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.

The Lancet Psychiatry. We congratulate the authors on conducting the first UK study of neurological and psychiatric complications of COVID-19 in 153 patients. However, we are concerned about the interpretation of the data on altered mental status, found in 37 patients. The authors state that 21 of these patients had new psychiatric diagnoses, including ten with new-onset psychosis, six with a neurocognitive (dementia-like) syndrome, and four with an affective disorder. It was noted that 18 (49%) of the patients with altered mental status were younger than 60 years.

For the **guideline from the Faculty of Intensive Care Medicine** see https://www.ficm.ac.uk/sites/default/files/ficm_rehab_provisional_guidance.pdf

Because the study was done with hospitalised patients who underwent only brief screening, the patients were likely to have been exhibiting acute symptoms, such as hallucinations and delusions, that are typical in patients with acute respiratory distress syndrome or other critical illness.[2] Although these experiences are similar to positive psychosis symptoms, in critical care they are usually temporary aspects of delirium, a syndrome affecting 50% to 80% of intensive care unit (ICU) patients of all ages.[3]

Other cognitive dysfunction, such as confusion, disorientation, memory loss, or inattention, is also seen in delirium. Additionally, many ICU patients experience acute stress, such as anxiety or low mood. In most cases, both cognitive and emotional features resolve naturally by hospital discharge. When symptoms persist, the most commonly reported psychological outcomes of critical illness are anxiety, depression, post-traumatic stress disorder (seen in around 40%, 30%, and 20% of cases respectively),[4] and mild cognitive difficulties.[5] However, there is no evidence that patients develop psychotic disorders as a consequence of critical illness.

As experienced clinicians who work with critically ill patients with COVID-19 during admission and post discharge, our observation is that these patients have similar psychological experiences to other critically ill patients. Many become delirious in hospital and report hallucinations and delusions. We are seeing patients with anxiety, depression, and post-traumatic stress disorder in critical care and COVID-19 follow-up clinics, but nobody with new-onset psychosis.

Our concern is that patients with transient symptoms will be labelled with serious psychiatric diagnoses, leading to distress and inappropriate commissioning of services. The British Psychological Society[5] and the Faculty of Intensive Care Medicine recommend that psychological difficulties following severe COVID-19 disease are managed by multidisciplinary rehabilitation teams with embedded psychologists. Large multicentre cohort studies of psychological outcomes and risk factors of patients with severe COVID-19 are urgently needed to provide more information.

We declare no competing interests. Psychologists in Intensive Care UK (PINC-UK) is a special interest group of psychology professionals working in critical care in the UK. It is a strategic partner of the Intensive Care Society, UK.

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Authors' reply

We thank Dorothy Wade and colleagues and Mark Oldham and colleagues for their recognition of the cross-speciality effort of members of the UK's major professional neuroscience bodies who undertook this challenging UK-wide study during the exponential phase of the COVID-19 pandemic.[1] We also welcome the involvement of geriatricians and psychologists in future research.

We agree that delirium is common, especially in severe infections and in the intensive care unit. As stated in our Article, we acknowledge that the study might have not recorded all such cases. Changes in mental status with clear and recognised risk factors were not the focus of this study (eg, those explained by severe systemic illness and associated with dementia or cognitive impairment). We agree that if such commonly observed complications were included, they might have substantially increased the number of patients recruited, mirroring the situation in other critical illnesses. In this situation, the burden of CNS complications arising from COVID-19 would be even greater than we found in our study.

We agree that consistent terminology is needed for the many causes of alterations of mental state and an improved understanding of the underlying pathophysiology that should determine this is urgently required. We acknowledge the position paper on a proposed terminology of these complex presentations and, appreciating the value of multidisciplinary approaches, would support involvement of the professional bodies in relevant areas of psychiatry, neuropsychiatry, and

neurological infection, as well as patient and public involvement, in future iterations.[2]

We understand the motivations for wishing to avoid the term altered mental status. However, we carefully considered the information notified and took an ontological approach for over-arching terms that include disturbances of mental state occurring without the clinical features of delirium (including isolated psychosis, catatonia, anxiety, and mania).

Our study was done with clear a-priori clinical case definitions, such as encephalitis, to support the experienced clinicians reporting cases, reflecting national guidelines, and it was clearly intended to report acute presentations. We took a strong view that the knowledge of the bedside specialist clinician assessing the patient was inherently valuable, and that rediagnosing patients from a distance would be neither wise nor accurate. Psychiatrists, for example, commonly differentiate psychosis from psychotic symptoms occurring as part of delirium; indeed, it is routine practice to provide reassurance that new-onset psychosis is actually delirium and should resolve. Even in 1918, both psychiatrists and neurologists, including Menninger and von Economo,[3] were careful to distinguish patients with primary brain dysfunction or disease from those whose symptoms were explained by systemic processes.

Our study was designed from the outset in a three-stage approach: stage 1 is the core dataset provided by clinicians during the pandemic;[1] stage 2 is detailed clinical data collection; and stage 3 is to evaluate disease mechanisms, including viral neurotropism and para-infectious or post-infectious innate and adaptive immune responses, polygenic risk, endothelial dysfunction, and coagulopathy. Stages 2 and 3 are underway.

Substantial evidence exists that non-CNS infection can cause neuropsychiatric presentations in the absence of delirium,[4] which has now been shown with severe acute respiratory syndrome coronavirus 2 infection.[5] We therefore strongly disagree that all acute COVID-associated neuropsychiatric phenomenology can be explained by delirium. Full detailed analysis of stage 2 and 3 data from this study is underway and the multidisciplinary authors will continue to be guided by the clinical data and underlying disease mechanisms.

Altered mental status will continue to remain an important term in our global WHO and World Federation of Neurology studies of COVID-19 and the brain until these mechanisms are elucidated. We welcome ongoing discussions and collaborations on the intersections of these complex concepts and disorders as this important work progresses.

AV is a Medical Research Council (MRC) PhD fellow. JPC received funding from the National Institute for Health Research (NIHR) Cambridge BioMedical Research Centre, during the conduct of the study. LAB reports funding from GlaxoSmithKline and Research England, outside the submitted work. AC reports personal fees from independent testimony in court on a range of neuropsychiatric topics and as a paid editor of the *Journal of Neurology, Neurosurgery and Psychiatry*, outside the submitted work. Additionally, AC is planning a rehabilitation trial after COVID-19, which could produce an application that might be associated with intellectual property. RHT reports personal fees from Eisai, GW Pharma, Sanofi, UCB Pharma, Zogenix, Bial, and Arvelle, outside the submitted work. RHT has received funding from the Academy of Medical Sciences (AMS) and Wellcome. BDM has received funding from the MRC, AMS, Wellcome, and the NIHR. BDM is supported by the NIHR Health Protection Research Unit in Emerging and Zoonotic Infections (IS-HPU-1112-10117) and the NIHR Global Health Research Group on Brain Infections (17/63/110). All other authors declare no competing interests.

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Reducing alcohol misuse during the COVID-19 pandemic in Kenya

Globally, concerns have been raised about the potential for the COVID-19 pandemic to be associated with an increase in alcohol misuse.[1] In Kenya, media reports during the COVID-19 pandemic suggest increased levels of alcohol use.[2] This increase is particularly worrying because Kenya has one of the highest disability-adjusted life-year counts (54 000) due to alcohol use disorders in Africa.[3] Since the start of the pandemic, policy responses to curb alcohol misuse from the Kenyan Government have been