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.

15 years, which could limit the understanding of the current state of cultural adaptation for mental health interventions among Chinese populations. Although Chinese mental health practitioners are often trained in Western-style psychology and psychiatry, cultural differences in symptom manifestations of depression have been noted among Chinese people, although studies are limited and have had mixed findings.[10] It is essential to specifically examine Chinese characteristics of common mental disorders to inform culturally compatible psychiatric practice.

Overall, Li and colleagues showed that culturally adapted interventions are efficacious in addressing common mental disorders among people of Chinese descent. Further efforts are needed to understand what contributes to effective cultural adaptation and what culturally adapted psychological interventions are available for Chinese people, especially among disadvantaged communities, such as ethnic minorities, as well as children and adolescents. Rigorous assessment tools and guidelines for cultural adaptation should be developed to ensure the quality of culturally adapted interventions for mental health, which would be beneficial to achieving mental health equity among Chinese populations. Finally, the development of unique interventions that centre Chinese knowledge and experience is needed as the field of psychological intervention continues to mature in China.

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1 Bernal G, Jiménez-Chafey MI, Domenech Rodríguez MM. Cultural adaptation of treatments: a resource for considering culture in evidence-based practice. *Prof Psychol Res Pract* 2009; **40:** 361–68.
2 Wang Z, Yang G, Guo Y. Harnessing the opportunity to achieve health equity in China. *Lancet Public Health* 2021; **6:** e867–68.
3 Ellis DM, Draheim AA, Anderson PL. Culturally adapted digital mental health interventions for ethnic/racial minorities: a systematic review and meta-analysis. *J Consult Clin Psychol* 2022; **90:** 717–33.
4 Harper Shehadeh M, Heim E, Chowdhary N, Maercker A, Albanese E. Cultural adaptation of minimally guided interventions for common mental disorders: a systematic review and meta-analysis. *JMIR Ment Health* 2016; **3:** e44.
5 Li S, Xi Z, Barnett P, Saunders R, Shafran R, Pilling S. Efficacy of culturally adapted interventions for common mental disorders in people of Chinese descent: a systematic review and meta-analysis. *Lancet Psychiatry* 2023; **10:** 426–40.
6 Arundell L-L, Barnett P, Buckman JEJ, Saunders R, Pilling S. The effectiveness of adapted psychological interventions for people from ethnic minority groups: a systematic review and conceptual typology. *Clin Psychol Rev* 2021; **88:** 102063.
7 Sit HF, Ling R, Lam AIF, Chen W, Latkin CA, Hall BJ. The cultural adaptation of step-by-step: an intervention to address depression among Chinese young adults. *Front Psychiatry* 2020; **11:** 650.
8 Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *J Abnorm Child Psychol* 1995; **23:** 67–82.
9 Hwang WC, Myers HF, Abe-Kim J, Ting JY. A conceptual paradigm for understanding culture's impact on mental health: the cultural influences on mental health (CIMH) model. *Clin Psychol Rev* 2008; **28:** 211–27.
10 De Vaus J, Hornsey MJ, Kuppens P, Bastian B. Exploring the East–West divide in prevalence of affective disorder: a case for cultural differences in coping with negative emotion. *Pers Soc Psychol Rev* 2017; **22:** 285–304.

Fast tracking informative clinical trials: lessons for mental health

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For more on the **World Health Assembly's Resolution to Strengthen Clinical Trials** see https://www.who.int/our-work/science-division/research-for-health/implementation-of-the-resolution-on-clinical-trials

For more on the **Independent Pandemic Preparedness Secretariat's 100 Days Mission** see https://ippsecretariat.org/

The COVID-19 pandemic has put clinical research and how it is organised, implemented, and disseminated under scrutiny, and has revealed not only capabilities, but also shortcomings and inefficiencies. Many of these observations reflected or magnified problems that preceded the pandemic in many areas of medicine and are likely to remain relevant in the years that follow. For example, it has been highlighted that more than 95% of clinical trials on COVID-19 were underpowered or poorly designed and thus had no possibility of providing meaningful evidence.[1] This problem sounds familiar to anybody observing the clinical trials landscape in psychiatry.

Overcoming such issues in pandemic preparedness has been a key aspect of policy initiatives such as the World Health Assembly's Resolution to Strengthen Clinical Trials and the Independent Pandemic Preparedness Secretariat's 100 Days Mission. We argue that similar efforts to improve the clinical research landscape are needed for non-communicable diseases in general and mental health in particular.

Although the mental health crisis might not dominate the headlines in the same way that a novel viral infection would, the silent pandemics of depression and other mental health conditions pose a major threat to health

and wellbeing globally.[2] Furthermore, the limitations of our evidence base are in many ways reminiscent of the methodological shortcomings observed during the COVID-19 pandemic. Indeed, clinical trials in psychiatry often fail to inform clinical practice,[3] and systematic analyses of clinical trials for psychological and pharmacological mental health interventions showed that most trials are dramatically underpowered to detect the effect sizes that one could reasonably expect from them.[4]

Big wins (ie, new interventions with large effects) seem unlikely for many health conditions, including mental disorders.[5] An intervention with a modest benefit on a common cause of disease would have a much greater public health impact than an intervention with a large impact on a rare cause. Given the high prevalence of mental disorders and the enormous disease burden,[2] socioeconomic costs,[6] and effects on morbidity and mortality,[7] even moderate to small treatment effects would be highly relevant. Thus, we have to ensure that trials are sufficiently powered to reliably detect such modest, but relevant, treatment effects.

Here, the mental health field can learn important lessons from the few exceptional trials that rapidly transformed the evidence base during the COVID-19 pandemic, such as the RECOVERY trial done in the UK. This trial was pragmatic in nature (eg, it had broad inclusion criteria and was open label), fully embedded in routine care (ie, it imposed a minimal additional burden for front-line health-care staff and patients), and sufficiently large to detect modest but clinically relevant effects. The trial produced the first guideline-changing result within 100 days of the protocol first being drafted,[8] and it has since provided answers for ten additional treatment options, definitively showing what works and, equally important, what does not.[9]

Of course, one cannot translate all aspects of trials such as the RECOVERY trial[8] directly into randomised controlled trials (RCTs) in mental health. However, trials such as RECOVERY have shown practical ways in which to produce more efficiently and at higher speed clinically meaningful results that have immediate implications for the standard of care worldwide.

Driven partly by the lessons learnt from the pandemic response, the Good Clinical Trials Collaborative, with support from the Wellcome Trust and the Bill & Melinda Gates Foundation, brought together and drew on the expertise and experiences of a diverse, multidisciplinary, global community, to identify and describe five fundamental principles that are required to deliver a good RCT; the full guidance is now available online. The principles, taken together, capture the necessary qualities of a well planned, well run, and clinically relevant RCT. The guidance recognises that the methods and approaches needed to achieve these qualities will differ in small or large ways from trial to trial, but that their validity is universal. These principles can be readily applied to mental health to make sure that future trials do not repeat the errors of the past and instead become increasingly informative (by making sure that each trial answers definitively an important question) and more relevant for clinical practice. In future, it will be important to elaborate what these fundamental principles of informative and relevant clinical trials mean for the mental health field with regard to, for example, proportionate risk management in clinical trials (in comparison with routine care) or appropriate inclusion and exclusion criteria (eg, with regard to comorbidities or suicidality). To achieve this improvement, the mental health field will need a collaborative conversation between people with lived experience, clinicians, researchers, ethics commissions, research funders, industry, regulators, and other key stakeholders.

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1 Bugin K, Woodcock J. Trends in COVID-19 therapeutic clinical trials. *Nat Rev Drug Discov* 2021; **20:** 254–55.

For more on the **RECOVERY trial** see https://www.recoverytrial.net/

For more on the **Good Clinical Trials Collaborative guidance** see https://www.goodtrials.org/

2 GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Psychiatry* 2022; **9:** 137–50.

3 Chevance A, Ravaud P, Cornelius V, Mayo-Wilson E, Furukawa TA. Designing clinically useful psychopharmacological trials: challenges and ways forward. *Lancet Psychiatry* 2022; **9:** 584–94.

4 de Vries YA, Schoevers RA, Higgins JPT, Munafò MR, Bastiaansen JA. Statistical power in clinical trials of interventions for mood, anxiety, and psychotic disorders. *Psychol Med* 2022; **19:** 1–8.

5 Leucht S, Hierl S, Kissling W, Dold M, Davis JM. Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. *Br J Psychiatry* 2012; **200:** 97–106.

6 Christensen MK, Lim CCW, Saha S, et al. The cost of mental disorders: a systematic review. *Epidemiol Psychiatr Sci* 2020; **29:** e161.

7 Plana-Ripoll O, Pedersen CB, Agerbo E, et al. A comprehensive analysis of mortality-related health metrics associated with mental disorders: a nationwide, register-based cohort study. *Lancet* 2019; **394:** 1827–35.

8 Horby P, Lim WS, Emberson JR, et al. Dexamethasone in hospitalized patients with COVID-19. *N Engl J Med* 2021; **384:** 693–704.

9 Pessoa-Amorim G, Campbell M, Fletcher L, et al. Making trials part of good clinical care: lessons from the RECOVERY trial. *Future Healthc J* 2021; **8:** e243–50.

Changing approaches to treating opioid withdrawal in the USA

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In 2020, an estimated 91 799 people in the USA died of substance-related overdose—75% were related to opioids, and 85% of these opioid deaths were related to fentanyl. In 2021, overdose deaths increased to over 108 000 and provisional data from 2022 show a further increase.[1] The presentation of opioid withdrawal in hospitals is sometimes overlooked or even ignored, both of which are unacceptable. Possible reasons for overlooking or ignoring opioid withdrawal in hospitals include: implicit bias, poor knowledge regarding approaches to the management of opioid-related presentations, or a misunderstanding of the implications of unmanaged opioid use disorder (OUD). If we, as a society, do not change our pedagogical and practical approaches to opioid withdrawal in the USA, we fear that we will continue to see a rise in these preventable deaths.

In the USA, societal attitudes towards the use of drugs and towards people who use drugs must be adjusted before meaningful change can be made. A shift to viewing the problematic use of drugs as a public health issue rather than a moral issue is necessary to improve outcomes. Stigma associated with recreational drug use, on both individual and policy levels, is a tremendous burden and discourages help-seeking behaviour in this vulnerable population. Restructuring drug-scheduling laws and eliminating jail time as a consequence of possession of small quantities of illegal drugs might be the most direct way to address this bias. Implementation of government-funded initiatives to reduce use-associated harms would provide much benefit to people who use drugs; ideally, in conjunction with decriminalisation. Drug-checking services (which test the safety and chemical content of the drugs), syringe service programmes, naloxone distribution and training on its administration, and increased access to public health and social services are common harm reduction measures that are underutilised in the USA. The only two sanctioned overdose prevention centres, or safe consumption sites, in the USA, both in New York City, have been operating since November, 2021, and have been used by thousands of people with no deaths on site, and hundreds of reversed opioid overdoses.[2] Increased use of these approaches might be the best option to decrease deaths and provide crucial points of intervention to engage people who use drugs in discussions about medications for OUD, physical health, and mental health.

Marginalised racial groups are facing the brunt of this crisis, as illustrated by the disproportionate increase in overdose death rates for Black and Hispanic people in the USA during the COVID-19 pandemic.[3] This increase is indicative of the existence of various social and health inequities which must be addressed. Elimination of disparities is essential, if we aim to reduce harms, such as incarceration and death, in these populations.

Legal implications of mismanagement of OUD, including possible violations of the Emergency Medical Treatment and Labor Act, the Americans with Disabilities Act, the Rehabilitation Act, or Title VI of the Civil Rights Act, were outlined in a 2021 report from the Legal Action Center.[4] Unfortunately, not much has changed since the release of this report, and violations of these acts are difficult to track and seldom disclosed. Knowledge of