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Division of Clinical Psychology
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Clinical Psychology Sexual Dysfunction Services in Sexual Health and HIV, and other NHS Services

A Guide for Commissioners of Clinical Psychology Services

Contents

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1. Executive summary

This Briefing Paper is one of a series offering advice to commissioners of clinical psychology services in Sexual Health and HIV. It is closely related to *Briefing Paper No.17, Clinical Psychology Services in HIV and Sexual Health: A Guide for Commissioners of Clinical Psychology Services* (BPS, 2002), to which it frequently refers.

Recognition has been given to the role that sexual dysfunction plays in compromising sexual health (MEDFASH, 2005). The identification and treatment of sexual dysfunction has been identified as an overlooked area of health care provision in the UK (DoH, 2002; IAG, 2004; MEDFASH, 2005). Sexual dysfunction is commonly identified in sexual health settings, however, people with sexual problems also present in a variety of different settings including general practice, gynaecology, urology, psychiatry, oncology, cardiology, diabetes, substance misuse, family planning and other contraceptive services. The identification of sexual dysfunction thus occurs in a range of acute and primary-care settings leading to complex commissioning decisions. This paper aims to address Commissioner's questions relating to Clinical Psychology services for sexual dysfunction irrespective of the settings in which such needs are identified.

The struggle to provide adequate sexual dysfunction services occurs in the context of an epidemic of sexually transmitted infections (STIs) and HIV (DOH, 2004a; IAG, 2005); this is of particular relevance given the increasing evidence of a strong association between sexual dysfunction and sexual risk taking behaviour (e.g. Cove & Petrak, 2004). Existing sexual dysfunction services are rarely adequately funded or staffed and often have lengthy waiting times. Challenges for treating sexual dysfunction include limited knowledge within the broader National Health Service (NHS) around how to appropriately assess and where to refer people who present with sexual problems. Treatments for sexual dysfunction vary widely and are not always based on the most up-to-date evidence-based practices. This can result in inappropriate and costly use of NHS resources.

MEDFASH (2005, p.53) states that 'PCTs should ensure that people with identified sexual dysfunction have access to services which can address their needs'. Clinical psychologists working in sexual health settings are well placed to play a key role in the development and delivery of sexual dysfunction services and the treatments they provide have been demonstrated to be cost-beneficial (Goldmeier *et al.*, 2004). Positive outcomes of providing co-ordinated sexual dysfunction services by appropriately trained professionals extend beyond the central aim of improving patients' sexual functioning. Clinical psychologists working in sexual health settings have the ability to address a range of factors commonly experienced by people who suffer from sexual problems, namely wider mental health and relationship issues, health promotion and the encouragement of safer-sex practices to help reduce the spread of HIV and STIs.

This Briefing Paper outlines the extent of need for services, the core services required and recommended staffing levels for clinical psychologists involved in the management and provision of sexual dysfunction services. The paper also describes standards upon which such services can be based, how these can be monitored, as well as suggesting a range of appropriate outcome measures. This includes teaching and consultation with those involved in assessing and treating sexual problems.

2. Introduction

Over the past two decades, global and local health care agencies have increasingly focused on sexual health, largely due to concerns regarding the recent spread of sexually transmitted infections, particularly HIV. In the UK, there has been a proliferation of initiatives aimed at reducing transmission rates and improving the overall sexual health of the nation (DoH, 2002). Despite these initiatives the UK continues to see a rise in sexually transmitted infections and HIV (IAG, 2005). Within this context there has emerged a growing demand on health services for the assessment and treatment of sexual dysfunction (Goldmeier, 2000). This may be due to increased awareness of the general public and of health care providers about medical advances (e.g. Viagra) and the impact of poor sexual health on quality of life (Araujo *et al.*, 1998; Litwin *et al.*, 1998; Shabsigh *et al.*, 1998).

The National Strategy for Sexual Health and HIV (DoH, 2002) defines essential elements of good sexual health as 'equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease' (p.7). Allocated resources, however, are usually directed towards tackling the spread of infectious illnesses, leaving few resources available to address other aspects of sexual health, particularly sexual functioning. The Independent Advisory Group (2004) made specific reference to the lack of co-ordinated sexual dysfunction services and noted that sexual dysfunction in the UK is an area that is under-funded and under-reported. The Department of Health's *National Strategy for Sexual Health and HIV: Implementation and Action Plan* (2002) also recommended that service standards, in consultation with health care providers and services users, be developed for the provision of sexual dysfunction services. In order to meet national standards and recommendations and the needs and preferences of service users primary care trusts (PCTs) should aim to commission a full range of sexual health services, including access to care for sexual dysfunction (MEDFASH, 2005).

The provision of psychological care within sexual health settings is considered an essential component of good clinical practice (BPS, 2002; MEDFASH, 2003, 2005). The role of clinical psychologists working more broadly in this area is outlined in *Briefing Paper No. 17, Clinical Psychology Services in HIV and Sexual Health: A Guide for Commissioners of Clinical Psychology Services* (BPS, 2002). Referrals to clinical psychologists working in sexual health have often included problems relating to sexual functioning (Hill & Matthews, 2004) and problematic or risky sexual behaviour (Thornton & Shah, 1999). However, people with sexual problems do not solely present at GUM settings. This may partly be due to existing referral pathways as well as a reflection of the different aetiologies that exist in the development of sexual problems.

Sexual dysfunction is associated with a wide variety of medical and psychological causes. It can develop either as a direct result of a medical condition, a side effect from prescribed treatment or as a consequence of physical or mental health related difficulties. It is further affected by access to accurate information/ education, relationship and socioeconomic factors, and individual expectations and beliefs. Specialties as diverse as oncology, urology, endocrinology, fertility, contraception services, gynaecology, physical disabilities, psychological therapies and psychiatry will thus frequently come into contact with patients who may have a sexual problem.

Sexual dysfunction can easily be de-prioritised in settings where more immediate physical or mental health issues are assessed and treated. Furthermore, professionals working in such settings may not always have the necessary skills to assess the relative impact of sexual problems on general mental health and quality of life or have the specialist knowledge, skills and experience to treat such problems. Due to their training and experience clinical psychologists working in sexual health settings are well positioned to respond to issues relating to human sexuality, which includes a focus on where sexual expression may be unfulfilling or harmful to individuals or couples. Sexual health settings also provide access to the multi-disciplinary health-professional team who play an important role in the identification and treatment of sexual problems (Goldmeier, 2000; MEDFASH, 2005).

3. Aims of clinical psychology services for sexual dysfunction

Clinical psychologists working in sexual dysfunction services aim to:

- provide the most effective, evidence-based treatments;
- improve the quality of life of clients via the application of theoretically-based interventions to reduce sexual dysfunction;
- provide a therapeutic service, which respects the sexual, spiritual and religious preferences of the client;
- provide, where possible, a therapist of the client's preferred gender (Glover & Wylie, 2002);
- provide a service which takes into account the source and social context of the referral;
- adhere to professional and ethical guidelines and regulations;
- take a lead role in clinical governance activities, including service evaluation and audit; and
- provide training and consultation for other multidisciplinary team members where appropriate.

The achievements of these aims will lead to:

- the utilisation of more cost-effective interventions and, therefore, a more appropriate use of NHS resources (Goldmeier *et al.*, 2004);
- improved adjustment in sexual functioning following sexual trauma, illness and medical interventions (e.g. Gamel *et al.*, 2000; Petrak *et al.*, 1997);
- decreased number of attendances at primary and secondary treatment agencies (Bancroft, 1989) and the number of investigations and procedures at tertiary level (Nazareth *et al.*, 2003);
- reduced HIV/STI transmission resulting from a decrease in unsafe sexual practices linked with sexual dysfunction (Cove & Petrak, 2004);
- improved adherence to medication regimes, the side-effects of which may potentially impact negatively on sexual functioning (Michaelson *et al.*, 2000);
- improved quality of life through the reduction of associated psychological health problems associated with sexual dysfunction, for example, anxiety disorders (Roth & Fonagy, 2005), depression (Labbak & Lare, 2000) and through increased relationship satisfaction (Bartlik & Goldberg, 2000); and
- increased knowledge and skills within the MDT, or other staff groups, with regards to identifying and treating sexual dysfunction (Nazareth *et al.*, 2003; Sherr, 1995).

4. The extent of psychological need

Definition

Sexual dysfunction can occur throughout the sexual response cycle, in that it can affect desire, arousal and the ability to orgasm. There are nine diagnostic categories for sexual dysfunction in the DSM-IV-TR (APA, 2000), which are conceptualised as either lifelong (i.e. primary) or acquired (i.e. secondary) difficulties, and can be either generalised (i.e. occurring across all situations) or situational (i.e. context specific).

Prevalence

A large UK-based prevalence study estimated that sexual dysfunction is present in approximately one-third (34 per cent) of men and two-fifths (41 per cent) of women at any one point in time in the general population (Dunn *et al.*, 1998). A large proportion of respondents (52 per cent) who reported sexual difficulties stated that they would like to receive professional help, however, only 10 per cent had received such help (Dunn *et al.*, 1998). In a study of heterosexual attendees of an inner London GUM clinic it was found that 37 per cent of men and 20 per cent of women reported that they experienced sexual dysfunction (Goldmeier *et al.*, 2000). In a recent study focusing on general practitioner attendees, Nazareth *et al.* (2003) found that 22 per cent of men and 40 per cent of women who attended 13 London GP practices reported current sexual difficulties. These figures are likely to be underestimates, as people may be reticent to disclose sexual problems, for reasons pertaining to culture (Beck *et al.*, 2005), gender and sexuality, as well as professionals' reluctance to encourage such disclosure due to a lack of expertise or limited local referral options (Gott *et al.*, 2004; MEDFASH, 2005). A number of clinical studies have found very high rates of sexual dysfunction in HIV positive individuals (Lamba *et al.*, 2001; Tindall *et al.*, 1994), particularly in gay and bisexual men (Catalan & Meadows, 2000; Cove & Petrak, 2004).

Aetiology

The causes of sexual dysfunction are varied (Wincze & Carey, 2001). They may include biological or organic reasons (e.g. diabetes, cardiovascular disease); psychological reasons (e.g. depression, anxiety) and/or social/cultural reasons (e.g. relationship difficulties, religious proscription). Leonie Tiefer (2001), a critical theorist, calls for the inclusion of socio-cultural, political and economic factors to be considered when focusing on factors that affect sexual expression. Such issues are particularly relevant for people who are marginalised or disenfranchised. Irrespective of underlying aetiological causes, loss of sexual functioning commonly causes psychological distress, which in turn further affects sexual performance. This has been demonstrated in research on erectile dysfunction (Tiefer & Schuelz-Mueller, 1995), sexual dysfunction following an HIV positive diagnosis (Green, 1994), depression (Hensley & Nurnberg, 2002), drug misuse (Levine, 2003), in refugees (Shaw & Tacconelli, 2006) and sexual assault (Petrak *et al.*, 1997). Specific factors relating to HIV positive populations include loss of interest due to psychological difficulties, for example, anxiety or depression (Petrak & Miller, 2002) or fear of infectiousness (Fisher *et al.*, 1998).

Two large-cohort US studies have pointed to the multi-factorial nature of loss of sexual functioning. These studies highlight anger and depression (Feldman *et al.*, 1994), stress, emotional problems and childhood sexual abuse (Laumann *et al.*, 1999) as being significant factors in the development of sexual problems. Sexual dysfunction can thus be understood to be a psychosomatic process that is complexly determined and highly related to physical and psychosocial dimensions of an individual's life (Hiller & Cooke, 2002; Heiman, 2002).

Treatment

As sexual dysfunction is complexly determined psychological interventions need to be able to address issues of comorbidity that are often present in people who present with sexual problems. Evidence suggests that individuals with sexual dysfunction are likely to experience psychological distress, reduced self-esteem and relationship problems (Catalan *et al.*, 1981; Roth & Fonagy, 2005). A high proportion of patients also exhibit affective and anxiety disorders. (Hawton, 1985; van Lankveld & Grotjohann, 2000). Psychological therapies have proven efficacy in addressing problems such as anxiety, depression, drug and alcohol misuse, low self-esteem and relationship difficulties (Roth & Fonagy, 2005). In addition, psychological models have much to offer in terms of understanding personal sexual behaviour and providing strategies for ways of altering behaviour that is problematic or undesirable for individuals or couples (Dubois-Archer & Carael, 2002). This is particularly important to consider when treating individuals who continue to engage in high risk sexual activities despite having sufficient knowledge regarding the potential health risks.

The evidence base for sexual dysfunction treatments is fast growing and indicates a number of psychological approaches to be effective. Behavioural approaches such as those advocated by Masters and Johnson (1970) have been found to be helpful for a number of difficulties, although the approach has been updated as the knowledge-base of the treatments has increased (Hawton & Catalan, 1986). Earlier literature points towards a split between couple therapy and sex therapy, however, current trends advocate integrating models due to the close connection between relational factors and sexual satisfaction (Hiller & Cooke, 2002; Weeks & Gambescia, 2002). Cognitive behavioural therapy (CBT) has also been used effectively to treat a variety of sexual problems (e.g. Trudel *et al.*, 2001; Spence, 1991). Heiman and Meston (1997) report an empirically validated intervention that includes sex education, behavioural assignments and communication skills training. Results from six comparison controlled studies found that cognitive behavioural techniques fared better than psychoanalytic approaches (Heiman & Meston, 1997). Combined psychodynamic (object-relations) and behavioural techniques have also been shown to be effective (e.g. Scharff & Scharff, 1991; Hiller, 1996) as has combining behavioural techniques, communication training, sensate focus and systemic interventions that take into account the multiple social systems that individuals are located within (e.g. Crow, 1995; Gehring, 2003).

Medical treatments, which are aimed at changing a person's physiological response, have been primarily focused on treating male sexual dysfunction. There are a number of pharmacological treatments (e.g. Sildenafil, Vardenafil) that are proven to be efficacious for a large number of men who suffer from erectile dysfunction. However, research indicates discontinuation from medical treatments, for those who find the treatment physically effective, to be as high as 50 per cent to 60 per cent (Althof, 2002). There are a number of factors that have been identified as playing a key role in this high drop out rate, including, the quality of the non-sexual relationship, the length of time couples have been unable to engage in penetrative intercourse, the meaning for each partner of using oral treatments to restore sexual functioning, the male partner's feelings of inadequacy and the effects of performance related anxiety (Althof, 2002; Hudson-Allez, 1998; Riley, 2002). Hiller and Cooke (2002) also draw attention to pharmacological treatments inability to address psychological and relational aspects of sexual functioning, in particular the experience of pleasure and intimacy. Evidence indicates that effective treatments for male sexual dysfunction usually involve a combination of pharmacological and psychological interventions including a focus on relationship issues that serve to maintain the dysfunction (e.g. Ackerman & Carey, 1995; Riley, 2002; Tiefer & Schuelz-Mueller, 1995).

The prevalence of female sexual dysfunction is estimated to be higher than male sexual dysfunction (Laumann *et al.*, 1999; Goldmeier *et al.*, 2004). The underlying physiological basis of female sexual response has been less systematically researched (Everaerd & Laan, 2000) and is felt by some to be under-diagnosed and under-treated (Goldmeier *et al.*, 2004). Goldmeier *et al.* (2004) examined the outcome and direct costs of treating women with sexual dysfunction in a large inner London sexual health clinic. The study confirmed clinical psychology input to be a cost-beneficial and effective way of managing female clients with sexual dysfunction.

Treatment programmes require a focus on safer sex practices to help prevent the onward transmission of HIV/STIs, as a strong association between sexual dysfunction and sexual risk-taking behaviour has been identified, with a recent study reporting that 90 per cent of HIV positive men with erectile dysfunction associated with condom use were using condoms inconsistently (Cove & Petrak, 2004). When constructing treatment programmes, clinicians also need to be familiar with the different issues that people who belong to sexual minority groups present with and be sufficiently skilled to work with such populations in a non-stigmatising way. This should include an awareness of sexual and relationship practices that fall outside of mainstream norms. Practitioners are thus required to have a high level of knowledge of sexual minority practices and sufficient level of skill to work with complex therapeutic and prevention issues.

Interventions can be applied to individuals, couples and groups (Shah, 1996). However, amongst certain cohorts, where mental health problems are known to be more prevalent (e.g. HIV populations), individual work is preferred and should be carried out by practitioners who are skilled at assessing and treating both general mental health problems and psychosexual difficulties (Thornton & Shah, 1999). Anxiety, depression (Petrak & Miller, 2002) and fear of infectiousness (Fisher *et al.*, 1995) are examples of mental health-related difficulties that commonly affect sexual functioning in HIV positive populations.

In summary, recent theoretical and research developments point to the need for an integrative approach in assessing and treating male and female sexual dysfunction. This is particularly important for clients who are unable to follow a particular therapeutic modality or for whom standard treatment aims are inappropriate. Through the input of a multi-disciplinary team, clinicians, in conjunction with clients, can choose from a number of therapeutic modalities based on available clinical evidence and client preference.

5. Assessing the needs for services

The prevalence of sexual dysfunction is difficult to accurately calculate for a number of reasons:

A. Problems of service provision, for example:

- Historically, a low priority has been attached to sexual dysfunction within health services (e.g. de Berardis *et al.*, 2002).
- Service providers' reluctance to elicit information regarding sexual functioning due to time and service constraints.
- Concerns around discussing sexuality with patients of the opposite gender, Black and ethnic minority groups, middle-aged and older adults, patients who are gay or lesbian, people who have learning difficulties, mental health problems or physical disabilities (e.g. Gott *et al.*, 2004).
- Lack of knowledge of the impact of certain medical conditions on sexual functioning, in particular women's sexual functioning, for example, diabetes (Rockcliffe-Fidler & Kiemle, 2003).
- Inconsistent availability of service provision across the UK.

B. Problems pertaining to the client, such as:

- Individual sensitivities to discussing matters relating to sexual problems.
- Difficulties accessing help from services.
- Lack of awareness regarding the existence of available services and how to access them.
- Lack of knowledge regarding treatment advances and the positive effect these may have on sexual dysfunction.

C. Limitations with existing epidemiological data, for example:

- Data is often collated from a limited number of sources and fails to cover services where people are likely to present with sexual dysfunction.
- Due to a lack of available epidemiological data MEDFASH (2005) recommends that commissioners should determine service and capacity planning on the basis of need and not only by service use.

The identification of need can be determined in a variety of ways:

- by local surveys and national prevalence studies (Mercer *et al.*, 2003);
- demographic profiles of the local population;
- comparative data from similar services;
- estimates of comorbidity of sexual dysfunction with medical conditions, for example, effects following a hysterectomy (Rhodes *et al.*, 1999);
- estimates of comorbidity following medical treatments that are known to effect sexual functioning, for example, treatment for HIV infection (Lamba *et al.*, 2004) or depression (Hensley & Nurnberg, 2002);
- by the client or partner identifying the problem and requesting help from services;
- via the identification of a problem whilst other conditions are being treated or investigated;
- by recognising when sexual dysfunction is preventing recovery from another problem, e.g. depression; and
- by recognising when a medical problem (e.g. cancer, diabetes) or trauma (e.g. sexual assault, female genital mutilation) causes sexual dysfunction.

This identification of need will be facilitated by:

- improving medical and nursing staff skills through training to enable clinicians to identify and basically assess sexual dysfunction (MEDFASH, 2005);
- enabling clients to discuss their sexual difficulties and request help by providing a supportive and reassuring environment that would encourage disclosure; and
- putting it 'on the agenda', for example, through routine screening questions at primary care level or when attending GUM clinics for other sexual health concerns (MEDFASH, 2005).

6. Outcome measures/health gains

The impact of sexual dysfunction treatment will extend beyond the improvement of sexual functioning. A comprehensive sexual dysfunction service will produce measurable gains across a wide range of psychological constructs central to physical and mental health.

The following quantitative tools can be of assistance in the assessment of sexual problems and the evaluation of treatment outcomes:

- sexual functioning, for example, Golombok and Rust Inventory of Sexual Satisfaction – GRISS (Rust & Golombok, 1986);
- erectile functioning, for example, International Index of Erectile Function – IIEF (Rosen *et al.*, 1997);
- female sexual functioning, for example, Female Sexual Function Index – FSFI (Rosen *et al.*, 2000), and
- relationship issues, for example, Golombok Rust Inventory of Marital Satisfaction – GRIMS (Rust *et al.*, 1988).
- general measures of psychological well-being including depression and anxiety, for example, Beck's Depression Inventory (Beck *et al.*, 1961);
- measures of anxiety and depressive symptoms in those with physical illness, for example, General Health Questionnaire (Goldberg, 1972) and the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983);
- anxiety with an emphasis on somatic symptoms, for example, Beck Anxiety Inventory (Beck *et al.*, 1988);
- psychological distress, for example, CAGE questionnaire (Mayfield *et al.*, 1974);
- measures of quality of life, for example, Manchester Quality of Life Scale (Priebe *et al.*, 1999); WHO Quality of Life Scale-BREF (WHOQoL, 1998).
- symptoms of trauma, for example, Impact of Events Scale (Horowitz *et al.*, 1979); and
- alcohol use, for example, Alcohol Use Disorders Identification Kit (Saunders *et al.*, 1993).

Cognisance must be given to the specific population groups that these measures have been standardised on and care should be taken when attempting to generalise findings to different populations.

Clinical psychologists are committed to the effective use of accurate qualitative and quantitative outcome measures. The profession as a whole acknowledges the limitations in applying psychometric measures that have been derived in western settings to people from different cultural and language backgrounds. A key issue for the development of sexual dysfunction services will be the establishment of appropriate assessment tools and outcome measures that reflect the cultural diversity as well as comorbidity of problems that clients present with. This is particularly important when dealing with people who belong to ethnic or sub-cultural minority groups and sexual minority groups, for example, lesbian, gay, bisexual and transgender clients (Moser, 1999).

Other process measures that can also be usefully applied include:

- increased referral and attendance rates at services established to assess and treat sexual dysfunction issues (e.g. GUM clinics);
- increased attendance at primary care and tertiary care level for people seeking referral to sexual dysfunction services;
- decreased use of inappropriate services and treatments; and
- improved client satisfaction.

7. Core psychological services

Clinical psychologists draw on a broad range of psychological models and techniques (BPS, 2001) to provide effective assessments and interventions for treating sexual dysfunction.

Core service components that clinical psychologists provide include the following:

Assessment

- Description of the presenting sexual problem in the context of a full relevant history including the social and interpersonal context.
- Identification of which aspects of sexual functioning the client (and their partner if appropriate) believes to be problematic and would like to change.
- Appropriate use of qualitative and quantitative assessment measures to obtain information about the client or couple's current level of functioning.
- Integration within a multi-disciplinary health professionals' team allowing for co-joint assessment where necessary and appropriate.

Formulation

- Clinical psychologists provide a theory driven formulation of presenting problems.
- Develop coherent explanations that are meaningful to the client or couple.
- This shared conceptualisation informs treatment choice and enables the reformulation of the problem throughout the treatment process.

Intervention

- Interventions can be applied to individuals, couples or groups.
- A range of evidence-based therapeutic approaches can be used, each of which will be tailored to the needs of clients.
- Clinical psychologists ensure clients have access to up-to-date information about safer sex practices and health promotion (e.g. Dubois-Archer & Carael, 2002) to reduce the transmission of STIs and HIV.
- Consideration is given to issues relating to relapse prevention, where antecedents or precipitants to the recurrence of sexual dysfunction are identified so as to develop contingency plans to avoid the re-emergence of similar problems (e.g. McCarthy, 1999, 2001).

Services for other professionals working with sexual dysfunction

- Training other health care professionals to develop clinical skills in conducting a sexual health assessment, identifying sexual problems and making appropriate referrals.
- Supervision and consultation with health care professionals concerning the psychological management of sexual dysfunction.
- Team development and support for staff who provide sexual dysfunction services.
- Liaison with mental or physical health services who have input into client care.

Clinical governance

- Clinical psychologists play a key role in clinical governance activities ranging from research and audit to service evaluation.
- Clinical psychologists have well developed research skills which enable them to compare treatments and therapies in order to expand the evidence base.
- The profession supports service development through the dissemination of research evidence and research programmes and the undertaking of research on psychological aspects of care and prevention.

Services for purchasers and planners

- Advising purchaser, providers and planning teams on psychological aspects of service provision and psychological needs of people with sexual dysfunction.
- This should include a focus on preventative measures (Dubois-Archer & Carael, 2002) and relapse prevention (e.g. McCarthy, 1999, 2001).

8. Organisation of clinical psychology services

At present services for sexual dysfunction are rarely specifically commissioned (Keane *et al.*, 1997; Goldmeier *et al.*, 2000). Specialist services (e.g. GUM, HIV, Obstetrics, Gynaecology, Urology) are often stretched to provide services for patients with sexual difficulties due to high demand and limited service provision.

A recent survey of clinical psychologists working with sexual dysfunction suggests that the organisation of services vary considerably across the UK (Shaw & Cutler, 2005). These findings are similar to those of a survey of GUM physicians (Goldmeier, 2000). The current provision of sexual dysfunction services thus falls short of the Department of Health's recommendations regarding equal and timely access for all people who present with sexual or mental health problems (DoH, 2002, 2004b).

It is recognised that the model of service provision can vary; however, the recommended model would be to develop a multidisciplinary sexual dysfunction service with dedicated staffing and resources, and clear referral pathways. The service should have access to clinical and management fora where policy, funding and development of services are discussed.

This would lead to improvements in a number of areas.

- Assessment – By clear division of labour amongst staff and the development of clinical practice guidelines and protocols leading to improved accessibility of the service and more accurate needs assessment.
- Treatment – The multi-disciplinary team allows for the provision of a range of evidence-based treatments, providing patients with choice, improving outcomes and preventing relapse.
- Clinical governance – Through training opportunities, research, inter-professional support and the sharing of knowledge.
- Management of services – By multi-disciplinary representation at management level encouraging appropriate resource allocation within the wider organisation.

As clinical psychologists are professionally responsible for the assessment, advice and treatment they provide, purchasers should, therefore, require that when providers employ clinical psychologists to deliver sexual dysfunction services, they be eligible for Chartered status, which will ensure adherence to professional and ethical guidelines.

9. Recommended staffing levels and other resources

In order to develop sexual dysfunction services as well as assess the level of local need it is recommended that a clinical psychologist at Grade B Consultant level with relevant specialist skills and experience be appointed to head the clinical psychology service in the first instance. The amount of input (full-time/part-time) will depend on local prevalence and need as well as the demands that are required to establish or co-ordinate existing service provision.

Briefing Paper No. 17 (BPS, 2002) recommends clinical psychology staffing levels in sexual health to be at a level of one psychologist per 250,000 population, which corresponds to roughly 40 to 80 referrals per year, per psychologist, depending on case mix, therapeutic modality and the extent of indirect work required to adequately support both clients and service development.

The provision of appropriate supervision, professional support and training is deemed essential in order to reduce the risk of burnout and maintain high standards of care (BPS, 2002). Other essential resources include secretarial support, administrative resources (including access to translators, libraries and IT systems) and appropriate clinic space.

10. Commissioning clinical psychology services

A specialist clinical psychology service is an effective way of both improving the treatment of patients with sexual dysfunction and of preventing sexual health and mental health problems in those attending departments such as GUM clinics, HIV services, family planning services and other medical specialities where people with sexual dysfunction are likely to present.

At present, there is considerable variability regarding where people with sexual dysfunction can be referred and the kind of treatments they are able to access. In some areas there is an absence of appropriate NHS services. This inequity requires addressing in order to move away from the 'postcode lottery' in health care provision. Commissioners need to target funding for sexual dysfunction services in order to support service development and improve standards of care. This is especially important for clinical psychology services, which by their nature are likely to be only a small part of overall sexual health service provision. Recognition of the additional funding, in terms of staffing and resources, including medication (IAG, 2004), is required. Adequate funding should be set aside for clinical psychology and the budget should remain separate from other aspects of sexual health or HIV services, as well as other clinical psychology services, and monitored according to service development and need. In order to balance recruitment, retention and serve local needs, permanent posts should be contracted in such a way that the development of comprehensive, responsive and adaptive psychology services is not limited by the source of funding.

Clinical psychologists often work across different Trusts in order to provide services to clinics, inpatient units and the Community, and may require service level agreements with different Trusts depending upon local sexual health and HIV organisation, however, these should not restrict psychologists' ability to work where the local needs are identified. Salaries, and terms and conditions of Clinical Psychologists are outlined by Agenda for Change Pay Scales. Purchasers should request monitoring of patient referrals and audits of working standards, drawn up locally or in accordance with British Psychological Society guidelines.

In order to ensure the most effective use of resources, providers of sexual dysfunction services, including clinical psychologists, should be consulted at an early stage of service design, planning and implementation. Clinical psychology services for sexual dysfunction need to be considered in all Sexual Health and HIV service contracts and business plans, and be involved in local strategy and planning groups in order to contribute and be directed effectively.

11. Standards upon which the service is based

The following standards are recommended for people working specifically with sexual dysfunction:

- Services need to be accessible and adhere to Department of Health and local trust guidelines.
- The specified maximum waiting time for assessment will adhere to Department of Health guidelines of maximum waiting times of three months for an outpatient by the end of 2005 (DoH, 2004c).
- Services will be sensitive to class, age, gender, sexuality, language, religion and ethnicity to improve access and effectiveness.
- A focus on STI and HIV prevention issues needs to be included at all stages of contact with clients where applicable.
- Service users will be consulted about service development.
- Confidentiality and record keeping guidelines will be adhered to.
- Clinical psychologists will adhere to the Division of Clinical Psychology's Continuing Professional Development Guidelines (DCP, 2001).
- Clinical psychologists require specialist knowledge and training in sexual dysfunction and should be eligible for Chartered Status with the British Psychological Society and belong to a specialist professional organisation that has policies, audit and research activity that promotes clinical excellence.

12. Monitoring of quality outcomes and service audit

The Division of Clinical Psychology and the Centre for Clinical Outcomes, Research and Effectiveness (CORE) has produced guidelines for clinical psychology services to help with audit and quality control (DCP/CORE, 1998). These clinical outcome measures have not been specifically devised to evaluate outcomes of psychological therapies used to treat sexual dysfunction. The 'End of Therapy Form' (DCP/CORE, 1998) can be more usefully applied, however, it requires a greater degree of specificity in order to accurately measure changes that occur following sexual dysfunction therapies. A key issue for the development of sexual dysfunction services will be the establishment of appropriate outcome measures that are able to assess change in the inter-related areas of sexual and relationship functioning and mental health. Clinical psychology as a profession is committed to the development of appropriate outcome measures to assist in the delivery of appropriate and cost-effective services.

Further monitoring of service development will include:

- Regularly analyses of client information activity to ensure that appropriate use is being made of the service;
- Regular service monitoring and 'benchmarking';
- Regular clinical audit; and
- Regular feedback to purchasers and commissioners.

Clear quality standards are crucial to all services provided by clinical psychologists. This contributes towards one of the central aims of clinical governance. Other activities that also contribute towards clinical governance include:

- identifying procedures and developing alternative strategies that contribute to poor performance;
- developing clear lines of accountability and responsibility;
- comprehensive programme of quality improvement activities;
- clear policies aimed at managing risk; and
- developing partnerships with clients to assist in the design and delivery of services.

13. Conclusion

Clinical psychologists play an integral role in the provision of sexual dysfunction services, as demonstrated by current work in GUM clinics and other health care settings. They are trained to provide assessment, treatment and consultation services and are well positioned to fulfil clinical governance requirements and initiate research activities. The profession has developed cost-beneficial and effective interventions for treating sexual dysfunction. However, their implementation is hampered by lack of resources and poorly co-ordinated services. This document highlights the need for commissioners to take a lead on ensuring that national standards and recommendations relating to sexual dysfunction are locally implemented in consultation with key stakeholders and service users. While a number of professional groups are in a position to deliver sexual dysfunction services, clinical psychologists are particularly well placed to work with such problems, given their extensive training, strict professional standards, and ability to place sexual dysfunction into the wider context of physical and mental health.

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