



# **Guidelines for the Therapy Management of Children and Young People with Juvenile Idiopathic Arthritis**

These guidelines have been compiled by the Allied Health Professionals Group of the British Society for Paediatric and Adolescent Rheumatology (BSPAR), 2011.

## **Introduction**

These guidelines are designed to help and support paediatric therapists working with children and young people with Juvenile Idiopathic Arthritis (JIA). They provide guidance on the therapy management of such children and young people to ensure optimum evidence-based management for all patients irrespective of geographical location. These guidelines should be read in conjunction with A Standard Assessment for Juvenile Idiopathic Arthritis (BSPAR 2003), Allied Health Professional Standards of Care for Juvenile Idiopathic Arthritis (BSPAR 2007) and the BSPAR Position Statement on Professionals Working in Paediatric Rheumatology Teams (2007) as well as related medical and nursing documents.

## **Objectives**

1. To facilitate the development of specialised, evidence-based and holistic management programmes for children and young people with JIA, using a biopsychosocial model which acknowledges the global impact of the disease.
2. To optimise the standard of care of children and young people with JIA by empowering them, their carers and other health professionals through the provision of education, information and support.
3. To enable children, young people and their parents to be active participants in their management.
4. To ensure efficient, cost effective and evidence-based therapy management for children and young people with JIA.

These standards will be reviewed in 2014

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## **Therapy Management Guidelines**

### **Assessment**

On first contact, therapists should carry out a comprehensive assessment of the child or young person to establish baseline data. This assessment should encompass the physical, psychological, occupational and social impact of the disease on the patient and their family. Detailed records should then be compiled. These can then be used to develop an appropriate individual management programme.

Due to the relapsing and remitting nature of JIA, all patients should have regular re-assessment of disease activity. This will allow prompt identification of disease flares and regular monitoring of the response to therapy and medical management (BSPAR 2007).

*Assessment should be carried out in accordance with A Standard Assessment for Juvenile Idiopathic Arthritis (BSPAR 2003).*

### **Patient Management**

All children and young people with JIA should have access to a multidisciplinary team with the appropriate specialist knowledge, skills and experience in managing children with JIA. Therapists should work in partnership with the child or young person, their family and other members of the MDT, both locally and within the specialist tertiary team.

*Refer to Allied Health Professional Standards of Care for Juvenile Idiopathic Arthritis (BSPAR 2007).*

## **A - Management during an acute disease flare**

During periods of acute flare it is vital that children and young people receive appropriate medical input in order to optimise their treatment and ensure that the potential complications of acute flare are minimised. Possible complications of acute flare include reduction in joint range of movement, joint damage, pain, muscle wasting, abnormalities in gait, reduction in activity levels and difficulties with participation in everyday ADL.

### **Medical Referral**

In the event of therapy assessment revealing an acute disease flare, it is imperative that this information is conveyed urgently to the relevant rheumatology medical team. This will facilitate efficient medical disease management, i.e. optimisation of drug management and/or joint injections.

### **Exercise Therapy**

During periods of acute flare, children and young people with JIA should be provided with the skills to maintain their range of movement, to maintain muscle strength and ensure optimal independent functioning (BSPAR 2007).

Exercise therapy can take the form of;

#### **i) Active range of movement exercises**

*Active range of movement exercises are useful during periods of acute flare as they allow patient the child or young person to be in control at all times, reducing the anxiety associated with moving a painful joint.*

*Young children can often be persuaded to carry out active exercises through play if they are too young to co-operate with formal exercises.*

*If multiple joints are affected, consideration should be given to practicality of and likely concordance with an extensive exercise regime for all joints. In this situation, gross exercises covering a range of joints should be considered or exercises chosen for the most severely affected joints.*

#### **ii) Passive range of movement exercises**

*Young people may find passive joint stretches helpful to maintain range of movement during an acute flare. These should be carried out gently, under the young person's control and within their tolerance of discomfort.*

*Occasionally younger children who are unable to co-operate with active exercises may benefit from gentle passive stretches to affected joints. Stretching active joints can be uncomfortable and upsetting for children. In view of the chronic nature of JIA the benefits of this approach must be weighed against the potential costs of muscle spasm resulting from pain, "battles" with parents and longer-term "therapy phobia".*

### iii) Strengthening exercises

*Muscles surrounding actively inflamed joints undergo muscle wasting. This may then result in secondary difficulties with participation in everyday ADL, gait abnormalities and limitation of cardiovascular activities, potentially resulting in more lengthy rehabilitation once disease control is re-established.*

*It may not be possible to rebuild muscle strength until disease control is re-established; however muscle wasting may be minimised through resisted exercise. Care should be taken with the degree of resistance as this may cause increased joint discomfort resulting in muscle spasm and reduced concordance with exercise.*

### iv) Cardiovascular activity

*Children and young people should be encouraged to continue cardiovascular activity during a flare as discomfort allows, in order to minimise loss of cardiovascular fitness and muscle strength, and to reduce the length of rehabilitation once disease control is re-established.*

*High impact activities should be avoided during acute flares of lower limb joints. Swimming and bicycles/scooters may be more acceptable forms of cardiovascular exercise when lower limb joints are painful.*

## **Splinting**

Splinting should never replace optimal medical management; however may be indicated in the following situations:

- i) Early morning stiffness resulting in stiff, flexed joints and impacting upon mobility and function. Provision of a knee/ankle/wrist night resting splint will allow joints to remain in a functional position for mobility and performance of everyday ADL.
- ii) Pain significantly interfering with occupational function or giving rise to anxiety and subsequent “guarding”. Provision of a work splint may give symptomatic relief during a period of acute flare. Patients should be instructed to remove the splint regularly to allow range of movement exercises and to maintain muscle strength.
- iii) Neck pain and stiffness resulting from cervical facet joint inflammation. A soft collar may be useful to give symptomatic relief during a period of acute flare. Patients should be instructed to remove the collar regularly to allow gentle range of movement exercises.
- iv) Flexion Contractures. A resting splint may prevent further loss of range of movement or may be used to improve range by applying a gentle stretch.

## **Aquatic Therapy (formally known as Hydrotherapy)**

As a result of improvements in the medical management of children and young people with JIA, aquatic therapy is now used less frequently. Aquatic therapy during periods of acute disease flare has been shown have a number of benefits and may be used to:

- i) Reduce pain and aid relaxation (Franchimont et al, 1983, O'Hare et al, 1985, Weston et al, 1987, Linneker et al, 2000 and Templeton et al, 1996).
- ii) Improve range of movement (Bacon et al, 1991)
- iii) Improve muscle power (Oberger et al, 1994 and Epps, 2005)
- iv) Improve cardiovascular fitness (Bacon et al, 1991)
- v) Enhance impaired function and independence (Hall et al, 1996)
- vi) Improve social/peer interaction (Takken, 2001 and Hall et al, 1996)

Refer to Guidelines for the use of Hydrotherapy for Patients with Juvenile Idiopathic Arthritis (BSPAR 2007).

## **Pain Management**

A key task of therapists is to enable children/young people and their families to manage pain effectively. Pain is often underestimated by health professionals (Anthony and Shanberg, 2003) and therefore careful assessment of pain is essential. A visual analogue scale may prove useful; however this may not be suitable for very young children and those with learning difficulties.

Patients and carers should be equipped with a range of pain coping skills and strategies to increase their sense of control over pain and to enable them to manage pain more effectively. These may include:-

- i) Appropriate use of analgesia
- ii) Use of cold/warm packs on active joints  
*Although physiologically cold packs are indicated in acute flare for their anti-inflammatory effects, many children and young people do not tolerate cold packs well and find the pain relief and relaxation resulting from warmth more beneficial.*
- iii) TENS
- iv) Relaxation techniques
- v) Avoiding prolonged periods in static postures
- vi) Gentle exercise/stretching
- vii) Use of splints (see above)
- viii) Distraction  
*Often children and young people will withdraw from normal everyday occupation and community based activities, e.g. social activities, school and clubs during periods of flare. This may result in a greater focus on pain and lead to social isolation and low mood. Patients should be encouraged to maintain normal routines as far as possible to provide distraction and social support.*
- ix) Pacing
- x) Ergonomic advice

## **ADL**

During a period of disease flare, ADL will invariably be affected, including self care tasks, school/college and play/leisure. The goal of occupational therapy is therefore to facilitate the child or young person's engagement in a range of meaningful occupations, maximise function and independence while maintaining their dignity and privacy.

Interventions may include the following:-

- i) Activities to optimise specific performance components, e.g. grip strength and participation in meaningful life roles
- ii) Individualised goal setting using evidenced based assessment tools/outcome measures
- ii) Group work to address a specific need
- iii) Social/emotional, e.g. relaxation/confidence building etc.
- iv) Provision of assistive devices
- v) Adaptation of the environment/tasks

## **Liaison with School/College**

JIA is a chronic condition which may affect children and young people for many years. It is therefore vital that the condition interferes with their academic performance as little as possible. Therapists should actively facilitate children/young people to reach their full academic and vocational potential. Due to the relapsing and remitting nature of JIA, schools and colleges can find it difficult to appreciate the potential implications for the child or young person. Therapists, therefore, have a vital role to educate staff about JIA, and to appreciate the psychosocial impact of a chronic illness. They should also assist them in establishing contingency plans for a child/young person in the event of a flare of their disease, during periods of flare, children and young people may experience difficulties in some or all of the following areas:

- i) **School access**
  - *Transport to and from school.*
  - *Early morning stiffness may make it necessary for pupils to be allowed to arrive late to school.*
  - *Disabled access facilities should be arranged to ensure safety and independence*
- ii) **Class access**
  - *When possible pupils should remain in class with their peers.*
  - *Schools may need to consider organising timetables to reduce the number of stairs and distances between classes.*
  - *Pupils may benefit from a pass to allow them to leave lessons a little early in order to reach the next activity in good time and to avoid being jostled by other pupils.*
- iii) **Seating**

*Pupils may find sitting and working for long periods uncomfortable: they may therefore need to move regularly during lessons to prevent stiffness.*

  - *Unsupported sitting can be difficult for pupils with back pain. Schools may in some cases need to invest in a science stool with a back rest attached.*
  - *Pupils with neck pain should face the teacher/front of the room to avoid continual twisting, thus facilitating a comfortable sitting position. An angled desk top surface may also prove beneficial.*
  - *It may be necessary for younger children to sit on a chair rather than sitting cross-legged on the floor.*
- iv) **Handwriting**
  - *Pupils with a flare in wrist and/or finger joints may find writing for long periods difficult. It may be beneficial for teachers to photocopy worksheets to prevent pupils having to copy out questions etc.*
  - *A laptop/word processor may be considered if writing becomes difficult; however the disadvantages, for example, carrying a laptop, should not be forgotten.*

- v) **School bags**
  - *Pupils at secondary school are often required to carry heavy books and other equipment to/from school and around school during the day. Pupils may need a locker or secure room to place books in or be given two copies of text books to enable them to leave one at home and one at school.*
- vi) **PE**
  - *Maintaining cardiovascular fitness and strength is vital during disease flares; however a pupil's level of ability may be affected. PE teachers should be advised regarding the most appropriate activities and levels of participation.*
  - *Advice regarding the adaptation of activities should be provided.*
  - *Additional time may be necessary for changing.*
- vii) **Exams**
  - *Additional time to complete exams can be arranged to accommodate rest periods.*
  - *Special consideration may also be applied if it is felt that the child/young person's condition impacted adversely on their performance.*
- viii) **Work experience**

*This area should not be overlooked, as the acquisition of vocational skills is particularly important for young people with JIA.*

*If a disease flare adversely affects the educational experience of the child/young person, a school visit is indicated in order to carry out a thorough and detailed assessment of occupational performance. This allows the Occupational Therapist (OT) to consider the impact on the child/young person, the task and the environment. Alongside the educational needs it also very important to consider the social impact at school, which may have an adverse effect on their emotional well-being.*

## **Disease Education**

A vital role of all AHP's is to educate children/young people and their families about their disease and its management. This should be done in a developmentally appropriate and culturally sensitive manner. The process is a continual one, which acknowledges that needs of the child/young person will change over time. A variety of methods should be used to encompass preferred learning styles, e.g. verbal, written, web based information etc

A range of useful resources exists including;

- |   |   |
|---|---|
| Arthritis Research Campaign publications –    | Arthritis: A Guide for Teenagers<br>Tim has Arthritis<br>When your child has arthritis  |
| CHAT (Children Have Arthritis Too) Alliance – | CHAT: A Guide for Parents<br>CHAT 2 Parents – Arthritis in Teenagers<br>CHAT: A Teachers Guide to Juvenile Idiopathic Arthritis |
| Arthritis Care publications -<br>CHOICES      | A Day with Sam<br>Kids with arthritis, a guide for families   |

Web sites – [www.arc.org.uk](http://www.arc.org.uk)

[www.kidswitharthritis.org](http://www.kidswitharthritis.org)  
[www.kidsunlimited.info](http://www.kidsunlimited.info)  
[www.ccaa.org.uk](http://www.ccaa.org.uk)  
[www.arthritiscare.org.uk](http://www.arthritiscare.org.uk)  
[www.backcare.org.uk](http://www.backcare.org.uk)

## Peer Support

Children/young people often describe feeling very isolated and have expressed a desire to meet others with similar experiences (Shaw et al 2004). Group work may prove beneficial in facilitating the development of peer support networks, or providing email addresses of suitable others requesting such interventions.

## Family Support

Therapists should also ensure that families are aware of organisations, which may be able to offer emotional, financial and practical support. A number of organisations that provide such help are listed below. Resources include handbooks, newsletters, and family holidays.

Contact a Family	<a href="http://www.cafamily.org.uk">www.cafamily.org.uk</a>	Helpline 0808 808 3555 freephone for parents and families (10am-4pm, Mon-Fri) E-mail: <a href="mailto:info@cafamily.org.uk">info@cafamily.org.uk</a>
Arthritis Care	<a href="http://www.arthritiscare.org.uk">www.arthritiscare.org.uk</a>	Tel: 020 7380 6500 E-mail: <a href="mailto:Info@arthritiscare.org.uk">Info@arthritiscare.org.uk</a>
Children's Chronic Arthritis Association (CCAA)	<a href="http://www.ccaa.org.uk">www.ccaa.org.uk</a>	Tel: 01905 745595 Email: <a href="mailto:info@ccaa.org.uk">info@ccaa.org.uk</a>
Choices	<a href="http://www.kidswitharthritis.org">www.kidswitharthritis.org</a>	Email: <a href="mailto:info@kidswitharthritis.org">info@kidswitharthritis.org</a>

## General Advice

During an acute flare it is important to offer reassurance and advice about remaining mobile, maintaining activity levels as well as retaining independence and optimising participation in everyday activities of daily living. Advice about play/leisure participation is beneficial as this can have an important role in distraction from pain as well as provide many psychosocial benefits. Advice about sleep hygiene, pacing and energy conservation will also enable the child/young person to manage any fatigue better.

## **B - Management following intra-articular steroid injections**

In many Paediatric Rheumatology centres, active joint inflammation is treated with an injection of steroid directly into the affected joint(s). Joint injections will in the majority of cases result in rapid resolution of synovitis in the injected joint(s) for a number of months, leading to a significant reduction in symptoms and minimising complications of ongoing active disease such as leg length discrepancy and joint contractures (Cleary et al, 2003).

Little consensus exists regarding the optimum therapy intervention post-joint injection and wide variation in individual practice exist (Cleary et al, 2003); however it is suggested that:

- i) Patients should be advised to rest injected joints for 24 hours as far as is reasonably practicable (Cleary et al, 2003; Chakravarty et al, 1994). Parents of younger ambulant children should be advised to avoid vigorous play and encourage sedentary activities, as complete rest is difficult to achieve for this age group.
- ii) All patients should receive a therapy review following joint injections to assess the effectiveness of the procedure, identify continuing physical, psychological or social difficulties and to instigate further therapy as indicated.
- iii) Patients should be given specific exercises as appropriate for joint restriction / muscle wasting to carry out following the rest period (Cleary et al, 2003). Therapists should prioritise joints of patients receiving multiple joint injections to avoid unrealistic exercise regimes. Splinting is rarely necessary to correct joint contractures due to the effectiveness of joint injections (Clearly et al, 2003).

## C - Ongoing management of well-controlled disease

As a result of recent advances in the medical management of JIA, many children and young people are now spending significant periods of time in remission. During these periods, the therapist's role is vital in optimising the patient's physical abilities, including joint mobility, muscle strength, exercise tolerance, stamina and independence in ADL. In view of the chronic nature of JIA; however, they also play an important role in providing psychosocial education and advice to optimise the patient's psychological and social functioning.

### Exercise therapy / fitness

Young people with JIA may be less physically active than their healthy peers (Henderson et al 1995, Takken et al 2003) resulting in deconditioning, decreased aerobic capacity and muscle weakness, which may then reinforce an inactive lifestyle. It has been reported that lack of fitness is not related to disease activity (Klepper et al 1992) thus other factors, such as family anxiety about the risks of exercise, must be considered.

During periods of remission, it may be necessary for patients to continue specific stretching or strengthening exercises targeting identified areas of difficulty. However, as JIA is a chronic condition and patients may be required to carry out exercises for many years during flares, consideration should be given to the practicality of and likely concordance with a formal exercise regime during periods of remission. A "therapy holiday" is often of benefit to the patient, in allowing them to pursue normal activities.

Most young people with JIA can participate in low-impact fitness programmes without any adverse effects (Klepper 1999, Takken et al 2001), with the possible exception of those with severe hip disease (Singh-Grewal et al 2006). Children and young people with JIA should therefore be encouraged to take part in active pursuits. Participation in PE and extra-curricular sports and activities can result in many benefits for patients with JIA:

- i) Enhanced cardiovascular fitness and stamina (Klepper, 1999)
- ii) Improved general muscle power (Oberg et al, 1994)
- iii) Positive interaction with peers
- iv) Increased self-esteem
- v) Management of mood through endorphin release
- vi) Prevention of osteoporosis through weight-bearing activity

*Patients with JIA taking regular corticosteroids for at least three months are particularly at risk of osteoporosis and need to be educated regarding the importance of regular weight bearing exercise, they should also be given appropriate advice about calcium intake and maximising vitamin D exposure.*

Children and young people with significant joint damage as a result of JIA may require adaptation of certain activities to enable them to participate. Patients who have experienced significant synovitis in the facet joints of the neck and/or have neck restriction should be advised against activities which could put them at risk of neck injury, e.g. trampolining, horse riding, contact sports such as rugby and forward rolls in gymnastics, unless advised otherwise by their Consultant Rheumatologist. A child with severe Polyarticular JIA might find it difficult to join in some games classes, so therapists need to be inventive and help find suitable activities to avoid sedentary lifestyles. Liaison with schools, particularly PE staff, to solve such issues is important.

## **Splinting**

Some children/young people may require splinting during periods of remission, indications include:

- i) Mechanical wrist pain secondary to joint damage significantly interfering with hand function. Provision of a wrist splint maintaining the wrist in a functional position may give symptomatic relief during exacerbating activities. Patients should be instructed to remove the splint regularly to allow range of movement exercises and to maintain muscle strength.
- ii) Subluxation of the wrist joint resulting in abnormal muscle and joint mechanics and reduced grip strength. Provision of a wrist splint to maintain the wrist in a more normal anatomical position may improve wrist and finger function. Patients should be instructed to remove the splint regularly to allow range of movement exercises and to maintain muscle strength.
- iii) Flexion contractures may benefit from night resting splints or serial casting which provides a long term stretch to improve range of movement.

## **Orthotics**

Custom foot orthotics can correct biomechanical alignment, increase the contact areas of the foot, and decrease areas of excess peak plantar pressure and pain. In addition, orthotics improves shock absorption in the joints. These therapeutic benefits may prevent loss of joint mobility, progression of deformities, abnormal joint pressures, pain and loss of functional abilities.

The following patients should be considered for Orthotics assessment:

- Symptomatic flat feet
- Calcaneovalgus
- Heel pain
- Cavus feet
- Inflammatory disease in ankle or knee joints
- Foot pain
- Abnormal gait
- Patients with previous orthoses – for review
- Leg length discrepancy – this should be monitored regularly while the child is growing (Scott, 2007)
- For a second opinion

In children with JIA, custom-made semi-rigid foot orthotics with shock absorbing posts significantly improve pain, speed of ambulation, and self-rated activity and functional ability levels compared with prefabricated off-the-shelf shoe inserts or supportive athletic shoes worn alone (Powell et al, 2005).

## **Assistive devices**

For some children/young people particularly those who have experienced long term active arthritis and a subsequent loss of independence in ADL, assistive devices should be considered as this can result in increased independence and dignity. Such devices should be considered carefully; however as for some they may not be acceptable and may

increase feelings of disability, and should never be considered as a first option if other steps can be taken to remedy the deficit.

## **Adaptations**

For those with severe and aggressive arthritis, which has resulted in damage, adaptations to the property should again be considered in order to increase safety, independence and privacy. This issue should be tackled sensitively and regularly reviewed, as adaptations may initially be unacceptable; however, during adolescence the need for increased independence may become more pressing.

## **Aquatic Therapy (Hydrotherapy)**

Aquatic therapy can be very beneficial during ongoing rehabilitation, providing cardiovascular fitness work improved stamina or muscle building and may have the added benefits of an informal peer support network for participants. For those who have access to local swimming pool or particularly enjoy water based activities, it may be useful to provide specific advice regarding exercises in water, to improve joint range of movement, maintain/improve muscle strength etc.

## **Occupational Performance**

For those in remission there may still be many difficulties with engagement in occupation. This may be as a result of many different issues including joint restriction, joint damage, pain, poor stamina as well as many other psychosocial issues. A careful assessment of these issues is important to determine the most appropriate interventions.

Interventions may include the following:

- Activities to optimise specific performance components, e.g. grip strength and participation in meaningful life roles
- Goal setting as above
- Group work to address a specific need, e.g. assertiveness, social, move to secondary school etc.
- Social/emotional, e.g. relaxation confidence building etc.
- Provision of assistive devices
- Adaptation of the environment
- Liaison with other organisations, e.g. school, connexions, employer to ensure optimum participation
- Advice regarding rights, e.g. eligibility to drive early, DDA

## **General Advice**

### **• Ongoing Disease Education**

Throughout the course of the disease it is important to offer continued information and advice on a range of topics, as needs will change over time. Disease specific information will remain important as cognitive skills develop.

### **• Fatigue Management**

Advice and support on a range of issues such as sleep hygiene, pacing and energy conservation etc. will also enable the child/young person to manage their fatigue better and increase activity and participation levels.

- **Play and Leisure Activity**

Particular advice to parent and carers regarding play and leisure participation is also recommended as it provides an important role in distraction from pain as well as psychosocial benefits.

- **Health Education**

All young people should have access to generic health education and advice appropriate to their age and understanding. This should include general health and well-being, pregnancy and sexual health, alcohol and recreational drugs.

- **Prevention of osteoporosis.**

Patients with JIA taking regular corticosteroids for at least three months should be given appropriate advice about calcium intake and maximising vitamin D exposure. They should also be informed about the importance of regular weight bearing exercise (van Staa et al, 2003).

- **Pain coping**

Pain is often underestimated by health professionals (Anthony and Shanberg, 2003). As disease activity and severity are not the only predictors of the degree of pain experienced, (Illoite et al, 1992), it is vital that a patient's degree of pain continues to be monitored during periods of disease remission.

Therapists must ensure that patients and their carers are equipped with a range of pain coping skills and strategies to enable them to manage pain more effectively during periods of remission. See section on Pain Coping during an acute disease flare.

- **Footwear**

Patients with lower limb disease should be encouraged to wear well fitting, supportive shoes with a low heel for most of the day. Trainers are ideal and an explanatory letter to school should enable permission to be given for them to be worn with school uniform. Shoes with a lace up or strap fastening must be worn with insoles in order to prevent them slipping. In order to increase adherence, patient should be allowed to wear other shoes for special occasions.

- **Disclosure**

The skill of disclosing a chronic illness has been reported to be an important issue for young people with JIA (Shaw et al 2004) and therapists can play a significant role in discussing this issue in light of the Disability Discrimination Act (1995 2005), highlighting the pros and cons of disclosure as well as equipping children/young people with the skills to do this in a concise and confident way.

- **Transitional Care**

The benefits of a coordinated transitional care programme in JIA have been shown to improve patient knowledge; satisfaction and health related quality of life (McDonagh et al 2007)

Young person centered transitional care planning addressing medical, psychosocial and educational/vocational aspects of care should ideally start for all young people with chronic rheumatic disease attending rheumatology clinics in early adolescence (11-13 years) in keeping with the NSF (2003, 2004) and as evaluated to be of positive benefit by BSPAR research (Shaw K L et al 2004, McDonagh J E et al, 2006, 2007). Services providing care for children and young people with rheumatic disease should also meet the Department of Health recommendations for transition services (2006).

Resources including transition plan templates; transition policy templates etc can be obtained from the following sites

[www.dreamteam-uk.org](http://www.dreamteam-uk.org)

<http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/ChildHealthPromotion/Transitionfromchildrenstoadultservices/index.htm>

<http://www.cypf.csip.org.uk/disability/disability/transition.html>

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