

HOW TO SET UP A PSYCHO-DERMATOLOGY CLINIC

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Abstract

Background: Psycho-dermatology is a recognized sub-specialty, however lack of awareness among dermatologists and limitation of resources make the management of these patients challenging. Colleagues are often unsure about the practicalities of setting up a psycho-dermatology service, there is confusion about which model is best suited to which service, and about the development of a psycho-dermatology multidisciplinary team.

Objective: To identify the necessary steps in setting up a psycho-dermatology clinic based on the experience from a UK-based psycho-dermatology unit and the recently published standards by the UK Psycho-dermatology Working Party.

Results: The type of service provision will depend on the type of patients seen in the unit. The core team will be composed of a psycho-dermatologist and a psychologist. Access to a psychiatrist is essential if patients present with primary psychiatric conditions or primary cutaneous conditions with suicidal or other psychiatric risks. Adequate training of the health-care staff is advised. The premises and time allocation should be adequate and this translates into higher tariffs. Using business care tariffs for people with mental health conditions might be more appropriate as the consultations are longer and involve more members of staff; however, overall cost remains lower than if these patients were seen in a general dermatology service or in the community.

Conclusion: Psycho-dermatology services are globally limited, and yet the demand for psycho-dermatology care is high. There is evidence that dedicated psycho-dermatology services are cost-effective. Health care professionals need to be aware of the steps necessary to establish and maintain psycho-dermatology services.

Introduction

Psycho-dermatology is a discipline, which is gaining recognition and relevance among the dermatological sub-specialties. The concept itself is not new, however the lack of awareness among dermatologists and lack of standard guidelines make the care of these patients challenging and can result in inefficient use of resources.

Patients seen in a psycho-dermatology unit can present with several skin problems. [1] Long-term cutaneous diseases exacerbated by stress or anxiety, like eczema and psoriasis, are extremely common in any dermatological service. Reducing levels of stress can improve treatment outcome. It is also common to see patients with primary skin conditions that lead to cosmetic disfigurement like alopecia areata, vitiligo or acne, and therefore carry an important psychological burden. Less frequently, patients can present with primary mental health disorders that cause secondary skin problems. The European Society for dermatology and psychiatry (ESDaP) has recently developed a classification for patients with self-inflicted lesions in dermatology. [2] Patients with primary psychiatric diseases such as delusional infestation and body dysmorphic disease find it difficult to engage with psychiatric services and hence, are suited to a psycho-cutaneous medicine unit. [3]

The Department of Health (DoH) in the UK has recently published a statement, highlighting the importance of enhancing the quality of life in patients with chronic diseases. [4] This is further supported by the All Party Parliamentary Group on Skin (APPGS) report, which highlights the lack of dedicated services to manage the psychological needs of people with skin disease. The report recommends changes to dermatology services to include improved education in the field of psycho-dermatology and also integrating or providing access to psychological support services. Psycho-dermatology clinics can provide a stepping-stone for this support to be given, and can integrate with community services to ensure this is continued.

The UK Psycho-dermatology Working Party is a group of UK health-care professionals with a special interest in psycho-dermatology. A survey carried

out in 2011 by the British Association of Dermatologists (BAD) [5] showed that the number of psycho-dermatology units has dramatically decreased in the last few years despite previous recommendations from the BAD survey in 2003 which showed an increasing demand of these services.

Until now, there were no standard national service delivery guidelines; however, the UK Working Party has recently published the minimum standards of provision for psycho-dermatology services. [6] This includes regional recommendations, as a named lead dermatologist with an interest in psycho-dermatology for each unit, clinical psychologist support or cognitive behavioral therapy (CBT) access for patients.

The aim of this report is to provide guidance about how to set up a psycho-dermatology unit, based on a UK-based psycho-dermatology unit, in order to improve the management of these patients and maximize the available resources.

The psycho-dermatology unit

The referral

All dermatologists should use standard scales such as the Dermatology Life Quality Index (DLQI) [7] and or Hospital Anxiety and Depression Scale (HADS) [8] in order to assess and identify patients who would benefit from psychological support. Healthcare staff involved in the management of patients with low levels of distress (DLQI <10, HADS 5-7) should be able to make an holistic assessment which includes identifying the key problems, assessing the impact of the skin condition and identify other minor mental health issues (e.g. alcoholism). Patients with moderate levels of distress (DLQI 10-20 and/or HADS 8-10) may require a higher level of support from local psychologists and healthcare practitioners. The staff involved should be able to make a more detailed assessment of the mental health status and make a tailored plan for the patient, which might involve other techniques such as CBT and lifestyle intervention. For patients with high levels of distress (DLQI>20 and/or HADS>10) or complex mental health problems that cannot be addressed by local services, referral to a regional unit is advised. These

patients require an in-depth assessment, a structured plan and access to professionals with advanced training in recognized therapies such as CBT, relationship counseling or schema-focused therapy. [9]

The team

Patients with psycho-cutaneous diseases are best managed by a multidisciplinary team consisting of dermatologists (for diagnosis and exclusion of organic disease), psychiatrists (for management of concomitant psychiatric disease), psychologists (to facilitate appropriate psychological therapy), specialist nurses, primary care physicians and allied health professionals (Figure 1). This allows a holistic assessment of the patient and focussed management.

The basic requirements of the service are:

1. A consultant dermatologist with a specialist interest in psycho-dermatology (the 'lead clinician')
2. A consultant psychiatrist
3. A clinical psychologist with an interest in dermatological disease

The lead psycho-dermatologist should be aware of regional and local community mental health services, such as integrated health and clinical psychology services or the Children and Adolescent Mental Health Services (CAMHS).

The role of dermatology nurses is also essential and there is increasing evidence that nurses are able to successfully deliver basic cognitive behavioral therapy (CBT) to psycho-dermatology patients. [10] Community healthcare professionals including general practitioners (GPs) and district nurses should be involved in management of patients at an early stage, as they are usually the first point of contact and will play a pivotal role in long-term care. Ongoing training for the multidisciplinary team should be sought as part of continuous professional development (CPD).

The consultation

The requirements of each psycho-dermatology unit will depend on the type of patients seen. There are 3 existing models for the consultation: a dermatologist as the only physician directly involved in the patient's care, the dermatologist and psychiatrist working together in same room or the dermatologist and psychiatrist working in conjunction, but in different rooms. The advantages and disadvantages of these three models are summarized in Table 1.

In the units that only manage patients with cutaneous conditions exacerbated by stress or where the primary skin condition has a high psychological burden, the role of the psychologist is essential and should work in close contact with the psycho-dermatologist, preferably in a separate room as the type of treatment or counseling has other specific requirements. However, in the units that manage patients with primary psychiatric conditions with secondary cutaneous involvement or cutaneous diseases with secondary psychiatric diseases, the presence of a psychiatrist within the primary consultation is recommended.

Joint consultations allow optimization of resources. The authors' personal experience is that a model involving both the dermatologist and psychiatrist in the same room, with an appropriate introduction to the patient about the purpose of both health professionals, leads to better treatment outcomes. [11]

There are currently 7 psycho-dermatology units in the UK. A few have access to a dedicated psychologist, however only one has the regular support of a psychiatrist with expertise in cutaneous diseases.

The clinics

Counselling and consultation rooms should be located within the dermatology department where possible, in a quiet area suitable for psychological interventions. For joint clinics, the consultation room will need to be able to accommodate up to 2 clinicians, the patient and a carer.

The time allocated should be 45 minutes for new patients and 30 minutes for follow-up appointments. The support of relatives and friends is usually beneficial but can sometimes be counterproductive, so initially, it might be worth seeing the patients alone, if possible.

The lack of psycho-dermatology clinics currently makes cost analyses difficult, as there are few effective comparators. Evidence suggests however, that patients with psycho-cutaneous disease use large amounts of NHS resources (largely due to extensive and often unnecessary investigations, specialist referrals, doctor-shopping etc.). Thus, there are positive indicators of financial viability of psycho-dermatology services.

In a psycho-dermatology unit, it is more appropriate to use psychiatry business case tariffs rather than dermatology tariffs, as the consultations are longer than general dermatology consultations. Additionally, patients with primary psycho-cutaneous disease normally require multiple consultations involving several physicians and numerous investigations before they are referred to a psycho-dermatology unit. A recent study calculated the cost of managing patients with dermatitis artefacta with nationally agreed tariffs. In a psycho-dermatology unit, the cost per patient was £1210 per annum, compared to £8063 per patient in a general dermatology clinic or community services. This difference was statistically significant. [12] Highlighting the overall reduced cost is an important aspect to mention when negotiating the tariffs with Clinical Commissioning Groups (CCG).

The main reason for cost-effectiveness of psycho-dermatology specialist clinics is the access the service provides to a number of specialists and the holistic approach to treatment. Unnecessary investigations and referrals are avoided and the patient is managed in one clinical setting. Currently, in the majority of cases, dermatology patients requiring specialist care are referred to outside services. Patients often have negative perceptions of these services, resulting in non-attendance, or rebuttal of referral. The multidisciplinary service provided by an in-house psycho-dermatology clinic would create rapport, enable integration of care, and promote the link between skin and the psyche. [13]

Management and treatment

The physician-patient relationship in psycho-cutaneous medicine is of uttermost importance [14]. Time is spent establishing rapport and trust, and often this will require more than one consultation. The management of patients with psycho-cutaneous disease can be difficult, not only because of the stigma attached to psychological or psychiatric therapy, but also because of complex patient needs. Previous studies have shown that around 60% of patients attending psycho-dermatology services are compliant to treatment and follow-up. [15] An empathic, non-judgmental and supportive approach is the mainstay of any psycho-dermatology consultation. The aim is to provide a holistic assessment of the patients' needs with a particular focus on the psychological and social aspects to enable improved treatment outcomes. Often detailed information needs to be given to the patient regarding the rationale of treatment plans. This is a time-consuming process, and in these situations, collaboration between the dermatologist and the psychiatrist is essential.

The psychologist's role in management of patients seen by psycho-dermatology services is to deliver tailored psychological therapy (e.g. habit reversal, CBT). This can help patients cope with their dermatological disease and secondary psychiatric/psychological problems as well as identify deep seated psychological issues that are outside of the scope of the combined consultation.

Clinical governance

Due to a lack of national guidelines, it is important to review the effectiveness of psycho-dermatology units on a regular basis. It has been suggested that annual audits and quarterly meetings to review activity and outcomes (including patient-reported outcomes) would help to improve and standardize these services [6]. Of particular value will be the review of waiting list data to assess service demand. Risk analysis should also be undertaken and standard procedures instituted to protect staff and patients. The lead clinician will be responsible for the development of the service, its associated protocols and governance points. The lead clinician will be supported by other

consultants with a special interest in psycho-dermatology, health professionals including clinical psychologists and specialist nurses. The workforce will be subject to the usual appraisal system, continued professional development assessments and regular monitoring of training needs.

Research

A research need in psycho-dermatology has been identified. Specialist clinics provide a base for such research to be conducted. New research opportunities have arisen as the sub-specialty has started to draw more attention. The focus is on improving the overall management and treatment of patients with psycho-cutaneous disease, as well as establishing national guidelines.

Discussion

Psycho-dermatology is a discipline that in the last few years has become more popular as a result of the high prevalence of patients with chronic cutaneous conditions that impair their quality of life and an increase of psychiatric patients with skin involvement attending general dermatology clinics. It is well established that the so-called brain-skin axis is responsible for the close relationship between skin involvement in psychiatric disorders and vice versa [16] and that acute inflammation is up regulated by emotional stress. [17], [18]

A number of psycho-dermatology units have recently been established due to an increasing demand of patients who require these services; however, the overall number of units remains low. Previous obstacles to adequate psycho-dermatology provision included lack of funding and interest, long consultation times, and poor training. (Riaz poster BAD 2004?)

Setting up a psycho-dermatology unit requires trained healthcare staff, in addition to a dedicated psycho-dermatologist, psychiatrist and experienced psychotherapist. The number of psycho-dermatologists is increasing but there is still a lack of confidence among dermatologists in managing these patients

in isolation from other specialist colleagues, [13] and the same problem applies to psychiatrists dealing with psycho-cutaneous disorders. [19]

In spite of psycho-dermatology being part of the trainees' curriculum, exposure during training is scarce. There are available courses provided in the UK and Europe, which provide an insight into this subspecialty, and it is possible to arrange rotations in dedicated units. By increasing exposure to psycho-dermatology the likelihood of trainees choosing this as a subspecialty in the future rises. Increasing the number of units also provides training opportunities for interested clinicians and healthcare professionals

It is also important to bear in mind the different healthcare funding systems across European countries. Countries like UK or Spain where healthcare is provided and financed by the Government through tax payments (Beveridge model) provide health care for all but at risk of reducing the quality of care. This will differ from countries like France or Germany where their healthcare is provided by an insurance system which is financed jointly by employers and employees through payroll deduction (Von Bismark model) that may imply a higher quality of service but cannot ensure the same care for all the population. [20]

In addition to setting an appropriate room to allocate the patient and the staff involved in the care, it is also important to reserve an appropriate time per consultation. The UK Working Party recommends up to 45 minutes for a follow-up consultation, but previous studies have suggested that the adequate time could be up to 1 or 2 hours per patient. [15]

It is also important to remember that the demography of these pathologies is diverse and consultations need to be prepared adequately in advance. Issues to consider are the age of the patient, cultural norms, stigma of attending a service with a dedicated psychological component, and the possibility of commencement of psychotropic medication.

Improving awareness among the dermatology community and reaching a consensus on how to set up dedicated units might help to increase the number of psycho-dermatology units. Introducing psycho-dermatology clinics

regionally will result in improved care for patients with psycho-cutaneous disease and also support clinicians with improved access to specialist services. This will in turn prove financially sustainable as patients are seen by the correct services in a timely fashion. For those clinicians and health professionals that have an interest in psycho-dermatology, such services will allow them to pursue their interests in a more formal role, improving their job satisfaction and meeting training needs.

What's already known about this topic?

- The number of psycho-dermatology units in the UK is scarce in spite of the fact that the demand has increased in recent years.
- There is confusion on how to set-up a psycho-dermatology unit.

What does this study add?

- Basic structure of psycho-dermatology units according to type of patients seen.
- Psychiatric business tariffs should be used, but these units are more cost-efficient than general dermatology clinics when managing patients with psycho-dermatological conditions.

Figure 1. The multidisciplinary team

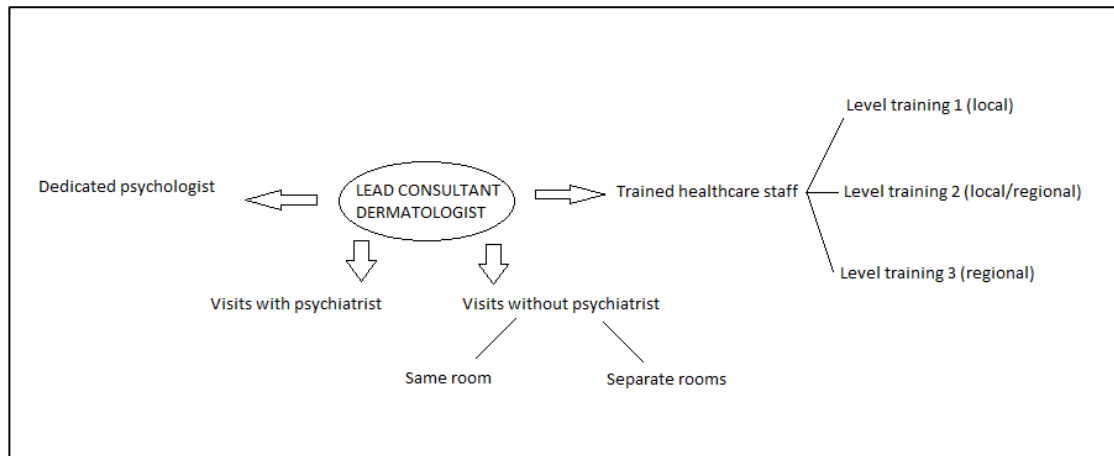


Table 1. Advantages and disadvantages of the three provision models

	Positive aspects	Negative aspects
Dermatologist alone	- Patient might feel less intimidated with only one physician	- Not adequate for patients with primary psychiatric problems
Dermatologist and psychiatrist in same room	- Shorter time per consultation than if psychiatrist in separate room - Patients may be more likely to engage with psychiatrists as they feel their skin problems are being addressed by the ~dermatologist - Reduced overall costs	- Some patients might be reluctant to see psychiatrists
Dermatologist and psychiatrist in different rooms	- Adequate for patients with primary psychiatric conditions reluctant to see a psychiatrist	- Patient will require two separate appointments

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