

AIDS, Tuberculosis and Malaria, which provided grants of more than \$850m, (£460m, €685m), did not focus either on assessing the impact of interventions or on a robust programme for health systems research.¹⁴ If the global agenda to reduce the burden of disease among poor children is to progress, evidence based interventions must be accompanied by meticulous documentation of impact and a clear process for learning.

This week has witnessed one of the largest assemblies of public health workers and partners at the ninth meeting of the Global Forum for Health Research in Mumbai, as well as the launch at the UN Summit in New York of the new global Partnership for Maternal, Newborn and Child Health. Both of these well intentioned events underscore the need to reduce the inequity in global child health through concerted action and appropriate research. It is now time to translate rhetoric into action.

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Evidence based reform of mental health care

Early, intensive, and home based treatments are the answer

Two big ideas have dominated reform in mental health care in recent years and underpin the widespread enhancement of services that is being attempted in England. These are that people with mental disorders should have treatment in the community, and that young people with early psychosis should receive timely and comprehensive intervention during the critical years following onset. Two large, high quality studies in this issue report much needed evidence on the impact and feasibility of these drivers for reform.^{1 2} Both studies are large and well designed and report positive results in support of the present reforms.

Johnson and colleagues (p 599) show elegantly that providing, in a disadvantaged inner city community, intensive treatment at home for acutely ill people with severe mental disorder substantially reduces the use of inpatient care.¹ The number needed to treat attests to the potency of this effect, which seems to be sustained for at least six months. Furthermore, although treatment at home did not increase risk, patients were less exposed to the disruption and the often harmful effects of inpatient care. This study also indicates that home treatment could be highly cost effective.

Petersen and colleagues (p 602) show that more intensive, assertive community treatment in early psychosis produces better outcomes at two years than does standard care,² reinforcing the message from a similar UK trial.³ Similarly, the OPUS study assessed intensive care during the critical period in early psychosis,⁴ but the content in the Petersen trial was less specific for that phase of illness than in the intervention used in other programmes for treating early psychosis.⁵ More phase specific forms of psychosocial intervention,⁶ preventive programmes to help

people back to work,⁷ and earlier detection of psychosis⁸ may further improve outcomes.

These two concepts of reform are related but have evolved sequentially. The model of community psychiatry was spawned within the wider process of deinstitutionalisation and was ignited sociologically, not scientifically. Science came later. And where the community model has struggled, it has been for economic rather than scientific reasons. The reforms towards early intervention in psychosis, catalysed by the rise of community psychiatry, have developed along with evidence based medicine, which emerged at the same time. Representing the overdue introduction of early diagnosis into psychiatry, this process has woven science, clinical care, consumerism, values, and sociology into a potent blend. This disturbs some people, who defend treatment as usual.⁹ Are they defending the indefensible?

The criticism that each reform process has attracted deserves deeper analysis. Both reform and resistance to it are complex phenomena influenced by values, evidence, and opinion. The resistance to early intervention in psychosis is based on an overly narrow interpretation of the evidence based model.¹⁰ Evidence based medicine refers to individual interventions and diagnoses while evidence based health care focuses on systems and models of care.¹¹ Evidence based practice is an even more pragmatic and mature concept which integrates the best research evidence with clinical expertise and patients' values. Studies of new approaches to evidence based practice are difficult to carry out, and high quality studies, such as the two in this issue are rare.^{1 2}

Critics argue that reforms to health care should not begin until the evidence base for them is virtually complete. Yet we cannot remain paralysed, waiting for

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perfect studies to be conducted and published before we respond to the needs of patients with serious health problems. To create the evidence for evidence based practice we should develop “best bets” in a stepwise manner and use well conducted evaluations to initiate, guide, and sustain effective models of care while weeding out ineffective, harmful, or wasteful ones.

In Australia, where the building blocks of both community treatment and early intervention were constructed and the first wave of reforms was rolled out,¹² there has lately been a loss of momentum and a corresponding decay in services.¹³ Many of the crisis resolution teams in big cities have lost funding, retreated into hospital emergency departments, or lost the key skills and sense of purpose required for this challenging role. Early intervention for psychosis is still supported by rhetoric but is struggling in practice.¹⁴ One main reason for this is the failure to grasp that reform is a continuing task requiring sustainability as well as innovation.

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Reforming research ethics committees

Latest proposals are a missed opportunity for a radical review

For the first 25 years of their existence in the United Kingdom research ethics committees were left more or less in peace by the Department of Health. Since the publication of the “red book” in 1991,¹ however, they have undergone a continual process of radical change, from the introduction of multicentre research ethics committees in 1997, through research governance, to various legislative reforms of research practice including the clinical trials regulations of 2004.²⁻⁴ Ethical review has been extended to more and more kinds and locations of research. At the same time, ethics committees have been subject to continuous criticism from researchers and public and private sector sponsors of research. Criticism from patients and the public has been less audible.

Some of the criticism of research ethics committees has focused on issues for which they can bear no responsibility, such as the interpretation of the Data Protection Act 1998 or the operation of trusts’ research governance procedures. Ethics committees have been the lightning rod for the frustration researchers have felt about the bureaucratisation of research. Yet much of this frustration is reasonably directed at ethics committees. They can be slow, idiosyncratic, and poorly informed about research methods or guidelines on the ethics of research. And researchers can reasonably feel that many of the reforms since 1991, while intended to simplify ethics review of research, have actually made matters worse. This criticism appears to be common across Europe, with wide variations in approval times and required amendments being reported by many researchers.⁵⁻⁶ Late last year Lord Warner, then a junior

health minister, commissioned an ad hoc advisory group to review the operation of NHS research ethics committees in the health and social care sector. The group’s findings were published in June.⁷

The group’s principal conclusions are that independent ethical review of research is important but that it needs to be efficient and timely and to concentrate on substantive ethical issues rather than scientific issues or minimal risk projects better overseen by other research governance mechanisms. Thus patient satisfaction surveys, assessment of the suitability of research sites, and research on NHS staff can all reasonably be dealt with outside research ethics committees. The processes of ethical review, such as the electronic form, can be simplified and improved. Decent administrative support needs to be provided for committees and for bodies such as the Central Office for Research Ethics Committees, which supports, manages, and trains ethics committees and their members. Most importantly, the report argues that committee process needs to be harmonised more closely both across Europe and within the United Kingdom and with a simplified research governance framework. The review also makes the important point that at least some “inconsistency” is actually the result of the inherent variability in moral judgment.⁸

All of these improvements should be welcomed by the research community: the test is whether they actually work as intended. More controversial are the conclusions that there are too many committees, some of which meet too infrequently to be useful, leading to preventable inconsistency, and that the way to deal