between the three trajectory groups and suicidality up to a decade later. Patients who were in the frequent-stable or the frequent-increasing groups, the two trajectory groups with more significant suicidal ideation over time, were more likely to report suicidal thoughts and attempts than those in the low-decreasing group only at 5-year follow-up. The magnitude of association was stronger for the frequent-increasing group. However, differential trajectories of suicidal ideation were not predictive of suicide or death by other causes at follow-up, despite a non-significantly higher proportion of participants who died at follow-up in the frequent-increasing (9%) and in the frequent-stable (5%) trajectory groups than in the low-decreasing (4%) group. Low statistical power might explain the absence of statistically significant effects because suicide, although important, is a relatively rare event, as is death by other causes given the age of the cohort members.

This study points to the importance of studying group or developmental trajectories rather than point associations when investigating predictors of suicidal behaviour. Although trajectory-based methods have already been used to study suicidal behaviour in both epidemiological[7,8] and clinical[9] samples, they have not been previously used to understand variation in the development and risk of suicidal behaviour in schizophrenia. Improved understanding of distinct group trajectories has important implications, as it might help to identify individuals who are particularly suited for specific preventive interventions. Madsen and colleagues[4] suggest in their study that prevention strategies targeting suicidal behaviour in first-episode psychosis should not be universal. Rather, they should target individuals who present frequent suicidal ideation at illness onset because these individuals are likely to present stable or increasing suicidal ideation and suicide attempts. Although the relevance of these findings to death by suicide needs to be determined, interventions that specifically aim to reduce suicidal behaviour could be explored in this group as a preventive strategy.

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How anthropological theory and methods can advance global mental health

Anthropologists have levied a range of concerns about the burgeoning field of global mental health.[1,2] These critiques encourage reflection about practice. The next step is for anthropologists to consider how their theories and methods can contribute to generation of empirical data to contribute to effective, ethical, and sustainable achievements for mental health worldwide.[3] Therefore, we propose five domains comprising a new agenda for anthropology to engage with global mental health.

First, medical anthropologists should engage with policy makers, clinicians, and people with mental illness to combat human rights violations. Improving human rights for people with mental illness is a central focus of global mental health.[4] Anthropologists traditionally

illuminate how institutions, practices, and beliefs affect institutionalisation in medical and correctional facilities, law-enforcement practices, community-based services, and psychiatric emergency services. Additionally, anthropologists have investigated discrimination related to mental health and other stigmatised disorders. The methods and theories developed from this work should focus on partnering with organisations addressing human rights and combating stigma and discrimination.

Second, anthropological research about health systems is required to understand and inform treatment processes in mental health. We call for integration of anthropological research as a standard component of public health and clinical intervention programmes. Since social and economic systems involve resources and power, health systems research should fall within the remit of anthropology. One reason for the absence of focus on health systems is that anthropologists have rarely studied elites in positions of corporate and government power. This gap was identified in 1972 by Laura Nader, who called for "studying up", referring to the tendency of anthropologists to focus studies on groups with lower socioeconomic status.[5] Studying up can identify institutional gaps in public health endeavors, as shown by anthropological research by institutions involved in polio eradication.[6] By studying the culture of global health institutions, anthropologists should broaden their methodological strategy to include the whole chain of health systems, from policy makers to those implementing services, including both non-governmental organisations and government institutions. For example, medical anthropologists have used data-tracing methods to follow chains of medications (for tuberculosis, depression, and inducing childbirth) from production and distribution to use.[7] This work showed that what is classified as a case, evidence-based practice, treatment resistance, or remission varies substantially, depending on the bureaucratic level of the health provider.

Third, anthropological research into diagnostic labels, idioms of distress, and ethnopsychology should be used and incorporated into mental health interventions. The effect of introducing new local labels or idioms of distress into health delivery systems should be studied for potential unintended effects. Use of local idioms for stress and general psychological complaints has proven beneficial to promote participation in psychological treatments.[8] By contrast, local idioms have also been used as a substitute for diagnostic categories, leading to potentially harmful use of psychotropic medication, justified as cultural adaptation.[9] Studying use of idioms is especially important in primary care centres for people with chronic illness; such patients might communicate their mental illness through medical dialogue about a chronic illness, such as diabetes, thereby making diabetes the idiom of distress.[10] One missed opportunity in global mental health is assessment of local idioms of distress in intervention studies. Anthropologists should work with clinical trial researchers to include more culturally appropriate outcome measures, such as tracking clients' endorsement of cultural concepts of distress as they go through intervention programmes.[11] Even if psychiatric symptoms only partly resolve, substantial simultaneous improvement in culturally idiomatic manifestations of distress might occur. This information is crucial because alleviation of cultural concepts of distress might be the most meaningful outcome of a community mental health intervention.

Fourth, ethnographic research needs to be done to understand how psychiatric medications are integrated into daily life and how they affect patients' lives. Anthropologists and cultural psychiatrists have raised concerns about medicalisation of experience and pathologising individuals; however, few examples exist to show whether and how this happens. It is crucial that anthropologists use ethnography to understand

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how medication is experienced phenomenologically, interpersonally, and sociopolitically. It is important to understand how (or whether) medications change patients' views of themselves and their illness. Anthropological research in India has shown that the treatment gap in antidepressant medication is a result of local disparities in overprescription and underprescription rather than a generalised dearth of pharmacological treatment.[12]

Fifth, an expanded role of medical anthropologists from low-income and middle-income countries is needed. Anthropological research on mental health remains dominated by researchers in high-income countries. Development of the next generation of medical anthropologists from low-income and middle-income countries requires current investigators to embed capacity building for PhD-level medical anthropologists into their research and teaching programmes.

Anthropologists should go beyond describing the local context to show how to make mental-health-care delivery work in a local context. It is crucially important to include local people—both researchers and community members—as real partners so that projects can be adapted rather than just implemented. As cultural brokers and engaged scholars, anthropologists have a crucial part to play, not only in understanding local problems, but also in helping to design, implement, and scale up local solutions for mental-health-service delivery.

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Mental health disorders in Northern Ireland: the economic imperative

High-income societies in general have high levels of mental disorder and an increase in rates in the past three decades, and Northern Ireland is no exception. However, evidence suggests that the years of violence associated with the Troubles in Northern Ireland have been an additional burden and have contributed to high rates of chronic and severe mental health problems and substance misuse. Based on an epidemiological study of mental health in Northern Ireland, Bunting and colleagues[1] found significantly elevated rates of mood, anxiety, and substance misuse disorders in men and women who had conflict-related trauma.

The effect of the Troubles on mental health is complex and cyclical. The effect is characterised by the interactions between the effects of parental mental health on attachment and parenting, exposure to traumatic life events, poverty, and social and cultural factors, and ongoing sectarianism and community violence. The high rates of mental disorders are reflected in the high usage of psychotropic medication in Northern Ireland. One in five people with direct experience of the Troubles had used psychotrophic medication in the past year, and the rates of medication use for mental disorders are higher in Northern Ireland than in other parts of the UK and Europe.[2]