WORKING PARTY REPORT ON MINIMUM STANDARDS FOR PSYCHODERMATOLOGY SERVICES 2012

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The remit of this working party was to provide a consensus statement for the British Association of Dermatologists (BAD) on the minimum standards required to support Psychodermatology service provision in the UK. The members of the group were chosen for their specialist experience of Psychodermatology practice in an acute delivery setting.

The objective for a consensus statement is borne out of a need to improve access and support to psychological and psychiatric care for Dermatology patients. This is in line with the Government's agenda to improve psychological support for patients, particularly those suffering from long-term conditions through the 'long-term care' and 'no health without mental health' strategies.

Further service provision information and resource tools, to support BAD members in providing Psychodermatology services, will be made available on the BAD website.

Introduction

Psychodermatology refers to either the primary psychiatric diseases with which patients present to Dermatology departments (and which are best treated by Dermatologists trained in Psychodermatology) or to the psychosocial comorbidities which are experienced by a majority of patients with skin disease. Skin disease may elicit psychosocial comorbidities, and psychosocial stresses may elicit skin disease.

Patients with conditions such as delusional infestation, factitious and induced skin disease, body dysmorphic disease, trichotillomania and other primary psychiatric diseases, are best treated in Dermatology departments by Dermatologists trained in psychocutaneous medicine as these patients will usually not engage with mental health specialists in isolation. Patients with psychosocial comorbidities of skin disease are best treated by a multidisciplinary team approach.

It is increasingly recognised that there is a high prevalence of psychological distress and psychiatric disorder amongst Dermatology patients.[1,2,3] Psychological distress is frequently reported as a precipitant of, or exacerbating factor in, skin disease[4,5] and is a major determinant in the outcome of treatment.[6] Skin conditions may have a detrimental effect on most aspects of an individual's life, including relationships, work, social functioning and sporting activities.[7]

Psychological intervention alone[8] or as an adjunctive treatment[9] may improve skin disease, and there is increasing evidence for the effectiveness of evidence based psychological interventions (such as cognitive behavioural therapy, internet based therapies[10]and bibliotherapy)[11] in effecting and maintaining behaviour change in long-term conditions.[12]

The National Institute for Health and Clinical Excellence (NICE) has recognised the importance of psychological approaches and recommends that mental health professionals should be involved in the care of patients with body dysmorphic disorder[13] (who often present to Dermatology units) and skin cancer.[14] The Department of Health (DH) has recently recognized the importance of enhancing quality of life for people with long-term conditions in the NHS Service Outcomes framework.[15]

Accessing Psychodermatology services

Dedicated Psychodermatology service provision (both Psychology and Psychiatry) in the UK is scarce despite a need for such services. A national survey undertaken by the BAD in 2011[16] to assess the availability of Psychodermatology services, revealed poor provision, despite Dermatologists reporting:

- 17% of Dermatology patients need psychological support to help with psychological distress secondary to a skin condition.
- 14% of Dermatology patients have a psychological condition exacerbating their skin disease.
- 8% of Dermatology patients present with worsening psychiatric problems due to concomitant skin disorders.
- 3% of Dermatology patients have a primary psychiatric disorder.
- 85% of patients have indicated that the psychosocial aspects of their skin disease are a major component of their illness.

Furthermore, the BAD 2011 survey[16] showed deterioration in the provision of Psychodermatology services across the UK, since the last survey undertaken in 2003. This is despite clear recommendations from the 2003 report that Psychodermatology services should be expanded. Present Psychodermatology provision is dependent on a very limited number of services provided by a small number of Dermatology teams, some of whom work with Psychiatrists, Psychologists and nurse specialists to offer services and support for Dermatology patients. The exact nature of the multidisciplinary team is highly variable. There is currently only one service in which a Psychiatrist and Dermatologist see patients concurrently, and there are very few dedicated Psychologists working jointly in Dermatology clinics. This is clearly an unacceptable level of service provision for an established clinical need.

Recommendations: The formalisation of regional and national clinical networks is essential to the identification of training needs, resources and audit. To ensure future needs of Dermatology patients are met, specifically:

- All regions should have at least one dedicated Psychodermatology service with a trained specialist Psychodermatologist.
- All regions should have dedicated clinical Psychologist support.
- Departments should have access to Cognitive Behavioural Therapy (CBT), delivered by a trained individual.
- It is recommended that all Dermatology units have a **named lead Dermatologist** who has some experience and expertise in Psychodermatology. The lead Dermatologist is responsible for coordinating service provision for Dermatology patients with moderate or severe levels of distress or severe mental health issues.

  The named lead Dermatologist should have knowledge of local services including:

  - Integrated health and clinical psychology services
  - Child and Adolescent Mental Health Services (CAMHS)
  - Integrated specialist adult psychiatric services
  - Old age psychiatric services
  - Community mental health teams

Assessments for patients across a stepped model of care

The different levels of psychological distress may not always be obvious[17], however it has been increasingly demonstrated that if healthcare professionals allow clinical time, patients will be explicit about their psychiatric and psychosocial comorbidities. Many Healthcare Professionals (HCPs) are able to assess patients' psychosocial comorbidities through a standard consultation / clinical interaction. However, simple tools such as the Dermatology Life Quality Index (DLQI) [18], Skindex 29[19] and Cardiff Acne Disability Index[20] allow clinicians to identify particularly vulnerable patients and may be very helpful. For many Psychodermatology patients, routine use of these tools provides invaluable diagnostic and assessment evidence.

There are several psychometric assessment tools that can be used to detect psychiatric comorbidity, such as clinically important anxiety and depression, e.g. the Hospital Anxiety and Depression Scale (HADS)[21] are essential when assessing patients with long-term skin conditions.

Annual DLQI or Skindex 29 and HADS assessments for all patients with a long-term or disfiguring skin condition are suggested across a stepped model of care (see figure one) discussed below:

Low level distress

The majority of Dermatology patients with low-level psychological distress (DLQI 5-9, HADS anxiety or depression 5-7) can be managed by Dermatologists and allied health professional staff who have level 1 training (see training section in this paper).

Moderate level distress

Most Dermatology patients with moderate levels of distress (DLQI 10-18, HADS anxiety or depression 8-10) or patients with skin cancer can be managed locally (either within the community or hospital setting), but may need higher level support from local Psychologists or health practitioners, psychological well-being practitioners or Cognitive Behavioural Therapy (CBT) trained therapists:

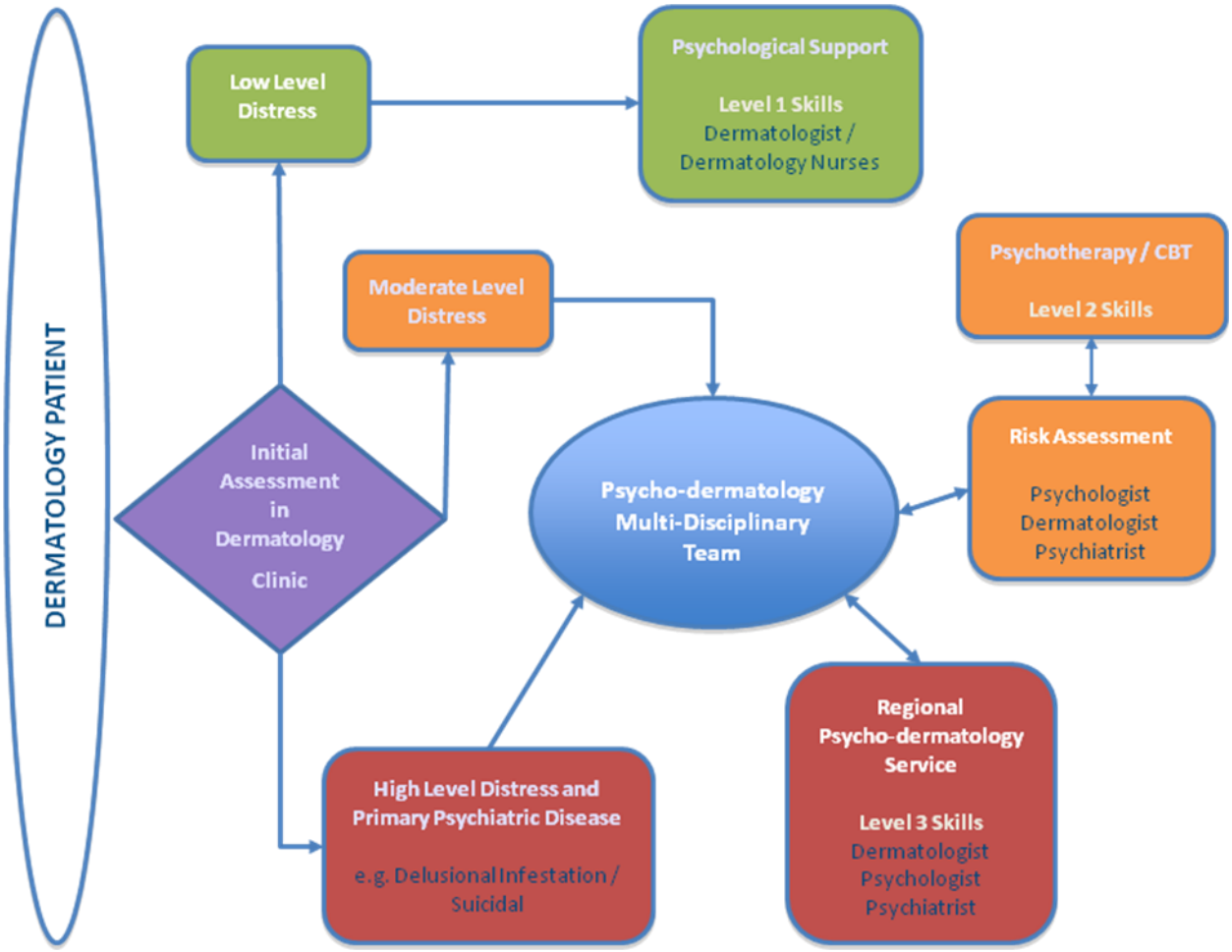
High level distress and more serious mental health issues

Patients with disfiguring and long-term skin conditions and high levels of distress (DLQI > 17, HADS anxiety or depression ≥11), complex mental health needs which cannot be addressed in a local service should be referred to a **regional service**, for specialised care.

The recognition and management of patients with serious mental health issues presenting to Dermatology, requires specific skills from clinicians with experience and expertise in this area. The costs involved in investigating and treating these patients can be great if not managed appropriately. This is especially true for patients suffering from primary psychiatric conditions such as:

- Factitious and induced illnesses
- Compulsive destructive habits
- Body dysmorphic disorder
- Delusional illnesses
- Severe depression and suicidiality
- Dermatitis artefacta

Figure 1: Stepped provision of Psychodermatology services



Skills appropriate to low, moderate and higher levels of Psychodermatological distress:

Level 1 skills are the minimum competencies required for all Dermatology staff regularly managing patients with long-term skin conditions and skin cancer, and include:

- ***Assessment:*** Impact of the skin condition on patients' wider life. This includes the use of a standardised quality of life measure such as the DLQI as well as a mood measure such as the HADS. Also identify minor mental health problems that may interfere with patients' ability to self-manage, for example poor motivation and unhelpful coping mechanisms such as over-reliance on alcohol.

- ***Problem identification:*** Ability to develop a list of the key problems, and in negotiation with the patient, a care plan that addresses the key issues in a systematic way. Where appropriate, involve other more specialist expertise (for example referral to weight management or smoking cessation support).

- ***Problem management:*** Signposting - i.e. being able to offer information and advice (where appropriate) around self-management of the psychological impact on life, for example around sleep problems, and identify more appropriate services to address specific issues.

- ***Medication management:*** To be able to inform and advise patients regarding medication self-administration, especially the need to address the necessity of and concerns about systemic and biological therapy use.

Level 2 skills: Training level appropriate for health workers managing patients with moderate levels of distress.

- ***Assessment:*** More detailed assessment of beliefs about their condition; mood and behaviour that may be problematic for self-management, for example self-medication as a means of coping; mental health assessment.

- ***Problem identification:*** More structured problem formulation and, in conjunction with the patient, development of a structured plan for addressing the main problems within an evidence-based framework (for example behaviour change using motivational approaches or low intensity CBT techniques.)

- ***Problem management:*** Development of a care plan that addresses psychological problems in an integrated way, with Dermatology care that is both specific and tailored to the patient. This will require some training in recognised techniques including CBT and may address issues such as mood management, stress management or lifestyle intervention, e.g. smoking cessation, weight loss, and alcohol reduction.

Level 3 Skills: A level of training suitable for health workers managing patients with severe distress and mental health issues in regional Psychodermatology services.

- ***Assessment:*** In-depth assessment of the full range of areas contained within a mental health assessment.

- ***Problem identification:*** In-depth problem formulation and, in conjunction with the patient development of a structured plan for addressing the main problems within an evidence based framework, for example using high intensity CBT techniques or similar specialist techniques.

- ***Problem management:*** Development of a care plan that addresses psychological problems in an integrated way with Dermatology care that is both specific and tailored to the patient. This will require advanced training in recognised techniques including CBT, relationship counselling or interpersonal therapy and may address issues such as mood management, stress-management or lifestyle intervention, e.g. smoking cessation, weight loss and alcohol reduction. In addition, this may include management of more specific mental health

problems such as psychosis management, factitious and induced illnesses, compulsive destructive habits, body dysmorphic disorder, delusional illnesses, severe depression and suicidiality related to the skin condition or dermatitis artifacta.

Developing a regional Psychodermatology service

Psychodermatology services within the UK are scarce. There are differing **models of Psychodermatology services**, which are used currently:

- A dedicated Psychodermatology clinic run by a Dermatologist with experience and expertise in Psychodermatology, where patients are referred on to a Psychiatrist or clinical Psychologist as appropriate.
- A joint clinic run by a Dermatologist with experience and expertise in Psychodermatology and a Psychiatrist or clinical Psychologist where both specialists see patients concurrently.
- A dedicated Psychology service for Dermatology patients run within the Dermatology clinic area in parallel with other Dermatology services.

Recommendations for setting up a Psychodermatology service:

1. **Financial Investment:** It is important to outline costs using Psychiatry or Psychology tariffs rather than Dermatology outpatient tariffs if appropriate. A trust will expect a business case outlining the requirements of the service, especially for joint clinics where patients are seen concurrently by more than one clinician.
2. **The team:** Psycho-dermatology is a multidisciplinary sub-speciality; building relationships with nursing staff, Psychiatrists, and Psychologists will be important. Establishing a team ethos that is able to respond to local and wider enquiries for establishing local services is essential. Units should have experienced Consultant Dermatologists with the relevant expertise.
3. **Clinic templates:** Consultations are often lengthy and appointments should be at least 45 minutes for new patients and 30 minutes for follow-up patients. A multidisciplinary approach is useful in selected cases with liaison between Dermatologists, Psychiatrists, Psychologists, nurses, primary care staff and sometimes social workers.
4. **Separate dedicated time** to liaise with other health care providers, especially primary care and community Psychiatric services, and to coordinate care is important.
5. **Facilities:** Counselling and consultation rooms are ideally situated within the Dermatology unit and in a quiet, undisturbed area suitable for psychological interventions. For joint clinics, the consulting room will need to be of an appropriate size to accommodate two clinicians, the patient and a carer.

Governance requirements

Clinical governance should be embedded in the clinical practice of all services in order to standardise and constantly improve clinical effectiveness.

At present there are no national standards for Psychodermatology. Until these are agreed, the following typical clinical governance framework for a local and regional service is suggested:

Recommendations

The **named Psychodermatology lead clinician** should take responsibility for ensuring the service is safe and effective and complies with:

- National service delivery standards
- Treatment specific guidelines (where available)
- Disease specific guidelines (where available)

Regular **clinical governance meetings** should be held (ideally 4 times a year) and should include the following elements for the Psychodermatology service:

- **Review of activity:** Numbers of patients going through the service, diagnoses, treatments and Does Not Attend (DNA's).

- **Review of outcomes:** Outcome data from screening questionnaires such as DLQI and HADS should be reviewed.

- **Review of waiting list data:** To assess demands on the service and issues for service delivery.

- **Review of incidents and complaints:** Services should have procedures in place to minimise risk to both service users and staff. Incidents and near-misses should be discussed, investigated and the root causes analysed.

- **Audit**: The Psychodermatology team should audit elements of the service, at least annually, and present to the local Dermatology team. Audit outcomes should be used to evaluate care pathways, monitor the quality of clinical activity and make changes as necessary to optimise care.

- **Patient experience & outcomes:** Psychodermatology services should gather patient-recorded experience measures (PREMs) and patient recorded outcome measures (PROMs). The results should be shared and any service actions agreed and taken forward. The BAD are presently working on Dermatology specific PROMs.

- **Staff training:** There is a need for on-going training of team members to support service development areas and maintain good clinical practice of the individual. Training undertaken, wherever possible, should be accredited by an approved organisation. Training and Clinical Professional Development (CPD) should be discussed and planned to ensure all team members fulfil professional requirements to be fully up-to-date with appropriate CPD compliance.

Training and education in Psychodermatology (psychocutaneous medicine)

The formalisation of regional and national cross-discipline clinical networks is essential to the identification of training needs, resources and audit.

There are dedicated Psychodermatology training courses available via Barts Health NHS Trust, the British Dermatological Nursing Group (BDNG), the European Society for Dermatology and Psychiatry (ESDaP), and the University of Hertfordshire. Dermatology and Psychological educational courses with basic Psychological training are available on the BAD and other websites.

Recommendations:

- All Dermatologists and Allied Health Professionals such as biologics nurses, Phototherapists and drug monitoring nurses who regularly manage patients with long-term conditions, should have received training to level one skills.

- Dermatologists practicing in Psychodermatology must have undertaken specific training in Psychodermatology via recognised courses.
- Development of training courses in Psychodermatology for all HCPs (nursing staff, Psychologists, etc).
- Ongoing training should include skills to support patients with long-term and disfiguring skin disease.
- All HCPs in Psychodermatology to observe appropriate ongoing training, CPD and clinical governance.

Summary of recommendations

In summary, these minimum standards for Psychodermatology have been written with the intention of highlighting the psychological impact of skin conditions, and expanding access to services, in order to improve the psychological health and wellbeing of Dermatology patients. It also aims to increase access to specialist Psychodermatology services for the management of patients with primary psychiatric conditions such as delusional infestation. The need for accredited training of relevant healthcare providers is highlighted. In particular, the working party expects that these standards will help inform Commissioners of the requirements and service standards for providing Psychodermatology services in the UK. These recommendations are based on the knowledge and expertise of this multi-disciplinary group. The need for a formal, evidence-based clinical governance guideline document to cover Psychodermatology is acknowledged by the working party.

References

1. *Kurd SK, Troxel AB, Crits-Christoph P, Gelfand JM. Arch Dermatol. The risk of depression, anxiety, and suicidality in patients with psoriasis: a population-based cohort study. 2010 Aug; 146(8):891-5*
2. *Sampogna F et al Acta Derm Venereol. Living with psoriasis: prevalence of shame, anger, worry, and problems in daily activities and social life. 2012 Jun 8;92(3):299-303.*
3. *Picardi A, Porcelli P, Mazzotti E, Fassone G, Lega I, Ramieri L, et al. Alexithymia and global psychosocial functioning: a study on patients with skin disease. J Psychosom Res. 2007;62:223–229.*
4. *Papadopoulos L, Bor R, Legg C, Hawk JL. Impact of life events on the onset of vitiligo in adults: preliminary evidence for a psychological dimension in aetiology. Clin Exp Dermatol. 1998; 23:243-248.*
5. *Schmid-Ott G, Jaeger B, Boehm T, Langer K, Stephan M, Raap U, et al. Immunological effects of stress in psoriasis. Br J Dermatol 2009*
6. *Fortune DG, Richards HL, Kirby B et al. Psychological distress impairs clearance of psoriasis in patients treated with photochemotherapy. Arch Dermatol. 2003; 139:752-756.*
7. *Kimball AB, Gieler U, Linder D, et al. Psoriasis: is the impairment to a patient's life cumulative? J Eur Acad Dermatol Venereol 2010.*
8. *Papadopoulos L, Bor R, and Legg C. Coping with the Disfiguring Effects of Vitiligo: A Preliminary Investigation Into the Effects of Cognitive-Behavioural Therapy. Br J Med Psychol. 1999;72:385-396*
9. *Fortune D G, Richards H L, Griffiths C E, Main C J. Psychological stress, distress and disability in patients with psoriasis: consensus and variation in the contribution of illness perceptions, coping and alexithymia. Br J Clin Psychol 2002; 41 (Pt2): 157-74.*
10. *Sunderland M, Wong N, Andrews G, Rossouw PJ, Hilvert-Bruce Z.: Adherence as a determinant of effectiveness of internet cognitive behavioural therapy for anxiety and depressive disorders. Behav Res Ther 2012*
11. *Naylor EV, Antonuccio DO, Litt M, Johnson GE, Spogen DR, Williams R, McCarthy C, Lu M, Fiore DC, Higgins DL: Bibliotherapy as a treatment for depression in primary care. J Clin Psychol Med Settings 2010*
12. *Lavda A, Webb T, Thompson A: A meta-analysis of the effectiveness of psychological interventions for adults with skin conditions. Br J Dermatol.2012*
13. *National Institute for Health and Clinical Excellence (Nov 2005) CG31 Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD)*

14. *National Institute for Health and Clinical Excellence (May 2010) Improving Outcomes for People with Skin Tumours including Melanoma*
15. *Department of Health (Dec 2010) NHS Outcomes Framework 2012-13 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944*
16. *British Association of Dermatologists: National Survey on Psychodermatology services http://www.bad.org.uk//site/1464/default.aspx*
17. *Richards H.L, Fortune D.G, Weidmann A, Sweeney S.K.T, Griffiths C.E.M (2004), Detection of psychological distress in patients with psoriasis: low consensus between Dermatologist and patient, British Journal of Dermatology; 151: 1227-1233.*
18. *Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI)-a simple practical measure for routine clinical use. Clin Exp Dermatol 1994; 19(3):210-6.*
19. *Chren MM, Lasek RJ,Quinn LM, Mostow EN, Zyzanski SJ (1996) Skindex, a quality-of-life measure for patients with skin disease: reliability, validity, and responsiveness. J Invest Dermatol.*
20. *Motley RJ, Finlay AY. Practical use of a disability index in the routine management of acne. Clin Exp Dermatol. 1992 Jan; 17(1): 1-3.*
21. *Zigmond AS, Snaith RP: The Hospital Anxiety and Depression Scale (HADS). Acta Psychiatr Scand 1983, 67(6): 361-370.*
22. *The British Association for Behavioural and Cognitive Psychotherapies: The complete register of accredited BABCP CBT and AREBT therapists in the UK and Ireland. http://www.cbtregisteruk.com/Default.aspx*