Improving the provision of multidisciplinary care for patients with psychodermatological problems: a trainee led pilot

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◆Background◆

Psychodermatology refers to the specialist assessment and treatment of the psychosocial co-morbidities experienced by people with skin disease, in addition to primary psychiatric disorders where the patient presents to the dermatology clinic.[1] The British Association of Dermatologists (BAD) Working Party report (2012) noted that **85%** of dermatology patients reported the psychosocial impact of their skin disease to be significant and **12.7%** had experience suicidal ideation (compared to 8% in controls).[2] A recent national review of psychodermatology services in the UK identified that service provision is improving but remains poor.[3]

It has been noted in the All Party Parliamentary Group on Skin (APPGS) 2020 report that multidisciplinary psychodermatology clinics offer significant cost effectiveness as compared to managing these patients within general healthcare settings.[4] The Royal College of Psychiatrists Faculty of Liaison report (2013) suggests that mental health problems occur in **30-60% of hospital outpatients**. The extra cost of physical healthcare in general hospitals associated with co-morbid mental health problems is approximately **15% of annual total expenditure.**[5] It suggests that certain cohorts of patients justify sub-teams and focused developments, especially in larger trusts such as University Hospitals Bristol and Weston (UHBW) trust.

◆Aims◆

UHBW trust has provided a supra-regional psychodermatology service since 2016, with one dermatologist providing 0.75 programmed activities (PA) per week. We propose that this service requires development and investment.

Our aim was to conduct a pilot of liaison psychiatry input to the UHBW psychodermatology clinic. We intended to review the care of patients seen in the clinic to establish whether a cost saving could be made, in addition to reviewing the complexities and treatment requirements of this patient cohort

◆Methodology◆

The pilot was conducted from April 2021 – April 2021. Twenty five patients referred to the psychodermatology service were screened and/or assessed by the dermatologist referred to a higher trainee in psychiatry completing an endorsement in liaison psychiatry. This was done via a regular multidisciplinary meeting. A pamphlet was created to advertise the pilot and service and referral pathway. The patients were assessed by the psychiatrist in the dermatology department, during allocated special interest session (as part of advanced training) and then followed up as necessary, sometimes jointly by both the psychiatrist and dermatologist.

A cost analysis of pre- and post-clinic costs for ten typical patients who attended the clinic was conducted – we endeavoured to include costs for appointments in primary and secondary care across specialities in addition to investigations, using local and national tariffs as required.

Figure 1: pilot clinic pathway

◆Cost analysis◆

Figure 2	Patient A	Patient B	Patient C	Patient D
Diagnosis	Severe eczema and PMDD	Eczema and BPAD	Delusional infestation	Dermatitis artifacta
Cost before	£1238	£9805	£634	£950
Cost after	£262	£942	£330	£350
Cost saving	**£976**	**£8863**	**£304**	**£600**

Figure 2: cost analysis for four psychodermatology patients

◆Results◆

The pilot has identified a significant need for psychiatric input for psychodermatology patients. All patients , except one, met the criteria for a mental disorder including depressive disorder (30%), anxiety disorders including generalized anxiety, social anxiety and OCD (32%), body dysmorphic disorder (16%), PTSD (12%), delusional infestation (12%) and unexplained medical symptoms (8%). Mean rating scale scores (using GAD7 and PHQ9) suggested **moderate to severe disease burden** in these patients. 88% of patients required treatment with psychiatric medication

Several patients had co-morbid diagnoses such as autism spectrum disorder and personality disorders, which increased the complexity of their presentation.

Of note, **40%** of these patients were deemed too complex for (or had already completed) psychological interventions in primary care (IAPT) but did not meet the threshold for secondary care (usually due to risk assessment). Therefore, the addition of a psychiatrist to this clinic is an opportunity to provide psychiatric input for a group of complex patients with significant psychosocial morbidity who sit in a 'grey area' between primary and secondary care and struggle to access appropriate mental health care.

'I have been seen in multiple different clinics in Bath and Bristol over the years and this was the first time I got to speak to someone about the mental health aspect of it, it's always been talked about as 'how are going to treat the immediate physical problem'. It is something visible and was good to speak to speak about how to learn to live with it'.

Figure 3: example of patient feedback

◆Conclusion◆

The results of this pilot clinic mirror the reports from established psychodermatology services in the UK.[6] Psychodermatology services improve the quality of care for this patient cohort, enable cost saving for the regional health economy and can reduce dermatology consultant workload, freeing up sessions for other activities/targets.

As a result of this pilot we have produced and presented a business case to UHBW trust with the recommendation that the addition of a funded consultant psychiatrist (at least 0.5 PAs) to this clinic would improve the quality of patient care and allow for their skin disease and mental health to be considered holistically.

◆REFERENCES◆

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