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.

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According to WHO, each suicide in a population is accompanied by more than 20 suicide attempts.[3] Thus, the number of mentally distressed people who might seek help from mental health services can be expected to increase in the context of the COVID-19 pandemic. Data from the economic crisis of 2008 showed that the increase in suicides preceded the actual rise in the unemployment rate.[2] We therefore expect an extra burden for our mental health system, and the medical community should prepare for this challenge now. Mental health providers should also raise awareness in politics and society that rising unemployment is associated with an increased number of suicides. The downsizing of the economy and the focus of the medical system on the COVID-19 pandemic can lead to unintended long-term problems for a vulnerable group on the fringes of society. It is important that various services, such as hotlines and psychiatric services, remain able to respond appropriately.

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Suicide prevention during the COVID-19 outbreak

Publications on mental health and psychosocial considerations during the COVID-19 outbreak[1,2] and on the psychological effects of quarantine[3] provide important information and recommendations. These are important publications that should be translated to the field for all three levels of suicide prevention: primary, secondary, and tertiary. These publications include sections on urgent mental health issues such as depression[2] and severe psychiatric conditions,[1] but directly addressing specific recommendations for suicide prevention is needed.

The COVID-19 outbreak is emotionally challenging for everyone, especially for individuals who are already at risk (eg, those suffering from depression). During and following the COVID-19 outbreak and the outcomes of isolation and quarantine, we might see an increase in suicide ideation and behaviour among at-risk populations.[4] Whether this increase will be in the short or long term (or both) remains unclear, but the mental health community should be prepared and can use this challenging period to advance suicide prevention. First, people are currently more able than in the past to talk about depression, anxiety, and suicide ideation. It appears that sharing experiences of negative emotions carries less stigma than it used to. Moreover, death has become a topic that all ages can more readily talk about, and it might be easier for people and mental health providers to ask directly about suicide risk. Second, people now understand the importance of social support in times of crises and tend to agree that it saves lives. Finally, people at risk for suicide can now get psychological help online, which might be more accessible for various reasons (eg, because of reduced stigma and removal of transportation or time barriers). The medical community needs to make sure that online providers can assess suicide risk and provide specific suicide prevention interventions.[5] Mental health providers should now directly convey to every patient that in any case of severe crises, they should not hurt themselves. It has always been our priority as mental health providers to reinforce to our patients that there is always hope and that there are several solutions to any problem. The challenge of the COVID-19 outbreak might bring with it an opportunity to advance the field of suicide prevention and thus to save lives. These suicide prevention efforts should be integrated into the overall reaction programme for dealing with the COVID-19 crisis.

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Public health messaging and harm reduction in the time of COVID-19

Coronavirus disease 2019 (COVID-19) was declared a pandemic on March 11, and the disease is now expected to spread to most countries, if not all.[1] The public health messaging mainly concerns personal hygiene, physical distancing, respiratory etiquette, stocking up on food supplies and essential medicines, contact tracing, and staying indoors as much as possible. We are concerned that the

current public health messaging might be leaving out an important at-risk population: people who use drugs, including beverage and non-beverage alcohol, and in particular, individuals who are marginalised and street entrenched. Marginalised people who use drugs might be at an increased risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, and of poor outcomes of COVID-19, because of limited personal resources, unstable and densely populated housing conditions, substance use sharing practices, and compromised immunity (eg, in individuals living with HIV, chronic obstructive pulmonary disease, and other comorbidities). Other concerns pertain to limited access to essential medicines (including opioid agonist treatments) and harm reduction supplies.

Investments in harm reduction supplies and services need to be expanded now. These investments should focus on increasing supplies for safer smoking, snorting, and injecting drug use, access to alternatives to non-beverage alcohol, and providing sanitising supplies and educational materials in harm reduction packages. Harm reduction services should prepare for logistical challenges by developing emergency plans for potential volunteer and employee absences, illness, and burnout as well as communication plans in case of service disruption in essential services (eg, access to prescribed medications, safe consumption rooms, and overdose prevention sites). Treatment continuity plans (eg, permitting online visits, phone-based refills, extended prescriptions, permitting take-home doses, permitting prescriptions to be transferred between pharmacies, and providing ongoing access through outreach and delivery options) are needed for individuals living with HIV, hepatitis C virus, and substance use disorders. Because emergency services are likely to be overburdened, responses to overdoses or other medical emergencies related to substance use (eg, severe alcohol withdrawal) might be delayed; efforts should be made to ensure access to appropriate clinical sites and specialist care, as well as a high penetration and uninterrupted supply of naloxone kits. In settings such as those in North America, where there is an influx of fentanyl and its analogues,[2] scaling up services to provide a safer supply of drugs, tablet-based and injectable agonist treatments, and slow-release oral morphine could help mitigate transmission of SARS-CoV-2 by reducing the need to spend time outdoors procuring drugs: these interventions could rapidly be incorporated in existing harm reduction services.[3–5]

Developing public health messaging tailored towards marginalised people who use drugs is of utmost importance. These messages should highlight the need to minimise sharing substance use supplies because respiratory infectious diseases can be easily transmitted via e-cigarettes, pipes, and nasal tubes. In situations in which sharing supplies is inevitable, harm reduction messages should emphasise washing or sanitising hands before substance use, wiping the supplies and surfaces used for drug preparation with alcohol or disinfectants, and stocking up on supplies to avoid unnecessary trips to harm reduction facilities. Public health messages around self-isolation and physical distancing should be modified for people who use drugs who live in shelters or who are involved in sex work.

As a society, we can protect vulnerable populations by practising the fundamentals of public health and prevention science. We have a moral, societal, and professional responsibility to ensure that people living on the margins are not left out of these efforts.

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