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A comparison of two psychological screening methods currently used for inpatients in a UK burns service

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ABSTRACT

Various types of psychological screening are currently used in the UK to identify burn patients who are experiencing psychological distress and may need additional support and intervention during their hospital admission. This audit compared two types of psychological screening in 40 burn inpatients. One screening method was an unpublished questionnaire designed to explore multiple areas of potential distress for those who have experienced burns. The other method was an indirect psychological screen via discussions within multi-disciplinary team (MDT) meetings where a Clinical Psychologist was present to guide and prompt psychological discussions. Data was collected between November 2012 and September 2016. Results suggested that both screening methods were similar in identifying patients who benefit from more formal psychological assessment. Indeed, statistical analysis reported no difference between the two screening methods (N=40, p=.424, two-tailed). In conclusion, measuring distress in burns inpatients using a burns-specific questionnaire and psychological discussions within MDT meetings are similar in their ability to identify patients in need of more thorough psychological assessment. However, both screening methods identified patients who were in need of psychological input when the other did not. This suggests that psychological screening of burns inpatients, and the psychological difficulties that they can present with, is complex. The advantages and disadvantages of both methods of screening are discussed.

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1. Introduction

The psychological consequences of burns have been relatively well researched [1,2], with common reported difficulties including depression and anxiety [3–5], post-traumatic stress disorder (PTSD) symptoms [6–9], appearance-related distress [10–13], distress related to pain [14], and procedural anxiety surrounding aspects such as dressing changes [15]. Additional difficulties that have been reported include key events during inpatient admission such as looking in the mirror for the first time [16] and difficulties surrounding rehabilitation such as scar management [17]. It is important to note, however, that most patients adjust without any significant psychological

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difficulties [18,19] and that furthermore some patients experience post-traumatic growth (i.e. positive aspects) following a burn [20].

In terms of the prevalence of psychological distress during the acute hospital admission phase, PTSD symptoms were found in 15–38% of patients assessed within one to two weeks of admission to a burns service [21]. Depression and anxiety symptoms at clinical levels, as measured by the Hospital Anxiety and Depression Scale (HADS) [22], have been reported to be prevalent in 2–35% and 22–40% of patients, respectively [4,21].

A previous audit [23] conducted at the same affiliated burn service as the current study compared two different methods of screening patients for psychological distress. One method involved using two validated questionnaires: the Impact of Events Scale—Revised (IES-R) [24] (to measure early post-traumatic stress symptoms) and the Hospital Anxiety and Depression Scale (HADS) [22] (to measure of anxiety and depression symptoms). The second method was an indirect screening method of psychological discussions within MDT meetings where a Clinical Psychologist was present. This audit [23] found no significant difference between the two screening methods, and concluded that indirect screening, such as via psychological discussions during MDT meetings, might be preferable in that it requires less time and fewer resources compared to administering questionnaires. This study also highlighted the possibility that the standardised measures used, the HADS and the IES-R, may not be suitable for use within burns services.

Indeed, the HADS [22] may be considered problematic as it incorporates some items which measure somatic symptoms of depression and anxiety, such as feeling slowed down. This is a concern, as patients' responses to these questionnaire items could be due to the physical result of the burn itself rather than their psychological reaction to it. Furthermore, it only measures depression and anxiety symptoms. Separate measures are thus required to assess early PTSD symptoms and these are available [24–26], but these trauma measures also have the same limitation of only measuring this single domain of distress. Furthermore, measures of PTSD incorporate longer-term symptoms that are necessary in terms of diagnosing the disorder but which are sometimes not yet relevant to burn inpatients (e.g. the ongoing avoidance of people and places that remind them of the incident) as they are still in hospital or it is too early to determine PTSD (less than one month since the event). Moreover, none of the above measures incorporate any items to measure any burn-specific difficulties, perhaps most notably appearance-related distress and pain-related distress. Although these can be assessed using separate measures (e.g. the Derriford Appearance Scale [27] to measure appearance-related distress or the Pain Catastrophizing Scale [28] to measure difficulties associated with pain), this would involve giving patients numerous different measures to complete. Moreover, there is currently no published psychological measure which measures acute distress about appearance, or which incorporates items to assess a number of the difficulties that patients can experience in the acute period following a burn. It can be concluded therefore that there is no one measure currently published that is suitable for capturing the broad range of psychological difficulties that burn patients can experience during their acute hospital admission.

The lack of appropriate and validated broad psychological measures for the burns population, and in particular for use within the acute admission phase, poses a difficulty both clinically and in light of the UK National Burn Care Standards [29], which states that all inpatients admitted for over 24 h should have a psychosocial screening assessment completed within two working days of entering the burns service. Screening is aimed to enable the early identification of psychological symptoms in order to guide psychological interventions, rather than enable a psychiatric diagnosis to be made. Burn services in the UK also have clinical quality service indicators and associated targets, which includes the psychosocial screening of burn inpatients before discharge.

Limited time and resources require streamlining and cost-effective clinical services. As such, current practice within UK burn services is to enable a range of psychological screening methods to be adopted, which is agreed nationally and accepted by the British Burn Association (BBA). It is largely accepted in the UK that the following psychosocial domains should be screened for during a patient's admission: depressed mood, anxiety, acute stress symptoms or early PTSD symptoms, appearance-related distress, pain-related distress, and risk of self-harm. A tiered approach to screening, as agreed by the BBA, enables the option of conducting face-to-face psychological assessments by psychosocial professionals, including Assistant Psychologists (graduates with an undergraduate psychology degree who are closely supervised by Clinical Psychologists in undertaking structured assessments and basic psychological interventions), Clinical Psychologists or Psychiatrists, a more basic screening process administered by nursing/medical staff, as well as indirect screening via psychological discussions at MDT meetings or ward rounds, with or without the presence and input of a Clinical Psychologist or other psychosocial professional. This tiered approach allows for a coding process (as to the level of psychological screening undertaken) to be used nationally. In the UK, some level of screening should be done within two working days of a patient entering the burn care service, for all patients admitted for over 24 h. It is also widely accepted within the UK that both such direct and indirect psychological screens should be undertaken by someone who has received relevant training in identifying psychological difficulties in burns patients, with this training usually having been provided by the Clinical Psychologist or other psychosocial professional working within each individual burns service. In the affiliated burns service, if patients are treated with intensive care then they are admitted to an intensive care ward in the first instance and then transferred to the burns unit once medically appropriate. Psychological screening is routinely completed once the patient has been admitted to the burns unit.

The authors are mindful that other countries will have their own guidance and recommendations that may differ from UK practice. For example, the American Burn Association (ABA) recommend that all inpatients are screened for depressive and acute stress disorder symptoms within 48 h of accessibility (e.g. no delirium) at least once before discharge, and whilst

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