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our minds, and still remain civil. However, the conclusions might well be uncomfortable for individuals who have benefited from the structure of traditional biomedical power. This discomfort might be particularly felt when, as in this case, long-established institutions are seen to change public positions. This change in position does not mean that there has been a failure of professional etiquette. It is, moreover, not merely another unproductive iteration of an unhelpful cycle, but rather, the principled and appropriate use of dispassionate analysis to address a need about which we all feel passionately engaged. We do not promote the unfettered prescription of so-called mother's little helpers. Dispassionate analysis of data has led to a change in public position, and we should politely and humbly welcome this change.

We are either members of, or are linked to, the Council for Evidence-Based Psychiatry and we are signatories on a recent complaint to the Royal College of Psychiatrists about related issues. In addition, we have received grant funding, consultancy fees, and royalties on published work in the field of mental health. We declare no other relevant competing interests.

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Mental health in Northern Ireland: an urgent situation

Northern Ireland has the highest prevalence of mental illness in the UK,¹ with an incidence of around 16 deaths per 100 000 individuals per year.² Psychiatric morbidity in Northern Ireland is 25% higher than in the UK, a legacy of more than 30 years of conflict (known as the Troubles), in which 3500 people died and 47 000 were seriously injured. In 2008, 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles.³ A 2015 analysis³ indicated that both childhood adversities and trauma relating to the Northern Ireland conflict have a major role in the development of psychopathology.

The proportion of the health budget in Northern Ireland devoted to mental health is around 6%, which is half that of England. This low investment has led to underfunded psychological and mental health services and increasing waiting times. This legacy of increased psychopathology and under-resourced services is shown in our general practitioner prescribing rates for antidepressant medication, which are the highest in the UK, with worrying trends of increased prescribing to children and young people.⁴

Service providers in both the National Health Service and in the community and voluntary sector are trying to deliver evidence based services; however, the demand continues to increase. Specialist perinatal psychology and community mental health services are available only in the area of Belfast (the capital city).

Northern Ireland had its own government with devolved powers from the UK Government, but its government broke down in January, 2017, and the enduring absence of government is weighing heavily on mental health services. Key

strategic developments have been put on hold. In particular, Protect Life 2, Northern Ireland's suicide prevention strategy, the consultation period of which ended in November, 2016, remains unimplemented as it requires ministerial sign off. Similarly, the Children and Young People's Strategy 2017–27 has stalled. The psychological therapies strategy is not fully implemented, and the psychology workforce continues to be under-resourced, leading to restricted access to specialist psychological services and concerns over training and governance of psychological interventions.

In a policy and practice briefing,⁵ we identified key recommendations on the basis of the evidence regarding suicide in Northern Ireland. In particular, we call for the screening and provision of timely suicide-specific interventions for people with mental illnesses, individuals presenting at hospitals after self harm, people who have experienced a conflict-related trauma, and people who have had adverse childhood experiences. The failure to provide appropriate and timely mental health care to people who have trauma-related mental illnesses and to provide early intervention for vulnerable families and children will cost us dearly. Health inequalities are increasing, with areas most affected by the Troubles experiencing high deprivation, substance misuse, and suicide rates.

It is incumbent upon all our political leaders to work together to address these issues, to implement Protect Life 2 and other mental health strategies, and to urgently direct funds towards providing appropriate psychological therapies for people in need.

We declare no competing interests.

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Non-diagnostic recording of mental health difficulties in ICD-11

In our previous Correspondence (Sept 1, 2017, p 664),¹ we recommended that mental health clinicians and policy makers routinely use ICD social codes to record psychosocial adversities known to be important determinants of our mental health. Despite arguments that traditional biomedical diagnoses ignore the social context and adversities survived by people who later report mental health problems,² supporters of diagnosis often suggest it is the only way to plan treatment and access services.³ Publication of the ICD-11, however, suggests that a more precise approach is within reach.

In addition to the social codes, ICD-11 contains the prototype of a system approximating the phenomenological approach to identifying mental health problems.⁴ Although offering a diagnosis of Moderate Personality Disorder (6D10.1) will remain possible, a clinician could instead record one or more adverse or traumatic experiences, and subsequent specific mental health difficulties. For example, personal history of sexual abuse (QE82.1), history of spouse or partner violence (QE51.1), and low income (QD51) leading (understandably) to anger (MB24.1), depressed mood (MB24.5), feelings of guilt (MB24.B), and non-suicidal self-injury (MB23.E). Any modern record system will use categorisation, but we can, and should, avoid unnecessary pathologisation and welcome methods that contribute to better clinical services. With clearer links to social inequity, this strategy would help establish a rights-based approach to care,² and service users need not be given a diagnostic label, which many find unhelpful.

Although clinical formulation can be used to explore relationships between adversities and mental health difficulties, using ICD codes would allow national data capture of these links. Our understanding of these relationships is hampered by focusing on heterogeneous diagnostic categories that correspond neither to biological nor psychosocial causal mechanisms.⁵ Capturing this data nationally would raise awareness of the specific impact of psychosocial adversities, and substantially develop the growing literature associating specific

adversities with particular mental health difficulties, such as childhood sexual abuse and voice hearing. This data would improve clinical practice, particularly early intervention, by facilitating the development of care pathways that target particular trajectories of distress following specific adversities.

Such an approach meets the universal call for appropriate, internationally recognised, data collection and shared language use, and avoids the well known inadequacies of reliability and validity associated with traditional diagnoses. To extend, therefore, our earlier recommendation that clinicians use ICD social codes,¹ we further recommend that these phenomenological codes offer a constructive, radical way forwards.

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