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neurological infection, as well as patient and public involvement, in future iterations.¹

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;² 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.

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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
To address the treatment of people with alcohol use disorder in Kenya during the COVID-19 pandemic, we recommend that the government increases access to treatment through mobile health strategies. Kenya has a high prevalence of mobile phone subscriptions and existing collaborations between the Ministry of Health and mobile network service providers, so such a strategy seems feasible for delivering psychological interventions. We additionally recommend that the government delists alcohol as an essential product.

We declare no competing interests.

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