DsPH Network and Office for sexualhealth South West

COMMISSIONING SEXUAL DYSFUNCTION SERVICES

RESPONSIBILITIES FROM APRIL 2013

For the purposes of this document, 'Sexual Dysfunction' is used to encompass sexual and psychosexual difficulties.

Written by the South West Sexual Dysfunction Expert Advisory Group specifically for sexual health service commissioners in Clinical Commissioning Groups (CCGs) and in Local Authorities, sexual health strategic leads and others who would benefit from a detailed description and definition of Sexual Dysfunction; an interim guide to support commissioners when planning and developing services. It also makes specific recommendations for organisations and policy makers at local and national level.

JULY 2015

EXECUTIVE SUMMARY

1. Sexual Dysfunction can have devastating and wide reaching effects on individual's wellbeing and ability to function in other areas of life, especially in forming relationships. 'Sexual Attitudes and Lifestyles in Britain: Natsal 2013' reported 42% of men and 51% of women aged 17-74 interviewed who had had sex in the previous year had experienced one or more sexual difficulties lasting a minimum of three months. http://www.natsal.ac.uk/media/823260/natsal_findings_final.pdf.

2. There is huge variation across the country in the provision of appropriate services for people experiencing sexual dysfunction, with services provided to a varying degree and within different models.

3. In brief, sexual dysfunction
   - is complex and multi-faceted
   - is any problem relating to sex that interferes with a person's ability to engage in a fulfilling sex life
   - is not something that happens once, but occurs repeatedly and/or consistently
   - can cause prolonged and sustained distress to the person
   - can have a physical or a psychological cause, but more often than not is a combination of both
   - requires diagnosis in terms of an initial discussion with a doctor to confirm or rule out a physical cause

4. There are 2 main diagnostic and classification systems, the **DSM-5** and the **ICD-10** (see Appendix A)**.** The classifications are based on the parts of the 'sexual response' cycle and as understanding of this cycle evolves so changes are made in the DSM and ICD classifications.

5. Sexual Dysfunction is presented overtly and covertly to health practitioners working in everyday (non-specialist) settings. Therapists working in a psychosexual service may come from a variety of professional backgrounds such as medicine, nursing, psychology, psychotherapy and counselling. They may work in the community, primary and secondary care sectors, offering a range of therapeutic interventions.

6. People experiencing sexual dysfunction, if unable to access a Sexual Dysfunction Service, are very likely to access other services which will generally be unable to diagnose and/or treat the underlying problem, referring on to another service/specialist. It can also mean that people requiring sexual dysfunction interventions experience significant delays in accessing care and support as integrated patient pathways will generally not be in place.

7. There is no national strategic guidance on the provision of services for Sexual Dysfunction, no evidence base, service standards or outcome measures.

8. The South West Sexual Dysfunction Expert Advisory Group believes the current split in commissioning responsibility between 'sexual health' and 'non-sexual health' aspects of sexual dysfunction is not useful or relevant in clinical practice, where both are clearly integrated in the same patient, professional and consultation. It is in essence 'body-mind' medicine. The outcome of this commissioning split could result in significant delay to patients accessing the appropriate help and to increased costs to the NHS.

9. Recommendations

9.1 National:

- There is one clear, consistent definition of Sexual Dysfunction
- Work towards a single commissioning pathway for Sexual Dysfunction Services
- Until the commissioning pathways are clear, CCGs and LAs jointly commission services for Sexual Dysfunction, ensuring the provision of timely, high quality services for their populations
- To ensure that the sexual dysfunction needs of the population are explicitly included in local sexual health needs assessments, and that local Sexual Dysfunction Services are audited
- Sexual Dysfunction Services are maintained, improved and protected as there is likely to be an increase in the need for these services in the future
- National Sexual Dysfunction Service standards/NICE guidelines are developed to provide commissioners and providers with clarity on what good looks like; to include information on cost-effective drug treatment
- Sexual Dysfunction Services need to develop and maintain links with primary care; to offer teaching and be a source of advice and support to primary care colleagues where patients not requiring referral to a specialist team can be managed
- The sexual dysfunction content in both undergraduate and post graduate medical training needs to be reviewed and improved. Further discussions are needed with the Royal Colleges to develop more defined and distinct curricula covering sexual dysfunction (see Appendix C)
- A comprehensive evidence base and outcome measures for sexual dysfunction need to be developed to inform and support the provision of high quality services across the country. Methodological problems, (uncontrolled/not blind/no outcome measures/length of follow up variable), are pervasive throughout the research due to the complexity of the integrative approaches used in sexual dysfunction work. The absence of nationally agreed appropriate outcome measures for sexual dysfunction work is a major gap currently.

9.2 South West:

- Advocate that in the South West, commissioning for Sexual Dysfunction becomes the responsibility of a single organisation or individual in each local area
- When commissioning Sexual Dysfunction Services, the relevant commissioning body ensures these services are fully linked to, with patient pathways into and out, a range of associated health and social care services
- Local areas map the provision of Sexual Dysfunction Services to inform official current co-commissioning arrangements between the CCG and Local Authority Public Health sexual health leads, to develop an integrated Sexual Dysfunction Service incorporating both ‘sexual’ and ‘non-sexual’ elements of sexual dysfunction.

1. INTRODUCTON

Sexuality and sexual expression are seen by most people as part of the infrastructure of life, which can impact on all daily living tasks. Sexual Dysfunction may be a part of broader difficulties, e.g. generalised anxiety, psychological difficulty or physical illness, and can have devastating and wide reaching effects on an individual's wellbeing and ability to function in other areas of life, especially in forming relationships. Societal and economic pressures also affect sexual function.

Sexual Dysfunction is common in the general population. The prevalence varies according to how people are asked and the definition of what represents a problem. The most recent study, *Sexual Attitudes and Lifestyles in Britain*: *Natsal3* 2013, found that:

- 42% of men and 51% of women aged 16-74 interviewed who had had sex in the past year had experienced one or more sexual difficulties lasting a minimum of three months. This included lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness, and problems getting or keeping an erection

- 1 in 6 men and women feel that their health affects their sex life, but few seek help from a health professional

- only a quarter of men (24%) and under a fifth of women (18%) who say that ill-health affected their sex life in the past year sought help from a health professional and when they did it was usually from a GP.

Further detail on this study can be found at:
http://www.natsal.ac.uk/media/823260/natsal_findings_final.pdf.

Commissioning sexual dysfunction services is currently a shared responsibility between local authorities and clinical commissioning groups and is split in commissioning responsibility between 'sexual health' and 'non-sexual health' aspects of sexual dysfunction (see table on p.10 & 11), but currently no nationally agreed definition exists.

2. WHAT IS SEXUAL DYSFUNCTION?

Sexual Dysfunction is multi-dimensional, based on biological, psychological, behavioural, and relational factors. It rarely originates from problems of the psyche (the mind) and the soma (the physical body) alone, and is usually a combination of both. The causes can be further understood in terms of chronology and where the difficulty occurs by using the following subsets:

- Life Long Type (Primary) - present since onset of sexual behaviour

- Acquired Type (Secondary) - developing after a period of normal functioning

- Generalised Type (Absolute) - not limited to certain types of stimulation, situation or Partner

- Situation Type (Situational) - limited to certain types of stimulation, situation or Partner.

Consequently, conditions may require both physical treatments and/or psychosexual intervention. Treatment for sexual dysfunction is provided by a variety of medical and nonmedical health and non-health professionals from a range of agencies.

There is huge variation across the country in the provision of appropriate services for people experiencing sexual dysfunction, with services provided to a varying degree and within different models. The South West Strategic Health Authority Sexual Health Services Peer Review Programme, 2010-2013, found that rarely were these services explicitly commissioned, although sometimes psychosexual/sexual dysfunction was included, with a brief mention, within a whole integrated sexual health service specification. However all local areas were found to be providing some element/s of service addressing sexual dysfunction, whether or not explicitly commissioned.

There is no national strategic guidance on the provision of services for Sexual Dysfunction, and although Sexual Dysfunction is mentioned in the National Strategy for Sexual Health and HIV and the Framework for Sexual Health Improvement in England documents, there is no agreed definition of the term.

3. DEFINITION OF SEXUAL DYSFUNCTION

According to the **World Health Organisation International Classification of Diseases (ICD10)**, "sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction."

(http://apps.who.int/classifications/icd10/browse/2010/en#/F52)

The American Psychiatric Association compiles the **Diagnostic and Statistics Manual of Mental Disorders** and the new 5th edition **(DSM-5)** states "sexual dysfunctions are a heterogeneous group of disorders that are typically characterised by clinically significant disturbances in a person's ability to respond sexually or to experience sexual pleasure." It further qualifies that "sexual function involves a complex interaction among biological, sociocultural and psychological factors."

Therefore sexual dysfunction:

- is complex and multi-faceted
- is any problem relating to sex that interferes with a person's ability to engage in a fulfilling sex life
- is not something that happens once, but occurs repeatedly and/or consistently
- can have psychological or physical causes, but is usually a combination of both
- always has a psychological component, but not always a physical component
- diagnosis requires an initial discussion with a doctor to confirm or rule out a physical cause.

4. CLASSIFICATION OF SEXUAL DYSFUNCTION

There are 2 main diagnostic and classification systems, the **DSM-5** and the **ICD-10**. The new DSM-5 edition was published in May 2013 and it is worth noting that vaginismus is no longer listed as a disorder. The ICD-10 is due revision in 2015 and may contain other changes. They are systems continually updated to reflect current research and clinical experience, and are used by clinicians in categorising sexual dysfunction in a standardised way, not only for diagnosis but also for research purposes. However they have been and are used to commission and agree payment for service provision.

The classifications are based on the parts of the 'sexual response' cycle and as understanding of this cycle evolves so changes are made in the DSM and ICD classifications (See Appendix A).

5. PRESENTATION OF SEXUAL DYSFUNCTION

Whilst the classification is important for commissioners and clinicians, it doesn't capture the wide range of everyday presentations of people experiencing sexual dysfunction. Further consideration to other factors concerning partners, relationships, individual vulnerability, cultural/religious and medical diagnoses must be made, as well as assessment of the severity**.** There are many factors which may result in a person or a couple experiencing sexual dysfunction. These may result from emotional and/or physical causes and can be experienced by anyone at any point in their life. Sexual dysfunction is also commonly caused by a number of other treatments or medications.

The following are some examples to aid understanding of the wide range of causes of sexual dysfunction. This is not intended to be comprehensive.

- Sexual Dysfunction may arise from emotional factors, including interpersonal or psychological problems. Interpersonal problems may arise from marital or relationship problems, or from a lack of trust and open communication between partners, and psychological problems may be the result of depression, sexual fears or guilt, past sexual trauma, sexual disorders, among others.

- For women, almost any physiological change that affects the reproductive system – e.g. premenstrual syndrome, pregnancy, postpartum, menopause - can have an effect on libido. Pain during intercourse can be a result of other related issues such as infection, anxiety disorders, anxiety secondary to difficult birth or during infertility investigations.

- Sexual Dysfunction is especially common among people who have anxiety disorders. Ordinary anxiousness can cause erectile dysfunction in men without psychiatric problems, but clinically diagnosable disorders such as panic disorder commonly cause avoidance of intercourse and premature ejaculation. In some cases, erectile dysfunction may be due solely to relationship problems.

- Sexual activity may also be impacted by physical factors. These would include use of drugs, both therapeutic and recreational, such as alcohol, nicotine, narcotics, stimulants, antihypertensives and some drugs used to treat mental disorders.

6. EXAMPLES OF SEXUAL DYSFUNCTION PRESENTATION ACROSS HEALTH SERVICES

Sexual dysfunction presents across a wide range of services within the NHS. This presentation is often covert as it can be difficult to verbalise and/or understand the source of the difficulty, examples include:

- Painful sexual intercourse, non-consummation (inability to permit vaginal penetration), loss of sexual desire and difficulties with orgasm
- Chronic pelvic pain, genital pain, recurrent discharge with or without a physical cause
- Emotional and psychosexual after-effects of sexually transmitted infections including HIV
- Erectile dysfunction, ejaculatory problems, other penile problems and loss of sexual desire
- Contraceptive related problems which includes the inability to find an acceptable method from any of those available
- Vasectomy and sterilisation requests with a hidden agenda of sexual problems
- Psychosexual problems associated with, and after, childbirth including painful intercourse and requests for elective caesarean sections
- Psychosexual problems after regretted abortion, repeated requests for abortions. continuation of unplanned pregnancy, or following miscarriage
- Psychosexual problems related to infertility and ending of fertility
- Emotional and psychosexual effects of surgical interventions, chronic conditions or terminal care
- Psychosexual after-effects of sexual abuse
- Effects of ageing, disability or illness on sexuality

There are new, emerging sexual dysfunction problems such as internet sex addiction and body dysmorphia, which require further specialist training and may need to be explicitly commissioned in the future.

Dr Sally Soodeen (Bristol): *"We are facing a future when young adolescents have access to a world of pornography which is graphic, objectifying and often violent. We are already seeing the effects of this huge social change as it translates to performance anxiety, body image issues and difficulty with sexual intimacy. The physical effects of this are often erectile or ejaculation difficulties in men and wide ranging effects in women (e.g. requests for labial surgery)."*

People experiencing sexual dysfunction, if unable to access a Sexual Dysfunction Service, are very likely to access other services which will generally be unable to diagnose and/or treat the underlying problem, referring on to another service/specialist. It can also mean that people requiring sexual dysfunction interventions experience significant delays in accessing care and support as integrated patient pathways will generally not be in place.

7. SPECIALIST TRAINING FOR SEXUAL DYSFUNCTION

There are different types of training and models of treatment for Sexual Dysfunction available within the NHS, for example:

Institute of Psychosexual Medicine (IPM): Psychosexual Medicine is a type of brief therapy practised by doctors, based on psychoanalytical principles, but drawing on medical

knowledge and skills. This approach allows addressing the biological, socio-cultural and psychological needs of the patient and is considered to be 'holistic'. Some of the basic skills taught by IPM are available to some allied health professionals.

College of Sexual & Relationship Therapists (COSRT): The focus of therapy is to provide a safe space and regular time to talk about what is going on in the life of the client/s. The treatment may utilise cognitive behavioural therapy (CBT), behavioural therapy or an integrative psychological model of care dependent on the individual patient's needs. If the client/s decide, with the therapist, that there are any physical factors that need to be checked, then they will need to be referred to their GP, or another specialist doctor.

British Association for Counselling and Psychotherapy (BACP): 'Talking therapies', with no physical examination possibilities.

Therapists working in a psychosexual service may come from a variety of professional backgrounds such as medicine, nursing, psychology, psychotherapy and counselling. They may work in the community, primary and secondary care sectors, offering a range of therapeutic interventions. Some examples are:

- Medical doctor working in urology or an erectile dysfunction setting, treating only the physical aspects
- IPM doctor working with both the psyche and soma, in a psychosexual service, erectile dysfunction clinic or integrated sexual health clinic
- COSRT trained therapist (majority are non-health professionals with a minority being medical doctors) working with the psyche using CBT
- 'Relate' trained 'sex therapist' (non-health professional) working only with the psyche, can be accessed privately or is sometimes a commissioned service
- Psychotherapist working with the psyche using various psychological theories.

It should be noted that there are different levels of training within these organisations which will determine at what level of expertise the practitioner can be employed i.e. specialist or not:

The IPM has Membership level which allows the doctor to practice as a specialist and to receive referrals from anywhere. However, there is also a basic Diploma level which trains the practitioner (may be an allied health professional) to recognise problems within their own clinic, but is certainly not at the level to take referrals as a specialist from outside their clinic.
http://www.ipm.org.uk/23/information

COSRT has several levels of membership, requiring different levels of evidence to gain recognition – there is a need to check the expert level of each individual.
http://www.cosrt.org.uk/members-and-professionals/documents/#supervisor/

It is the practitioner's **training** that will determine how they approach the patient and how many sessions they are likely to need and use for each patient, the latter having a cost impact. (see Appendix C)

8. PROVISION OF A SEXUAL DYSFUNCTION SERVICE

The management of Sexual Dysfunction can be complex; commissioners need to ensure that all provider services pay attention to biomedical, psychological, relationship and social factors.

The British Society of Sexual Medicine (2015) believes that in order for proper care to be provided to patients, all aspects of sexual dysfunction should be considered and treated ideally within a single service. Many of these patients will have had multiple medical appointments prior to attending a Sexual Dysfunction Service, so the hidden costs of sexual dysfunction are under-reported, as are the costs of associated anxiety and depression and the societal costs of relationship breakdown.

The patient may present with an issue that stems from a physical cause, but whilst the source is physical the impact is emotional and therefore in theory the commissioning responsibility is shared. For the patient's wellbeing, it would not be appropriate to treat these aspects separately, either with a different service or different practitioner and would not be in the best interest of the patient, particularly if the aims below are to be realised.

This body/mind approach is at high risk of being lost under the current commission guidelines.

A Sexual Dysfunction Service should aim therefore to:

- provide a service which is evidence based
- adopt a holistic and integrated approach
- provide access to specialist skills and treatment as determined by clinical need
- provide a co-ordinated service of assessment, advice and treatment for patients presenting with problems of sexual functioning.
- show quantifiable outcomes
- promote close links with other service providers, offering help to patients with sexual problems in primary, secondary and community care.

An example of a service model and service options is provided in Appendix B.

Regardless of which service model is used, it is expected that appropriate drug treatment is given when indicated.

The patient group of the service will in the main consist of individuals or individuals and their partners. The absence of a partner or the unwillingness of a partner to become involved does not preclude the individual from receiving the service. The service should be also offered to individuals and their partners regardless of sexual orientation.

9. COMMISSIONING SEXUAL DYSFUNCTION SERVICES

From April 2013, a number of different commissioning organisations became involved in commissioning various aspects of sexual health services. Local authorities are responsible for commissioning most sexual health services and interventions, but some elements of care are commissioned by Clinical Commissioning Groups (CCGs) or by NHS England.

In the Introduction to *Making it work* (Public Health England September 2014) Duncan Selbie, Chief Executive, Public Health England emphasises that sexual health, reproductive health and HIV services make an important contribution to the health of the individuals and communities they serve. Their success depends on the whole system - commissioners,

providers and wider stakeholders - working together to make these services as responsive, relevant and as easy to use as possible and ultimately to improve the public's health. Service users' needs for integrated pathways are at the heart of the case for whole system commissioning in sexual health. Poorly connected care increases the risk of service users falling out of the system which can reduce their treatment adherence and worsen subsequent health outcomes.

A whole system approach to commissioning takes a broad view across the full range of responsibilities undertaken by commissioners in local authorities (including public health, social care, education, leisure and recreation) and the NHS. In sexual health, reproductive health and HIV commissioning, relationships are between NHS England through its specialised services, primary care and public health commissioners, clinical commissioning groups (CCGs) and local authority public health and social care departments.

Making it work states that collaboration between commissioners is essential to develop local commissioning strategies, assess the implications of decisions across the whole system and agree shared pathways that will secure seamless services for patients. It also specifically suggests that in terms of "psychosexual services", it may be more productive for local authority and CCG commissioners to identify what "psychosexual" services are needed locally, for both partners to agree to commission it and agree how the cost of the service is split rather than spending time and resource on working out detailed definitions of the "sexual health" and "non-sexual health" elements of psychosexual services. These arrangements can be reviewed as information on service use develops over time.

Commissioning Sexual Health Services and Interventions (DH 2013) refers to the commissioning responsibilities for Sexual Dysfunction Services being split into two categories:

- "sexual health aspects of psychosexual counselling" - to be commissioned by local authorities, with

- "non-sexual health elements of psychosexual health services" to be commissioned by CCGs (as detailed in the table below).

Commissioning Sexual Health Services and Interventions however does not define the terms "sexual health aspects", "non-sexual health elements", "psychosexual counselling" or "psychosexual health services".

Additionally, there is no national strategic guidance on the provision of services for Sexual Dysfunction and although "psychosexual services" are mentioned in the *National Sexual Health Strategy* (DH 2001), (p.13 section 13), there is no agreed definition of the term and only a brief mention in the recent *Framework for Sexual Health Improvement in England* (DH 2013) document of erectile dysfunction, with limited reference to other elements of sexual dysfunction.

Commissioning Responsibilities		
Local Authorities	***CCGs***	***NHS England***
• *Comprehensive sexual health services, including:* • *Contraception, including LESs (implants) and NESs (intrauterine contraception) including all prescribing costs – but excluding contraception provided as an additional service under the GP contract* • *STI testing and treatment, Chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing* • ***Sexual health aspects of psychosexual counselling*** *(this has been interpreted by many commissioners as being interventions where a psychological or emotional issue has caused sexual dysfunction, for e.g. historic sexual assault or rape which has caused sexual anxiety and dysfunction with a current partner)* • *Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies* • *Social care services including: HIV social care and wider support for teenage pregnancy (funding for these services sits outside the Public Health grant*	• *Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for foetal anomaly by specialist foetal medicine services)* • *Female Sterilisation* • *Vasectomy* • ***Non-sexual health elements of psychosexual health services*** *(this has been interpreted by many commissioners as being interventions where a physical illness has caused sexual dysfunction, for e.g. erectile dysfunction as a result of arterial disease)* • *Gynaecology, including any use of contraception for non-contraceptive purposes* • *HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)*	• *Contraception provided as an additional service under the GP contract* • *HIV treatment and care services for adults and children, and cost of all antiretroviral treatment including post-exposure prophylaxis after sexual exposure* • *Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs* • *All sexual health elements of healthcare in secure and detained settings* • *Sexual Assault Referral Centres (SARCs)* • *Cervical screening in a range of settings* • *HPV immunisation programme* • *Specialist foetal medicine services* • *NHS infectious disease in pregnancy screening programme*

10. THE NEED TO CHANGE COMMISSIONING DEFINITIONS

It is clear that Sexual Dysfunction is difficult to define; however, the South West Sexual Dysfunction Expert Advisory Group believes that the commissioning guidance as detailed in *Commissioning Sexual Health Services and Interventions* does not adequately cover the scope and range of sexual dysfunction. The split between "sexual health aspects" and "non-sexual health elements" and the further split between "psychosexual counselling" and "psychosexual health" is likely to lead to confusion between commissioners and health professionals within both specialist and non-specialist services. When this is added to a situation where Sexual Dysfunction often goes unrecognised in mainstream health services, there is significant potential for services to be inappropriately commissioned or not commissioned at all and for patient needs to go unmet.

The 2012/13 NHS Standard Contract for Integrated Sexual Health Services includes a template specification for psychosexual services as an appendix which does not separate between sexual health elements and non sexual health elements.

Currently there is neither published NICE guidance covering the treatment of psychosexual problems, nor guidance for commissioners from the Joint Commissioning Panel for Mental Health.

The defined outcome of the *Framework for Sexual Health Improvement in England* (DH 2013) is "to enable everyone involved in sexual health to work collaboratively to ensure that accessible, high quality services and interventions are available". This outcome is unlikely to be met under the current commissioning guidance for Sexual Dysfunction services

11. CASE STUDIES

The real-life case studies below (names have been changed) illustrate patients who were all suitable for a Sexual Dysfunction service. However, using the current commissioning guidance which splits definitions, the following examples demonstrate that in reality patients present with sexual dysfunction caused by a combination of both sexual and non-sexual health elements:

Case study 1

Mary is a 45 year old woman who when presenting gives a one year history of itchy vulva. In the past she had had a high vaginal swab from which candida had been grown but her symptoms were not responding to repeatedly prescribed antifungal cream. The Nurse Practitioner refers her to the sexual/psychosexual dysfunction service because she suspects Mary has issues with sex. "It only seemed to have started since I had sex with my new man". On examination, it is determined that the patient has vulval carcinoma, and she is further referred for surgery. However following the operation the patient is unhappy with her vulva and cannot face intercourse. The patient wants to return to the sexual/psychosexual dysfunction service to help deal with these issues.

Case study 2

David is a 60 year old man with erectile dysfunction. He is convinced that the problem is physical and isn't confident in his GPs knowledge "I want to see a specialist". Upon examination no pathology is found but he describes significant relationship problems with his partner. He can only protest about this to his partner by "failing to perform". The couple agree they need relationship counselling and went to Relate.

Case study 3

Pete is a 50 year old man complaining of erectile dysfunction. He has been caring for his wife whilst she has had chemotherapy for breast cancer. She has since recovered and demands to have her sex life back. He finds changing from the role of carer to lover difficult. However blood tests also reveal he has an over active thyroid. Upon attending the Sexual/Psychosexual Dysfunction Service he was delighted that it was able to manage both conditions.

Case study 4

Zac is a 21 year old man who has a history of extensive heart surgery. He has long been experiencing early ejaculation and takes a long time to obtain an erection. Neither cardiologist nor GP feel equipped to deal with him and the counselling service feels he is "too physical". The local PSM service undertake further examination (both body and mind) and determine that there is no organic pathology to explain his symptoms but he is terrified that sex will damage his heart. Once this fear has been voiced he is able to enjoy a more fulfilled sex life.

Case study 5

Don is a 36 year old man, who experienced a gradual loss of interest in sex over one year. He sought help from his GP because it was affecting his relationship. He thinks it started after intercourse exacerbated genital eczema and so he began to avoid sexual intercourse. Don was aware that he became increasingly anxious prior to intercourse for fear of precipitating another attack of eczema. He has had no problem obtaining or maintaining an erection or ejaculating. However, erections may not be as firm as they have been. Don is fit and well and experiences unusual tiredness all of the time – but a check at a private hospital didn't reveal any problems. After his first session at the PSM clinic he reported some improvement however, the service had carried out some blood tests and detected that he had an abnormal hormonal profile, possibly due to a type of brain tumour known as prolactinoma.

Case study 6

Shirley is a 57 year old woman experiencing painful sex. The GP put it down to her age and offered HRT. So she sought help at the Sexual Health Clinic and happened to see a doctor trained in Psychosexual Medicine. Examination showed her to have a pelvic mass, no evidence of menopausal changes and no pain elicited. Psychosexual intervention at the time led to resolving of the sexual difficulty.

She was urgently referred to Gynaecologists and had a hysterectomy with removal of benign cystic ovarian tumours. When she was followed up, she tried to tell them that she couldn't feel anything below mid abdomen and couldn't allow sexual penetration due to pain. But her problem was not being addressed. She returned to the same doctor and further psychosexual intervention, allowed her to understand her fear- that the penis could no longer fit in and that her clitoris had not been taken away. She has returned to satisfactory sexual function.

The cases below are examples not suitable for a Sexual Dysfunction service and are definitely not sexual causes. They are best dealt with by forensic or tertiary services:

- Middle aged man becomes alcoholic because he cannot satisfy his desire to continually expose himself

- Young man who feels compelled to have sex with many women in the hope that he can feel as good as he did the first time he had sex

- The man who has erectile dysfunction unless he can have sex with very young women because they are "pure" and not manipulative

- The woman with long standing schizophrenia who may or may not have been abused as a child.

12. CONCLUSION

In brief, Sexual Dysfunction

- is complex and multi-faceted

- is any problem relating to sex that interferes with a person's ability to engage in a fulfilling sex life

- is not something that happens once, but occurs repeatedly and/or consistently

- can cause prolonged and sustained distress to the person

- can have a physical or a psychological cause, but more often than not is a combination of both

- requires diagnosis in terms of an initial discussion with a doctor to confirm or rule out a physical cause

- Service commissioning split responsibilities are currently not adequately defined resulting in local interpretations, potentially leading to inequity of access to high quality Sexual Dysfunction Services.

13. RECOMMENDATIONS

In order to support the commissioning of appropriate Sexual Dysfunction Services and meet the aims of the *Framework for Sexual Health Improvement in England* (DH 2013) the South West Sexual Dysfunction Expert Advisory Group recommends the following:

13.1 National:

- There is one clear, consistent definition of Sexual Dysfunction

- Work towards a single commissioning pathway for Sexual Dysfunction Services

- Until the commissioning pathways are clear, CCGs and LAs jointly commission services for Sexual Dysfunction, ensuring the provision of timely, high quality services for their populations

- To ensure that the sexual dysfunction needs of the population are explicitly included in local sexual health needs assessments, and that local Sexual Dysfunction Services are audited

- Sexual Dysfunction Services are maintained, improved and protected as there is likely to be an increase in the need for these services in the future

- National Sexual Dysfunction Service standards/NICE guidelines are developed to provide commissioners and providers with clarity on what good looks like; to include information on cost-effective drug treatment

- Sexual Dysfunction Services need to develop and maintain links with primary care; to offer teaching and be a source of advice and support to primary care colleagues where patients not requiring referral to a specialist team can be managed

- The sexual dysfunction content in both undergraduate and post graduate medical training needs to be reviewed and improved. Further discussions are needed with the Royal Colleges to develop more defined and distinct curricula covering sexual dysfunction (see Appendix C)

- A comprehensive **evidence base** and **outcome measures** for sexual dysfunction need to be developed to inform and support the provision of high quality services across the country. Methodological problems, (uncontrolled/not blind/no outcome measures/length of follow up variable), are pervasive throughout the research due to the complexity of the integrative approaches used in sexual dysfunction work. The absence of nationally agreed appropriate outcome measures for sexual dysfunction work is a major gap currently.

13.2 South West:

- Ideally in the South West, commissioning for Sexual Dysfunction becomes the responsibility of a single organisation or individual in each local area

- When commissioning Sexual Dysfunction Services, the relevant commissioning body ensures these services are fully linked to, with patient pathways into and out, a range of associated health and social care services

- Local areas map the provision of Sexual Dysfunction Services to inform official current co-commissioning arrangements between the CCG and Local Authority Public Health sexual health leads, to develop an integrated Sexual Dysfunction Service incorporating both ‘sexual’ and ‘non-sexual’ elements of sexual dysfunction.

APPENDIX A

TABLE 1: Classification of Sexual Dysfunctions

DSM-5	ICD-10
Disorders of desire	
Male hypoactive sexual desire disorders	Lack or loss of sexual desire
	Excessive sexual drive
	Sexual aversion and lack of sexual enjoyment
Disorders of arousal	
Female sexual interest/arousal disorder	Failure of genital response
Erectile disorder	
Disorders of orgasm	
Female orgasmic disorder	Orgasmic dysfunction
Delayed ejaculation	
Premature ejaculation	
Disorders of sexual pain	
Genito-pelvic pain/penetration disorder	Non-organic vaginismus
	Non-organic dyspareunia
Other dysfunctions	
Substance /medication-induced dysfunction	
Other specified sexual dysfunction	Other sexual dysfunction, not caused by organic disorder or disease
Unspecified Sexual dysfunction	Unspecified Sexual dysfunction, not caused by organic disorder or disease

The DSM-5 further uses **sub-types** to qualify the dysfunction with a requirement that disorders are present for a minimum duration of 6 months and a frequency of 75%-100%:

- **Life Long Type (Primary) -** present since onset of sexual behaviour
- **Acquired Type (Secondary) -** developing after a period of normal functioning
- **Generalised Type (Absolute) -** not limited to certain types of stimulation, situation or partner
- **Situation Type (Situational) -** limited to certain types of stimulation, situation or partner

It is also worth noting that in the DSM-5 system, if the sexual dysfunction is mostly explained by a mental disorder, another medical condition, severe relationship distress, partner violence or other significant stressors, then a sexual dysfunction diagnosis is not made. The ICD-10 follows a similar separation of organic and mental disorders elsewhere.

APPENDIX B

PSYCHOSEXUAL THERAPY SERVICE IN GWENT

By Dr Jasmin Khan-Singh, 2006

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The Revised Psychosexual Services Standard (Jan. 2006) wants:

- Sexual Health Unit staff to have some **basic knowledge** about psychosexual problems.
- Sexual Health Units to ensure that all service users have access to **qualified, specialists** in psychosexual medicine, counselling and therapy, as part of an integrated sexual health service.
- Services to be inclusive and sensitive to the diversity of sexualities, sexual relationships and cultures and is respectful of personal dignity, autonomy, choice and enhances safe sexual expression and personal relationships.
- The service to be patient/client centred with a **holistic** approach i.e. takes account of physical, psychological and emotional health and well-being.

It further states that in working practice,

- Qualified psychosexual therapists may use a mixture of techniques in order to work effectively. **The approach should not be prescriptive as one pattern does not fit all.**
  Psychosexual Medicine uses the **psychodynamic model**, where practitioner and patient gain understanding together, the patient is considered the 'expert' and is helped to find answers and solutions. Psychosexual counselling and therapy uses a predominantly **Cognitive Behavioural approach**. Both may also incorporate physical treatments for some dysfunctions.

- The practitioner must have undertaken an approved training leading to **accreditation** with either the Institute of Psychosexual Medicine (IPM) or British Association for Sexual and Relationship Therapy (BASRT) and registration with the United Kingdom Council for Psychotherapy (UKCP) or the Institute of Psychosexual Medicine.

SERVICE OPTIONS AVAILABLE

❖ For Primary level of service:

This is where the majority of patients present.

A short skills course, to address basic knowledge, for all clinicians in an integrated sexual health service is required here. At present, there is no such course. However, the IPM (see**) Curriculum group is developing a short ***"skills awareness"*** course, with a view to addressing this training need .It is envisaged this would empower clinicians to recognise and

acknowledge a patients sexual difficulties (start the healing process) and refer on as necessary. Of course there are other specialities where sexual problems are likely to be presented eg urology, diabetic clinics, cardiology, vulval clinics and gynaecology etc. It would be best if staff here also had the opportunity of acquiring similar skills or at the least be aware of referral pathways to access the specialists in a psychosexual service.

❖ For Specialist referral services:

1. ***Multidisciplinary with physical treatment***

This is the gold standard, involving both IPM (Member) and BASRT trained specialist, working with a shared generic referrals list, where physical treatment is also offered e.g. for erectile dysfunction. When the patient needs to be referred to the specialist service, it is imperative that the referrer should know that both IPM and BASRT therapy is available within the service so that the referral is appropriate. Both approaches are valid and would be the "core" provision within any psychosexual service.

2. ***Multidisciplinary without physical treatment***

Multidisciplinary i.e. both IPM and BASRT trained specialist, working with a shared generic referrals list, BUT NO physical treatment is offered.

3. ***IPM with physical treatment***

IPM trained doctor with nurse support to allow physical treatments to be taught and dispensed. The IPM doctor is well placed, of all specialists working in the Psychosexual field, to make the initial assessment as both the physical and psychological issues of the patient are dealt with at the same time. ***Patients do not split themselves into body and mind for the convenience of the practitioner. It is better that those who can look at both together, do so.*** The revised specification requires that contraception and safe sex issues are addressed as part of the treatment plan also. A BASRT specialist would not be able to prescribe drugs and address medical needs or "examine" the patients.

4. ***IPM without physical treatment***

IPM doctor provides a holistic approach, using brief psychotherapy, and can examine the patient as necessary. Onward referral for those who cannot make use of this "therapy" will need to be considered.

5. ***BASRT without physical treatment***

The CBT approach is used alone and patients who need examination will need to be sent on elsewhere for this, **thus splitting body and mind**. Again onward referral for patients who cannot make use of this "approach" will need to be considered.

The multidisciplinary service model is the most favoured one throughout the U.K. Any differences in service provision are determined mostly by the availability of accredited specialists within the locality and whether physical treatments are to be provided or not. With all of the choices above a network of referral pathways will need to be

established for those who need a treatment plan that is not a remit of the service e.g. long term psychotherapy.

Remit of services offered:

The revised specification wants a service offering ***"brief therapy and counselling (6 sessions)*** for ***"anyone who has a sexual problem, concern and dysfunction"*** i.e. the general population**.** Therefore the following could be included:

- Those experiencing sexual dysfunction relating to sexual drive, desire, arousal or orgasm whether as a primary problem or as a complication of medical or psychiatric (see exclusions) condition.
- Those experiencing sexual pain disorders e.g. dyspareunia or vaginismus
- Those with psychosexual dysfunction as a consequence of:- sexually transmitted infections, sexual abuse, sexual assault or rape

However certain cases will not be suitable for this service and such exclusions would be:

- Issues of gender orientation i.e. those requesting sex change
- Marital relationship difficulties, unrelated to sexual issues
- Those with untreated serious psychiatric disorders or where there is a lack of patient insight
- Forensic sexology i.e. sex offenders
- Children who are not competent to give informed consent under the current "Children Act" or "Fraser" guidelines.

****** The Institute of Psychosexual Medicine offers a holistic training to Health Professionals (HPs) and a holistic response to patients. It is Medicine not Counselling. It offers a psychodynamic response to patients in the "here and now" of clinical practice but also in a referral clinic. The IPM approach allows for understanding of the origin of the psychosexual symptom so as to empower the individual patient to make choices, physically, emotionally and within relationships in the present and for the future. Resolution of the presenting symptom might not be the solution that the patient requires.

It is a model that can be used in the everyday practice of HPs with patients, in short consultations, without the need in many cases for expensive investigations and reduces waiting times to referral clinics.

Sometimes such examination is a sufficient response for patients where the body and mind have been dissociated, metaphorically, in their psychosomatic sexual presenting symptom. It is this particular aspect of the work of psychosexual medicine that allows such HPs to work so quickly with patients.

Contraception and safe sex issues are of course fundamental in the work of HPs practising within sexual health services. Negative responses to such discussion would alert the HP to the need for further understanding with that patient.

HPs trained with the IPM have developed an invaluable skill when addressing patients requiring intimate examinations e.g. a cervical smear. This can be the moment when the body and associated fantasies, feelings and defences of the individual patient can be examined and understood. To examine this part of the patient in a separate clinical setting with another practitioner would seem inappropriate and even negligent.

Note: BASRT has subsequently changed name to COSRT.

APPENDIX C

TRAINING IN SEXUAL DYSFUNCTION

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1. INTRODUCTION

Patients who have sexual problems see their doctor as the most appropriate professional source of information and help. To be able to provide this adequately, doctors require training in the subject of human sexuality. The extent to which this training is provided in UK Medical Schools and by post graduate training schemes varies enormously from a formal, comprehensive course to an *ad hoc* experience if and when problems arise with individual patients, or no training at all. (Reference: Training in Human Sexuality in the undergraduate Medical curriculum in UK. Sexual and Marital Therapy Volume 2 Issue 1 1987 Mary Davis)

2. POSTGRADUATE TRAINING

In the **Royal College of General Practitioners (RCGP)** curriculum no specific mention is made of sexual dysfunction and reportedly, owing to time restraints this topic is rarely covered (with the exception of management of erectile dysfunction). The GP is the first port of call for most patients.

There appears to be no mention of sexual dysfunction on the curriculum for **Genitourinary (GU) Medicine** trainees. Yet in many services a significant percentage of referrals come from GU Medicine. Patients are used to talking about sex with GU Medicine clinicians and like the anonymity the service provides.

The **Royal College of Obstetricians & Gynaecologists (RCOG)** curriculum, in its details of knowledge criteria state that a trainee should know:

- the anatomy and physiology of human sexual response
- the psychogenic aetiology and presentation of common sexual problems
- the effect of age, culture, illness and drugs on sexual behaviour and performance
- gender dysphoria
- principles of psychosexual counselling
- sexual problems in special needs groups
- covert presentations of psychosexual problems and childhood sexual abuse
- referral pathways to local expertise.

The trainees should have the clinical competence to take a sexual history and recognise sexual problems. However, the curriculum doesn't give any indication about how these skills are assessed or list training support from any of the organisations devoted to training in this area.

The Faculty of Sexual and Reproductive Healthcare (SRH) has the most comprehensive training for this topic detailed in their curriculum. Trainees are required to keep a log book

from which reflective case based discussions are used as the basis for assessment. Training support comes from a wide variety of sexual dysfunction training organisations. At the end of the module the trainee should be:

- aware of the various ways in which sexual problems can present
- able to take a basic sexual problem history
- able to initiate and review investigations to exclude a physical cause of for the problem
- understand the different management options for sexual problems
- aware of the doctor-patient interactions that can occur within a consultation
- recognise own limitations in managing sexual problems
- aware of the local referral pathways
- able to identify if they wish to pursue further training in this area.

However, relative to the other groups, SRH consultants are few and far between.

Nothing is mentioned on Sexual Dysfunction in Core Learning Outcomes in SRH and HIV for medical undergraduates entering Foundation training (2005, joint statement by BASHH and FSRH).

If the sexual dysfunction content in post graduate medical training is increased and improved as recommended, there are currently two main organisations able to provide this training – the Institute of Psychosexual Medicine (who train medical doctors) and the College of Sexual and Relationship Therapists (who train non-health and health professionals).

IPM and COSRT

Whilst within these 2 training organisations there will be outliers in membership, particularly with medical doctors (e.g. doctors who are COSRT approved and IPM doctors who are psychotherapists), they make up a very small percentage at best. Please note that the content of this document is focused on the majority membership not the exceptions.

Furthermore it is the training provided that is of importance here as this will determine how the therapist approaches the patient and how many sessions are likely to be needed.

- **COSRT** training is in essence a portfolio style accreditation, involving Cognitive Behavioural Therapy, behavioural therapy or an integrative psychological model. There are several levels of membership depending on which COSRT 'approved' courses have been attended (provided by external agencies eg Relate/Tavistock Institute); and whether a 2 year or 4 year training, with supervision, has been completed. The 4yr training allows registration with UKCP.

  As carrying out genital examinations is not a component of this training, it is open to non-health professionals.

  As a psychological therapies intervention, treatment plans are longer term and can often extend well into double figures.

  It is important that the correct Member level is employed for service needs and cost for the usual number of sessions required.

- **IPM** training is case-based experiential learning in seminar groups with criterion-referenced exit exams available after 2 years (Diploma) and 4 years (Member of the IPM, medical doctors only).

It is skills-based, using a psychoanalytical model approach with the patient and uniquely involves learning to make use of the genital examination in a psychotherapeutic way.

It is a training that all doctors and allied health professionals who carry out genital examinations can access.

As Psychosexual Medicine is brief therapy, treatment plans are usually 1-4 sessions and rarely exceed 6.

It is important to ensure that for specialist services, where taking referrals from outside agencies is required, IPM Members are employed, and in terms of costing, to bear in mind very few sessions are required.

There are other organisations offering CPD opportunities and details can be accessed via: http://www.bashh.org/documents/Professional%20Development%20in%20Management%20of%20Sexual%20Dysfunction.pdf

3. UNDERGRADUATE TRAINING

In most medical schools the departments involved in teaching human sexuality are obstetrics and gynaecology and psychiatry. The amount of time spent on sexual dysfunction varies between schools. Royal colleges also vary in how much if any time they suggest should be given over to talking about sex with patients. Here are a few examples;

- In the UK consensus statement for all 33 medical schools (Fungstein 2008) on the content of communication curriculum in undergraduate education, it is stated that a specific area that should be covered was “skills that enable doctors to talk about sensitive issues such as sex”.

- The British association of urologists state that the undergraduate core curriculum for urology should cover “what the physical and psychological causes of erectile dysfunction are” and understand the implication of erectile dysfunction as a marker for systemic vascular disease.

- The Association of British Neurology state that students should “Know the structure and function of spinal cord with particular reference to movement, sensation and autonomic control (that includes sexual function)”

- The RCOG state that undergraduates should “have awareness of sexual problems”

- Neither the Psychology or Psychiatry core curriculum for undergraduates mentions sex.

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