On system management and regulation in the NHS, the update is important as much for what it hides as for what it reveals. The Department of Health promises that more detail on the future of regulation will come in a consultation document this autumn. This suggests that ministers have not yet decided whether to create a single NHS regulator that brings together the functions of Monitor (the current independent regulator of foundation trusts), the Healthcare Commission (the body that safeguards quality in the NHS), and other agencies.

The government's plans for the future of "payment by results" (the method for paying providers from a fixed tariff for each individual case treated in NHS hospitals) are equally vague, with little progress evident since the last update on the reform programme in December 2005. This is particularly worrying, given that providers of specialised services such as paediatrics say that the tariff is inadequate[2] and given the need for incentives to shift services from hospitals to the community for people with chronic diseases.[3]

Much more progress has been made on commissioning. An annex to the update, twice the length of the main document, describes the roles of practice based commissioners, primary care trusts, and specialised commissioning groups. It also signals a commitment to harness through national procurement the skills of companies with expertise in commissioning. The new guidance focuses only on hospital services but promises more detail later in the year for other services such as those for people with mental health problems and other long term conditions.

Whether the government's plans will succeed in strengthening commissioning depends on two factors. The first is the ability of the newly reorganised primary care trusts to perform better than their predecessors. The second is the willingness of general practitioners and primary care teams to use practice based commissioning.

The signs that the trusts can perform better are decidedly mixed. On the upside a development programme to support them is under way, and a national model contract for them to use with providers will be published in the autumn. The ability of primary care trusts to access expertise on commissioning from the private sector—for example, in information analysis—should also help.

On the downside, most primary care trusts are in the early stages of formation, and it will take time for them to build up the necessary capabilities. Managers in both the NHS and the wider public sector lack expertise in commissioning. The detailed advice in the update's annex on managed care techniques to be used by commissioners reinforces the feeling that the Department of Health is not confident that primary care trusts, left to their own devices, will deliver what the NHS needs.

Furthermore, the new guidance suggests that primary care trusts should offer additional incentives to persuade general practices to participate in practice based commissioning. This reflects doubts about slow uptake of practice based commissioning and lack of engagement among practices.[4] General practitioners' substantial increases in income for work done in their practices under the new general medical services contract may make the offered benefits of practice based commissioning less attractive. Commissioning will require harder work, not least because practices will have to collaborate with each other to change the behaviour of powerful hospital providers.

This update on the NHS reforms and the new commissioning guidance fill gaps in the government's strategy and offer a more coherent narrative of the direction the reforms are taking. But how commissioning will work beyond hospital services is not clear, and difficult questions have still to be answered about payment by results and regulation. Above all, there is a lingering doubt that ministers have put the cart before the horse in developing the role of providers before that of commissioners.

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Psychological and social interventions for schizophrenia

Robust evidence supports a wide range, including cognitive therapy

Over the past two decades few disorders have been subject to such big changes in management as schizophrenia. Yet these have gone unnoticed by the general medical and popular press—possibly because these changes have not arisen from breakthroughs in research on genetics, receptors, anatomy, or neuropharmacology.

The new generation of antipsychotic drugs has not fulfilled its promise of substantially increased effectiveness or even of much better tolerability.[1] In this week's *BMJ* Tiihonen and colleagues show that, in practice, some older drugs such as perphenazine are as efficacious as the newer ones.[2] This follows the findings of the National Institute of Mental Health clinical antipsychotic trials of intervention effectiveness (CATIE) study that 74% of patients with established symptoms of schizophrenia discontinued their medication within 18 months and there was no overall difference in effect between perphenazine and the newer atypical drugs.[1 3] When patients can accept

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and tolerate clozapine, this does seem to have some benefit over other drugs but still has substantial side effects.[1]

In contrast, psychosocial research has started to pay dividends in schizophrenia and is leading to big changes in service delivery. There is now evidence to support psychological targets for interventions, for instance experiences of childhood mental and physical trauma,[4] oversensitivity to everyday stresses,[5] and use of hallucinogenic drugs,[6] along with a range of other psychological and social factors.[7] Working with families to improve coping and reduce high expressed emotion is already well established as a means to reduce relapse rates in schizophrenia.[8] More than 20 randomised controlled trials and five meta-analyses have shown cognitive behaviour therapy to be beneficial in schizophrenia, reducing both positive and negative symptoms during therapy and beyond.[9] This evidence warrants an about-turn in the approach to symptoms: cognitive therapy focused on the content of psychotic symptoms should now be replacing purely supportive therapy that avoids such discussion.

But, despite the inclusion of psychosocial and cognitive therapies in clinical practice guidelines, such as those produced by the National Institute for Health and Clinical Excellence (NICE) in England, there remain considerable problems with implementing these new treatments. Even where therapies and services are available, only a minority of patients and families have access to them.[10]

The original research into family therapy in schizophrenia comprised pairs of workers meeting family members for 10 or more sessions,[3] a commitment that few services can make. Simpler, briefer interventions with families combined with cognitive therapy with individual patients have produced positive results and may, at least in the first instance, be the way forward.[11]

Training schemes to expand the number of therapists are undersubscribed owing to the current severe restrictions on NHS funding. Once trained, therapists need continuing supervision and support but this is often not available because caseloads are too big and therapists' managers do not give this work sufficient priority.[10] NICE guidelines recommend that all patients with schizophrenia should be referred for cognitive therapy but, again, this does not happen. Reasons for failing to refer include concern that the person with schizophrenia will not engage with therapy or is too well.[10] But rates of engagement with cognitive therapy and family work have been high—up to 90%—both in research studies and in clinical practice. Furthermore, patients who are stable or are not complaining about their symptoms may yield other benefits from cognitive therapy including social recovery and relapse prevention.[9]

Social change has also played a part in revolutionising services for people with schizophrenia. The programme to close mental hospitals is near completion in the United Kingdom. Treatment at home enables patients to avoid admission to acute mental health wards and allows early discharge of inpatients. Early intervention teams are now at work in many areas of the United Kingdom. In the prodromal period of schizophrenia, cognitive therapy may reduce the risk of developing psychosis.[9] (Such risk reduction has not been shown with psychotropic treatment,[12] although it is widely used in this context.) Supported employment schemes can help many people with schizophrenia make the transition to work, improving their social life, finances, and self esteem.[13]

Overall, mental health professionals view schizophrenia much more hopefully than in the past, giving stronger emphasis to social inclusion and recovery. This is warranted, given that long term studies now show that, for more than 50% of patients, schizophrenia is not a chronic and continuous illness.[14] Stigmatisation remains substantial, however, not least because of negative publicity in the media. The term schizophrenia is unpopular with patients and carers—and alternative names for the "group of schizophrenias," as Bleuler originally described them in 1911, have been proposed, based on psychosocial concepts, such as sensitivity and drug related or traumatic psychoses.[15]

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