

## UK MHRN Response to Cooksey review

This is the response to the Cooksey review on behalf of the UK Mental Health Research Network, one of the topic specific networks funded by DH, and administered jointly by the Institute of Psychiatry and University of Manchester.

### **Context: UK research in mental health**

The strategic analysis of UK mental health research funding (November 2005) <sup>1</sup> found that approximately £74 million was spent annually in the UK on mental health and related neuroscience research. Of this, MRC spent £35 million, BBSRC £19 million and Department of Health total approximately £5.5 million. Important sources such as the Wellcome Trust were omitted. International comparisons suggest that, in general, rather less is spent on mental health research than research into cancer and cardiovascular disease in the UK.

The UK CRC report UK Health Analysis ([www.ukcrc.org](http://www.ukcrc.org))<sup>2</sup> examined patterns of research funding from MRC and major charities awarded in the 2004-5 financial year. This was broken down into disease areas and compared with WHO estimates of disability-adjusted life years (DALYs). This showed that the research funding for neurological disease and mental health was slightly, but not disproportionately, low compared to other disease areas. However, a subsequent re-analysis<sup>3</sup> separated neurological disease and mental health to show that the former was comparatively well-funded compared to the DALY burden, but that mental health research was very substantially under-funded. This tallies with the perception of the mental health research community.

The paucity of research in mental health has been recognised - the Dept of Health is keen to have more research on these disorders, which, with stroke, form the most burdensome and expensive of all diseases. Over recent years randomised controlled trials submitted to MRC have failed to reach the size and scientific quality necessary for funding.

In response to this the Department of Health established the UK Mental Health Research Network in 2004, in order to increase the capacity of the research community to run large-scale mental health trials and other high quality studies. The UK MHRN is perceived to have been successful in its remit thus far, involving service users formally in reviewing studies and by mid-2006, hosting 42 externally-funded multisite trials and other studies, including one funded by pharma. *This is an example of the DH successfully deploying funds to improve the scope and quality of mental health research in the UK.*

Also in response to this deficiency of high quality mental health research, the MRC pumped new research in the area with its Brain Sciences initiative: 57 new projects were funded at a value of £10.3 million including 23 trial platform grants, which are designed to pave the way for larger subsequent randomised controlled trials. The second call was run in partnership with the DH, which added £1 million to the MRC funds identified for this initiative. *This is an example of collaboration between DH and MRC: DH contributed funds to the MRC, which managed the call and administered the awards on behalf of both organisations.*

The trial platform grants within the Brain Sciences Initiative were intended to lead to more high quality RCTs being submitted to MRC in the future. If half of the 23 are

successful and if each costs £2-4 million (more with full economic costing?), approximately £36 million would be needed to fund the research costs of these trials over the next few years. A further £5-10million will be required to provide treatment costs. The latter have been so difficult to obtain over recent years that the viability of many trials have been threatened. Where will this money come from?

*Additional funding from a common DH/MRC funding stream needs to be identified if the Brain Sciences Initiative is to reach its potential and high quality trials are successfully funded.*

**Overall, the UK MHRN welcomes the opportunities promised by the proposed merger of the two funding streams.** There are currently a series of developments which have the potential to improve UK Health Research and its impact on patient care and public health. These developments include Best Research for Best Health, The Walport and Finch initiatives for training, and the increasingly positive interface of NHS and HEIs with the commercial sector. As ever, change must be carefully managed to avoid jeopardising existing strengths.

#### **Response to review questions:-**

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

MRC: high international standing; high quality peer review mechanisms; focus on highest quality science.

Weaknesses: failure to support research of substantial clinical importance but of lesser intellectual value, particularly in mental health.

DH: attempted focus on major public health issues; innovative establishment through funding academic posts and infrastructure of disciplines of NHS relevance, including key disciplines traditionally not considered adequately scientific, such as psychiatry.

Weaknesses (being addressed in best research for 'Best Research for Best Health'): excessive bureaucracy; difficulty in moving funds historically from infrastructure or clinical subsidy to projects or from poor to good research; poor evaluation of quality.

The analysis of UK mental health research funding<sup>1</sup> identified most of the MRC research spend in the categories "understanding brain and minds in individuals and society" and "causes or processes leading to specific states, conditions and illnesses". By contrast, the Department of Health spend was mostly in the category "therapeutic approach and health/social care delivery".

We believe that both types of research activities are important and need to be maintained under the new funding arrangements, but there might be advantages in reviewing the research funded by the Health Services and Public Health Research Board of MRC and HTA, Policy Research and Forensic Mental Health Programmes of Dept of Health to assess the degree of overlap and ways of improving the quality of their research and the responsiveness to needs of the health service and the population.

*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?*

It has proved possible for MRC and DH to combine resources and fund high quality preliminary projects (Brain Sciences Initiative). This was cost effective as the MRC used its existing structures and peer review system on behalf of both organisations. Whether this can reach its full potential will depend on much larger sums being earmarked for the large RCTs, including treatment costs, and other research that will follow from these preliminary projects.

The DH alone has established the Mental Health Research Network, which is essential for future large Trials. This is a major achievement of recent years that might transform mental health research in the next decade if funds are available to do the trials.

Some areas of research in their infancy, e.g. Forensic Mental Health, need a specific research programme with its own funding stream. The DH has been prepared to fund this even though the initial quality of research might have been at a standard lower than that usually funded by MRC. Such responsiveness to the needs of Health Services should be maintained. This applies to both national and local R & D funding; the latter has been lost.

A specific problem for clinical research, particularly trials, in mental health funded by MRC has been the weak Support for Science mechanisms in the NHS. The mechanism derived from the Culyer concordat was that funding for the treatment costs of a clinical trial whose research costs had been awarded by the MRC should be met from the local contracts between commissioners and providers. However, no operational process to enforce this arrangement had been established and local NHS organisations regularly failed this commitment. In most instances outside mental health this was not a major issue: treatment costs were often the costs of new medication, so not excessive. In mental health however, in line with DH policy of evaluating new psychosocial interventions, the treatment costs were often considerable: the salary of an experienced clinical psychologist to deliver the experimental treatment, for instance. The resulting disputes over meeting these costs led in almost all cases to delays in project initiation and, by mid 2005, refusal by local NHS and DH to fund them at all. This resulted in a series of MRC-funded trials being delayed indefinitely, until the DH brokered a resolution in mid 2006. The merging of MRC and DH funding streams should be able to address this issue.

*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?*

Much of UK mental healthcare policy and practice is not based on research evidence, despite mental health disease areas (depression, psychosis and schizophrenia, dementia) being at or near the top of the national league table in terms of direct and indirect costs. There is now the opportunity to redress this imbalance.

*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?*

*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?*

The two-way continuum between basic and clinical research and public health and service improvement needs to be more effectively managed to reduce cultural, practical and institutional barriers within and between organisations and professions. Even with the UK MHRN, resistance to conducting research in NHS provider organisations remains a major problem. At Board level, Trusts see research activity as risk rather than benefit, with no mechanism to reward the hosting of research projects. This institutional ambivalence feeds, rather than dispels, the day to day failure at individual clinician/practitioner level to recognise research as a legitimate clinical activity.

Institutional incentives and accountabilities need to be lined up to support research and its incorporation into evidence-based practice (e.g. identification of true costs, better measures of healthcare benefit, the laying of a duty to support research and development on PCTs and SHAs, incorporation of R & D criteria in Healthcare Commission Audits.)

*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?*

Better esteem for and cultural understanding between preclinical scientists in the laboratory and clinicians in the work place including a brief induction period for non clinical biohealth-related PhD students in clinical settings would be helpful.

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

See above

*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?*

See above.

*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?*

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.

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?

Connecting for Health has great potential. The ethical issues need to be carefully worked out and the support of the public developed. Research networks can deliver some of their potential through existing mechanisms and databases but will only be fully beneficial if connecting for health is successfully rolled out and with effective capacity and permission to support research.

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**References:**

- 1 Margaret Bryant (Medical Research Council) and Michael Clark (Department of Health) on behalf of the Mental Health Research Funders Group. *Strategic Analysis of UK Mental Health Research Funding* Nov 2005
- 2 Mayor S. Report gives snapshot health research funding in the UK. *BMJ* 2006; 332: 1230.
- 3 Kingdon D. Mental health research continues to be underfunded. *BMJ* 2006; 332: 1510.