Clinical Psychology Services in HIV and Sexual Health

A Guide for Commissioners of Clinical Psychology Services

The British Psychological Society
Division of Clinical Psychology
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This briefing paper is one of a series offering advice to commissioners of clinical psychology services. It provides information about the role and function of clinical psychologists in sexual health and HIV settings with consideration of the recent National Health Service initiatives and reforms. It outlines the broad areas of psychological need for those people whose lives are affected by sexual health problems, including HIV infection.

Psychological health conditions often arise secondary to genito-urinary problems, gynaecological problems and sexual trauma. These typically include forms of adjustment disorder, depression, anxiety, obsessive-compulsive disorder, self-harm behaviour, post-traumatic stress disorder, addictive behaviours, relationship difficulties and psychosexual problems. The medical conditions that can give rise to these kinds of psychological problems include HIV infection, genital herpes, genital warts, hepatitis, chronic non-specific urethritis, pelvic inflammatory disease, genital pain, chronic thrush, abnormal cervical smear and reproductive cancers. Other conditions giving rise to psychological problems include unplanned pregnancy, termination of pregnancy and sexual trauma. Adults with primary psychological health problems are those without an identifiable medical condition who nevertheless suffer with emotional or behavioural disorders related to sexual health. These include those with anxiety disorders (particularly HIV anxiety), depression, somatoform disorders, sexual dysfunction, high-risk sexual behaviours, compulsive sexual behaviours, offending sexual behaviours and sexuality problems.

Clinical psychologists’ direct clinical work includes the assessment and treatment of primary and secondary psychological health problems, the prevention of primary and secondary disease transmission including prevention and management of unplanned pregnancy, and the prevention of psychological health problems. Prevention work is achieved through the application of individualised psychological therapy programmes to effect behavioural, cognitive and emotional change, reduce health risks and improve self-efficacy, self-care, self-esteem and overall well-being.

Indirect clinical work includes service management, service planning, policy development, supervision, consultation, liaison, teaching and research. The profession is unique in its ability to apply psychological theory and empirical research findings across a range of settings – clinical, academic and research.

This paper concludes with an outline of core psychological service requirements, outcome measures, recommended quality standards, monitoring procedures, staffing levels and other resource requirements.
Sexual health in the UK
The World Health Organisation (WHO, 1975) defined sexual health as ‘the integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are enriching and that enhance personality, communication and love’. Thus sexual health can be said to imply genital health, reproductive health, psychosocial and emotional health, freedom of reproductive rights and choices, full access to sexual health education, healthcare and decision-making, recognition of the meaning of sex in the lives of those addressed, and freedom from the burden of stigmatisation, discrimination, legal and socio-political repression (Miller, 1997).

There are a number of recognised indicators of poor sexual health and the need to address national sexual health issues was highlighted in the government’s white paper Saving Lives. It is known that virtually all the sexually transmitted infections are increasing and the number of attendances at departments of genito-urinary medicine now totals one million per year, a doubling over the last decade. The commonest conditions are chlamydia, non-specific urethritis and wart virus infection. Whilst the prevalence of HIV in the UK remains low compared to other European countries, the number of newly diagnosed HIV infections in 2000 was the highest since reporting began (CDR, 2000). In 1997 the conception rate for girls under the age of 16 was 8.9 per 1000. For girls aged 15–19 the rate was 62.3 per 1000. These are the highest rates of teenage pregnancies in Western Europe; in 1999 there were nearly 174,000 abortions performed in England and Wales (DoH, 2001b). There are wide variations in the prevalence of sexually transmitted diseases, HIV and unplanned pregnancies both across the country and within health regions. It is recognised that the impact of factors such as poverty, social deprivation, social exclusion, childhood abuse, racial discrimination and mental health problems, amongst others, place individuals at risk of sexually transmitted infections and early parenthood (Social Exclusion Teenage Pregnancy Report, 2000).

Clinical psychology is a well-established profession within the National Health Service and has been recognised as making a valuable and specific contribution to health care (Management Advisory Service to the NHS, 1989). Clinical psychologists aim to reduce psychological distress and enhance and promote psychological well-being through the systematic application of knowledge derived from psychological theory and research. Clinical work is undertaken directly with individuals, couples, families and groups, and indirectly at the organisational and policy formation level. The theory and practice of clinical psychology aims to be reflexive and empowering and seeks to create an understanding of psychological distress that includes consideration of the person’s socio-economic situation in the context of issues of class, gender, sexual orientation, religion, disability and cultural background.

Clinical psychology service provision within genito-urinary medicine (GUM) evolved as part of NHS and government responses to the emerging health crisis in 1981 when acquired immune deficiency syndrome (AIDS) was first identified. Human immunodeficiency virus (HIV) was recognised in 1983 and HIV testing was introduced in 1985. Further rapid treatment developments included the introduction of viral load testing in 1996 as well as new combination antiretroviral treatments, which have since resulted in major reductions in mortality rates and improvements in overall health and well being. It is recognised that an HIV diagnosis and subsequent illness and treatment issues can give rise to a range of psychological problems. It is also recognised that members of the population groups most affected by HIV may already be disadvantaged and experience social exclusion, harassment or even violence, for example because of culture, sexual orientation or drug use. The provision of psychological care is now a recognised component of good clinical practice in HIV healthcare (A First Class Service, DOH 1998; Main et al., 1998) and more broadly within genitourinary medicine (Monk et al., 1988).

The psychological impact of emotional, social and economic deprivation can lead to problems such as anxiety, depression, low self-esteem, drug and alcohol problems and repeated patterns of abuse, all of which can lead to high-risk sexual behaviours with associated risks to health (Heise, 1994). In turn, acquired sexual health problems and pregnancy-related problems then both add to, and exacerbate, pre-existing difficulties.
2. introduction (cont.)

The link between sexual health problems, poverty and social exclusion has been clearly recognised.

Psychological therapies have proven efficacy addressing problems such as anxiety, depression, drug and alcohol problems, low self-esteem and relationship problems and have a clear role in relation to modifying sexual health risk behaviours (Fonagy & Roth, 1996).

Psychological models have provided a basis for prevention work in sexual health and HIV as they have much to offer in terms of ways of changing or understanding personal sexual behaviours. These include The Health Belief Model (Becker, 1974), Theory of Reasoned Action (Ajzen & Fishbein, 1980), Perceived Self-Efficacy Theory (Bandura, 1977), AIDS Risk-Reduction Model (Catania et al., 1989).

Prevention of STI, HIV and unplanned pregnancy, is based upon the knowledge that many factors are relevant to behaviours likely to affect contraceptive use, safer sexual practices, safer drug practices and the spread of infection. These include demographic and cultural factors, levels of knowledge about risk, social norms and attitudes to behaviour change. It is recognised that psychological factors such as attitudes to risk-taking, search for excitement, low self-esteem, low mood and search for immediate gratification are relevant factors (for example, in relation to HIV risk behaviours see Kelly et al., 1991; Gold & Skinner, 1992; Whitmire et al., 1999) and provide a basis for psychological interventions.

The Future

A government-led consultation process which aims to develop the first national strategy in the UK for sexual health and HIV (DOH, 2001b) is currently under way. It emphasises that sexual health is an important part of physical and mental health and aims to improve services and prevention. Other government and NHS initiatives with relevance to clinical psychology in the context of HIV and sexual health include targets to reduce rates of unplanned teenage pregnancy (DoH, 1999b), the need to maintain awareness amongst the general population about the continuing risks from HIV; targets to reduce rates of suicide (DoH, 1999) and general aims to invest in, and improve, mental health services (DoH 1999a).
3. Aims of clinical psychology services in HIV and sexual health

Psychological theory, assessment methods, clinical and research skills have much to contribute to the understanding, detection and relief of sexual health problems.

Clinical psychology is firmly rooted in academic psychology and quantitative and qualitative science and draws upon the three established traditions of cognitive-behavioural theory, psychoanalytic theory and systemic theory.

A wide range of modalities of psychological interventions have been developed to help manage various forms of psychological distress and enhance the patient’s ability to cope (Catalan, 1995). A recent DoH document reviewing psychological therapies, treatment choice and empirical evidence, details the interventions that help with different problems (DOH, 2001a; Roth & Fonagy, 1996).

Clinical psychologists aim to:

● address the effects of the significant psychological co-morbidity in sexual health service attendees;
● work at the level of prevention through implementation of individualised and group programmes of cognitive, emotional and behavioural change.

In addition to the obvious health gains of improved mental health and quality of life for patients, these changes also lead to other benefits including:

● reductions in infection transmission rates;
● reductions in unplanned pregnancy;
● reductions in numbers of medical investigations requested by patients seeking non-identifiable organic causes for somatic disorders;
● reduction in number of medical out-patient appointments when needs are met more appropriately in other ways;
● avoidance of inappropriate hospital admissions;
● improved medical staff knowledge and earlier detection of mental health conditions leading to identification and treatment of mental health problems including anxiety, depression, suicidality, drug and alcohol problems (e.g. Verbosky, 1995).
A variety of studies have demonstrated a range of rates of psychological disorder amongst people with sexual health problems and HIV. Psychological problems are now a well-documented consequence of HIV infection and are recognised to relate to the potential terminal nature of the disease with its associated stigmas (Miller & Riccio, 1990; O’Dowd et al., 1991; Seth et al., 1991; King, 1989; Katz et al., 1996; Catalan et al., 2000).

Prevalence rates suggest 20 to 50 per cent of people with HIV infection may have significant mental health problems at some time (Catalan, 1991) and, for example, recent meta-analysis suggests the rates of depressive disorder is twice as high in HIV-infected individuals than in negatives (Ciesla et al., 2001). These studies suggest that the most common presenting problems are mood disorder, adjustment disorder, personality disorder and psychosexual dysfunction. One study at a London teaching hospital indicated that 20 per cent of all HIV-positive patients seen in the HIV clinic were referred to clinical psychology in a one-year period (Hedge & Sherr, 1994).

High anxiety about health (especially HIV) in adults who are physically well is a recognised psychological condition (Miller, 1998). These patients perceive their risk of being HIV positive as high and feel highly anxious, in spite of low HIV risk behaviours, and repeated clinical and serological evidence to the contrary. Suicidal ideation is not uncommon in this group. This patient group takes up a relatively high proportion of clinical services and resources in relation to other client groups (Miller et al., 1998).

Prevalence studies suggest significant rates of psychological disturbance in GUM populations, ranging from 20 to 40 per cent of attendees (Catalan et al., 1981; Fitzpatrick et al., 1986; Ikkos et al., 1987; Catalan et al., 1988; Ciesla & Roberts, 2001). It has been suggested that this psychological morbidity reflects the concerns that patients have in relation to their illness. The particularly emotive significance of sexually transmitted infections is recognised (Bancroft, 1989). Unlike many other medical conditions, these infections are sexually transmitted by a partner and are strongly associated with value-laden concepts such as ‘promiscuity’, ‘uncleanliness’ and ‘immorality’. Individuals have varied reasons for presentation, including anxieties about contracting sexually transmitted infections as well as those with confirmed diagnoses. GUM consultations may also unmask previously undisclosed difficulties such as sexual dysfunction, childhood sexual abuse and adult sexual assault (Petrak et al., 2000).

Aside from HIV, sexually transmitted infections particularly associated with psychological difficulties include genital herpes and genital warts. Psychological problems associated with the diagnosis and management of the herpes simplex virus are now well documented and include relationship difficulties and adjustment problems (Drob et al., 1985; Brooks et al., 1993; Swanson & Chentiz, 1993; Goldmeir et al., 1988; Shah & Button, 1998). Those associated with genital warts are less documented but have also been recognised within the research literature (Persson et al., 1993; Reitano, 1997; Maw et al., 1998; Filiberti et al., 1993).

Other genitourinary medical conditions associated with psychological problems include abnormal smear test results (Campion, 1988; Richardson et al., 1997), vulval problems (Jadresic et al., 1993; Nunns & Mandal, 1997; Stewart et al., 1994), pelvic pain (Renaer et al., 1979) and vaginal candidiasis (Irving et al., 1998).

Presenting problems of adult rape and sexual assault have clear and well-recognised psychological sequelae such as post-traumatic stress disorder (Foа et al., 1991; Foа & Riggs, 1993; Rothbaum et al., 1992; Golding, 1994; Koss et al., 1991; Petrak et al., 1997). In a study by Petrak et al. (1995) it was reported that a prevalence rate of one in four women and one in ten men attending a genitourinary clinic described a history of sexual assault. Sexual dysfunctions are common and represent a serious mental health problem. A substantial proportion of patients are likely to show a mix of organic and psychological pathology (Roth & Fonagy, 1996). Common male sexual problems include erectile disorder, premature ejaculation, anorgasmia and loss of desire. Common female sexual problems include arousal disorder, anorgasmia and loss of desire. Several surveys have suggested that the prevalence of sexual dysfunction amongst GUM attendees is high. Catalan et al. (1981) reported rates of 23 per cent in men and 41 per cent in
women and noted that most of these patients would have welcomed therapy for their dysfunction. It has been recognised that sexual disorders often arise as secondary problems to physical health conditions (HIV infection, diabetes, hypertension, heart disease, multiple sclerosis), psychological problems (anxiety, depression) and prescribed drugs (antidepressants, anxiolytics, antihypertensives, neuroleptics). Psychological factors contributing to sexual dysfunction include anxiety, depression, relationship problems and sexually aversive experiences in adulthood or childhood.

There is a clear relationship between sexual health conditions (e.g. genital herpes and vulvar vestibulitis) and sexual dysfunction (Nunns & Mandal, 1997). Since referrals for sexual dysfunction services are likely to be received from a number of specialities, including genito-urinary medicine, general practice, diabetes, cardiology, neurology, oncology and urology, the funding implications of providing such a service clearly need to be considered and managed appropriately (Keane et al., 1997).
In determining the needs of the local population, purchasers may use a variety of assessment methods. These include local surveys of need, national prevalence surveys, demographic profiles of the local population, comparative data from other similar services, and estimates of co-morbidity of sexual health and mental health problems. On the basis of the data, purchasers need to consider the contribution psychological services can make with respect to the following types of problem that people present to sexual health and HIV services.

### Mental health problems in HIV and sexual health settings

These include the following:
- adjustment disorders (following diagnosis of HIV or sexually transmitted infections);
- treatment-related problems;
- transmission risk problems;
- disclosure problems;
- anxiety disorders, including phobias and obsessive-compulsive disorder;
- depression, including suicidal ideation, suicidal intent and self-harm behaviours;
- personality problems;
- low self-esteem, shame and stigma;
- childhood sexual abuse;
- adult sexual assault;
- hypochondriasis and somatoform disorders;
- relationship problems;
- sexual dysfunctions including compulsive sexual behaviour;
- gender identity and sexuality problems;
- alcohol and drug dependency problems;
- chronic illness management problems (such as recurrent herpes);
- reproductive health problems (such as infertility);
- adjustment difficulties following termination of pregnancy;
- chronic pain.

### Problems specifically associated with HIV infection

In addition to the previously listed mental health difficulties these also include:
- difficulties coping with acute, chronic and terminal illness;
- physical disability problems;
- treatment adherence problems;
- management of common symptoms (such as pain, fatigue, sleeping difficulties);
- body image problems (including lipodystrophy);
- organic brain problems (including memory and personality disturbance, and HIV dementia);
- multiple bereavement problems;
- refugee related problems;
- history of abuse or persecution;
- occupational problems;

### Problems associated with prevention

- problems maintaining safer sexual practices (for those with and without STIs and HIV);
- depression related to low self-worth and lack of self-care;
- drug and alcohol problems related to sexual risk taking;
- problems using contraception;
- problems using condoms;
- relationship problems contributing to unsafe sexual practices;
- emotional and physical abuse – past or current.

### Complex case management

Clinical psychologists can provide a psychological contribution to complex case management difficulties such as for people presenting with:
- personality problems;
- somatic complaints;
- health anxiety;
- child and family problems associated with HIV such as disclosure and treatment issues;
- multiple or complex needs.
6. Outcome measures/health gains

An effective psychological service will produce measurable gains across a wide range of outcomes. The following measures can be applied to assess the effectiveness of psychological interventions, dependent on presenting problems and clinical context:

- a reduction in symptoms such as anxiety, depression, relationship and sexual difficulties;
- an increase in adaptive coping styles, with a concomitant decrease in maladaptive coping styles (e.g. avoidant, addictive);
- the achievement of mutually agreed goals for change;
- the acquisition of new skills and strategies for dealing with stress;
- improved quality of life;
- improved psychological management of a patient’s care;
- improved patient satisfaction;
- appropriate use of services.

A range of standardised measures are available for particular problem measurement, such as the Impact of Events Scale (Horowitz et al., 1979) for symptoms of trauma, the Beck Depression Inventory (Beck et al., 1961) for symptoms of depression, the Beck Hopelessness scale (Beck et al., 1974) for assessing suicidal risk (level of hopelessness has been shown to be associated with risk of suicide – Beck et al., 1985), the Hospital Anxiety and Depression Scale (Zigmund & Snaith, 1983) for measurement of anxiety and depressive symptoms in those with physical illness, the General Health Questionnaire (Goldberg, 1972; Goldberg and Williams, 1988) for measuring psychological distress, the CAGE questionnaire (Mayfield et al., 1974) for assessing alcohol use, the State-Trait Inventory (Spielberger et al., 1968) for assessing transient, situational anxiety as well as long-term tendency to be anxious, and the Beck Anxiety Inventory (Beck et al., 1988) for measuring anxiety with an emphasis on somatic symptoms.
Clinical psychology training enables psychologists to create flexibly tailored interventions for psychological problems encountered by drawing on a broad range of psychological models and techniques to a high level of skill. This differentiates them from other emotional support providers in sexual health and HIV settings such as counsellors and health advisers. (See Appendix 1 for clinical psychologists’ training and qualifications.)

A comprehensive range of psychological services is needed in order to meet the complex and diverse needs of people presenting to sexual health and HIV services. In order to obtain the best value out of often-scarce psychological resources, direct psychological assessments and treatments need to exist alongside indirect approaches such as staff supervision and training.

Core psychological services include the following:

**Assessment**
Assessment includes some or all of the following:
- description of presenting problems in the context of full relevant history;
- detailed psychological formulation of the presenting problem;
- psychometric testing, for example to assess HIV-related cognitive impairment;
- evidence-based recommendations about the healthcare and psychological treatment most likely to benefit the client.

**Treatment and intervention**
Interventions are based on the assessment and can be applied individually, in family units, couples, or groups. They are based on a range of proven therapeutic approaches, each of which is tailored to the identified needs of the patients.

**Services for professionals working in sexual health and HIV services**
- training other health care professionals in direct clinical skills, such as breaking bad news, or aspects of communicating with patients;
- consultation (offering a psychological perspective) to other workers’ treatment and management of people using services;
- supervision of other professionals who apply psychological theory and techniques to their work;
- team development and staff support;
- liaison with mental health services.

**Services for purchasers and planners**
- advising purchasers, providers and planning teams on psychological aspects of service provision, and psychological needs of people with sexual health and HIV problems;
- service evaluation and audit;
- measuring health outcomes;
- research on psychological aspects of care such as questions about quality of life, behaviour change, adherence to treatment, prevention and prevalence studies;
- prevention research, training in psychological models of prevention, behaviour and belief modification, and the impact of psychological interventions and treatments.
8. Organisation of clinical psychology services

Clinical psychologists working in the area of sexual health and HIV are usually located close to, or based within, sexual health departments and HIV services. They work as part of multidisciplinary teams, but also often in partnership with other NHS departments and organisations including health psychology services, drug services, adult mental health services, paediatric services, social services, general practice, police and voluntary organisations.

It is recommended that funding for psychology posts in sexual health and HIV settings be negotiated and managed through local general clinical psychology services in order to enable professional support, supervision, training and management of the post. In addition, it is recommended that the service be linked to academic departments to expand research capability and the evidence base through collaborative activities.

The clinical psychologists are professionally responsible for the assessment, advice and treatment they provide. Purchasers should, therefore, require that providers employ clinical psychologists eligible for Chartered status, which will ensure adherence to professional and ethical guidelines.

A partnership with sexual health and HIV services is ideally formed if the clinical psychologists have access to clinical and management forums where policy and cases are discussed and where the psychologist's expert knowledge and skills are available.

9. Recommended staffing levels and other resources

Minimum staffing levels will depend on local variations in prevalence. In order to assess the need and develop the clinical psychology provision, it is recommended that a clinical psychologist at Grade B consultant level with relevant specialist skills and experience be appointed to head the service in the first instance. In a previous briefing paper (Services for People with HIV), it was suggested that at least a half post per consultant-led service was appropriate. Staffing levels are recommended at a level of one psychologist per 250,000 population, which corresponds roughly to 40–80 referrals per year, per psychologist, depending on case mix, type of therapy provided and extent of indirect work required.

In addition to staffing levels, purchasers need to consider setting up factors such as provision of appropriate, convenient and comfortable space in which to work with patients, which is essential to ensure privacy and confidentiality. There is also a need for adequate secretarial support, and for professional support, training and supervision in order to reduce the risk of burnout and professional isolation and in order to maintain high standards of care. Access to translators, libraries and computer facilities is also recommended.
10. Commissioning clinical psychology services

Many medical sexual health conditions are as much social and psychological as medical phenomena, and investment in clinical psychology services recognises this through the provision of multi-disciplinary services for patient management and preventative programmes. Communication across disciplines is required at an early stage of service design and planning especially since acute hospital services may be in separate Trusts from their associated mental health services. It is essential that commissioning strategies are themselves integrated and designed to avoid fragmentation. This is especially important for clinical psychology services, which by their nature are likely to be a small part of the overall service. Services need to be provided, according to need and where appropriate, for people from the time of diagnosis, through their possible hospitalisation for treatment to possible terminal care.

A specialist clinical psychology service is an effective way of both improving the treatment of patients with HIV and sexual health problems, and of preventing sexual health, unplanned pregnancy and psychological health problems in those attending departments such as GUM clinics, HIV services, family planning services, forensic sexual assault centres, termination of pregnancy services, gynaecology, oncology and urology departments.

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.

Posts may be funded by Primary Care Trusts, HIV service commissioning, social services or other sources of funding. In order to balance recruitment, retention and serve local needs, permanent posts need to be contracted in such a way, that the development of comprehensive, responsive and adaptive psychology services to a number of agencies is not limited by the source of the funding.

Salaries, and terms and conditions of clinical psychologists are outlined by the Whitley Council. Adequate funding should be set aside for clinical psychology and the budget should remain separate from other aspects of sexual health or HIV services, or other clinical psychology services, and monitored according to service development need. Purchasers should request monitoring of patient referrals and audits of working standards drawn up locally or in accordance with The British Psychological Society guidelines.

Clinical psychology services need to be included 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 standards for clinical psychology services, based on British Psychological Society guidelines, are as follows:

- services need to be easily accessible in terms of information available, appointment times and location, in convenient and comfortable settings;
- there will be specified maximum waiting times;
- services will be appropriate and affirmative to a client’s age, gender, ethnic background, language and sexuality;
- service users will be consulted on their views of the service and involved in its service development;
- there will be adherence to the professional and ethical guidelines of the Society;
- services will only employ clinical psychologists eligible for Chartered status;
- clinical record-keeping will adhere to Society standard guidelines of clients, maintaining confidentiality according to professional guidelines and local service requirements;
- services will offer a broad range of psychological services, according to resources;
- services will ensure that there is appropriate provision for supervision, support and continuing professional development and have a method for staff appraisal;
- services will provide adequate administrative support and access to computer facilities;
- services will be equipped with adequate information systems for evaluation, research and audit;
- services will include readily available and easily understood information about the service, how to refer, confidentiality and team working.
Clear quality standards are crucial to all services provided by clinical psychologists. It is recognised that clinical governance is based upon principles of client-centred care that are accountable in giving a safe, high quality service in an open and questioning environment; the five key components are as follows:

- procedures for all professional groups to identify and remedy poor performance;
- clear lines of accountability and responsibility;
- a comprehensive programme of quality-improvement activities;
- clear policies aimed at managing risk;
- a partnership with patients in the design and delivery of services.

A number of methods to maintain and improve quality of services are used by clinical psychologists, including systems of management and individual personal review, clinical supervision, a programme of continuing professional development and service audit. Quality indicators need to include the acceptability of the service to patients, accessibility of the service to patients and referrers, the outcomes of psychological treatment and patient and referrer satisfaction with the service. The benefits of user forums and patient surveys are recognised.

Monitoring also needs to include the following:

- regular analyses of patient activity information to examine the use being made of the service, by type of psychological problem, type of sexual health problem, identity of referrer, patient age and gender;
- reviews of agreed performance indicators such as length of treatment, response following referral and response time to referrers regarding the outcome of treatment;
- clinical audit by peers via case reviews;
- visits by Trust board members and purchasers with feedback to providers.

The British Psychological Society’s Centre for Clinical Outcomes, Research and Effectiveness has produced guidelines for clinical psychology services to help with audit, covering operational aspects of the service, case management, professional support and quality control (Guidelines for Clinical Psychology Services).
Clinical psychologists are trained to provide assessment, treatment and consultation services and to carry out research, evaluation and teaching in National Health Service settings. They offer a wide range of skills to adults with mental health problems and, as a postgraduate trained profession, draw on a wide theoretical base to devise psychological interventions tailored to deal with complex presenting problems. Clinical psychologists bring to their work an understanding of the impact of acute illness and chronic disease on people’s lives. In addition, the role of factors such as poverty, deprivation and social exclusion are understood to play a significant role in relation to physical and mental health problems. In order to provide the most cost-effective services, direct work (assessment and therapy) is provided in balance with consultation, training, evaluation and research services to improve skills and healthcare across the whole service.

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Appendix: Quality principles for clinical psychology services

This statement from the Division of Clinical Psychology outlines the responsibilities of psychologists for quality improvement of their practice and services. It applies equally to practitioners working on their own in independent practice and to psychologists employed in service organisations.

1. All psychologists have a responsibility for the quality of their practice and the services they provide. This is inherent in The British Psychological Society’s Code of Conduct, the legal duty of care of professionals, and in broader ethical principles.

2. In carrying out their responsibility for quality, all psychologists will be involved in a systematic process of examining and improving their practice. Individual practitioners should ensure that at least one other psychologist or professional peer is involved to ensure objectivity.

3. All psychology services should have written principles and processes for quality improvement. These principles and processes and their implementation need to be open to inspection by outside parties.

4. Psychology services in organisations are usually part of a wider network of services. Psychologists have a joint responsibility in organisations, to be part of and contribute to, improving the quality of the services provided by the organisation as a whole.

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