

National Programme on Forensic Mental Health Research & Development

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21 July 2006

Consultation Responses
Cooksey Review Secretariat
HM Treasury, 4th Floor
1 Horse Guards Road
London SW1A 2HQ

Dear Sir David

Consultation on Cooksey Review of UK Health Research

I am pleased to submit a response to this consultation on behalf of the Programme Advisory Committee of the National Forensic Mental Health R&D Programme. The Programme has funded research to support the provision of mental health services for people with mental disorders who are offenders or at risk of offending. The mental health services are provided in secure and community NHS and criminal justice settings. The patients, whether in prisons or NHS services include difficult, dangerous and/or extremely vulnerable people whose behaviours present a risk to themselves as well as others.

The patients can be difficult to engage in assessment, treatment and research. Staff must meet the therapeutic needs of patients whilst addressing legal, security and public safety issues. Commissioning and carrying out research in forensic mental health is therefore particularly challenging.

We are often dealing with high risk individuals with serious offending behaviours resulting in high economic and social costs including those imposed upon victims of crime. The services provided have high unit costs and it is imperative to know that these are both effective and economic in providing mental health gain and reduced crime.

Research on forensic services must address a difficult legislative context and matters of public and patient safety as well as health gain for mentally disordered offenders. A complex network of criminal justice, health, social care and private agencies are involved in delivering forensic mental health services

Forensic Mental Health Research thus needs to be strategically driven to support policy and service developments in the new arrangements. The National Programme on Forensic Mental Health R&D is due to close next year. I am responding to the questions posed in your consultation in this light.

In essence it is critical, if forensic mental health provision in the UK is to continue to develop at the leading edge, that the institutional arrangements for health research must (i) enable basic and applied research issues relating to mental health and offending to be identified as policy and public health priorities, (ii) ensure the academic posts and infrastructure for FMH (currently almost entirely funded by NHS Trusts) survive the current changes in NHS R&D funding brought about by Best Research for Best Health, (iii) create strong interactive links with stakeholders amongst policy colleagues, service commissioners, managers and providers across health, social care and criminal justice as well as academics to identify important questions and implement solutions supported by evidence.

1. *What are the strengths and weaknesses of the MRC and NHS R&D programmes at present? How does each of these support the research and training needs of the NHS, social care, industry and academia? Does more need to be done?*

- The strengths are the high standing and quality of much research funded by the MRC; some NHS research is of high standing and quality and relevant to NHS needs.
- A key weakness is that both MRC and NHS must do more to ensure that stakeholder groups, including the people who commission, design and provide front line services in NHS and social care organisations, can fulfil their roles as (a) identifiers of important research questions and (b) customers of research if the health and economic gains of evidence based practice are to be achieved.
- Some research needs in support of health policy do not fall directly within the remit of the DH Programmes (HTA or SDO programmes), for example epidemiological studies and it is important that the long term gains of these are understood and that they are adequately supported.
- “High impact” journals do not necessarily have high impact on services. Not all clinical questions will be covered by NICE guidance so more work needs to be put into translating the messages of research into products for the end customer.
- “Best Practice” and implementation guidance can correspondingly seem to be relatively free from a rigorous examination of available research evidence and this needs to change.
- This initiative to improve health services research must strategically address research needs of multi-agency service provision such as that provided by social care, criminal justice and voluntary agencies.

2. *What do you believe are the key scientific and organisational challenges facing health research, and underpinning training, in the UK over the next decade? How might the UK Government best help address those challenges? What do you believe should be the Government’s objectives for health research, and why?*

- The Department of Health needs to develop a research strategy that responds to policy and support it. Once strategies are developed there needs to be research funding to commission the necessary research.
- We need a well trained stable research workforce in sufficient numbers with appropriate geographical and organisational spread to undertake research of the highest quality from basic science through to organising to deliver multi-agency services based on the best available evidence. For forensic services this will include criminological, social and economic as well as health evidence.
- Service contestability, multi agency provision in multiple NHS community and prison sites means that a model of science which is explicitly or implicitly based on undertaking research in large teaching hospitals is not appropriate.
- The support of training and science must enable the highest quality clinical research which is situationally appropriate i.e. can answer questions about providing evidence based services for hard to reach people with complex needs who in fact constitute the majority of users of some very resource intensive services.
- A programme of research in this high risk/high cost area needs to be strategically developed and followed through. With the demise of the National Programme on Forensic Mental Health R&D there needs to be a replacement mechanism for setting a strategic direction for research and following it through by commissioning the research that is needed.

3. *What should be the Government's priorities for health research? Is there anything it should stop doing or funding? What is it not doing or funding that it should do, and, in the absence of further sources of support, what can it lower in order to release the necessary funds?*

- A key element of DH Best Research for Best Health provides structure to support drug trials and large scale trials of other interventions. There is an opportunity to look to where there is opportunity for drug research to be undertaken ethically on a full cost recovery basis for the NHS to see if this saves money which can be invested in research funding.
- Funding for health research should be in line with the economic, social and personal burden of particular disease groups. The recent UKCRC analysis of UK research funding failed to distinguish mental health from neurological disease. However, the data were presented in a recent letter to the British Medical Journal (Kingdon, BMJ 24 June 2006) and demonstrate the shortfall in funding for mental health research.
- The government needs to consider how new innovative research ideas will come forward to address major suffering and the economic impact of people with mental illness and personality disorder who are offenders. The amount invested in relevant research is minimal in comparison with economic burden and cost of treatment (*crudely £1.7m pa research funding has been available for this Programme - beds in the sector cost between £150--250k per annum, the estimated economic cost of a murder is £1.1m*)

4. How should decisions be taken on the balance between the long-term economic and social benefits of a high quality biomedical research base; and the needs for research to improve healthcare and other public services? What is the appropriate balance between public funding for investigator-led and priorities led research? How do we balance funding for basic science, translational science and applied science? Is this something that should vary over time? What mechanisms should be used to make judgements about this balance?

- There is no obvious answer – a balanced portfolio of research is more likely to emerge if there is structured involvement of stakeholders (as above) around consideration of key issues in developing a plan with short, medium and long term objectives. We need to maintain a strong commitment to investigator-led high science, but also to be more strategic about policy and health service research funding.

5. In your experience, how have the results of publicly-funded health research in the UK been used, both in the development of new treatments and to influence / change wider policy and healthcare practices? What lessons can usefully be learned to improve the uptake of advances in science and medicine?

- There is no doubt that much remains to be done to make the results of research more applicable to and useful for end users. There are two key issues – the relevance of the questions which funded research addresses and the synthesis and communication of results to make the products usable by relevant stakeholder groups. More needs to be done to create a shared understanding of the role of evidence across professions and health, social care and criminal justice agencies.
- We need to create customers for research amongst commissioners, service managers and clinical social care professions. We need to target the needs of these groups as well as those of end service users.

6. How might better links be forged between ‘basic’, translational and applied researchers, working across the whole field of health research, from the laboratory bench to the front line of the NHS? How might better links be forged across disciplines, e.g. with engineers, physicists, and social scientists?

- By joint calls by Research Councils – at present a single fund must encourage collaboration between disciplines by introducing incentives – this will only work if there is perceived mutual benefit.
- Encouraging large research groups encompassing basic through to applied research
- Research commissioning which brings together relevant stakeholders and professions in understanding how “systems” work and the kinds of skill needed to identify the questions, fund the answers and disseminate the results in a useful targeted way.

7. How can the Government encourage translation, entrepreneurship and innovation in health research to improve public services in the UK?

- There should not be micro management of research but an assurance of ethics, quality and where appropriate relevance to policy and service priorities in the short medium or long term.
- The Government should not appear to promote the idea that there is only one useful model of research (the large scale trial with simple outcomes).
- The Government should support the piloting and evaluation of ideas put forward by stakeholders to answer questions thrown up in providing services and meeting unmet needs (rather than universal implementation from the centre of the latest developments).
- Note that a key difference between health and FTSE 100 providers is that the former should not choose not to invest resource in “non-viable” people.
- Fund pragmatic innovative pilots of new approaches.

8. *How can UK health research funding be most effectively used to provide the appropriate infrastructure for basic, translational and applied research, whether funded by the UK public sector or other sectors? How can UK health research funding be most effectively used to support the work of NICE, facilitate innovation and collaboration with industry, and address market failures in the application of healthcare?*

- Translational research is not simply bringing basic science to the development of new drugs, and any proposed infrastructure should support translational research in the round.
- Infrastructure support should be diverse e.g. include support for maintain cohort studies.
- The lengthy prioritisation process carried out by the HTA Programme does not facilitate timely commissioning and the extent to which the HTA Programme responds to research needs identified by NICE is limited.
- It is important that we do not extend the cancer network model to areas where the successes may not be replicated and the shortcomings prove fatal to developing research areas.

9. *What lessons should the UK learn from other countries in making the proposed changes to the institutional arrangements for the funding of health research?*

- It is interesting that UK is seen as a leading edge provider of forensic mental health services (recent Royal College of Psychiatrists report). However there are no University funded academic posts in forensic psychiatry all are dependent upon NHS funding and thus the success of the new DH research strategy.
- Action to improve the stability and security of academic careers whilst ensuring that these careers are enmeshed with practice is required. A recent project linking the Karolinska Institute research strategy and the services

supported by Stockholm County Council to bring a research perspective to clinical practice may be of interest.

10. In implementing the single fund for health research, to what extent should the MRC and DH / NHS R&D be merged or brought together? And to whom should the single, ring-fenced fund be accountable? Please provide reasons and any supporting evidence for your response.

- The most important issue is that, whether or not MRC/DH research is merged, the funding body does not adopt a “one size fits all” approach irrespective of the policy and commissioning needs of different areas of research.

11. To what extent does the success of recent innovations in health research (e.g. Clinical Research Networks) and the proposed structures rely on the new Connecting for Health NHS IT system, and to what extent should it do so?

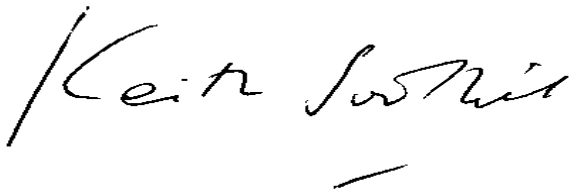
- It might be best to see the extent to which Connecting for Health proves fit for purpose. The history of large scale IT projects in the NHS does not inspire confidence. It would be safer not to rely on Connecting for Health in the short term. In the longer term there may be substantial opportunities which will depend on sorting out ethical and consent issues.

12. Given that NHS R&D is currently devolved, but that the work of Research Councils is not, how can these functions work best together to maximise the health and economic benefits to the UK?

- NHS R&D is to an extent devolved (e.g. SDO and HTA Programmes) but will be a central commissioning function. The regional response mode programmes will be centrally commissioned but with decisions made at local level. This is appropriate for small grant schemes but competition needs to be nationally co-ordinated for basic science and strategic NHS or policy research.

I will be pleased to answer any queries you may have.

Yours sincerely



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Chair
Programme Advisory Committee
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