Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

yet the sight of a person self-harming without a diagnosis of psychosis or depression provokes a visceral emotional response. Clinicians are left feeling hopeless and incapable. One strategy is to keep the patient out of services, another is to move them. Professionals who are distressed by the risky behaviour of patients continue to find that "whatever admission to [another] hospital might do for the patient, it would also do much for them".[8]

Otherwise thoughtful professional meetings that incorporate patients' wishes and principles of good practice can change as soon as suicide is mentioned, leading to defensive and restrictive practice. According to the Independent Review of the Mental Health Act,[9] we as practitioners have too often stopped managing the risks to our patients and are instead managing the risks to ourselves.

Some NHS providers do not use out-of-area placements, showing that the use of this model of care is a choice, not a necessity.[10] Current expenditure, for example, can be used to develop evidence-based community services. Most importantly, we as mental health professionals must address the culture of fear and blame affecting clinicians and services, and instead enable them to deliver meaningful help. This change requires a cultural shift and an adjustment in political priorities.

Spending £250 000 per person per year to ensure untoward incidents happen elsewhere might be an issue that is unique to the UK. It is not an innovation of which to be proud. The cost is too much for the taxpayer and far too much for the individuals whose lives are damaged.

KH is the Chief Executive Officer and Clinical Lead of Beam Consultancy (Chester, UK) which helps organisations work with clients perceived as high-risk, including the avoidance of out of area placements. We declare no other competing interests.

*Keir Harding, Rob Poole, Catherine Robinson
keir@beamconsultancy.co.uk

Beam Consultancy, Chester, UK (KH); Centre for Mental Health and Society, School of Health Sciences, Prifysgol Bangor University, Bangor, UK (RP); and School of Health Sciences, University of Manchester, Manchester, UK (CR)

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Innovative strategies to support physical distancing among individuals with active addiction

To date, over 4 million people globally have been infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), resulting in more than 250 000 deaths.[1] Populations at particular risk include many of the most vulnerable sectors of society: incarcerated people, those residing in long-term care, minorities, and people with substance use disorders. Considering the high mortality rates attributable to the ongoing opioid overdose crisis, those who use illicit substances are now caught up in two simultaneous public health emergencies.[2] This group might be additionally disadvantaged by barriers to the implementation of public health measures aimed at reducing virus transmission (eg, physical distancing) due to a myriad of social and structural issues including poverty, unstable employment, marginalisation, and homelessness, while having higher rates of comorbidities that portend worse outcomes if they become infected.

In response to these dual crises, health authorities have implemented policy changes to provide new tools to practitioners who treat patients with substance use disorders, circumventing previous barriers to treatment, such as inadequate access and prohibitively regimented


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medication management. For instance, in various North American jurisdictions buprenorphine plus naloxone can now be initiated by telehealth, pharmacists have been granted flexibility in adjusting doses for opioid agonist therapy, restrictions have been loosened on eligibility for take-home opioid agonist therapy, and delivery programmes have been established to bring methadone directly to homeless patients housed in isolation hotels.[3-5] In the UK, the Advisory Council on the Misuse of Drugs has recommended that pharmacists be granted the authority to temporarily provide controlled medications without prescriptions, and adjust dispensing frequencies as needed.[5] All of these measures are intended to help patients self-isolate and flatten the curve, but for many with especially severe substance use disorders they are insufficient.

In British Columbia, an epicentre of the overdose epidemic in Canada, unique steps are being taken to mitigate risk for people who use drugs in the context of SARS-CoV-2. The provision of regulated pharmaceutical-grade opioids has been discussed by public health officials and drug user advocates for years as a potential response to an overdose crisis driven by the infiltration of fentanyl into the illicit drug supply. These conversations have accelerated in the face of the additional threat posed by SARS-CoV-2. Clinical guidance published by the British Columbia Centre on Substance Use in collaboration with the provincial Ministry of Health has, for the first time, proposed an approach to prescribing these medications to patients with active substance use disorders who are thought to be at high risk for SARS-CoV-2.[6] This harm-reduction measure includes providing unwitnessed doses of morphine, hydromorphone, dexamfetamine, methylphenidate, or a combination of these, to people whose current treatments (ie, methadone, buprenorphine plus naloxone) have not led to a sustained remission from drug use. These medications can be dispensed at varying frequencies, with patients having the discretion to use them however they find helpful to support them in their goal of physical distancing, alone or in combination with opioid agonist therapy.

At baseline, such an approach has been suggested to help curb the increasing rate of overdose deaths that have occurred since the arrival of fentanyl in the illicit drug supply. In the setting of current pandemic, these measures also help to promote physical distancing among people who use drugs by obviating the need to engage in high-risk behaviours to procure these substances. They are complemented by the ongoing provision of evidence-based harm-reduction strategies, including distribution of naloxone, sterile injection equipment, and access to safe injection sites (with capacity modified to promote physical distancing).[7] Early anecdotal evidence (Sutherland C, Brar R, unpublished) suggests those receiving prescription alternatives to illicit drugs are able to avoid more routine contacts with drug dealers, and can reduce activities that might put them at risk of acquiring or transmitting SARS-CoV-2 (eg, sex work). An evaluation of the effect on other health outcomes, including rates of overdose deaths, is underway. The benefits of this approach on facilitating physical distancing and reducing use of illicit drugs will need to be assessed alongside the possible risks of drug diversion and other unanticipated harms.

People with substance use disorders face compounded risk in the context of SARS-CoV-2, and implementing physical distancing measures among this population presents unique challenges. Although evidence to address these issues remains limited, innovative strategies must be trialled and rapidly evaluated. Here, sensible public policy and clinical experience can be leveraged to develop an evolving solution to help protect some of the most susceptible populations. Ultimately, a prescription cannot solve the unprecedented morbidity and mortality that is a result of prohibition—this fact remains a social justice issue that will require fundamental regulatory and ideological changes to achieve sustainable improvement. In the meantime, health systems must bravely explore potential solutions to a complex problem that imminently threatens thousands of lives.

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**Paxton Bach, Samantha Robinson, Christy Sutherland, Rupinder Brar*
paxton.bach@bccsu.ubc.ca

Department of Medicine, University of British Columbia, Vancouver, BC, V5Z 1M9, Canada (PB); British Columbia Centre on Substance Use, Vancouver, BC, Canada (PB, SR, CS, RB); School of Nursing, University of British Columbia, Vancouver, Canada (SR); and Department of Family Practice, University of British Columbia, Vancouver, Canada (CS, RB)

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How might the NHS protect the mental health of health-care workers after the COVID-19 crisis?

Throughout the COVID-19 crisis, many health-care workers have worked long hours in high-pressured novel circumstances characterised by trauma and moral dilemmas.[1] Health-care workers have contended with the risk of infection, and by extension infecting their families, with outcomes seemingly worse for some, including black, Asian, and minority ethnic staff. Additionally, remote working is likely to have had its own challenges. Some staff will undoubtedly thrive in such circumstances, but we should now plan how to identify and support those who do not.

Post-trauma social support and stressors experienced during recovery are the risk factors most strongly predictive of longer-term mental health status.[2] Such stressors might be directly attributable to the crisis (eg, a colleague's death) or secondary (such as relationship or employment difficulties).[3]

Much evidence shows that supportive managers foster better mental health.[4] Furthermore, there are lessons from military practice[5] that can be applied to the post-COVID-19 health-care landscape. There are four key elements in an evidence-based staff National Health Service recovery plan. First, giving thanks, both written and verbally, which acknowledges the challenging work undertaken, can foster individual resilience.[6] This communication should include accurate up-to-date information about potential psychological difficulties and supports. Second, return-to-normal work interviews by supervisors who feel confident speaking about mental health. These interviews allow for a better understanding of a staff member's experiences, while identifying secondary stressors in order to collaboratively design individualised recovery plans. Such discussions reduce sickness absence in other trauma-exposed occupations.[7] Third, active monitoring for anyone exposed to potentially traumatic events, particularly individuals considered to be at higher risk of developing mental health problems.[8] Although such monitoring is another function of good management, evidence supports proactive case finding, which proved successful after the London bombings.[9] An anonymous online self-check tool might encourage honest and meaningful responses while providing automated tailored feedback. Fourth, group discussions to help staff to develop a meaningful narrative that reduces risks of harm. Schwartz rounds, a structured forum for clinical and non-clinical staff to discuss emotional and social aspects of work, are one such evidence-based model.

Successful recovery planning[10] should minimise the onset of mental illness while maximising the opportunity for psychological growth.[1] Proactive managers should follow the evidence, which is both legally required and what staff deserve.

NG runs a psychological health consultancy that provides resilience training for a wide range of organisations, including a few UK National Health Service (NHS) teams. The work was supported by the UK National Institute for Health Research (NIHR) Health Protection Research Unit in Emergency Preparedness and Response at King's College London (London, UK), in partnership with Public Health England and in collaboration with the University of East Anglia (Norwich, UK) and Newcastle University (Newcastle upon Tyne, UK). The views expressed are those of the authors and not necessarily those of the NHS, NIHR, UK Department of Health and Social Care, or Public Health England. All other authors declare no competing interests.

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