Recommendations for DV Programs on Lifting of Stay-Home Orders & COVID-19

Created by Washington State Coalition Against Domestic Violence
Reviewed by Joshua A. Barocas, MD, Boston Medical Center
Megan H. Bair-Merritt, MD, MSCE, Boston Medical Center
Annie Lewis-O'Connor, PhD, NP-BC, MPH,, Brigham and Women's Hospital
Emily F. Rothman, ScD, Boston University School of Public Health

As states move forward to lift their stay-at-home orders and open up businesses, domestic violence programs will need to adapt to this changing environment. Most communities will be gradually re-opening businesses and services over the next several months, and while this will look different for each state or territory, these guidelines are designed to help local domestic violence programs continue to provide services in as safe a way as possible.

- Please play close attention to case rates (also known as incidence rate) in your state, as following these trends is important in considering operating procedures. While following these trends, remember that hospitalizations and deaths are "lagging" indicators, meaning that they will happen on average 14-21 days after cases spike.

These guidelines are recommendations based on input from domestic violence providers and health care professionals, including public health and infectious disease experts. As more experience and knowledge is gained from the field and from researchers, these guidelines may be updated.

If your experiences lead you to suggest other recommendations, or changes to these guidelines, please contact us at capacity_ta@nnedv.org

What does this mean for domestic violence advocacy programs?

- Your advocacy practices should not change much, if at all, during the phased re-opening period.

- And, public health experts tell us that we will need to take a number of preventive measures until we have a vaccine or effective treatment against COVID-19. These measures include:
  - physical distancing of at least 6 feet for others,
  - wearing a mask outside of your home,
  - avoiding densely populated areas,
  - rigorous handwashing with soap and water or hand sanitizer, and
  - staying home if you feel ill.
- Best estimates are that a vaccine is likely to be at least a year away (Spring 2021), if not longer.

What about in-person, face-to-face advocacy?

- Any in-person, face-to-face advocacy will need to be done with at least 6 feet of distance. This is for the protection of the survivor and your staff.
- During face-to-face advocacy, both survivors and advocates should wear face masks at all times.
- If the survivor and advocate share a pen, wash hands after use.
- This may work in some situations, for example, if your program has lots of large, private meeting space, or individual housing units, or flexibility to meet privately while outdoors. However, think carefully about what must be done face-to-face versus what could be done virtually. If at all possible, it is safer to meet virtually even if the physical space will allow for distancing.
- This may *not* work in other situations. For example, if you have small private spaces for advocates and survivors to meet, or communal living shelter, or a big support group in a small space, reconsider the safest location (where there can be physical distancing or consider a virtual meeting).
- Locations in which face-to-face advocacy take place should have adequate ventilation. Opening windows is the easiest way to improve ventilation. Other ways include increasing the ventilation rate, changing air filters, and installing or acquiring portable HEPA filters.
- As long as advocates and survivors need to stay 6 feet away from each other (which will be until we have effective treatments and/or a vaccine), meeting in person may not be practical.
- We will need to continue to use technology to connect with and support survivors. Programs should continue to invest in the technology and systems that make it possible to do confidential, survivor-driven advocacy remotely and through mobile advocacy.

What about shelter?

- DV programs will need to continue to ensure at least 6 feet of distance for residents and staff, and have ways to shelter and care for people who have been exposed to or have COVID-19 (i.e., cohorting people who have tested positive).
- When possible, use scattered site placements or hotels/motel rooms, so that residents who have been exposed to or have COVID-19 would be housed in separate locations.
- All clients and staff should wear masks at all times.
    - In most cases, cloth face masks are adequate though some evidence suggests that surgical masks may be more protective than cloth masks.
    - Staff working with a client known to be COVID+ ideally should also wear gloves and a face shield--consider N95 masks, which do require a special fitting.
    - Please note, masks are not effective unless they fully cover the nose and the mouth at all times. Avoid touching the front of the mask. Remove it using the straps and wash your hands well after removal.
- Schedules should be created for use of common spaces (such as kitchens) with only one survivor/family using the space in a specific time window. The space should be thoroughly sanitized after each person uses it. This means that there should be no communal meals.
- Protocols for cleaning common areas, including wiping bathroom fixtures and other hard surfaces (*e.g.,* the toilet flush handle, the sink faucet handles, the doorknob), should be clearly communicated and posted in multiple languages to ensure residents and staff know the protocols.

- If a survivor is COVID+, this person should be isolated for at least 14 days, with food and medications delivered to their door. Consult medical personnel if there is concern that this person requires a higher level of care (e.g., hospitalization).
- If a survivor is COVID+, then decontamination of shared spaces is necessary including carpet cleaning as outlined by the CDC. (https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html)
- If a survivor is COVID+, then a facility should undertake contact tracing to the extent that it is safe and logical to do so. Determine who that individual was in close contact with and when. Consider testing and/or quarantine for close contacts—again, if that is safe and logical (*i.e*., you are not obligated to contact a perpetrator of domestic violence or their close friends or family because of contact tracing, if the safety of the survivor is at stake).
- Residents and staff should self monitor symptoms: fever, cough, sore throat, muscle aches, running nose, loss of smell, diarrhea.

When can we go back to normal?

- We will likely have a "new normal" instead of resuming or returning to baseline as usual. It is likely we will need to reimagine and embrace new ways of working.
- It will be unsafe to resume our 'normal' routines until a proven vaccine or effective treatment is available. This may take at least a year (until Spring 2021), if not longer. Thus, physical distancing and using protective gear while socially connecting with families and friends, are likely here to stay in the foreseeable future.
- It is likely that we will all have to adapt to a "new normal." This will be challenging. You may already feel worn out. We can be resilient if we help each other.

What do the Phases mean?

- Even though most state plans talk about "re-opening," this is a very gradual approach. We don't expect things to be anything like back to normal for many months or even years.
- Changes to the stay-home orders during the various phases of re-opening are informed by State Governors. Paying close attention tp these mandates will help you as policy and procedures change. Wearing a mask and good handwashing practices should be continued in all phases.
- Subsequent phases will last a certain period of time, and then communities will most likely be able to move to the next phase depending on the spread of the virus, and the capacity of the health care system to respond.

What about people in high-risk categories?

- As we move forward, it is recommended that everyone over age 60 and individuals with certain health conditions (including high blood pressure and other heart conditions, diabetes, cancer, obesity and asthma and other lung diseases) continue to stay home, at least during the first phases. If these individuals do leave the home, we recommend they avoid densely populated areas, wear a mask at all times, bring hand saniziter with them, and try to patronize stores that have special hours for high-risk groups (e.g., grocery stores with specific hours for people over the age of 60).
- Trauma stresses the immune system. The survivors we see often have health conditions due to years of abuse and historical trauma. Survivors seeking emergency shelter often have

endured recent injuries, and this should be taken into account when considering how freely residents should engage in the broader community.

What about when other services re-open in our community?

- Some of the decisions about what to re-open and when will be made at a county and local level and state level. It is important to stay informed at both levels.
- At this point, we expect that some services like courts and public benefits offices, would begin to re-open during a third phase in most communities. Again, this is being determined at the state level and in most cases by the Governor's Office. If advocates in your program routinely accompany survivors to these kinds of services, you may need to re-assess what you are able to do safely while following public health guidelines.

But if hair salons and stores resume in-person business, why shouldn't DV programs?

- It is important to recognize that stores and other businesses will be subject to new state governmental regulations to maintain the minimum of six-foot distancing and other prevention measures, such as erecting barriers to block sneezes and coughs. If DV programs can't set up such barriers, you may not be able to interact with clients in person within six feet. Consider working closely with your State Coalition and representatives from the Governor's Office and the Office (or Department/Bureau) of Public Health.
- DV programs provide services to vulnerable and often health-compromised people, which means that we should be erring on the side of caution to protect our service population. Our service population may be more vulnerable to severe COVID effects than the general population.

May 18, 2020
Updated July 7th, 2020