

who monitors the care plan and to whom the patient and relatives can turn. These principles of care are appropriate for mildly depressed patients seeing one doctor in an outpatient clinic as well as for a patient with severe schizophrenia who sees several professionals.

I believe that the current frustrations with the care programme approach have arisen largely because it has highlighted the fact that, in many areas, good practice is impossible to implement owing to insufficient resources. All too often mental health services offer little more than reactive, crisis driven care, with their high staff turnover making continuity of care an impossible aspiration. The care programme approach is helping to show the true picture of mental health services, and it is not a pretty picture.

Marshall points out that a recent controlled trial reported a doubling of admissions to hospital after the introduction of the care programme approach.² Rather than being interpreted as a failure of the approach, this may indicate that the approach is doing its job—that is, helping services maintain contact with patients and drawing attention to unmet need, including the need for admission to hospital. It is oversimplistic to regard admission to hospital as a measure of failure.

It is easy to criticise the care programme approach, but can anyone suggest a better way of developing proactive and comprehensive mental health services into the next century?

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Case management confers substantial benefits

EDITOR,—Max Marshall claims that case management is “a dubious practice...underevaluated and ineffective...bedevilled by a tendency to lump two different approaches under one name.”¹ He then bedevils it further by equating care programming with “standard” case management, and what is frequently referred to in the American literature as case management as “assertive community treatment.” In a recent editorial on the subject in the *Lancet* “case” and “care” were used interchangeably.²

These terms are not difficult to distinguish, and much is to be achieved by distinguishing them. The meaning of case management evolved rapidly, reflecting the context in which it operated and increasing understanding of its working. Initially the focus was on the coordination of care and obtaining access to support and benefits by an office based administrator, who often had no health or social services background. This model (“brokerage case management”) was soon recognised to be of limited value in serious mental illness, and this was confirmed by controlled studies.³ Case managers shifted their emphasis to more direct care (“full support” or “clinical case management”), which has become the dominant approach in the United States.

Clinical case management increasingly emphasises outreach, small caseloads, and a broad clinical remit. Consequently, the term is now virtually synonymous with what is done by the assertive community treatment team (itself a concept that evolved from “training in community living”). These teams have been subjected to

over 13 randomised controlled trials, which have overwhelmingly shown their value.⁴

The research evidence is therefore clear and unusually abundant. Brokerage case management (renamed care management in British social services) is costly, with no added benefits for patients,⁵ and its adoption as policy in England threatens to damage mental health social work severely.² Case management (clinical case management) has been extensively researched and confers substantial benefits.

Use of the care programme approach with long term and complex problems arises logically from the philosophy of case management, is clinically coherent, and generates little controversy. Insistence that every patient of the mental health services should be included in this approach is a bureaucratic diktat that perpetuates confusion over whether it is clinically derived practice or an administrative procedure.

All three processes have a clear clinical identity. For two of them adequate evidence exists to make informed decisions about their value. For the care programme approach, clinicians need to take responsibility for shaping and researching it. Administratively coherent but clinically nonsensical definitions should not be allowed to confuse thinking or determine practice.

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Administrative demands of care programme approach

EDITOR,—Max Marshall makes the point that the care programme approach has never been fully evaluated, and that its American counterpart, case management, has not proved to be a particularly successful approach.¹ In Britain, some studies have claimed that the approach is successful—for example, in tailoring care to individual needs—whereas others have shown that care programme approach fails to improve outcome and has no effect on rates of suicide or reoffending.^{2,3}

We investigated the implementation of this approach within a mental health trust, studying administrative demands and the opinions of practitioners regarding the potential benefits and problems. Our results suggest that the care programme approach increases workload disproportionately to its perceived benefits. The most commonly cited problems included increased demands of time and workload due to extra administrative tasks and, perhaps more worryingly, the consequent detraction from time available to spend with patients.

The same issues were highlighted in the observational component of the study, using a multidisciplinary team meeting. These meetings are now required to discuss and review the care plans and complete the associated paperwork for all clients, but data from one such meeting indicates that this may not actually be feasible or appropriate in terms of time and human resources. In the one meeting studied, 110 minutes were spent discussing matters generated

solely by the care programme approach. Fourteen practitioners were present, so this amounted to a total of 1540 minutes (25.7 hours) of extra staff time. Previously the average meeting time was 60 minutes; this meeting was 170 minutes long. Practitioners had accommodated this added time commitment by cancelling ward rounds and community visits. Therefore, 25.7 hours of time had been effectively taken away from patients. During this time, only 13 patients were discussed.

In a trust currently dealing with over 7000 open cases, our preliminary results suggest that the demands the care programme approach puts on the system are logistically impractical, if not impossible.

It seems ironic that, in the current climate of evidence based medicine, the care programme approach continues to be not only advocated but enforced, despite a lack of supporting evidence for its usefulness. It would seem that this approach is being pursued so relentlessly because of its status as a government policy, rather than on its own merit.

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Continuing transmission of sexually transmitted diseases among patients infected with HIV

Qualitative study gave different results

EDITOR,—M A Catchpole and colleagues report evidence of continued transmission of sexually transmitted diseases in homosexual and bisexual men infected with HIV-1.¹ They reach several conclusions based on these findings, including that (a) unsafe sexual practices are continuing in substantial numbers of such men; (b) only a minority of these cases of sexually transmitted diseases are likely to be due to long term infections, infections acquired during safer sexual practices, or infections acquired in relationships in which the partners are aware of their infectious status; and (c) changes in sexual behaviour after the diagnosis of HIV infection are short lived or infrequent.

We recently completed a qualitative study of the sexual health of HIV positive homosexual and bisexual men; the results shed further light on the debate concerning the sexual practices of this group of patients. The study sample (n=40) was recruited through community groups (n=25) and HIV outpatient clinics (n=15) covered by the Northern and Yorkshire Health Authority. All the men in our study reported regularly practising safer sex with casual partners and partners whose status was unknown or negative. Only three men reported isolated incidents of unsafe sex with casual partners or those of unknown serostatus after their own HIV infection was diagnosed. All other reports of unsafe sex (n=8) occurred within regular relationships where the partner was also positive. Our participants typically reported that they

abstained from sex immediately after their diagnosis, for periods ranging from a few months to two years, with a return to sex coinciding with a return of confidence and self esteem and a greater knowledge of the risks involved. Almost all participants observed that the frequency with which they had sex had declined since their diagnosis. Indeed, five men reported that they had not had a sexual relationship since their diagnosis.

We are aware that the self selected nature of our sample may have biased the results obtained. Our study strongly suggests, however, that the sexual practices of many HIV positive homosexual and bisexual men may not correspond to those described by Catchpole and colleagues. Nevertheless, we agree with the authors' contention that their data highlight the need for more effective health education messages, and we have found that this need was also expressed by the patients we surveyed.

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Several reasons exist for failure of health education message

EDITOR,—M A Catchpole and colleagues report the continuing transmission of sexually transmitted diseases among homosexual and bisexual men infected with HIV-1 who were attending genitourinary medicine clinics; this indicated that a quarter of this group was practising unsafe sexual behaviour.¹ Self reported data on sexual behaviour gathered from HIV positive men in our clinic support these findings. Almost two thirds (221) of our sample of 349 reported having anal sex; among 155 men who responded to a question about condom use, 59 reported that they either used condoms inconsistently or never used them for insertive anal intercourse with their regular partners, while 40 said that this was the case for insertive anal intercourse with casual partners. A substantial minority (45 men) perceived the maintenance of safer sex as a problem.

There is now an extensive literature on the factors associated with unsafe sexual behaviour. This shows that accurate information and access to condoms alone are not sufficient to ensure safer sexual practices and that personal and interpersonal variables are important influences.² There is evidence of the effectiveness of cognitive and behavioural interventions to help those who have difficulties in adopting or maintaining safer sex,³ and in our centre we have

introduced a risk reduction service, which translates research evidence into practice and is offered to all people, particularly those who are HIV positive.

We agree with the authors that there has been a failure to deliver an effective health education message to those who are already infected with HIV. The reasons for this include the assumption that all HIV positive people will refrain from unsafe sexual behaviour, fear of further stigmatising those with the infection, and anxieties among health care staff that discussing safer sex with HIV positive people is inappropriate and may deter them from seeking medical care. It is important that, whatever the difficulties, we do not fail to help HIV positive people to protect themselves and others against genital infection and the further transmission of HIV.

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HIV infection must be destigmatised

EDITOR,—M A Catchpole and colleagues report that the current system of voluntary confidential HIV testing in genitourinary medicine clinics in England and Wales is failing to identify a substantial proportion of patients with HIV infection and that many patients who are identified as HIV positive do not adopt or sustain safer sex practices.¹ These findings have major policy implications. Should routine testing for HIV be introduced in genitourinary medicine clinics in England and Wales? Would this help to identify a larger proportion of the population with HIV infection?

Mandatory HIV testing at genitourinary medicine clinics has been carried out in Hungary since 1988 and is considered by Hungarian public health officials to be a highly effective component of the HIV prevention programme.² Whereas only 30% of all HIV tests in Hungary are carried out mandatorily (the rest being voluntary), the National Institute of Hygiene estimates that these tests account for 80% of positive results. Positive results are followed by intensive counselling and contact tracing. Infected people are offered high quality medical treatment, psychosocial support, and welfare assistance when these are needed. Most importantly, perhaps, routine testing for HIV infection seems to be widely accepted in much the same way that screening for syphilis is. Opportunities to object to the testing programme exist but have not been exploited even by the groups most closely affected by the programme.

Conversely, the introduction of routine HIV testing in England and Wales could well trigger a

chain of ultimately counterproductive events. After 15 years of the control of AIDS being based on voluntarism the introduction of routine testing would almost certainly inspire vigorous opposition. At least some people with suspected or confirmed sexually transmitted diseases would avoid going to genitourinary medicine clinics for fear of being tested and identified as HIV positive. These people, with undetected and untreated sexually transmitted diseases, would then be at increased risk of transmitting HIV.

Moreover, Catchpole and colleagues' findings suggest that, even if routine testing were introduced, this would not of itself result in reduced transmission. Informing people that they are HIV positive is no guarantee that they will consistently adopt safer sex practices.^{3 4}

What these findings point to is the urgent need for new approaches that destigmatise HIV infection while providing encouragement to people to accept responsibility for protecting themselves and their partners.

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Sexual behaviour of homosexual men with and without HIV infection differs

EDITOR,—M A Catchpole and colleagues suggest that there has been a failure to deliver effective health education messages to those at highest risk of acquiring HIV infection and those who have already been diagnosed as infected with HIV.¹ This generalisation does not take into account nuances in the behaviour of the two subgroups. Evidence suggests that considerable differences in sexual behaviour exist between homosexual men at high risk and those who are already infected with HIV. Recent data on gonorrhoea from Brighton confirm this behavioural difference.

The number of cases of gonorrhoea in homosexual men attending the department of genitourinary medicine in Brighton fell dramatically from 70 in 1993 to 35 in 1994 and 36 in 1995. Among homosexual men infected with HIV, 13 had gonorrhoea in 1993, seven in 1994, and seven in 1995 (1 in 5 in all three years). In 1995, 24 of 29 men not infected with HIV acquired gonorrhoea through unprotected oral sex under the misconception that the practice is safe. By contrast, five of the seven men with HIV infection acquired the infection through unprotected active and passive anal sex (three rectal and two urethral). The pattern was similar in the previous two years.

Clearly, a substantial majority of homosexual and bisexual men not infected with HIV are well informed of the risks of unprotected anal sex and behave accordingly, although they are misguided, at least as far as other sexually transmitted diseases are concerned, about the safety of unprotected oral sex. By contrast, a substantial number of homosexual men who are infected with HIV seem to ignore safer sexual practice. Education programmes should address this