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.

BHP Billiton, and Herbert Smith Freehills. All other authors declare no competing interests. SMWR and MEH were co-senior authors.

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Authors' reply

We share the sentiment of Mark É Czeisler and colleagues that sources of bias must be carefully considered to determine whether they are the cause of changes when monitoring longitudinal trends in data. However, neither our methods nor other UK data from the same period suggest that our findings are due to non-response bias.

Our decision to restrict the analytical sample to participants with three repeated measurements had a technical basis, to meet the minimum timepoints needed for use of free time scores in latent growth modelling. The sample was weighted only after sample selection to remove the risk of attrition that would otherwise potentially lead to an analytical sample with improved mental health. The percentage of participants with diagnosed mental illness in the analytical sample (6679 [18·3%] of 36 520 participants) and excluded sample (724 [18·1%] of 4000 participants) was similar. Retention rates week-on-week in the study were high in the analytical sample (appendix). Although baseline Patient Health Questionnaire (PHQ) and Generalised Anxiety Disorder assessment (GAD) scores were both negatively correlated with the number of weeks observed (appendix of the Article), on further analysis the correlations were small (PHQ: Pearson's r=–0·16, GAD: r=–0·12). Additionally, our models applied full information maximum likelihood estimation, which uses the observed values to supplement loss of information due to missing data and has been shown to yield unbiased estimates of both parameters and their standard errors in simulation studies.[1]

Comparing our results to studies published after ours, including those of both longitudinal and repeated cross-sectional samples, the same pattern of improvements as shown in our data are found.[2,3] However, our study only covers the first 20 weeks of the pandemic in the UK following the start of lockdown in March 23, 2020. So we agree that the improvements seen in this time should not be taken as conclusions that individuals showed recovery in mental health after the shock of the pandemic. Further data from the UCL COVID-19 Social Study and other studies suggest that mental health worsened again in England (and across Great Britian) in the autumn of 2020 as virus prevalence increased and restrictions were once again tightened.[3] As the pandemic continues, monitoring of changes in mental health should be maintained to support planning and resources for mental health services.

We declare no competing interests.

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People with mental illness should be included in COVID-19 vaccination

In *The Lancet Psychiatry*, Victor Mazareel and colleagues clearly defined the issues related to vaccination for people with psychiatric conditions.[1] In the United Arab Emirates (UAE), COVID-19 vaccination is well organised thanks to strong government leadership. However, during the early stages of the vaccination drive in December, 2020, the national press reported mental illness as an exclusion criterion for COVID-19 vaccination.[2] Subsequently, in January, 2021, we received email communication from the College of Medicine and Health Sciences, Al Ain about the inclusion and exclusion criteria for COVID-19 vaccination. This message had been

See Online for appendix

passed on from the Occupation Safety and Health, Abu Dhabi health services. The information was directed to all staff and faculty. Among the stated exclusion criteria for COVID-19 vaccination was a recent history of convulsion, epilepsy, encephalopathy, or mental illness. This statement was surprising, as it contributes to the stigma surrounding mental illness, which is an ongoing concern in the Middle East. According to this policy, a person with generalised anxiety disorder, panic disorder, depression, or even stable psychosis could not be vaccinated against SARS-CoV-2.

ES, on behalf of the department of psychiatry, pleaded for this decision to be reversed. An email stating our reservations against these criteria was sent to the Dean of the college, who agreed for that to be escalated to the health authorities. The exclusion criteria have now been modified, and presence of mental illness is no longer deemed an exclusion criterion for COVID-19 vaccination in the UAE.[3] As psychiatrists and teachers, we would like to make our community aware that patients with mental illness should not be automatically excluded from any vaccination programme, particularly against COVID-19. Helping such patients means helping the community as a whole.

We try, as members of an academic department, to promote psychiatry and a positive view of our patient population. We hope this positive and constructive feeling is shared by our colleagues, fellow teachers, and doctors in the Middle East. Vaccination against SARS-CoV-2 cannot be imposed. Therefore, a successful campaign requires clear and unambiguous official information. All people, including those who have a psychopathology, must be able to express their wish to be vaccinated or not, and be respected in their choice. Therefore, it is essential for physicians to have the skills and ability to obtain informed consent from patients regarding administration or refusal of vaccination. Patients with both a recent diagnosis of a mental disorder and COVID-19 infection show a death rate of 8·5%, compared with 4·7% among COVID-19 patients who do not have a mental disorder.[4] This fact alone is a major reason to actively prioritise vaccination of people with mental illness globally.

We declare no competing interests.

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Erroneous NICE guidance on autism screening

The 10-item Autism Spectrum Quotient (AQ10)[1] is used internationally for autism screening, in line with the National Institute for Health and Care Excellence (NICE) guidelines.[2] We have found a worrying discrepancy between the clinical cutoff recommended by NICE and the research informing their guidance.[1,3] The NICE Guideline Development Group examined the suitability of the AQ10 for autism screening, on the basis of research indicating that a cutoff score of 6 or higher should inform referrals for specialist diagnostic assessment.[1] However, NICE incorrectly recommend that a score above 6 (ie, 7 or higher) should be used for screening purposes. This cutoff of a score of 7 or higher was, in fact, examined and rejected by the NICE Guideline Development Group in favour of the 6 or higher value,[3] which leads us to conclude that NICE have erroneously recommended the higher cutoff.

This discrepancy in the AQ10 cutoff scores is concerning because of its far-reaching effect on clinical practice and research. Screening accuracy is intrinsically related to cutoff values, whereby the 7 or higher cutoff set by NICE is less sensitive than the correct 6 or higher value. Because the AQ10 is used by general practitioners (typically the first to identify people who might have autism), the insufficiently sensitive implementation of this screening tool will be contributing to missed referrals, diagnoses, and opportunities for intervention. Some researchers are also using the incorrect 7 or higher cutoff,[4] often misattributing this value to the original AQ10 research.[1] Others use the correct 6 or higher cutoff, but mistakenly attribute this value to NICE guidance.[5] Erroneous NICE guidance thus underlies several inconsistencies in the use and reporting of the AQ10, raising broader concerns about the robustness of recent research on autism and co-occurring psychiatric conditions.

In consideration of these issues, the NICE guidance on autism should be revised, emphasising the correct 6 or higher AQ10 cutoff. NICE recommendations are deeply embedded into resources for clinicians, particularly general practitioners, who should be made aware of the correct clinical cutoff. We hope that this Correspondence