be guided by results of well designed controlled trials and laboratory monitoring. Clinicians are likely to minimise the emergence of resistance by hitting the virus hard with adequate dosing regimens. Clinical failure of antiviral therapy in the presence of high drug levels may be due to drug resistance, and second line therapy should then be considered.

Since we now recognise the potential for antiviral compounds to generate viral resistance, it would be foolish not to monitor carefully the current and future use of these drugs, if only to ensure that they are prescribed appropriately, to maximum patient benefit and with minimal risk to the population at large. In response to these concerns the Public Health Laboratory Service, in collaboration with the University of Birmingham, has recently announced the setting up of an antiviral susceptibility reference laboratory to undertake

surveillance for resistance to existing and new drugs, assess the public health implications of resistance, and provide a readily available service of diagnostic assays to assess viral susceptibilities to drugs.

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The NHS reforms revisited

Health care systems change as societies change

See p 566

Born amid anger and bitterness, the 1991 reforms of the NHS continue to be a subject of controversy. No consensus about the balance of costs and benefits has emerged, and disagreement about the NHS will doubtless feature as prominently in the next general election campaign as it did in the previous two. Not only is the available evidence about the NHS's record since 1991 fragmentary and often ambiguous, but the fiercely partisan positions taken up by advocates and critics when Kenneth Clarke launched *Working for Patients*¹ in 1989 suggest that, even if more had been invested in evaluation, any further evidence would have been used to fuel argument rather than to resolve it.

It is therefore bold of the BBC to launch its three-part television series *Safe with Us*, designed to document the genesis, implementation, and impact of the NHS reforms. The series, to be screened over the next three weeks, illustrates both the strengths and weaknesses of television when tackling issues of public policy. Nothing can match television's ability to recreate political conflict. Facing the television cameras, Kenneth Clarke and the BMA leadership refight and reflect on their battles, while the newsreel images of protesting nurses and doctors convey the near hysterical atmosphere of the time.

The second programme, dealing with the implementation of the changes, has less overt drama to feed off. But, as the programme reminds us, conflict did not end with the enactment of the legislation. Consultants were bitterly divided about hospitals adopting trust status—first wave fundholders, as one of their number recalled, were treated like “Christians in the arena” by their colleagues. In short, the new NHS was launched in an atmosphere of acrimonious turbulence, with even its sponsors worried about the feasibility of making the internal market work. It is a story well told by the programme,

exploiting to the full the ability of television to use the words of the participants to provide the script.

But in attempting to draw up some sort of balance sheet in the third programme, the makers of *Safe with Us* faced a rather different problem. Here there was no simple story of conflict to tell but a complex set of issues to explore. Instead, the programme chose to extract a simple theme from the welter of evidence: that, while the reforms had not destroyed the NHS, they had redefined it. The result is oversimplification, teetering on the edge of misrepresentation. For example, the expansion of private sector activity is emphasised, with no mention of the fact that the main expansion took place long before 1991.² Similarly, rationing in the contemporary NHS is stressed, with no recognition that this has been a feature of the service since 1948.³

Drawing up a balance sheet of the NHS reforms has baffled many academics,⁴ so it may be unfair to criticise the makers of *Safe with Us* too harshly. Instead, perhaps, we should reflect on some of the wider implications of the programmes. First, the very fact that the post-1991 NHS has not solved many of the problems that it inherited—that it has disappointed the expectations of its advocates, just as it has disproved many of the fears of its critics—suggests that further change is likely. The pressures that generated Mrs Thatcher's reforms have not disappeared. Second, the story of the NHS reforms suggests that we should be thinking more about the process of change. Is conflict the inevitable price of introducing radical change in health care, as in 1948 and 1991, or is it possible to reach a consensus about desirable reform?

Neither of these issues is likely to be resolved in the context of health care policy. There may be a danger, as the editor of the *BMJ* points out in the third programme, that the NHS will become the system of last resort for the least well off. But this

may reflect less the health care policies or ideology of a particular government than the fact that society has become more polarised. Just as the NHS was born in 1948, when inequalities in income were diminishing, so the new tensions have made themselves evident at a time of increasing inequalities. It may therefore be overoptimistic to expect that the NHS can be used as a kind of institutional glue for society, symbolising mutual support, unless this is part of a wider change of direction. Similarly, it may be unrealistic to hope that future changes in policy can be negotiated rather than imposed if the present system of adversarial politics persists. If achieving change through consensus is the aim, constitutional reforms

like proportional representation may be the necessary means. In short, health policies inescapably raise questions about the nature of our society and our political system.

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Family interventions in schizophrenia

An effective but underused treatment

The systematic review by Mari and Streiner of family interventions for people with schizophrenia,¹ abstracted in a recent issue of *Evidence-Based Medicine*,² confirms what mental health researchers have suspected for some time³—that such interventions reduce relapse rates, rehospitalisation, and costs of treatment and also increase compliance with medication. This is good news for schizophrenia sufferers, their families, and others involved with their care, because family interventions promise an effective strategy in schizophrenia that complements other interventions such as antipsychotic medication.⁴ Despite this, acceptance of the treatment into clinical services has been slow.⁵

Mari and Streiner included 12 randomised controlled trials of family interventions in their review, selected after systematic search of the research literature by predetermined methodological criteria. The interventions all offered family psychoeducation and support, and most included some form of skills based training for relatives, although the theoretical orientation of these programmes varied considerably. The cultural backgrounds and therapeutic environments in which the studies were conducted also differed. However, the intervention trials together showed reasonably consistent, if moderate, effects. After about one year of follow up, preventing a single additional relapse in a person with schizophrenia required intervention with seven families. The number of subjects studied in these trials was small, and the results of the meta-analysis remain vulnerable to the possibility that larger trials in the future will produce negative results.⁶ Nevertheless, the current evidence is clear.

The accumulation of research evidence in this field followed a classic progression.⁷ An unexpected observation that people with schizophrenia relapsed more frequently after discharge from hospital if they had more contact with their families, first published over 30 years ago,⁸ led to the experimental construct of family "expressed emotion."⁹ People with schizophrenia living in families characterised by high levels of hostility, criticism, or emotional overinvolvement had higher relapse rates than those who did not.¹⁰ The numerous and diverse studies that investigated this association, reviewed by Kavanagh,¹¹ generally replicated the original findings. Nevertheless, sufficient theoretical and methodological ambiguity remained to allow considerable divergence of conclusions in traditional, non-systematic, reviews published in the late 1980s.¹²⁻¹³ Two more recent systematic reviews, using aggregated data,¹⁴ place the association of high expressed emotion and increased rate of relapse in schizophrenia beyond doubt. But even these had limited clinical relevance until the results of trials of family intervention became available. In 1991, a traditional, non-systematic review of intervention trials was generally positive,⁵ but could not produce an aggregate estimate of the effect of family intervention. It also raised methodological

and theoretical concerns about the published data. Here, then, is the value of the Mari and Streiner systematic review.¹ Strict inclusion criteria allowed the reviewers to control for methodological differences between studies and, by meta-analysis, to derive aggregate effect sizes for the family interventions. Furthermore, publishing the study in the Cochrane Schizophrenia Group module of the Cochrane Database of Systematic Reviews¹⁵ allows for regular updates of the data and cumulative meta-analyses as new studies come to hand. The current version of the database contains four studies in addition to the eight included in the original "paper" publication of the review in *Psychological Medicine* in August 1994.

Over a decade ago, Kuipers and Bebbington concluded that family intervention as a treatment modality in schizophrenia should move from the research environment to influence clinical practice.¹⁶ The evidence to support this move has strengthened since, and this recent systematic review recapitulates it. Yet the availability of this treatment remains poor, and descriptions of its use in routine clinical settings are rare and confined to authors with a strong research interest in the field.^{5, 17} Perhaps this reflects resource issues—while no formal economic evaluation of family intervention for schizophrenia exists, the large number needed to treat (seven families for a year) to prevent one relapse suggests that the intervention is highly labour intensive. But this conclusion became available only with the present review and, in any case, the provision of mental health services bears little relation to research. Judged by the best available evidence from systematic reviews, psychiatry incorporates many commonly used treatments whose comparative effectiveness is equivocal at best. Among biological treatments, selective serotonin reuptake inhibitors provide a notable example,¹⁸ while among psychosocial treatments, the implementation of case management programmes is similarly debatable.¹⁹ It is tempting to speculate that the current status of family intervention programmes for treating people with schizophrenia might be different if they attracted the research resources and marketing prowess associated with drug treatments, or the political will associated with case management.

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