Furthermore, to protect a growing population from spending money they do not yet earn, we as a society must ensure that players, politicians, physicians, and policy makers understand the potential harms of what has become a lucrative addition to the gaming market.

We declare no competing interests.

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A call for action on overdose among LGBTQ people in North America

North America is in the midst of an unprecedented overdose crisis. Although data regarding the magnitude of overdose experienced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) people are sparse, a well known interrelated series of individual (eg, suicide and mental illness),[1–3] social (eg, violence, bullying, and rejection from family and friends),[1,3] and structural (eg, poverty, homophobia, transphobia, and stigma)[3] factors are known to put this population at disproportionately high risk of substance use-related harms. Despite the availability of several key sources of epidemiological data, substantial gaps in the evidence base regarding LGBTQ people and overdose are challenging the capacity to comprehensively address these inequities. We hereby highlight two key areas that require new scientific and public health investments to more fully measure, report, and address overdose among LGBTQ people.

First, to improve our understanding of the magnitude and distribution of the overdose crisis and the corresponding effects on LGBTQ people, new strategies for data capture are urgently required. Current approaches to large-scale community health surveys around the world, and in North America in particular, often lack high-quality measures to assess differential effects that occur based on sexual and gender identities.[4] For example, the Canadian Community Health Survey,[4] the Canadian Alcohol and Drug Use Monitoring Survey,[4] the US National Survey on Drug Use and Health,[2] and the US Youth Risk Behavior Surveillance System[1] are among the only nation-wide community health surveys that actively collect (albeit very limited) measures of sexual identity and substance use. However, none of these surveys have contributed to our understanding of overdose among LGBTQ people. We therefore call on major national funding agencies (such as the US National Institutes of Health and the Canadian Institutes of Health Research) to demand that all large-scale health surveys adopt standard metrics of sexual and gender identity to more fully characterise how overdose is affecting LGBTQ people across North America. These inequities, both known and unknown, also oblige those of us working in this area to think innovatively about identifying new surveillance data capture strategies to more effectively engage and sample LGBTQ people (eg, network-based sampling), especially given that LGBTQ people might be unwilling to disclose their sexual or gender identities in traditional surveillance systems.

Second, despite a limited yet emerging evidence base indicating that the provision of tailored addiction-treatment services for LGBTQ people is feasible and can improve treatment uptake and adherence,[5] the majority of the treatment infrastructure in North America and elsewhere fails to respond to the unique needs and diversity of LGBTQ people. Challenges to improving LGBTQ-appropriate care for addiction remain, however, in that LGBTQ people are often less likely to adhere to treatment for substance misuse, partly because of negative interactions with health-care services that are not well equipped to address the needs of LGBTQ people.[3] It is essential for addiction services for LGBTQ people to be welcoming, evidence-informed, client-centred, safe, reflexive, and non-judgmental, while also promoting dignity and respect in all encounters with LGBTQ clients. We call on substance-use care and treatment services to equip care providers with the skills and competencies they need to navigate conversations about gender, sexual identity, and substance use with their LGBTQ clients.

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Belgian Superior Health Council advises against the use of the DSM categories

Worldwide, the DSM is, much like the ICD, a frequently used classificatory diagnostic instrument. However, questions have been raised about its pragmatic and scientific status.[1–3] Therefore, in 2016, the Belgian Governmental Superior Health Council set up an expert group comprised of academics and practitioners in psychiatry, clinical psychology, sociology, and philosophy as well as a service user to evaluate relevant literature and evidence.[4]

Epistemologically, the expert group concluded that mental disorder categories should not be treated as natural kind categories but as constructs that have a causal impact on those who are classified. Sociologically, the group observed that diagnostic classifications tend to legitimise organisational structures and protect psychiatry from pressures to change. Moreover, the literature suggests that a biomedical approach does not, as hoped, reduce stigma and discrimination. Clinically, the group concluded that common diagnostic categories lack validity, reliability, and predictive power. Additionally, these do not tally with new conceptions of health, defined by the ability to adapt despite biopsychosocial obstacles.[5]

The Council observed that multilayered clinical case formulation provides a useful alternative. Thus, symptoms, complaints, and suffering can best be contextualised in terms of biographical information, existential challenges, contextual-interactional functioning, mental processes, and biological considerations. Classification can still occur but on the basis of a small number of general syndromes (eg, psychotic syndrome or depression syndrome), which stimulates personal diagnostic formulation. These should be discussed in terms of a continuum from crisis to recovery to assess the need for care and support.

The report ends with recommendations that encourage contextualised patient-centred psychiatry. These recommendations include the advice to refrain from using the DSM categories for organising and reimbursing interventions and for organising prevention and promoting mental health literacy.

The report has five key recommendations aimed at clinicians, policy makers, and the general public: (1) default non-problematising and non-medicalising approaches to mental complaints or crises because they might express existential and social problems; (2) careful listening to subjective experiences; (3) providing help and support for mental complaints or crises without a formal diagnosis as a precondition; (4) taking the perspective of people with mental complaints or crises and the way in which they give meaning as central to diagnosis and treatment; and (6) when formulating a case, paying close attention to the person-specific way in which, among other things, mental, existential (giving and losing meaning), biological, social, and cultural factors take shape.

To our knowledge, this is the first time a public body has drawn such an explicit conclusion about how psychiatric diagnosis might best be used in clinical and public health practice.

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