Editorial

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Dual diagnosis – what's in a name?

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Introduction

There is still variation in terminology for the definition of substance use and co-existing mental disorders. Although the term "dual diagnosis" is used in the UK, Australia, Spain and Spanish-speaking countries, the same term in Canada refers to intellectual or developmental disorders, and co-existing mental disorders. In the USA, the term "co-occurring disorders" is used. The World Health Organization (Askey *et al.*, 2007) and European Monitoring Centre for Drugs and Drug Addiction (Baldacchino *et al.*, 2011) still use the term "dual diagnosis" to define the co-existence of two or more psychiatric disorders as defined by the International Classification of Diseases – one is of which is problematic substance use.

Background

The association between substance use disorder and other mental disorders has been noted as far back as the 1960s, when a close relationship was found between the number of readmissions to mental health in-patient units and a diagnosis of alcohol use disorder (Pokorny, 1965). Until that time, the term was used to describe the co-existence of intellectual disability and other mental disorders. It was not until the era of widespread deinstitutionalization 15 years later that a focus on substance use disorders in people living with other mental disorders in the community became stronger. The term first appeared in a series of articles that highlighted the use of illicit drugs to cope with mental disorders in the "young adult chronic patient" living in the community (Caton, 1981) but the term "dual diagnosis" was yet to find its place in routine clinical practice.

By the mid-1980s, it was noted that people with "dual disorders" received care from either addiction or mental health services and those with dual diagnosis were often excluded from both (Ridgely *et al.*, 1987). Since that time, the term "dual diagnosis" has remained a standard term across many countries, with research extending into topics such as homelessness (Roth *et al.*, 1987), violence (Swanson *et al.*, 1990) and the criminal justice system (Mafarlane *et al.*, 1989).

Perspectives on dual diagnosis

Although a medical perspective prevails to provide a validated evidence base for access to services, the predominant lens of substance use disorders as mental disorders based purely on brain pathways is now outdated (Heather *et al.*, 2018). Instead, the role of coping mechanisms (Moggi *et al.*, 1999), cultural norms (Healy *et al.*, 2009), health and social inequalities (Wright and Smeeth, 2003), as well as social (Drake and Mueser, 2000) and family (Drake *et al.*, 2001) networks provide opportunities for harm reduction through integrated care.

Such an approach should incorporate psychosocial interventions aimed at addressing education, employment, housing, social support and family involvement through a community reinforcement approach towards that provides a biopsychosocial pathway to recovery.

The test of time

When first published 14 years ago, the main aim of *Advances in Dual Diagnosis* was to improve the care of people living with dual diagnosis and others involved with their journey from accessing services through to recovery. An important point was raised as to how best to align the journal's aims and scope with clinical practice, which was to include substance use and mental health along its full continuum. That said, the journal remains focused on substance use and mental health as mental disorders. This should not ignore the relevance of dual diagnosis prevention at a public health level.

The future of dual diagnosis

In 2015, Professor Liz Hughes, co-editor of the very first issue of this journal, wrote in *The Guardian* newspaper "Dual diagnosis is one of the biggest challenges facing mental health and substance use services, but after 15 years of a variety of initiatives it's hard to see how things have changed on the frontline." Seven years later, there still remain gaps in research, policy and practice, which we aim to cover in this journal over the coming years. One of these has already received our attention in the form of recovery stories, two which are included in this issue (Maken and Oglive, 2022; Ogilvie, 2022). Another is to include best practice around integrated care. Although developed in older adult populations for more than 10 years (Rao and Shanks, 2011); there is still further scope for expansion into other populations.

As we look to the future, there are still topics that we would like to see included in future issues. These include stigma, professional attitudes to dual diagnosis, education and training, mental capacity and commissioning structures to improve health and psychosocial outcomes. We will also be commissioning international perspectives on dual diagnosis.

For the moment, dual diagnosis is here to stay as an internationally recognised term that has the potential to improve the treatment and care for a group that deserves better treatment and better care.

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