

mutation (2). This line of research may eventually allow more accurate personalized medicine approaches based on an individual's genetic profile.

This historical context of BEN shows that some attempts to eliminate race-based laboratory adjustments could perpetuate the very disparities that we are attempting to address. Although BEN falls under the race-based medicine umbrella, it is also a thoughtful, well-researched, and justice-oriented approach. Nonetheless, the use of the word "ethnic" is problematic because it reinforces a Eurocentric worldview. Although the BEN variant is more common among individuals of African and Middle Eastern ancestry, it can be diagnosed in any patient. We therefore propose renaming this label (for instance, simply "benign familial neutropenia" or "constitutional neutropenia," as it is sometimes called). Such an approach may be a preferable compromise between alternative proposals, such as race-specific normal values (a race-based medicine approach that could lend undue biological credence to social categories) (5) or expansion of the "normal" ANC range (a "color-blind" approach that could overlook meaningful genetic diversity in the population) (3).

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Recommendations to Improve Medication-Assisted Treatment Implementation in Correctional Health

TO THE EDITOR: Opioid overdose deaths have more than tripled over the previous two decades (1), coinciding with a 43% growth in substance-involved incarcerations from

1996 to 2006 (2). Consistent with national averages and typical treatment opportunities in jail, 60%–70% of people facing incarceration in California's San Mateo County (SMC) are held on substance-related charges, often suffering withdrawal symptoms in the absence of comprehensive medication-assisted treatment (MAT) programming (3).

MAT has been shown to reduce recidivism and post-release opioid overdose deaths, among other benefits, and is the standard of care for incarcerated individuals with opioid use disorder (3, 4). In 2019, SMC jails (census approximately 1,500 individuals) initiated buprenorphine treatment alongside established methadone and naltrexone treatment options. Using qualitative research methods adapted to a quality improvement framework, we set out to understand the facilitators and barriers to implementation of a MAT program in the correctional health setting. A literature review informed the construction of a semistructured interview guide. We identified clinical staff involved in MAT services (N=4), correctional health administrators (N=2), and community partners (N=2) and conducted 45-minute interviews with them. Interview summaries were independently coded by two research staff using thematic analysis, and differences were arbitrated by the senior author. The University of California, San Francisco, and SMC institutional review boards approved this study.

We found that participant attitudes toward MAT were polarized, including among the clinical staff. Those opposed to MAT expressed concerns that providing MAT was equivalent to providing illicit substances and frequently used the motto "skills, not pills" as a rebuttal to MAT. One perception was that evidence for MAT's efficacy was insubstantial and lacked specificity for correctional populations. Most respondents felt that implementation was planned unilaterally and excluded stakeholder involvement. Another perception was that opioid usage was not a problem in SMC and that the risk of introducing MAT was outweighed by risks of diversion. In addition, participants raised concerns that the pharmaceutical industry was encouraging MAT implementation.

Proponents of MAT cited the differential benefits (lack of euphoria, long-acting injection formulation) of medications approved by the U.S. Food and Drug Administration and the risk of unintentional overdose death upon community reintegration as principal reasons to pursue pharmacotherapy.

Regardless of preference, respondents unanimously acknowledged that substance use disorders are a significant problem in SMC. All respondents suggested that diversion of MAT is a risk, although most felt that jail protocols (observed administration, not offering buprenorphine induction) curtailed diversion. All participants indicated that social supports were vitally important, although lacking, for those facing reentry.

Although MAT is a standard of care in correctional settings, our findings are similar to those in existing literature describing strong reservations among key stakeholders (5). Our recommendations to facilitate more robust uptake of MAT implementation in corrections facilities include

communication with frontline providers outlining reasons for initiating MAT, staff education regarding MAT evidence, and measures to address potential risks. Monitoring and sharing outcome data may demonstrate program efficacy and safety. Proactive engagement of a range of clinical and nonclinical stakeholders could encourage problem solving and prevent alienation during implementation of MAT. Finally, sustaining partnerships with community organizations and health systems is indispensable in coordinating patient care on release.

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Mental Health in the Aftermath of the Beirut Blast: Community Healing and the Quest for Justice

TO THE EDITOR: On August 4, 2020, two explosions rocked Beirut, causing over 200 deaths and 7,000 injuries and leaving 300,000 people homeless. The event was linked to 2,750 tons of ammonium nitrate that had been stored without proper safety measures in the port, adjacent to residential areas, for 6 years (1). The blast is one of the largest nonnuclear explosions in history and happened while Lebanon has been struggling with severe economic and political instabilities and the ongoing COVID-19 pandemic.

In the aftermath of this tragedy, the demands for justice and reparations from Lebanon's residents have been striking. In contrast to reactions to natural disasters, the blast is perceived by Lebanese people as an act of murder resulting from their government's negligence. It is also evident in people's narratives that they no longer relate to the "resilience" of the Lebanese (2), a notion now equated with resignation and acceptance that living is merely

surviving. From social media to large-scale protests, marches, and grassroots efforts, people have been unrelenting in their calls for accountability and to never forget what happened.

In this context, the mental health response must acknowledge this collective suffering and emphasize that justice is essential for healing. Helping individuals alleviate their emotional difficulties must be offered in tandem with a mental health analysis and response grounded in a socio-political and socioeconomic contextualization and guided by people's aspirations and needs (3). Beyond treating individual symptoms of distress, collective healing over the long term necessitates a resourceful mental health response centered on advocacy for justice and on people's needs and rights to reconstruct and sustain the foundations of their communities' social safety and health.

The Beirut blast happened at a time when the pandemic exposed worldwide that a meaningful response to this health crisis requires acknowledging the structural drivers of social, economic, and health inequities (4). It also occurred at a time in Lebanon when an economic crisis and sociopolitical unrest are still growing, putting at the forefront the detrimental impacts of socioeconomic and security adversities and the notions of collective suffering and strength. The mental health response to the Beirut blast should be embedded within these realities. It should combine interventions for mental health conditions with community interventions that can target social distress and promote the recognition of the social, political, and economic hardships that Lebanese people are facing as inherent components of distress. Focusing on individual symptoms while neglecting the systems that perpetuate them can negatively affect acute and long-term care of individuals and communities (5). Mental health professionals, researchers, and policy makers in Lebanon have the responsibility to acknowledge structural drivers of collective distress. Their work must go beyond clinical interventions for individual symptoms and integrate awareness and intervention efforts that target social distress, with acknowledgment that suffering is felt collectively and is unique to the individual yet is not an isolated experience. Community-targeted and long-term strategies that address multiple layers of distress, build capacities that reflect communities' needs, and advance advocacy for justice are central for reconstructing the mental health of the Lebanese people.

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