change.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
6. exp Self Efficacy/
7. exp Relaxation Therapy/
8. Stress, Psychological/
9. stress management.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
10. exp "Power (Psychology)"/
11. empowerment.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
12. exp Counseling/
13. exp Exercise Therapy/

14. exp Health Promotion/
15. exp Information Dissemination/
16. exp Pamphlets/
17. exp Patient Education as Topic/
18. exp Patient Participation/
19. exp Patient-Centered Care/
20. exp Professional-Patient Relations/
21. exp Self Care/
22. exp Teaching/
23. exp Teaching Materials/
24. (educat: adj (patient: or consumer: or health:)).tw.
25. (information adj (patient: or consumer: or health:)).tw.
26. (advice adj (patient: or consumer: or health:)).tw.
27. consumer health information.tw.
28. (shared decisionmaking or informed choice).tw.
29. (patient adj3 education).ti,ab.
30. (patient adj3 information).ti,ab.
31. (education adj2 program\$).ti,ab.
32. (leaflet\$ or booklet\$ or pamphlet\$ or poster\$).ti,ab.
33. ((written or printed or oral) adj3 information).ti,ab.
34. academic detailing.ti,ab.
35. training program\$.ti,ab.
36. (professional patient relation: or physician patient relation: or doctor patient relation: or nurse patient relation: or physical therapist patient relation: or physiotherapist patient relation: or occupational therapist patient relation).tw.
37. (professional patient interaction: or physician patient interaction: or nurse interaction: or physiotherapist patient interaction: or physical therapist patient interaction: or occupational therapist patient interaction).tw.
38. (patient physician communication: or patient doctor communication: or patient nurse communication: or patient physical therapist communication: or patient physiotherapist communication: or patient occupational therapist communication).tw.
39. (patient professional relation: or patient physician relation: or patient doctor relation: or patient nurse relation: or patient physical therapist relation: or patient physiotherapist relation: or patient occupational therapist relation).tw.
40. (patient professional interaction: or patient physician interaction: or patient doctor interaction: or patient nurse interaction: or patient physical therapist interaction: or patient physiotherapist interaction: patient occupational therapist interaction).tw.
41. or/1-40

42. exp arthritis, rheumatoid/
43. ((rheumatoid or reumatoid or revmatoid or rheumatic or reumatic or revmatic or rheumat\$ or reumat\$ or revmarthrit\$) adj3 (arthrit\$ or artrit\$ or diseas\$ or condition\$ or nodule\$)).tw.
44. (felty\$ adj2 syndrome).tw.
45. (caplan\$ adj2 syndrome).tw.
46. still\$ disease.tw.
47. bechterew\$ disease.tw.
48. exp Spondylarthropathies/
49. (ankylos\$ or spondyl\$).tw.
50. (bekhterev\$ or bechterew\$).tw.
51. (Marie adj struempell\$).tw.
52. exp Arthritis, Psoriatic/
53. (psoria\$ adj (arthriti\$ or arthropath\$)).tw.
54. ((arthriti\$ or arthropath\$) adj psoria\$).tw.
55. undifferentiated oligoarthritis.tw.
56. (inflamm\$ adj5 (arthrit\$ or arthrop\$)).tw.
57. or/42-56
58. 41 and 57
59. exp clinical trial/ or comparative study/ or consensus development conference/ or evaluation studies/ or meta-analysis/ or multicenter study/ or twin study/ or validation studies/ or exp epidemiologic study characteristics as topic/
60. study.ti.
61. trial.ti.
62. 59 or 60 or 61
63. 58 and 62
64. limit 63 to "review articles"
65. 63 not 64
66. limit 65 to (french or english or german or spanish)
67. limit 66 to last 10 years
68. limit 67 to ("adult (19 to 44 years)" or "young adult and adult (19-24 and 19-44)" or "middle age (45 to 64 years)" or "middle aged (45 plus years)" or "all aged (65 and over)"

Online supplementary file 3: Categories of evidence and Strength of recommendations

Categories of evidence

Category	Evidence
----------	----------

1A	From meta-analysis of randomized controlled trials
1B	From at least one randomised controlled trial
2A	From at least one controlled study without randomisation
2B	From at least one type of quasi-experimental study
3	From descriptive studies, such as comparative studies, correlation studies, or case control studies
4	From expert committee reports or opinions and/or clinical experience of respected authorities

Source: Dougados et al. EULAR standardised operating procedures for the elaboration, evaluation, dissemination, and implementation of recommendations endorsed by the EULAR standing committees. *Ann. Rheum. Dis.* 2004;63(9):1173

Strength of recommendations

Strength	Directly based on
----------	-------------------

A	Category 1 evidence
B	Category 2 evidence or extrapolated recommendations from Category 1 evidence
C	Category 3 evidence or extrapolated recommendations from Category 1 or 2 evidence
D	Category 4 evidence or extrapolated recommendations from Category 2 or 3 evidence

Source: Dougados et al. EULAR standardised operating procedures for the elaboration, evaluation, dissemination, and implementation of recommendations endorsed by the EULAR standing committees. *Ann. Rheum. Dis.* 2004;63(9):1174

Online supplementary file 4: List of papers included from the systematic literature review

Systematic reviews

Albano MG, Giraudet-Le Quintrec JS, et al. Characteristics and development of therapeutic patient education in rheumatoid arthritis: analysis of the 2003-2008 literature *Joint Bone Spine* 2010;**77**:405-10.

Badamgarav E, Croft JD, Hohlbauch A, et al. Effects of disease management programs on functional status of patients with rheumatoid arthritis. *Arthritis Rheum* 2003;**49**:377-87.

Christie A, Jamtvedt G, Dahm KT, et al. Effectiveness of nonpharmacological and nonsurgical interventions for patients with rheumatoid arthritis: an overview of systematic reviews. *Phys Ther* 2007;**87**:1697-715.

Cramp F, Berry J, Gardiner M, et al. Health behaviour change interventions for the promotion of physical activity in rheumatoid arthritis: a systematic review. *Musculoskeletal Care* 2013;**11**:238-247.

Cramp F, Hewlett S, Almeida C, et al. Non-pharmacological interventions for fatigue in rheumatoid arthritis. *Cochrane Database Syst Rev* 2013;**8**:CD008322 doi:10.1002/14651858.

Dissanayake RK, Bertouch JV. Psychosocial interventions as adjunct therapy for patients with rheumatoid arthritis: a systematic review. *Int J Rheum Dis* 2010;**13**:324-34.

Knittle K, Maes S, Gucht V. Psychological interventions for rheumatoid arthritis: examining the role of self-regulation with a systematic review and meta-analysis of randomized controlled trials. *Arthritis Car Res [Hoboken]* 2010;**62**:1460-72.

Niedermann K, Fransen J, Knols R, et al. Gap between short- and long-term effects of patient education in rheumatoid arthritis patients: a systematic review. *Arthritis Rheum* 2004;**51**:388-98.

Riemsma RP, Kirwan JR, Taal E, et al. Patient education for adults with rheumatoid arthritis. *Cochrane Database Syst Rev* 2003;**2**:CD003688 doi:10.1002/14651858.

Savelkoul M, de Witte L, Post M. Stimulating active coping in patients with rheumatic diseases: A systematic review of controlled group intervention studies. *Patient Educ Couns* 2003;**50**:133-43.

Warsi A, LaValley MP, Wang PS, et al. Arthritis self-management education programs: A meta-analysis of the effect on pain and disability. *Arthritis Rheum* 2003;**48**:2207-13.

Randomised Controlled Trials

Barsky AJ, Ahern DK, Orav EJ, et al. A randomized trial of three psychosocial treatments for the symptoms of rheumatoid arthritis. *Sem Arthritis Rheum* 2010;**4**:222-32.

Bearne LM, Manning VL, Scott DL, et al. A brief exercise and self management programme improves upper limb disability in people with early rheumatoid arthritis [abstract]. *Arthritis Rheum* 2012;**64**(Suppl10):2439doi:10.1002/art.40170

Breedland I, van SC, Leijmsma M, et al. Effects of a group-based exercise and educational program on physical performance and disease self-management in rheumatoid arthritis: a randomized controlled study. *Phys Ther* 2011;**91**:879-93.

Brodin N, Eurenus E, Jensen I, et al. PARA Study Group. Coaching patients with early rheumatoid arthritis to healthy physical activity: a multicenter, randomized, controlled study. *Arthritis Rheum* 2008;**59**:325-31.

Carson JW, Keefe FJ, Affleck G, et al. A comparison of conventional pain coping skills training and pain coping skills training with a maintenance training component: a daily diary analysis of short- and long-term treatment effects. *J Pain* 2006;**7**:615-25.

Conn DL, Pan Y, Easley KA, et al. The effect of the Arthritis Self-Management Program on outcome in African Americans with rheumatoid arthritis served by a public hospital. *Clin Rheumatol* 2013;**32**:49-59.

de Brouwer SJM, Kraaimaat FW, Sweep FCGJ, et al. Psychophysiological responses to stress after stress management training in patients with rheumatoid arthritis. *PLoS ONE*. 2011;**6**:e27432.

El Miedany Y, Gaafary ME, Arousy NE, et al. Arthritis education: The integration of patient-reported outcome measures and patient self-management. *Clin Exp Rheumatol* 2012;**30**: 899-904.

Giraudet-Le Quintrec JS, Mayoux-Benhamou A, et al. Effect of a collective educational program for patients with rheumatoid arthritis: a prospective 12-month randomized controlled trial. *J Rheumatol* 2007;**34**:1684-91.

Gronning K, Skomsvoll JF, Rannestad T, et al. The effect of an educational programme consisting of group and individual arthritis education for patients with polyarthritis--a randomised controlled trial. *Patient Educ Couns* 2012;**88**:113-20.

Hammond A, Young A, Kidao R. A randomised controlled trial of occupational therapy for people with early rheumatoid arthritis. *Ann Rheum Dis* 2004;**63**:23-30.

Hammond A, Freeman K. The long-term outcomes from a randomized controlled trial of an educational-behavioural joint protection programme for people with rheumatoid arthritis. *Clin Rehabil* 2004;**18**:520-8.

Hammond A, Bryan J, Hardy A. Effects of a modular behavioural arthritis education programme: a pragmatic parallel-group randomized controlled trial. *Rheumatology* 2008;**47**:1712-8.

Hewlett S, Ambler N, Almeida C, et al. Self-management of fatigue in rheumatoid arthritis: a randomised controlled trial of group cognitive-behavioural therapy. *Ann Rheum Dis* 2011;**70**:1060-7.

Homer D, Nightingale P, Jobanputra P. Providing patients with information about disease-modifying anti-rheumatic drugs: Individually or in groups? A pilot randomized controlled trial comparing adherence and satisfaction. *Musculoskeletal Care* 2009;**7**:78-92.

Hurkmans EJ, van den Berg MH, Runday KH, et al. Maintenance of physical activity after Internet-based physical activity interventions in patients with rheumatoid arthritis. *Rheumatology (Oxford)* 2010;**49**:167-72.

John H, Hale ED, Treharne GJ, et al. A randomized controlled trial of a cognitive behavioural patient education intervention vs. a traditional information leaflet to address the cardiovascular aspects of rheumatoid disease. *Rheumatology (Oxford)* 2013;**52**:81-90.

Krauth C, Rieger J, Bönisch A, et al. [Costs and benefits of an education program for patients with ankylosing spondylitis as part of an inpatient rehabilitation programs-study design and first results] [German]. *Z Rheumatol* 2003;**62**:14-16.

- Lorig KR, Ritter PL, Laurent DD, et al. The internet-based arthritis self-management program: a one-year randomized trial for patients with arthritis or fibromyalgia. *Arthritis Rheum* 2008;**59**:1009-17.
- Lovisi Neto BE, Jennings F, Barros OC, et al. Evaluation of the efficacy of an educational program for rheumatoid arthritis patients. *Clin Exp Rheumatol* 2009;**27**:28-34.
- Masiero S, Bonaldo L, Pigatto M, et al. Rehabilitation treatment in patients with ankylosing spondylitis stabilized with tumor necrosis factor inhibitor therapy: a randomized controlled trial. *J Rheumatol* 2011;**38**:1335-42.
- Masiero S, Boniolo A, Wassermann L, et al. Effects of an educational-behavioral joint protection program on people with moderate to severe rheumatoid arthritis: A randomized controlled trial. *Clin Rheumatol* 2007;**26**:2043-50.
- Mathieux R, Marotte H, Battistini L, et al. Early occupational therapy programme increases hand grip strength at 3 months: results from a randomised, blind, controlled study in early rheumatoid arthritis. *Ann Rheum Dis* 2009;**68**:400-3.
- Mayoux-Benhamou A, Giraudet-Le Quintrec JS, Ravaud P, et al. Influence of patient education on exercise compliance in rheumatoid arthritis: a prospective 12-month randomized controlled trial. *J Rheumatol* 2008;**35**:216-23.
- McKellar G, Morrison E, McEntegart A, et al. A pilot study of a Mediterranean-type diet intervention in female patients with rheumatoid arthritis living in areas of social deprivation in Glasgow. *Ann Rheum Dis* 2007;**66**:1239-43.
- Niedermann K, de Bie RA, Kubli R, et al. Effectiveness of individual resource-oriented joint protection education in people with rheumatoid arthritis. A randomized controlled trial. *Patient Educ Couns* 2011;**82**:42-8.
- Niedermann K, Buchi S, Ciurea A, et al. Six and 12 months' effects of individual joint protection education in people with rheumatoid arthritis: a randomized controlled trial. *Scand J Occup Ther* 2012;**19**:360-9.
- Nunez M, Nunez E, Yoldi C, et al. Health-related quality of life in rheumatoid arthritis: therapeutic education plus pharmacological treatment versus pharmacological treatment only. *Rheumatol Int* 2006;**26**:752-7.
- O'Brien AV, Jones P, Mullis R, et al. Conservative hand therapy treatments in rheumatoid arthritis - A randomized controlled trial. *Rheumatology (Oxford)* 2006;**45**:577-583.
- Parker JC, Smarr KL, Slaughter JR, Johnston SK, et al. Management of depression in rheumatoid arthritis: A combined pharmacologic and cognitive-behavioral approach. *Arthritis Car Res (Hoboken)* 2003;**49**:766-77.
- Pradhan EK, Baumgarten M, Langenberg P, et al. Effect of Mindfulness-Based Stress Reduction in rheumatoid arthritis patients. *Arthritis Rheum* 2007;**57**:1134-42.
- Ravindran V, Jadhav R. The effect of rheumatoid arthritis disease education on adherence to medications and followup in Kerala, India. *J Rheumatol* 2013;**40**:1460-1.
- Rudd RE, Blanch DC, Gall V, et al. A randomized controlled trial of an intervention to reduce low literacy barriers in inflammatory arthritis management. *Patient Educ Couns* 2009;**75**:334-9.

- Sharpe L, Sensky T, Timberlake N, et al. Long-term efficacy of a cognitive behavioural treatment from a randomized controlled trial for patients recently diagnosed with rheumatoid arthritis. *Rheumatology (Oxford)* 2003;**42**:435-41.
- Sharpe L, Allard S, Sensky T. Five-year followup of a cognitive-behavioral intervention for patients with recently-diagnosed rheumatoid arthritis: effects on health care utilization. *Arthritis Rheum* 2008;**59**:311-6.
- Sharpe L, Schrieber L. A blind randomized controlled trial of cognitive versus behavioral versus cognitive-behavioral therapy for patients with rheumatoid arthritis. *Psychother Psychosom* 2012;**81**:145-52.
- Sjoquist ES, Almqvist L, Asenlof P, et al. Physical-activity coaching and health status in rheumatoid arthritis: a person-oriented approach. *Disabil Rehabil* 2010;**32**:816-25.
- Sjoquist ES, Brodin N, Lampa J, et al. PARA Study Group. Physical activity coaching of patients with rheumatoid arthritis in everyday practice: a long-term follow-up. *Musculoskeletal Care* 2011;**9**:75-85.
- van den Berg MH, Runday HK, Peeters AJ, et al. Using internet technology to deliver a home-based physical activity intervention for patients with rheumatoid arthritis: A randomized controlled trial. *Arthritis Rheum* 2006;**55**:935-45.
- van den Berg MH, Runday HK, Peeters AJ, et al. Engagement and satisfaction with an Internet-based physical activity intervention in patients with rheumatoid arthritis. *Rheumatology (Oxford)* 2007;**46**:545-552.
- van Lankveld W, van Helmond T, Naring G, et al. Partner participation in cognitive-behavioral self-management group treatment for patients with rheumatoid arthritis. *J Rheumatol* 2004;**31**:1738-45.
- Walker D, Adebajo A, Heslop P, et al. Patient education in rheumatoid arthritis: the effectiveness of the ARC booklet and the mind map. *Rheumatology (Oxford)* 2007;**46**:1593-6.
- Zangi HA, Mowinckel P, Finset A, et al. A mindfulness-based group intervention to reduce psychological distress and fatigue in patients with inflammatory rheumatic joint diseases: a randomised controlled trial. *Ann Rheum Dis* 2012;**71**:911-7.
- Zautra AJ, Davis MC, Reich JW, et al. Comparison of cognitive behavioral and mindfulness meditation interventions on adaptation to rheumatoid arthritis for patients with and without history of recurrent depression. *J Consult Clin Psychol* 2008;**76**:408-21.
- Controlled Clinical Trials
- Abourazzak F, El Mansouri L, Huchet D, et al. Long-term effects of therapeutic education for patients with rheumatoid arthritis. *Joint Bone Spine* 2009; **76**:648-53.
- Bagheri-Nesami M, Mohseni-Bandpei MA, Shayesteh-Azar M. The effect of Benson Relaxation Technique on rheumatoid arthritis patients: Extended report. *Int J Nurs Pract* 2006;**12**:214-9.
- Johansson K, Katajisto J, Salanterä S. Pre-admission education in surgical rheumatology nursing: Towards greater patient empowerment. *J Clin Nurs* 2010;**19**:2980-8.
- Kennedy CA, Beaton DE, Warmington K, et al. Prescription for education: development, evaluation, and implementation of a successful interprofessional education program for adults with inflammatory arthritis. *J Rheumatology* 2011;**38**:2247-57.

Mohammad A, Kilcoyne A, Bond U, et al. Methotrexate information booklet study 2008. *Clin Exp Rheumatol* 2009;**27**:649-50.

Oh H, Seo W. Decreasing Pain and Depression in a Health Promotion Program for People With Rheumatoid Arthritis. *J Nurs Scholarsh* 2003;**35**:127-32.

Stockl KM, Shin JS, Lew HC, et al. Outcomes of a rheumatoid arthritis disease therapy management program focusing on medication adherence. *J Manag Care Pharm* 2010;**16**:593-604.

Pre-post-test studies

Brosseau L, Lineker S, Bell M, et al. People getting a grip on arthritis: A knowledge transfer strategy to empower patients with rheumatoid arthritis and osteoarthritis. *Health Educ J* 2012;**71**:255-67.

Chui DYY, Lau JSK, Yau ITY. An outcome evaluation study of the Rheumatoid Arthritis Self-Management Programme in Hong Kong. *Psychol, Health Med* 2004;**9**:286-92.

Lacaille D, White MA, Rogers PA, et al. A proof-of-concept study of the "Employment and Arthritis: Making It Work" program. *Arthritis Rheum* 2008;**59**:1647-55.

Meesters JJ, de Boer IG, van den Berg MH, et al. Evaluation of a website providing information on regional health care services for patients with rheumatoid arthritis: an observational study. *Clin Rheumatol* 2012;**31**:637-45.

O'Gorman A, Nolan M, Doyle C, et al. R.A.I.S.A. (Rheumatoid Arthritis Information, Support and Education): a four week multidisciplinary education programme. Rehabilitation and Therapy Research Society Third Annual Conference: Collaborative research... making it a reality 2007. *Phys Ther Rev* 2008;**13**:119-20.

Siu AM, Chui DY. Evaluation of a community rehabilitation service for people with rheumatoid arthritis. *Patient Educ Couns* 2004;**55**:62-9.

Sudre A, Figueredo IT, Lukas C, et al. On the impact of a dedicated educational program for ankylosing spondylitis: effect on patient satisfaction, disease knowledge and spinal mobility, a pilot study. *Joint Bone Spine* 2012;**79**:99-100.

Vriezokolk JE, Eijsbouts AM, van Lankveld WG, et al. An acceptance-oriented cognitive-behavioral therapy in multimodal rehabilitation: a pre-post test evaluation in highly distressed patients with rheumatic diseases. *Patient Educ Couns* 2013;**91**:357-63.

Zangi HA, Finset A, Steen E, et al. The effects of a vitality training programme on psychological distress in patients with inflammatory rheumatic diseases and fibromyalgia: a 1-year follow-up. *Scand J Rheumatol* 2009;**38**:231-2.

Cross-sectional studies

Adab P, Rankin EC, Witney AG, et al. Use of a corporate needs assessment to define the information requirements of an arthritis resource centre in Birmingham: comparison of patients' and professionals' views. *Rheumatology (Oxford)* 2004;**43**:1513-8.

Blalock SJ, Norton LL, Patel RA, et al. Patient Knowledge, Beliefs, and Behavior Concerning the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis. *Arthritis Car Res (Hoboken)* 2005;**53**:732-9.

Cadena J, Anaya JM. Education for patients with rheumatoid arthritis: is it worth it? *Arthritis Rheum* 2003;**49**:738-40.

Claudepierre P, Flipo RM, Sibilia J, et al. Patient knowledge of their disease: a French multicenter study in ankylosing spondylitis. *Joint Bone Spine* 2004;**71**:550-6.

Cumming J, Hull RG. The information and support needs of people living with rheumatoid arthritis [abstract]. *Rheumatology (Oxford)* 2012;**51**(Suppl 3):iii159.

Cunha-Miranda L, Costa L, Ribeiro JS. NEAR study: Needs and Expectations in Rheumatoid ARthritis - do we know our patients needs? *Acta Reumatol Port* 2010;**35**:314-23.

Garneau K, Iversen M, Jan S, et al. Rheumatoid arthritis decision making: many information sources but not all rated as useful. *J Clin Rheumatol* 2011;**17**:231-5.

Hennell SL, Brownsell C, Dawson JK. Development, validation and use of a patient knowledge questionnaire (PKQ) for patients with early rheumatoid arthritis. *Rheumatology (Oxford)* 2004;**43**:467-71.

Hurkmans EJ, De Gucht V, Maes S, et al. Promoting physical activity in patients with rheumatoid arthritis: rheumatologists' and health professionals' practice and educational needs. *Clinical Rheumatology (Oxford)* 2011;**30**:1603-9.

Kaariainen M, Kukkurainen ML, Kyngas H, et al. Improving the quality of rheumatoid arthritis patients' education using written information. *Musculoskeletal Care* 2011;**9**:19-24.

Leung YY, Tam LS, Lee KW, et al. Involvement, satisfaction and unmet health care needs in patients with psoriatic arthritis. *Rheumatology (Oxford)* 2009;**48**:53-6.

Meesters JJ, Vliet Vlieland TP, Hill J, et al. Measuring educational needs among patients with rheumatoid arthritis using the Dutch version of the Educational Needs Assessment Tool (DENAT). *Clin Rheumatol* 2009;**28**:1073-7. [Erratum appears in *Clin Rheumatol* 2009;**28**:1357].

Meesters J, de Boer I, van den Berg M, et al. Unmet information needs about the delivery of rheumatology health care services: A survey among patients with rheumatoid arthritis. *Patient Educ Couns* 2011;**85**:299-303.

Mäkeläinen P, Vehviläinen-Julkunen K, Pietilä A. Change in knowledge and self-efficacy of patients with rheumatoid arthritis: a six-month follow-up study. *Int J Nurs Pract* 2009;**15**:368-75.

Mäkeläinen P, Vehviläinen-Julkunen K, Pietilä AM. Rheumatoid arthritis patients' knowledge of the disease and its treatments: a descriptive study. *Musculoskeletal Care* 2009;**7**:31-44.

Mäkeläinen P, Vehviläinen-Julkunen K, Pietilä AM. Rheumatoid arthritis patients' education- Contents and methods. *J Clin Nur*. 2007;**16**:258-67.

Ndosi M, Tennant A, Bergsten U, et al. Cross-cultural validation of the Educational Needs Assessment Tool in RA in 7 European countries. *BMC Musculoskelet Disord* 2011;**12**: 110.

Ndosi M, Bremander A, Hamnes B, et al. Validation of the educational needs assessment tool as a generic instrument for rheumatic diseases in seven European countries. *Ann Rheum Dis* 2013; [Published Online First: [6 Aug 2013] doi:10.1136/annrheumdis-2013-203461.

Neame R, Hammond A, Deighton C. Need for Information and for Involvement in Decision Making Among Patients With Rheumatoid Arthritis: A Questionnaire Survey. *Arthritis Car Res (Hoboken)* 2005;**53**:249-55.

Örnberg LM, Andersen HB, Kryger P, et al. What do patients in rheumatologic care know about the risks of NSAIDs? *J Clin Rheumatol* 2008;**14**:69-73.

Pytel A, Wrzosek Z. Estimation of patient knowledge on rheumatoid arthritis in the range of their own disease--preliminary study. *Adv Clin Exp Med* 2012;**21**:343-51.

Richter JG, Becker A, Koch T, et al. Internet use in rheumatology outpatients in 2006: gender less important. *Clin Exp Rheumatol* 2009;**27**:15-21.

Sowden E, Hassan W, Gooden A, et al. Limited end-user knowledge of methotrexate despite patient education: an assessment of rheumatologic preventive practice and effectiveness. *J Clin Rheumatol* 2012;**18**:130-3.

Werner CA, Kaliski KS, Salazar QK, et al. [Knowledge about their disease and treatment among patients with rheumatoid arthritis] [Spanish]. *Rev Med Chile* 2006;**134**:1500-6.

Qualitative Studies

Ahlmen M, Nordenskiöld U, Archenholtz B, et al. Rheumatology outcomes: the patient's perspective. A multicentre focus group interview study of Swedish rheumatoid arthritis patients. *Rheumatology (Oxford)* 2005;**44**:105-10.

Bergsten U, Bergman S, Fridlund B, et al. "Delivering knowledge and advice": Healthcare providers' experiences of their interaction with patients' management of rheumatoid arthritis. *Int J Qual Stud Health Well-being*. 2011;**6**:1-9.

Bergsten U, Bergman S, Fridlund B, et al. "Striving for a Good Life"--The Management of Rheumatoid Arthritis as Experienced by Patients. *Open Nurs J* 2011;**5**:95-101.

Bode C, Taal E, Emons PA, et al. Limited results of group self-management education for rheumatoid arthritis patients and their partners: explanations from the patient perspective. *Clin Rheumatol* 2008;**27**:1523-8.

Brand C, Claydon-Platt K, McColl G, et al. Meeting the needs of people diagnosed with rheumatoid arthritis: an analysis of patient-reported experience. *J Nurs Healthc Chronic Illn* 2010;**2**:75-83.

Davies H, Brophy S, Dennis M, et al. Patient perspectives of managing fatigue in Ankylosing Spondylitis, and views on potential interventions: A qualitative study. *BMC Musculoskelet Disord* 2013;163.

Dures E, Kitchen K, Almeida C, et al. "They didn't tell us, they made us work it out ourselves": patient perspectives of a cognitive-behavioral program for rheumatoid arthritis fatigue. *Arthritis Car Res (Hoboken)* 2012;**64**:494-501.

Ellard DR, Barlow JH, Paskins Z, et al. Piloting education days for patients with early rheumatoid arthritis and their partners: a multidisciplinary approach. *Musculoskeletal Care* 2009;**7**:17-30.

Hamnes B, Hauge MI, Kjekken I, et al. 'I have come here to learn how to cope with my illness, not to be cured': a qualitative study of patient expectations prior to a one-week self-management programme. *Musculoskeletal Care* 2011;**9**:200-10.

Hirsh D, Clerehan R, Staples M, et al. Patient assessment of medication information leaflets and validation of the Evaluative Linguistic Framework (ELF). *Patient Educ Couns* 2009;**77**:248-54.

Kristiansen TM, Primdahl J, Antoft R, et al. Everyday Life with Rheumatoid Arthritis and Implications for Patient Education and Clinical Practice: A Focus Group Study. *Musculoskeletal Care* 2012;**10**:29-38.

Mitton DL, Treharne GJ, Hale ED, et al. The health and life experiences of mothers with rheumatoid arthritis: a phenomenological study. *Musculoskeletal Care* 2007; **5**:191-205.

Primdahl J, Wagner L, Hørslev-Petersen K. Being an outpatient with rheumatoid arthritis-A focus group study on patients' self-efficacy and experiences from participation in a short course and one of three different outpatient settings. *Scand J Caring Sci* 2011;**25**:394-403.

Radford S, Carr M, Hehir M, et al. 'It's quite hard to grasp the enormity of it': perceived needs of people upon diagnosis of rheumatoid arthritis. *Musculoskeletal Care* 2008;**6**:155-67.

Ryan S, Lillie K, Thwaites C, et al. 'What I want clinicians to know'- experiences of people with arthritis. *Br J Nurs* 2013;**22**:808-12.

Schildmann J, Grunke M, Kalden JR, et al. Information and participation in decision-making about treatment: A qualitative study of the perceptions and preferences of patients with rheumatoid arthritis. *J Med Ethics* 2008;**34**:775-9.

Shigaki CL, Smarr KL, Gong Y, et al. Social interactions in an online self-management program for rheumatoid arthritis. *Chronic Illn* 2008;**4**:239-46.

Tammaru M, Polluste K, Lember M. The sources of disease-related information for Estonia's rheumatoid arthritis patients: A qualitative study. *J Clin Nurs* 2010;**19**:1343-51.

Ward V, Hill J, Hale C, et al. Patient priorities of care in rheumatology outpatient clinics: a qualitative study. *Musculoskeletal Care* 2007;**5**:216-28.

Zangi HA, Hauge MI, Steen E, et al. "I am not only a disease, I am so much more". Patients with rheumatic diseases' experiences of an emotion-focused group intervention. *Patient Educ Couns* 2011;**85**:419-24.

Zwikker H, van den Bemt B, van den Ende C, et al. Development and content of a group-based intervention to improve medication adherence in non-adherent patients with rheumatoid arthritis. *Patient Educ Couns* 2012;**89**:143-51.