Q&A from RCPsych COVID-19 Webinar - Friday 3 April

Responses as of 9 April 2020. Please note that guidance is constantly under review and may have now been updated. For the latest updates, please visit: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians

Question	Answer
The occupational Health is advised to guide NHS staff regarding their health and risk. However Our Occupational Health team at Trust does not respond to queries. Is there any obligation for them to response to queries within definit period.	We understand there are no national obligations in place for occupational health services, trusts are advised to establish an SLA with its contracted service, along the lines of those suggested by NHS Health at Work. The #OurNHSPeople Wellbeing Support programme has launched on 8 April with a free helpline available from 7am-11pm every day and online services.
ECT clinics are cancelled across the country. What is our ethical stance in no providing a treatment that we have always defended as potentially lifesaving?	We are in the process of updating our guidance on ECT, providing clinicians with the necessary knowledge on safety precautions and alternatives to ECT.
I have a question about caring for people in inpatient settings who refuse to cooperate with infection control procedures both people with capacity and those who lack capacity. The College guidance deals with the MH Act and the MCA legislation but there is no mention of the Health Protection legislation, which can be used where it is thought there is a reasonable risk of infecting others and which applies to the whole population (there don't appear to be any exemptions).	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
I have noticed inconsistent messaging in MH Trusts regarding use of PPE for staff - this is both for the protection of staff but also of our service users who may often have little social contact and so be at less risk of transmitting infection that staff who will mix with their families and colleagues. How can the College address this? College members may see the guidance but it doesn't seem to reach managers etc.	We are aware this is an issue and will be raising this with NHSE/I and PHE. We will include any updates to the national guidance on our website.
There is conflicting guidance from Resus Council and PHE regarding PPE while administering Cardiac Compressions during CPR.	We are aware this is an issue and we have raised this with PHE, NHSE/I and the Resusciation Council UK. We are hoping to have an update about this soon and will update the PPE section of our website accordingly.
We all know it's ver difficult time but during MHA assessments in A&Es patients, police, AMHPs and Psychiatrists have been exposed to risk of COVID-19 due to - 1-Small rooms-social distancing not possible 2-No PPEs 3-With risks of assaults/spitting/coughing or sneezing with intent to harm to professional & other A&E patients 4-Still no opportunity to get test for COVID/19 for staff Please advise how to manage risks Thank you.	We are aware this is an issue and we have raised this with PHE and NHSE/I. We will include any updates to the national guidance on our website.
I would like to ask about resus guidance - Resus council advice is different for inpatient + community settings. Does a mental health unit count as inpatient (need FFP3 for chest compressions) or community (towel alone)?	We are aware this is an issue and we have raised this with PHE, NHSE/I and the Resusciation Council UK. We are hoping to have an update about this soon and will update the PPE section of our website as soon as we do.
What ethical frameworks apply to working during a pandemic. I am aware of WHO guidance. Is there one by RCPsych or a nationally agreed one? Resource allocation, moral injury, equity and end of life issues are all relevant currently.	We have developed guidance on ethical considerations (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/covid-19-ethical-considerations) which provides overarching advice on articular dilemmas for psychiatrists, and links to guidance developed by the Royal College of Physicians and the British Medical Association. We strongly recommend that all psychiatrists check that their local clinical ethics committees are in place as they can provide advice and guidance in real-time.
Is it excessive to produce advance care and treatment escalation plans about COVID 19 for inpatients at before they develop COVID19 or severe symptoms? What about those at higher risk such as people prescribed clozapine? Or those in the shielded groups?	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
Should we be initiating conversations about advance planning and DNACPR with our patients in the community and their families?	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
guidance on DNR in people who are detained , and have no physical health comorbidities but lack capacity to make the decision around DNR .... some trusts advocating the need for DNR...why is such a person so different from the general public in the community who can deteriorate very fast and need a ventilator and no one knows the predicted outcome once on it.	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
We are being told we may need to treat patinets in inpatient SecurE Care who may normally be expected to be admitted to hospital and in worst case scenarios no ambulance will arrive if called. Will we really be protected as clinicans provding treatments we would not normally do (e.g. IV fluids etc) in clinical settings not designed for these treatments?	The GMC Good Medical Practice Guidance states that patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains. A key part of that is recognising and working within the limits of your competence. https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530 For clinicians looking to refresh some of their skills or undertake CPD, we have compiled several resources on an e-learning hub which can be found here - https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/elearning-covid-19-guidance-for-clinicians
For inpatients who are too unwell to understand the need o isolation. How to keep them isolated? Can we use the MCA?	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
Is it possible that psychiatrists are asked to help in Covid wards if not enough medical cover?	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
Is there any college guidance or advice about inpatient settings and trying to encourage self isolation of detained patients in their room who have Covid?! Thanks.	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
As a way of limiting spread and the burden on people who are at work and not self isolating, could there be a revamping of work schedules? For example if possible, not requiring people to be at work everyday and enabling them to follow government advice(social distancing) by reducing the number of people on mental health units site per day while still ensuring that this is still at a safe level and services continue to run. Can staff be allowed to come into work on a rotational basis instead of the expected coming into work daily?	We are aware of this issue and are currently working with an advisory group and NHSE/I to understand what guidance would be most helpful to clinicians.
How can we ensure equity of access when it is not OUR decision who gets treated?	We have developed guidance on ethical considerations (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/covid-19-ethical-considerations) which provides overarching advice on articular dilemmas for psychiatrists, and links to guidance developed by the Royal College of Physicians and the British Medical Association. We strongly recommend that all psychiatrists check that their local clinical ethics committees are in place as they can provide advice and guidance in real-time.
what is the RCPsych view on patient requests for masks when staff might be wearing PPE?	We understand PHE are currently undertaking a review of the PPE required by patients. At present, the national guidance states that only those patients who are shielded/ extremely vulnerable are advised to wear a surgical mask.
Surprisingly there is no mention of any chronic psychiatric illness in list of people who needs shielding?.. Is this because of disparity or discriminatory attitudes to our patients & profession	We are aware this is an issue and it has been raised with NHS England & Improvement, in particular in relation to eating disorders.

Will the College produce guidance on restraint during this pandemic? We are acutely aware that many situations requiring restraint are unpredictable and would potentially involve staff having to be in very close contact with a patient who might be hyperventilating, shouting, spitting etc. Thank you	We do not currently have specific guidance on restraint but do provide some information about managing behavioural crises in our advice for secure hospital and criminal justice settings (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/secure-hospital-and-criminal-justice-settings), highlighting the need for staff to plan for the practice of safe control and restraint, and how this will be affected when wearing protective clothing. This should be agreed at the hospital, trust or the unit's clinical reference group (or similar) as part of contingency planning. You can also find advice on use of personal protective equipment here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/personal-protective-equipment-ppe
I have heard of patients being placed in seclusion primarily because they are symptomatic and will not self-isolate. Is this ethical/legal??	We have developed guidance on ethical considerations (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/covid-19-ethical-considerations) which provides overarching advice on Particular dilemmas for psychiatrists, and links to guidance developed by the Royal College of Physicians and the British Medical Association. We strongly recommend that all psychiatrists check that their local clinical ethics committees are in place as they can provide advice and guidance in real-time. We currently working with an advisory group and NHSE/I to understand what further guidance would be most helpful to clinicians.
Is there any guidance for patients in care homes who would still like to go out for walks (with appropriate social distancing)?	Public Health England's guidance on social distancing - https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults - applies to everyone. People aged over 70, regardless of any underlying health conditions, are advised to be particularly stringent in adhering to the guidelines but are permitted to go for a walk unless they are showing possible symptoms of COVID-19.
Has the College produced advice for the general public, as well as people living with SMI to help them with the significant heightened psychological stress of living under the lockdown and having constant Covid coverage everywhere on infections, death rates, international crises etc?	While our initial focus was on producing guidance for our members, we have started to develop a range of resources to support patients and carers, that we will be continuing to add to. These are available here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/covid-19-and-mental-health
Question for Neil - can he expand on 'P' of PIES - recommendation is to keep people in work	Question should be answered by Neil Greenberg
For Prof Greenberg. I wonder if another word can be used than trauma which infers victimhood and has such a lot of baggage . Stress or distress may be healthier word and build on people's resilience.	Question should be answered by Neil Greenberg
Can consultant psychiatrists be deployed to work in medical wards or A& E	As far as we know, consultant psychiatrists are not being redeployed to work in medical wards or A&E. However, we understand many FY1 doctors have been asked to do support frontline clinical services. Clinicians should consult with their workforce lead within the trust to find out more. Clinicians should ensure they follow the GMC Good MEdical Practice guidance and recognise and work within their competencies.
Some trusts are allowing community psychiatrists to work from home entirely, while some are insisting on them being at work even though they are not seeing patients face to face, & only doing telephone reviews. How is it justified to expose some psychiatrists to increased risk, while protecting others.	We are encouraging as many practices as possible to be done remotely and have provided this guidance on remote consultations. It will be necessary that some NHS staff have to go into work and Trusts should manage this as best they can.
What should be our approach to Advance Decision making, End of Life Care planning in people who may lack or have variable capacity as a result of long-term and life-long conditions. My particular interest is people with learning disabilities or autism but I realise there are other groups. Family members are raising huge concerns.	We are considering this complex issue. We are clear that the availabilty of care (because of increased pressure from COVID-19) should not be a factor in this decision making but there is not an agreed position on the approach beyond this.
Not really a question but an observation. Much current concern about homess people being either viewed as a problem because of poor compliance with social distancing, or being temporarily accommmodated in hotels etc where some do not cope; absconding, jumping and using drugs referred to on national radio this morning. In effect we are creating concentrated psychiatric "wards" ... opportunity for assertive outreach and need to make sure such people arent further stigmatised and inappropriately dealt with.	An observation and not a question, so no response is required
what is the ethics of stopping most f2f and vastly increasing admission threshold iand MHA detention due to fear of risk of Covid on in-pt wards. ids that balanced.	We have developed guidance on ethical considerations (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/covid-19-ethical-considerations) which provides overarching advice on Particular dilemmas for psychiatrists, and links to guidance developed by the Royal College of Physicians and the British Medical Association. We strongly recommend that all psychiatrists check that their local clinical ethics committees are in place as they can provide advice and guidance in real-time. We currently working with an advisory group and NHSE/I to understand what further guidance would be most helpful to clinicians.
There are so many people who are miserable at the moment, and yet they have not become unwell by the virus. In my opinion it is their reaction to the fear that is making them unwell (encouraged by sources such as the media, as Adil mentions above. However if I, or like-minded individuals, say this, we are often met with the response that mental health is secondary - this is a real, life-threatening problem. I have been very frustrated by this, envisaging a world (or at least country) of people released from this "prison" with lots of mental health problems, and I wonder if you have any advice?	The College has produced guidance on patient engagement detailing ways in whichto stay well during this period and linking to many other useful resources. https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/patient-engagement-covid-19-guidance-for-clinicians
Do you think the people working in the media are doing their work in a way that may help people to be in a stable mental state or just they compete to raise the stress and anxiety level?	During times such as this, it is inevitable that there will be heightened emotions and scary headlines. The College is doiing it's bit to stay calm and rational as well as responsive to the media and to the crisis. Though we are not able to control the media's output, we are working to ensure our own does not encourage unwaaranted panic or worry.