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From the Editor's desk

By Peter Tyrer

Timeliness is all

'If it were done when 'tis done, then 'twere well it were done quickly.' Tongue-twisting descriptions of assassinations in Shakespeare's plays are just as appropriate for treatment in psychiatry. We often agonise over how we should distribute our resources to improve mental health. In my own practice I have long been aware of what I call the Geoffrey Rose dictum. Geoffrey was one of the pioneers in epidemiology and public health research, and the dictum he developed[1] can be briefly summarised as 'large numbers at small risk give more cases of disease than small numbers at high risk', and this argues for a population rather than an individual strategy to improve overall health. The main problem is that there are many pressures in society to go for the latter rather than the former; personality disorder is one good example from psychiatry.[2,3] And of course each individual wants the best treatment for himself or herself; if others get left behind, it is unfortunate but competition is unavoidable. So in planning our interventions for common mental disorders do we look at the bigger or smaller pictures and do we intervene early or late? In the spirit of inclusiveness, all are in this issue.

When people feel bad nowadays they look, sometimes too much,[4] for answers in the universal dictionary of fiction and knowledge, the internet. So Morgan *et al* (pp. 412–418) have focused their intervention on this earliest group, almost a pre-group, in the healthcare system. They also provided a fully automated treatment for depression in their Mood Memos study, so no direct therapeutic involvement was made – but as their treatment plan involved 'persuasive framing, tailoring, goal setting and limiting cognitive load' it was certainly a sophisticated one. They expected a small effect size from their intervention, and duly got one, and the number needed to treat to prevent one case of major depression was 25. But their numbers were large, and although they did not record cost-effectiveness this is generally good with these therapies[5] and the value of this form of delivering treatment, particularly if it involves a real therapist in some form,[6,7] is now strong enough to be undoubted. But is this suitable for a population health strategy? It is probably not, as despite the growth of mental health literacy and access to treatment in one advanced country, Australia (Reavley & Jorm, pp. 419–425), the mental health gains have been limited.[8] Suicide is probably the most important public health outcome and, despite great efforts to link a fall in the suicide rate with successful treatment, only improving the recognition of depression and restricting access to lethal methods has good evidence of efficacy.[9] But still we struggle to do better, and as the internet is not of high value in providing good information here[10] we intervene in the high-risk group, those who have already self-harmed (Kuo *et al*, pp. 405–411), especially in the older group (Murphy *et al*, pp. 399–404; Dennis & Owens, pp. 356–358), and hope that apparent gains in subsequent self-harm[11] will be shown eventually on suicide itself once we have a large enough trial base. And the implications are the same with schizophrenia and obsessive–compulsive disorder, both common conditions; but if a minority have an auto-immune disorder (Chen *et al*, pp. 374–380; Nicholson *et al*, pp. 381–386), it suggests a different approach to prevention and possibly treatment for a pathology that may extend across the diagnostic spectrum (Davison, pp. 353–355). At the opposite extreme of timeliness we have the sad face of prison mental health, where intervention for illness tends to take place very late in its course, if at all, and the conclusion of Fazel & Seewald's study (pp. 364–373), that one is seven prisoners has depression or a psychosis, is perhaps predictable but still shocking.

A boost for mental health research in Northern Ireland

We do not publish many papers from Northern Ireland; none in the past 2 years and two just previously,[12,13] and we were getting concerned that this relatively small but active area with a vibrant population of nearly 2 million was dropping behind some others. It has now been bolstered by an initiative of the Northern Ireland Association for Mental Health, leading to the establishment of a Northern Ireland Mental Health Research Network to be linked to the others in Scotland, Wales and England and, before long, to the other 17 European research networks that joined in the recent Madrid Declaration[14] to promote collaborative mental health research. This will be an important asset. Unlike many other countries, Northern Ireland has an excellent integrated health and social care system, a high standing for probity in research, and exciting mental health initiatives are taking place in the University of Ulster and in the voluntary sector that could have an influence far beyond its shores. At the 100th anniversary of the sinking of *The Titanic*, another Northern Irish product, we need a launch with a better prognosis and less complacency – and the NIMHRN fits the bill.

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