Original Article

sb&h

Scars, Burns & Healing
Volume 9: 1–7
DOI: 10.1177/20595131221141083

journals.sagepub.com/home/sbh
SAGE

An evaluation of clinical psychology input into burns multidisciplinary follow-up clinics

Melissa Potter[1], David Aaron[1], Rachel Mumford[1] and Lucy Ward[1]

Abstract

Introduction: Research highlights the complex psychological needs that patients and their families can face following a burn injury, regardless of the objective severity of the injury and often beyond the timeframe of physical healing. Identification of psychological needs at different stages post-burn recovery is therefore a key role of clinical psychologists working in burn care services.

Method: This paper presents audit data collected across a two-year period in routine paediatric and adult multidisciplinary team follow-up clinics in a UK burns service. 808 clinical contacts (331 adults, 477 paediatrics) were recorded. Data gathered related to the identification of patient and/or family psychological need and the level of psychology input within clinic.

Results: For 43% of adult patients and 46% of paediatric patients seen in clinic, some degree of psychological need for the patient and/or family was identified during the consultation. A large majority of concerns related directly to the burn injury. This is consistent with previous research into the psychological impact of burns. Even for patients with no identified psychological needs, psychology presence enabled the opportunity for brief screening, preventative advice or signposting to take place during clinic.

Discussion: A substantial number of individuals and families presented with some level of psychological concern in relation to a burn injury when attending burns multidisciplinary team follow-up clinics.

Conclusion: A substantial number of patients and families presented with psychological needs in relation to a burn injury when attending burns MDT follow-up clinics. The presence of Clinical Psychologists at burns MDT follow-up clinics is beneficial for the identification of burns and non-burns related psychological concerns and is a valuable use of psychological resources within a burns service.

Keywords

Burn care, psychology, MDT, scar clinic, clinical psychology, audit

[1]Department of Clinical Health Psychology, Mid Yorkshire Hospitals NHS Trust, Wakefield, Yorkshire, UK

Corresponding author:
Melissa Potter, Department of Clinical Health Psychology, Mid Yorkshire Hospitals NHS Trust, Aberford Road, Wakefield WF1 4DG, Yorkshire, UK.
Email: melissa.potter2@nhs.net

Lay Summary

The Regional Burns Centre holds regular outpatient scar clinics to monitor recovery and healing. As well as the medical professionals, the clinics are joined by Clinical Psychologists who can assess, refer, and support individuals struggling with their burn or scarring on a mental level. Over 15 months, data was collected about patients attending the clinics and the involvement of the psychologists. 43% of adult patients and 46% of paediatric patients were identified as having some psychological need, either related to their burn or to other aspects of their life. This demonstrates the benefits of having psychology presence within scar clinics, as nearly half of the patients seen in clinic received an assessment and further support (such as signposting and referrals to psychological support). Burns staff also felt that psychology presence enhanced conversations and increased collaboration with decision making around treatment.

Introduction

Sustaining a burn injury can be a traumatic experience and have a detrimental impact on an individual's physical and psychological well-being, and quality of life.[1] Common psychosocial difficulties for patients and their families following a burn injury include anxiety, depression, grief, post-traumatic stress disorder (PTSD), pain, drug and alcohol abuse, appearance-related and adjustment difficulties and difficulties with sexuality and relationships.[2] Children and young people may also experience different or additional difficulties relating to school performance/attendance and behavioural problems,[2] whereas families often report vicarious suffering, difficulties with financial support and sibling adjustment difficulties.[3] Research highlights that psychosocial difficulties can present regardless of the objective severity of the injury, time spent in hospital or demographic factors.[4]

Early psychosocial screening can identify patients who may be vulnerable to psychological difficulties post-injury and in need of proactive or preventative psychosocial intervention.[5] National Burn Care Standards (NBCS)[6] identify that all patients and/or families should be screened as soon as clinically appropriate and prior to discharge. Research has demonstrated the value of implementing psychosocial screening at multiple stages of a patient's burn care treatment, often through the use of repeated measures.[7] There is also an acknowledgement that psychological difficulties may fluctuate post-injury and be sensitive to different screening methods.[8] Therefore, psychosocial screening as part of burn care follow-up is important to identify those who may need further psychological assessment, resources and input.[7]

NBCS[6] indicate that where there are psychosocial concerns, the level and type of psychological intervention required should be identified and appropriate evidence-based treatment offered. This approach has predominantly been researched in inpatient settings.[8] Wisely et al.[4] outlined their approach across three levels of psychosocial input:

- Level 1: general support and listening skills
- Level 2: normalising symptoms, discussing anxiety and pain management strategies
- Level 3: assessment of risk, formulation and indirect working with teams

Research exploring psychosocial screening and input during the outpatient post-injury phase is limited, despite evidence suggesting high levels of psychosocial difficulties at the point of discharge from hospital,[9] as well as at 12–24-month post-injury follow-up.[10] NBCS[6] also place emphasis on psychosocial screening throughout rehabilitation stages.

NBCS[6] for adult and paediatric burn care highlight that burn care services should provide an integrated multidisciplinary team (MDT) follow-up pathway that can facilitate the delivery of specialised burn care and advice to patients and their families; this should include wound management, scar therapies, social and functional rehabilitation and psychological care. Burns MDT follow-up clinics are a feature of many burns units and centres across the UK and may comprise the following burns care professionals: surgeons, nurses, occupational therapists, physiotherapists and, in some services, clinical psychologists. Appointments may be offered at regular intervals or annual follow-up, until no further treatment is considered. Patients can also be re-referred into burns MDT follow-up clinics years after their burn injury for consideration of further treatment. Clinical psychologists can offer different levels of input into a multi-disciplinary setting. Psychologists are central to the assessment of psychosocial difficulties that can develop for individuals and families

sustaining a burn injury, therefore allowing psychological care to be preventative, as well as reactive.[4] Research suggests that specialist burn care services need to respond to a breadth of psychological difficulties and require a tiered model of psychological care.[4] Psychological interventions within a burns MDT follow-up clinic exist on a continuum, from indirect interventions (such as outlining available support, normalising psychological responses to burn injuries) to more direct interventions (including rapid assessment and intervention, psychoeducation and liaison with other psychological services).[7]

Whilst the role of psychosocial practitioners in MDT follow-up burns care has been acknowledged,[4] no research has formally evaluated this in the context of an MDT clinic setting. Specifically, research has yet to explore the need and input of clinical psychologists within outpatient MDT burns follow-up clinics in the UK. In light of this gap, this paper aims to identify:

- The level of psychological need for burn patients and/or families identified by clinical psychologists through screening patients in burns MDT follow-up clinics.
- The different levels of psychological input for burn patients and/or families provided by clinical psychologists in MDT outpatient follow-up clinics.

Methods

Design

This study is an audit of routine clinical practice in the Burns Psychology Service at a UK paediatric and adult burns service. Data was collated using an anonymised screening template, devised and completed by the clinical psychologists present at routine paediatric and adult outpatient burns MDT follow-up clinics. Psychosocial screening in this setting is a routine part of burns MDT follow-up clinics that enables clinicians to consider individual patient circumstances and promote flexible and responsive input, as opposed to utilising a standardised questionnaire or proforma. Screening questions aim to identify potential areas of burns-related distress, pre-burn vulnerability factors or general mental health concerns and functioning. Consent was not obtained from patients as the audit utilised anonymised data and evaluated routine clinical practice.

Patients and setting

Patients included adults and children who sustained a burn injury requiring scar management and had attended their routine appointments at burns MDT follow-up clinics. Some patients may have been known to the Burns Psychology Service; they may have already accessed psychological support as an inpatient or have been the subject of indirect screening via MDT discussion or consultation with burns care staff. The data set included patients that attended MDT follow-up clinics between April 2018 and November 2019. The MDT follow-up clinic included a consultant plastic surgeon, an Occupational Therapist, a Physiotherapist, and a Clinical Psychologist; not all professionals were present at every appointment as this was dependent on identified patient need.

Data collection

An audit template was produced to record data. Anonymized data was collected for all MDT follow-up clinic appointments attended by the Burns Psychology Service. Patient demographic data consisted of age and gender.

A coding system was devised to gather data relating to:

- Patient demographics (age, gender)
- Attendance status
- The level of psychology input into clinic appointment
- The psychological needs of patients and/or families

Psychological input provided within each individual burns MDT follow-up clinic was identified and classified into three different levels of input in line with previous research,[4] highlighting the different tiers of psychosocial input that clinical psychologists offer in an MDT setting. At each level, the complexity and amount of input offered from the clinical psychologist increases. An assumption was made that all patients receiving a higher level of input had also received the subjacent tier(s) of input.

Level 1: brief screening. This is an initial stage of gauging psychological need prior to possible formal psychological assessment. Its aim is to introduce the idea of potential psychological difficulties following a burn injury and to gather a sense of their applicability to patients. Psychological screening is in line with NBCS[6] and established clinical practice within burns care services.[11] Further psychology input was then delivered if required. At the time of audit, there was no established service screening tool for burns outpatients.

Level 2: psychological assessment. This is a more detailed assessment of psychological need, comprising presenting problems, background information, as well as maintaining and supportive factors.

Psychological assessment assists in any decision to provide further input and may include providing psychoeducation and signposting information.

Level 3: formulation and signposting. This goes beyond assessment towards helping patients make sense of their psychological difficulties, including a potential interplay between burns related and non-burns related factors. This may include an introductory formulation, with the intention of developing this further through either individual sessions (following an internal referral to the Burns Psychology Service) or an outward referral to other services (to supplement, or as an alternative to, burns psychology input) (Figure 1).

Psychological need of patients and/or families was classified into three categories:

- Burns related psychological concerns, including (but not limited to) emotional dysregulation and mood difficulties, appearance-related anxiety, trauma symptoms, surgical anxiety/preoperative assessment.
- Non-burns psychological concerns and concerns met by other services, including, for example, pre-existing mental health difficulties or safeguarding concerns.
- No psychological concerns identified.

Where signposting was discussed within Levels 2 and 3 of input, the options included:

- Third sector organisations, such as Children's Burns Trust, Changing Faces and Dan's Fund
- Burns camp activities
- Adult mental health services
- Child mental health services
- School reintegration
- Other (e.g., citizens advice bureau, special educational needs leads, vocational organisations).

Ethics

Psychosocial screening is a routine aspect of burns MDT follow-up clinics. The rationale for including psychosocial screening within a full MDT approach is to normalise psychological need and therefore, to increase the chance of capturing and addressing it, whilst also providing holistic patient care. For clinic consultations where highly emotive or sensitive content was discussed, a separate space with the clinical psychologist for psychosocial screening was accessed to maintain patient privacy and confidentiality.

Results

Data was analysed using descriptive statistics. Demographic data was recorded including patients' age and identified gender. Clinic contacts included in the data included first or subsequent appointments at the MDT follow-up clinic for patients with healed burns/scars. Patients were screened at each clinic appointment and information from each appointment was captured in the dataset, as psychosocial needs fluctuate over time post burn injury. Therefore, data may include multiple contacts belonging to the same patient.

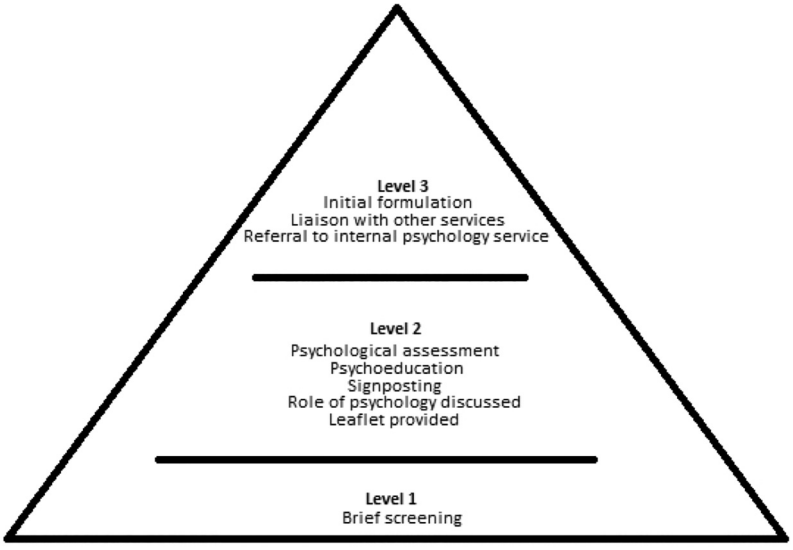

Figure 1. Levels of input provided by the clinical psychologist in routine Burns MDT followup Clinics.

Attendance

From an initial sample of 1297 scheduled patient appointments, 512 were adults and 784 were paediatric (0–18 years). Clinical Psychologists were present at 90% of burns MDT follow-up clinics (n = 1180). Of these, 68% of clinics were attended by patients. This resulted in a total dataset of 808 clinic appointments (331 adults and 477 paediatrics). One participant was excluded due to having a non-burn injury.

In adult clinics, clinical psychologists were present at 96% of burns MDT follow-up clinic appointments. Reasons for psychology absence were due to service demand (under-resourced (under-resourced, n = 6; with another patient, n = 5), or due to staff absence (n = 10). In paediatric clinics, clinical psychologists were present at 89% of burns MDT follow-up clinic appointments. Reasons for psychology absence were due to service demand (under- resourced, n=72; with another patient, n=3), or due to staff absence (n = 11). On one occasion, the patient declined to have the psychologist present at the clinic.

Demographics

In adult clinics, 46% (n = 235) of patients offered appointments identified as female and 53% (n = 277) identified as male. Patients' ages ranged from 17–93 years old; the modal age group was 18–29 years old (n = 124). In paediatric clinics, 44% (n = 342) were female and 46% were male (n = 359). Patients ages ranged from 0–18 years old, and the modal age group was 0–5 years old (n = 361).

Psychological input

All patients and/or families seen were at least 'briefly screened', with further input being delivered if required.

In adult clinics, 65% (n = 217) of clinic appointments were recorded as involving Level 1 brief screening only, with no further input required. 18% (n = 59) of adult appointments were recorded as involving Level 2 input, which constituted a more in-depth psychological assessment, psychoeducation and/or signposting. The remaining 13% (n = 45) of adult appointments were offered the highest tier of input (Level 3), comprising initial psychological formulation, referral to burns psychology services, and/or liaison with other services (see Figure 2).

In paediatric clinics, 51% (n = 243) of clinic appointments were recorded as involving Level 1 brief screening only. Over a third (39%;n = 187) of paediatric appointments were recorded as involving Level 2 input, and 9% (n = 43) received the highest Level 3 input (see Figure 2).

The level of psychological need for patients and/or families attending their MDT clinic contact was assessed and recorded by the Clinical Psychologist based on an evaluation of presenting problems.

In adult clinics, a degree of psychological concern relating directly to the burn injury was identified for 38% (n = 126) of patient contacts. In 4% (n = 12) of patient contacts, psychological concerns were identified that related to other aspects of their life. This resulted in a total of 42% (n = 188) of adults in clinic with some degree of psychological concern.

In paediatric clinics, a degree of psychological concern relating directly to the burn injury (for either patients or families) was identified for 39% (n = 188) of patient contacts. In 7% (n = 33) of patient contacts, psychological concerns were identified that related to other aspects of their lives. This resulted in a total of 46% (n = 221) of children and/or their family in clinic with some degree of psychological concern.

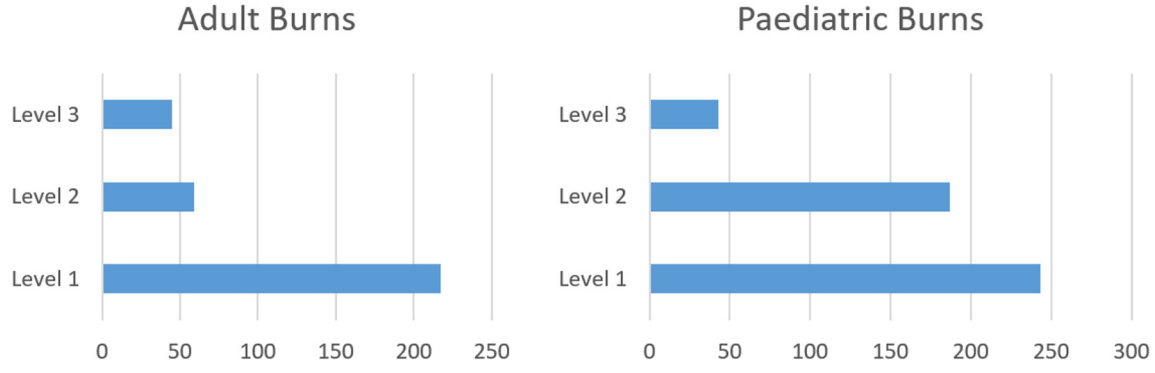

Figure 2. Levels of input from psychology.

Discussion

An audit of routine clinical practice for clinical psychologists in burns MDT follow-up care within a UK paediatric and adult burns service demonstrated that almost half of all patients and/or their families presented with some degree of psychological concern in an MDT follow-up clinic. For both patient groups, the vast majority of these were identified as being psychological difficulties directly related to the burn injury and a smaller proportion were classed as being related to wider psychological difficulties. Given that patients attend burns follow-up clinics at varying time points, and often many years post-injury, this finding supports previous research that patients and families experience psychological concerns at various stages following a burn injury.[1,2,7,12]

In the current study, clinical psychologists were present for the vast majority of follow-up clinics. In line with National Burn Care Standards (NBCS[6]) this allowed for effective screening of patients and families, alongside timely access to psychological care for those where difficulties were identified. As part of a tiered approach, a third of adult patients and almost half of paediatric patients and/or families required an additional level of psychology input within the follow-up clinic, beyond brief screening; this included both Level 2 and Level 3 input. The benefit of a tiered approach to psychological care within burns services has been demonstrated[13] and highlighted as part of NBCS. Results from the current study also suggest that burns MDT follow-up clinics provide an appropriate window of opportunity to offer patients and families brief, preventative psychology input or signposting where needs were either not previously present, established or met earlier in the burns treatment pathway. This is crucial to note, given previous research has demonstrated the difficulties in future engagement with psychology when clinical psychologists are not present during screening. Thomas et al.[7] found that 25% of patients did not engage with psychology services where psychological difficulties post-burn injury were identified using screening questionnaires and clinical cut-offs alone.

Anecdotal feedback from wider burns professionals about the presence of clinical psychologists in burns MDT follow-up clinics was positive, with particular reference to how it enriches patient conversations and facilitates effective decision-making around treatments. Whilst this warrants further qualitative research, the data presented in this paper emphasises the value of psychology input into burns MDT follow-up clinics. This contributes to holistic burns MDT follow-up care and allows for effective use of clinical psychology time. For patients and families presenting with psychological need, it also presents the opportunity for the clinical psychologists to engage and provide containment, as well as support to the wider team in their burn care treatment plans.

There are limitations to the present study. Since the completion of this audit, psychosocial screening tools have been developed and implemented in inpatient burns care. A future direction would be to utilise these for standardised assessment and data gathering and to monitor potential changes in psychosocial needs during the inpatient and outpatient phase post-burn injury. The nature of the psychology service being embedded within the burns MDT clinic may also create challenges for replicability, despite being a positive aspect in patient-centered care. Psychologists who are less embedded within services and thus separate from the MDT, may experience unique barriers in the routine psychosocial screening of patients. Furthermore, the clinical psychologists in this study were likely to have had some degree of familiarity with the patient, even if indirectly. This is likely to have helped with rapport building and psychological input at all levels.

Collecting additional data on the nature of patients' burn injuries and the length of time since injury may have been of interest, alongside examining any potential patterns in relation to the level of psychology need and input identified in clinic across different age groups of patients and their families. Wider demographic data was not collected pertaining to patients' ethnic background, religion and first language. Capturing this information in future research would contribute a useful perspective in relation to health inequalities, psychological need and accessibility of psychological services. In addition, it may have been of benefit to more thoroughly identify whether patients were signposted to or currently accessing additional services. Based on the data set, it was not possible to undertake more complex statistical analysis of these demographic factors. Due to time constraints, it was also not possible to establish inter-rater reliability of clinical psychologists coding each clinical contact.

Further research should focus on exploring the relationship between psychological needs, intervention and additional demographic factors, such as age and time since injury. This would help services understand the presentation and patterns of psychological need and/or input at follow-up clinics. Future work should also explore the experiences of patients, families and MDT professionals in experiences in having psychology presence in clinic, including the use of case studies. This would be important to continue to shape national guidance relating to psychological care in burns services.

Conclusion

A substantial number of patients and families presented with psychological needs in relation to a burn injury when attending burns MDT follow-up clinics. The presence of clinical psychologists at burns MDT follow-up clinics is beneficial for the identification of burns and non-burns related psychological concerns and is a valuable use of psychological resources within a burns service.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Melissa Potter https://orcid.org/0000-0001-6251-8313

References

1. Attoe C and Pounds-Cornish E. Psychosocial adjustment following burns: an integrative literature review. *Burns* 2015; 41: 1375–1384.
2. Duke J, Randall SM, Vetrichevvel TP, et al. Long-term mental health outcomes after unintentional burns sustained during childhood: a retrospective cohort study. *Burns Trauma* 2018; 6: 32–41.
3. Gullick JG, Taggart SB, Johnston RA, et al. The trauma bubble: patient and family experience of serious burn injury. *J Burn Care Res* 2014; 35: 413–427.
4. Wisely J, Hoyle E, Tarrier N, et al. Where to start? Attempting to meet the psychological needs of burned patients. *Burns* 2007; 33: 736–746.
5. Gaskell S, Cooke S, Hodgetts R, et al. Psychosocial screening and outcome measurement in paediatric burns services in the UK. *Burns* 2009; 35: S30.
6. British Burn Association. National Standards for Provisions and Outcomes in Adult and Paediatric Burn Care. https://www.britishburnassociation.org/wp-content/uploads/2018/11/BCSO-2018-FINAL-v28.pdf (2018, accessed 11 February 2022).
7. Thomas B, Ford CG, Addicks S, et al. Implementation of a psychosocial screener for adults in an outpatient burn clinic. *J Burn Care Res* 2019; 40: 331–335.
8. Shepherd L, Tew V and Rai L. Comparison of two psychological screening methods currently used for inpatients in a UK burns service. *Burns* 2017; 43: 1802–1808.
9. Wisely JA and Tarrier N. A survey of the need for psychological input in a follow-up service for adult burn-injured patients. *Burns* 2001; 27: 801–807.
10. Van Loey NE, Faber AW and Taal LA. A European hospital survey to determine the extent of psychological services offered to patients with severe burns. *Burns* 2001; 27: 23–31.
11. Oaie E, Piepenstock E and Williams L. Risk factors for peri-traumatic distress and appearance concerns in burn-injured inpatients identified by a screening tool. *Scars Burn Heal* 2018; 4: 1–10.
12. Baker CP, Russell WJ, Meyer W, et al. Physical and psychologic rehabilitation outcomes for young adults burned as children. *Arch Phys Med Rehabil* 2007; 88. https://doi.org/10.1016/j.apmr.2007.09.014
13. Shepherd L and Beveridge A. A tiered approach to inpatient psychosocial screening in an adult UK burns service. *Burns* 2022; 48: 698–702. https://doi.org/10.1016/j.burns.2021.05.017

How to cite this article

Potter M, Aaron D, Mumford R, et al. An evaluation of clinical psychology input into burns multidisciplinary follow-up clinics. *Scars, Burns & Healing*, Volume 8, 2022. DOI: 10.1177/20595131221141083.