

**Amended Specification: February 2009**

**SERVICE SPECIFICATION**

**PSYCHOSEXUAL MEDICINE AND THERAPY SERVICE**

**CHESHIRE AND MERSEYSIDE**

## **1. Introduction**

The management of psychosexual dysfunction can be complex and this service seeks to address this area of care by providing both a range of expertise and a variety of interventions to ensure a comprehensive and flexible approach.

The background of therapists working in a psychosexual service can be varied and may include counsellors, psychologists, psychotherapists, medical and health practitioners in the community, primary and secondary care sectors. The service will offer a range of therapeutic interventions.

Throughout this document, those providing the service are referred to as therapists, those availing themselves of the service (and their partners) as clients, and the available interventions as treatment.

This service is based upon the available research literature.

Psychosexual problems are not uncommon. There is little evidence supporting how best to formally match access to services / skills and client need. The service will seek to resolve these issues by audit and evaluation outcomes.

## **2. Aims of the Service**

- To provide an evidence based system of advice and treatment with quantifiable outcomes.
- To provide a co-ordinated service of assessment, advice and treatment for patients with sexual problems.
- To provide equality of access to specialist skills and treatment as determined by clinical need.
- To adopt a holistic and integrated approach.
- To promote close links with other sexual health providers in primary, community and secondary care
- To increase awareness of psychosexual problems, provide ongoing specialist support and training for primary and secondary care
- To recognise the importance of sexuality and relationship issues in health and education
- To act as a reference specialist point for training allied health professionals and clinicians

### **3. Background**

The remit of a psychosexual service is to provide help for clients presenting with problems of sexual dysfunction as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association Revision IV with Text Revision 2000 (DSM IV TR). This classification follows the physiology of sexual functioning and is used widely as an International Classification and in the Academic World. It classifies according to the cause of the sexual dysfunction and distinguishes between psychological cause, combined (psychological and medical) cause and wholly medical cause.

See Appendix 1.

The list of conditions is not exhaustive but is a guide as to what conditions are deemed suitable for treatment within the local psychosexual services. As a general rule, it will be expected that physical causes for problems will have been excluded prior to a referral being made. Where it is thought that the presenting sexual dysfunction is a symptom of disease (e.g. genitourinary infection, depression) and where it is felt that the problem could be reasonably expected to resolve following treatment of the underlying pathology, clients will be referred to the appropriate service within the NHS.

Whilst all services will see patients who have sexual problems as a result of physical ill health the remit of the service would be to help manage the problem rather than treat the underlying medical condition.

All services would be willing to discuss the appropriateness of possible referrals with the referrer prior to a referral being made.

Assessment and treatment strategies for this group of disorders include elements of psychodynamic, cognitive behavioural and systemic approaches as well as psychosexual and sex therapy counselling. Physical treatment and recommendations as appropriate.

### **4. Scope of the Service**

**4.1.** The service will take referrals from clients aged 16 years and over in line with individual trust policies.

**4.2.** The service chooses the most appropriate method of assisting clients and their partners, by a process of screening written requests from primary and secondary care and subsequent assessment of clients with psychosexual dysfunction where appropriate. In the majority of cases the service will then provide that care, although for clients in whom it is deemed inappropriate, suggestions for alternative sources of help will be made to the professional requesting assessment and the client.

**4.3.** Communication difficulties, lack of intimacy or trust and power conflicts have all been acknowledged as frequent concomitants of sexual dysfunction. Consequently, integral to the service will be provision for clients to address the relationship issues which are identified as predisposing or maintaining factors in the presenting sexual dysfunction. This will be the case as long as the service therapists deem that these issues can be dealt within the framework of the relatively brief interventions offered by this service.

**4.4.** Where significant problems are found to exist in the client's relationship with their partner, the couple will be advised to address these issues prior to beginning a programme of psychosexual treatment. The service will advise clients and those requesting assessments of sources of such help when necessary.

**4.5.** The client group will, in the main, consist of individuals and their partners. However, the absence of a partner or the unwillingness of a partner to become involved does not preclude the individual receiving help.

The service is offered to individuals and their partners regardless of sexual orientation.

**4.6.** It is currently beyond the remit of this service to provide care for the following:

- Sexual practices which would be the subject of action under the criminal justice system.
- Some sexual addictions and paraphilia

The service should be able to act as a source of information on other agencies able to offer help in such circumstances.

**4.7.** Production of guidelines/pathways and linkage with other services/groups

## **5. Service Requirements**

### **5.1. Principles**

**5.1.1** The service will be provided by a team of skilled professionals with the appropriate qualifications and experience to enable them to work with this group of clients. The potential for additional expertise of some practitioners within the team is recognised and would be reflected in their caseload. Equally, there are practitioners whose skills are in the management of a particular dysfunction and again, this would be reflected in their caseload.

**5.1.2** A named individual within the team will take responsibility for the establishment of documentation, audit and other managerial issues. This individual is known as the Clinical Lead for Psychosexual Service.

**5.1.3** The needs of the client group could be served by the formation of an alliance of the present practitioners in this field. This partnership could in the future possibly permit access to a wide range of expertise that could be shared amongst a professional group and this could allow appropriate means of achieving equity of access to such skills regardless of address.

**5.1.4** In the treatment of erectile dysfunction, the service will liaise closely with others providing care, especially those treating clients in whom the predominating cause of erectile dysfunction is organic. An agreement will be reached on assessment and selection criteria for clients, the acceptance of cross referrals and collaborative work on the provision of guidance for those requesting assessments. (Please see Erectile Dysfunction pathway – Appendix 1)

## **5.2. Referrals**

**5.2.1** The service will accept written referrals from primary, community and secondary health care sectors for assessment, diagnosis and advice or treatment. Referrals directly from clients will not be accepted.

**5.2.2** The Clinical Lead is responsible for reviewing the referrals that are received. Clients for whom assessment is warranted are allocated to individual therapists based upon the client's needs and the model of care that is thought to be most appropriate. The service will ensure that those making referrals for assessment are aware of the information needed by the service.

**5.2.3** See Care Pathway

## **5.3. Assessment and Process of Care (see also appendix 2)**

**5.3.1** Formulation of the treatment plan and subsequent care of the individual is undertaken by one therapist. However, where it is felt that the needs of that individual are best met by another member of the team, internal referral occurs.

**5.3.2** Usually, psychosexual interventions will be brief and focused. Most clients will have completed therapy within 12 sessions, although successful outcomes may be achieved in fewer

sessions. There may, however, be occasions where engagement in a longer course of therapy is necessary. If more than 12 sessions are required, the therapists will either present the case and / or discuss with their Clinical Lead (see also Appendix 2, Page 10).

- 5.3.3 The importance of outcome measures is recognised. They will be used before and after completion of the treatment plan (to assist in quantifying any alterations produced by the therapeutic interventions) in line with any forthcoming standardised guidelines.

## **6. Quality**

### **6.1. Clinical Quality**

- 6.1.1 All therapists hold appropriate qualifications for undertaking the therapy of this specific client group. These qualifications will usually be in therapy / counselling for psychosexual and relationship problems, from Post Graduate diploma level, or in an appropriate branch of psychotherapy or counselling.
- 6.1.2 The service includes support for supervision of therapists in line with British Association Sexual & Relationship Therapy (BASRT) and Institute Psychosexual Medicine (IPM) recommendations.
- 6.1.3 The service adopts a holistic approach to this area of care, avoiding a mutually exclusive division into organic or psychological aetiology. Although the therapists may have different professional backgrounds and psychosexual qualifications they will only be identified to the clients as a psychosexual therapist. (See Appendix A for an outline of the service staffing structure, job descriptions and roles and responsibilities).
- 6.1.4 To provide a fully integrated therapy service there needs to be access for the therapists to a clinician with a medical background or one working within the team.
- 6.1.5 Regular team meetings will provide an opportunity for supervision, case discussion, peer review, audit and service planning

### **6.2. Service Standards**

- 6.2.1 The professional requesting assessment receives notification of receipt of the request. If the request is accepted, the referrer and client will receive notification of this. The client will receive an

invitation to make an appointment with the therapist/opt-in questionnaire, together with some information on the service.

- 6.2.2** If the needs of the individual are judged not to be within the remit of the service, the professional requesting assessment receives information on the reasons behind this decision together with advice on alternative services or options for the client.
- 6.2.3** Brief letters will be written to the referring agency and General Practitioner, if not the referring agency, following assessment highlighting the diagnosis and treatment programs offered to the patient.
- 6.2.4** At the completion of treatment, a brief summary is sent to the clients GP (and professional requesting assessment if different) within 10 working days or in line with individual Trust procedures
- 6.2.5** Formal complaints procedure is available for clients and responses should be in line with individual Trusts complaints procedures. Further information on the NHS complaints procedure can be obtained from PALS.
- 6.2.6** Should a patient not attend an appointment (DNA) without cancelling the appointment, a standard DNA letter will be sent to the referring agency and the general practitioner if not the referring agency.
- 6.2.7** Confidentiality is assured at all times in line with Trust policy. As it is recognised that extremely sensitive information is kept on patients, as such case notes are kept confidential and separate from other hospital records. Access to patient records is restricted to the patient and therapist plus the therapist's supervisor/supervision group. Written permission from the patient is required for any other access. In couple therapy it is important to remember that an individual patient only owns his/her own words and not those of the partner. No information other than attendance is kept on shared NHS computer systems.

### **6.3. Audit and Monitoring/capacity**

Audit reports should be produced in line with local requirements. Monitoring includes;

- Total number referrals annually
- Caseload analysis
- Waiting times for first appointment
- Duration of treatment sessions
- Current standard outcome measures.
- DNA and cancellation rates

### **6.4. Professional Development and Planning**

Therapists working in the service are expected to maintain current professional standards as recommended by their appropriate professional bodies; including participation in activities that contribute to continuing professional education and development. This may include supervision, further training/continuation seminars and educational meetings, as well as PDP's and PDR's for agenda for change staff and appraisals where appropriate.

## **6.5. Links to Primary and Secondary Care**

- 6.5.1** It is envisaged that the majority of requests will be from this source. The service welcomes informal enquiries from primary care for advice and contributes to the existing framework of continuing education programmes i.e. postgraduate meetings and practice visits.
  
- 6.5.2** Assessment and treatment sessions will be conducted in a variety of settings, including primary care, community and some secondary sector sites. The proportion of care delivered in these areas will be determined in part by the provenance of the team members.

**Appendix 1**

Sexual Desire Disorder

- 302.71 Hypoactive Sexual Desire Disorder
- 302.79 Sexual Aversion Disorder

Sexual Arousal Disorder

- 302.72 Female Sexual Arousal Disorder
- 302.72 Male Erectile Disorder

Sexual Orgasmic Disorder

- 302.73 Female Orgasmic Disorder
- 302.74 Male Orgasmic Disorder (Retarded Ejaculation)
- 302.75 Premature Ejaculation

Sexual Pain Disorder

- 306.51 Vaginismus
- 302.76 Dyspareunia

Non Sexual Pain Disorder

Male Sexual Pain Disorder

Sexual Dysfunction due to a combined Condition

- 625.8 Female Hypoactive Sexual Desire Disorder Due to.....
- 608.89 Male Hypoactive Sexual Desire Disorder Due to.....
- 607.84 Male Erectile Disorder Due to.....
- 625.0 Female Dyspareunia Due to.....
- 608.89 Male Dyspareunia Due to.....
- 625.8 Other Female Sexual Dysfunction Due to.....
- 608.89 Other Male Sexual Dysfunction Due to.....

302 Gender Identify Disorder

N.B. Whilst the ICD Classification is recognized as the usual classification used in NHS settings, the classification is not helpful for sexual dysfunctions. The ICD classification lacks specificity in terms of diagnosis of sexual dysfunctions, whereas the DSM IV classification offers specificity in line with known sexual physiology. Hence the DSM IV classification is used worldwide as an academic and Research tool.

## Appendix 2

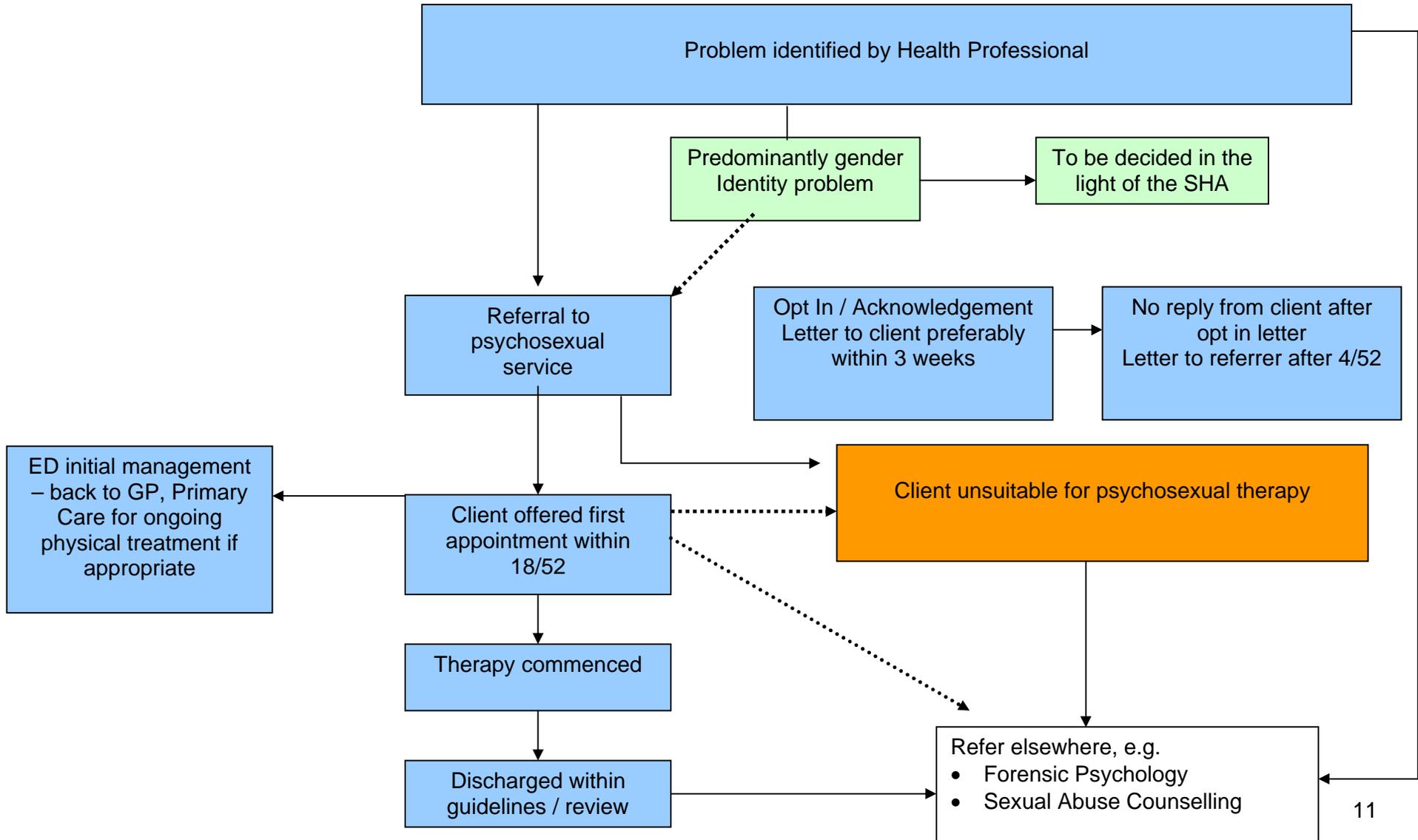
### Process of Care

**This document attempts to look at the average number of sessions required for working with sexual dysfunction.**

Sessions 1 - 3	Assessment Formulation Action plan
Sessions 1 – 4	Exploration of sense of self Body image work Sexual Orientation Gender dysphoria (pre referral work to specialist gender identity service)
Sessions 1 – 6	Brief Therapies; Programmes for: Performance Anxiety Sensate focus  And for simple problems:- Co – morbidities Erectile Dysfunction Vulval dysasthesias
Sessions 1 – 10	Longer programmes also useful in complex problems:- Vaginismus Loss of desire Relationship issues
Sessions 2 – 15/20/30	Very complex issues with underlying problems:- Sexual abuse Gender dysphoria with relationship and children issues

Appendix 3

PSYCHO SEXUAL THERAPY CARE PATHWAY



**GUIDELINES FOR THE INITIAL MANAGEMENT IN PRIMARY CARE OF PATIENTS WITH ERECTILE DYSFUNCTION (ED)**

**Initial Assessment**

- Include: BMI, BP, urinalysis, fasting glucose and cholesterol, smoking status
- Consider full profile (LFTs, U&Es, testosterone, prolactin, TSH, fasting glucose and cholesterol) especially in patients under 50 years of age or where loss of libido appears to be a primary problem. Family History (FH) IHD < 60

**History \* (see notes)**

- Explain possible causes of ED and treat any co-morbidity
- Consider withdrawal of any drugs possibly causing ED

**Examination**

(External genitalia secondary characteristics, lower limb pulses, gross sensation, possibly PR)

**Treatment (see also cautions and contra-indications below)**

Explain the government guidelines regarding prescribing and methods of obtaining drugs. Available at:

<http://www.advisorybodies.doh.gov.uk/smac/viagra.htm>

**Phosphodiesterase type 5 (PDE5) inhibitors**

All patients should be offered a trial of 8 doses of a PDE5 inhibitor unless contra-indicated. Onset of action may be delayed if taken with food.

Sildenafil and Vardenafil have a similar, short duration of action. Tadalafil is longer acting.

- **Sildenafil** 50mg approx 1 hour before sexual activity. Adjust subsequent doses according to response if necessary to 25-100mg. Max 1 dose in 24 hours. Cost per month: 25mg £16.59, 50mg £21.27, 100mg £23.50
- **Vardenafil:** 10mg (elderly 5mg) 25-60 minutes before sexual activity. Adjust subsequent doses to between 5mg and 20mg if necessary. Max 1 dose in 24 hours. Cost per month: 5mg £16.59, 10mg £22.24, 20mg £23.50
- **Tadalafil** 10mg at least 30 minutes before sexual activity. Adjust subsequent doses up to max of 20mg if necessary. Max 1 dose in 24 hours. Cost per month: 10mg and 20mg both £23.40

**Treatment Failure**

- Check the patient used the drug appropriately
- Increase the dose of the same drug, if tolerated, or try an alternative PDE5 inhibitor
- Referral to an appropriate clinic for other treatment options

PDE5 inhibitors are effective in approximately 80% of patient. Patients who fail to respond or cannot be prescribed a PDE5 inhibitor can still be managed in primary care, particularly by GPs with a special interest, but management is easier with the facilities in a specialist ED clinic

**Cautions and contraindications with PDE5 inhibitors**

- Concomitant treatment with nicorandil or nitrates (potentially serious hypotension and possibly myocardial infarction)
- Recent MI (within the last 90 days [6 months for vardenafil])
- Recent CVA (within the last 6 months)
- Unstable angina or uncontrolled arrhythmias
- Hypotension-blood pressure, 90/50 mmHG
- Uncontrolled hypertension
- Severe hepatic impairment
- Retinitis pigmentosa
- Hypotensive effect with alpha blockers, establish treatment before starting PDE5 inhibitors
- Drug interactions
- Erythromycin, itraconazole, ketoconazole, possibly cimetidine – reduce dose of sildenafil or tadalafil
- Use with extreme caution if taking ritonavir or saquinavir
- Rifampicin, barbiturates and phenytoin may possibly reduce serum levels of sildenafil and tadalafil
- No need to avoid PDE5 inhibitors in patients taking other antihypertensives but see alpha blockers above

**Patients to consider referral to Psycho Sexual Therapy**

- ★ Specific nature of patient's erectile dysfunction
- ★ Libido, psychological and partner factors