

**Review of UK Health Research**  
**Chair: Sir David Cooksey**

20 July 2006

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

Dear Sir David

**Re: 'Cooksey Review' Consultation on UK Health Research**

We are writing in response to your letter dated 4 May 2006, inviting the submission of comments on 'the best institutional arrangements for this new single fund for health research.' We are writing on behalf of:

- The officially appointed Expert Advisory Group for the Dangerous and Severe Personality Disorder (DSPD) Programme, which is a Health Offender Partnership bridging the Department of Health and the Home Office. The Advisory Group, which comprises independent experts in the field, considered this issue at its most recent meeting.
- The DSPD Programme, which has been established to arrange for the management and treatment of offenders with severe personality disorder who have committed serious crimes of violence, often of a type which attract life sentences, and who are considered to remain dangerous.

Offenders who suffer from severe personality disorder have been of considerable Governmental concern in the last few years. There is however a serious lack of the kind of evidence base that would help us to prevent at least some of these offences. This requires further targeting of research.

**Your key issues**

2. We accept that heavily de-centralised research within the NHS has not always been fully beneficial in the past. Coherent research needs an 'intelligent customer', or commissioner, who can provide a sensible framework at national level in terms of criteria for research projects.

3. We also note, from Gordon Brown's press release of 31 March 2006 concerning your appointment to lead the health research review, that 'America has its pathbreaking National Institutes of Health – we will now build agreement on the right design and institutional arrangements for a British model.'

4. In essence, we too believe that, while the concept of a single fund is helpful, it should be underpinned, just as in the United States, by a coherent set of subordinate organisational components. Those subordinate organisational components are likely

to need to be relatively more developed in those fields where there is relatively little input from specific disease charities and from pharmaceutical companies. One such field is that of forensic mental health. In the past, when new arrangements for research or for services have been introduced, such small special and less glamorous areas have tended to suffer until some time later new arrangements have been made to accommodate them. We recognise that any arguments for specific arrangements may be perceived as special pleading, but the problem has repeatedly been a real one, which has ultimately required remedy.

### **Our evidence - forensic mental health**

5. It may now be helpful to provide some evidence, as suggested in your letter.

- First, in this country as elsewhere (US, Canada, Australia) ‘mental health research receives proportionally less research funding than cancer and cardiovascular disease, both per head of population and relative to burden and economic impact of disease.’ This points to deep-seated policy issues needing to be addressed. (Source: ‘Strategic Analysis of UK Mental Health Research Funding’, 2005.)
- Secondly, the interlocking fields of forensic mental health and personality disorder (PD) are historically under-developed in research terms, in this country. Yet individuals with PD are heavy users of health services in general, including inpatient services, A&E and GP services (Dolan, Warren, Menzies et al, 1996).
  - ‘Little is known about the relationship between different types of personality disorder and offending behaviour.’
  - ‘There are few randomised controlled trials.’ Numbers of participants tend to be small.
  - Nonetheless, ‘research findings suggest that people with personality disorder can be successfully treated using psychological therapies.’ (Source for these last three points is ‘Understanding Personality Disorder: A Report by the British Psychological Society.’ 2006.)

### **Future arrangements**

Briefly, the National Institute for Health Research needs to start to look as fit-for-purpose as its American equivalent. While we do not need the same number, size and configuration of institutional components as the 27 institutes and centres of their National Institutes of Health in this smaller country, we do need to create some of the major elements. One obvious element would be a national research institute covering mental health. (We should make it clear that we are talking about an organisation for supporting research, rather than the National Institute for Mental Health in England or CSIP/Care Services Improvement Partnership, both of which have been concerned primarily with appropriate delivery of treatment rather than research.) This research institute should include specific provision for support of forensic mental health. Such provision need not involve much more than a few posts (e.g. the National Forensic Mental Health R&D Programme, which has three posts, has done much to develop

forensic mental health research since it was set up in April 1999 – though it will be closing in March 2007).

The optimum balance between the central planning/commissioning and some local arrangements (within the parameters of a single fund) will only be achieved over a period of time. The main priority now ought to be to secure relevant continuity at a time of transition. In particular, certainly in so fragile a field as forensic mental health, it would make very good sense:

- To ensure that funding of research is preserved in transitional arrangements and beyond (see next section, on transitional arrangements in forensic mental health).
- To support and extend some of the new response modes being developed by the National Institute for Health Research, including the Research for Patient Benefit Project Scheme, the RISC Schemes (Research for Innovation, Speculation and Creativity), and Programme Grants for Applied Research.
- To fund the small number of academic posts currently supported by the NHS in the field of forensic mental health, which provide essential infrastructure for related research, for a further period, ideally at least five years in the first instance. (See next section.)

### **Transitional arrangements in forensic mental health**

As matters stand, the forensic health research field appears to be exceptionally ‘at risk’ of collapse in the implementation of ‘Best Research for Best Health’. This field faces a ‘double whammy’:

- First, there is the closing of the Forensic Mental Health R&D Programme, from March 2007. Through active management, this has done much to stimulate this under-developed field since it was set up in 1996 – and we would like to think, as suggested above, that this remit could still be taken forward in future in some other way.
- Secondly, there are serious issues around staffing in this field, which is on an exceptional footing. The implementation plans for ‘Best Research’ point to the need for ‘researchers to apply for research programme grants under our other schemes.’ Unfortunately, researchers in this field are very heavily dependent on NHS research funding even for their existence. If that funding, as expected, is turned off abruptly, this group of researchers will tend to disappear before they have much chance to apply for funding from other sources. The bottom line, to put it crudely, is that virtually every FMH research post at professorial or senior lecturer level (there about 20 of them, as documented in the annex to this letter) is currently funded by the NHS rather than academic organisations. Already some of those posts have started to become vacant. A five year stay of execution would help enormously in softening the transition.

Again, we fully recognise that this may seem like special pleading, but we feel, from our combined perspectives of the DSPD Expert Advisory Group and its Central Programme Unit, that the need for further consideration of funding arrangements in this field is exceptionally compelling.

## **Conclusion**

It is essential that the new arrangements for managing the single research fund include strong safeguards to support the development of the evidence base for forensic mental health in general and personality disorder in particular – or society will continue to pay a high price for failures that are preventable at least to some extent.

Yours sincerely

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Chair  
DSPD Expert Advisory Group

Dr Savas Hadjipavlou  
Head of DSPD  
Programme Unit

## **ANNEX: POSTS IN FORENSIC PSYCHIATRY**

There are around 20 such posts. Already numbers are shrinking.

Many of the main centres for forensic psychiatry have at least one dedicated academic post, funded by the NHS but as university appointment(s). Almost all have staff who have primary NHS appointments, but have some honorary contract with the affiliated university. There are no university-funded academic posts in forensic psychiatry.

Three of the four main Colleges of London University (Imperial, Queen Mary and Westfield, King's), and St George's Hospital Medical School, have NHS supported chairs. All four have other NHS supported senior academic posts in forensic psychiatry. There are no other chairs in Britain (or even Northern Ireland or the Republic of Ireland).

Otherwise, the academic forensic psychiatry lead is dependent on NHS supported senior lecturer posts in forensic psychiatry in Birmingham, Bristol, Cambridge, Edinburgh, Manchester and Oxford.

The 'superspecialities' are represented by a single senior academic post nationally in forensic psychotherapy (St George's Hospital), in forensic child and adolescent psychiatry (University of Central Lancashire), and in forensic learning disability (Newcastle), all NHS supported.

Finally, there are currently three occupied posts (out of five) for NHS funded, university employed lecturers.