

Recommendations for Responding to COVID-19 in Domestic Violence Shelters

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Introduction

Coronavirus disease (COVID-19) is a newly discovered, highly contagious infectious disease. For most people, COVID-19 causes mild to moderate respiratory illness, but for a small percentage of the population, particularly people with underlying conditions, COVID-19 can cause severe illness requiring hospitalization and death. Until such time as an effective vaccine or treatment is identified, domestic violence shelters need plans for safely accommodating survivors and families, while protecting staff. Therefore, this document was prepared by a team of health care professionals with expertise in infectious disease, pediatrics, adult medicine, nursing, and sexual and domestic violence survivor advocacy in order to provide information and recommendations for practice.

Local communities are experiencing diverse conditions with regard to the prevalence of COVID-19 in the community, the availability of COVID tests, medical resources, and policies related to stay-at-home orders and physical distancing. We also recognize that clients and staff may fall into the following categories, making decisions about safe work flows somewhat more complex:

- Healthy individuals who have not had a known exposure to COVID-19
- Asymptomatic individuals who have been exposed to COVID-19
- Symptomatic individuals who have not been tested for COVID-19 or are awaiting results
- Individuals who are known to be COVID+
- Individuals who have had COVID-19 and are recovered

Therefore, users of this document will need to interpret the recommendations in light of their own local policies, conditions, clients/staff and resources. Further, as we move forward in time in this pandemic, we are gaining knowledge and recommendations are changing. We, therefore, view this as a “living document” and will provide updates as needed.

(1) Should our shelter be using a series of questions to screen prospective clients for COVID-19 prior to intake?

Denying a person access to shelter or services on the basis of a medical condition is not permitted if a shelter is federally funded. Shelters and hotlines should *not* ask prospective clients COVID-19 screening questions to deny them shelter or services based on how they answer.

However, there may be some valid reasons for understanding potential risk for COVID-19 exposure or disease in order to decide how to safely house a survivor and their family. At the beginning of the COVID-19 pandemic, some domestic violence shelters and homeless shelters

were asking prospective clients a series of questions to try to assess whether that individual might have COVID-19. For example, shelter workers may have asked clients questions about whether they were experiencing fever, cough, and shortness of breath (the hallmark symptoms of the disease) or if they had recently been out of the country. To date, screening questions about COVID-19 symptoms have proven to be largely ineffective for at least three reasons. First, people can have disease without symptoms (asymptomatic); in these cases, symptom-based screening would miss what appears to be a reasonable percentage of COVID-positive patients. Second, even for people who become symptomatic, there is a period of time before they exhibit those symptoms when they are still infectious; again, symptom-based screening misses this group of people. Finally, individuals may be reluctant to answer honestly about symptoms if they are worried that their responses will result in services being denied. As of April 2020, we therefore believe that these questions do not accurately identify people with disease (and indeed may lead to a false sense of security).

We recommend instead that, if possible, shelter staff put into place universal precautions inclusive of physical distancing. These precautions include attempting to maintain at least 6 feet of physical distance from other people at all times. Additionally, it includes separate rooms for each family; staff use of personal protective equipment (face mask, gloves, and face shield if possible); vigilant cleaning and disinfecting; providing face masks for all clients and children >2 years; forgoing group meetings; and developing protocols for distancing in shared spaces such as kitchens and play rooms. For domestic violence organizations and shelters with more limited space capacity, screening for symptoms may allow people who are symptomatic to be provided isolated living space and testing for COVID-19.

(2) Should our shelter be reducing the number of people we house to prevent COVID-19 transmission?

Yes. All domestic violence and homeless shelters, and residential substance use disorder programs, should be increasing the physical distance between residents and reducing the total number of residents served until 2021. As a general guide decreasing capacity by 50% is recommended. In other words, if your shelter normally houses 20 adults, it should consider 10 adults to be “at capacity” for the duration of 2020. Reducing the capacity is critically important for the safety of residents, shelter staff, and community members.

It is exceedingly difficult to limit shelter capacity for public health reasons when prospective clients are in afraid for their lives. Unfortunately, COVID-19 can also threaten lives, with disproportionate impact on communities of color and people with underlying medical conditions including obesity and high blood pressure. On balance, the way to maximize safety for the largest number of domestic violence survivors and their children is to adhere to the recommendation that capacity be reduced by 50% for the duration of 2020, or until a vaccine, treatment and/or widespread universal testing is available.

We recognize that, concurrent with this pandemic, we are seeing surges in calls to domestic violence support lines as people are being asked to shelter-in-place with abusers, and stressors increase in communities across the US. Therefore, we urge policy makers to consider the impact of the need to decrease shelter capacity; there has never been a more important time to expand

funding to allow additional domestic violence advocacy staff and spaces (such as motel rooms or dormitory rooms) to house survivors and their families.

(3) When someone in shelter is COVID+ or is symptomatic, what should we do?

People who are COVID+ or COVID-exposed should be served by your agency. Services should be provided in a way that maximizes safety for shelter staff and for other residents, and that minimizes transmission to others.

If you believe that a client is COVID+ or has had COVID exposure, attempt to isolate them from others in your facility. Provide them with a face mask if they are not already wearing one. As well, ensure that any staff working with the client is wearing a face mask, gloves, and, if possible, a face shield. If you believe they are medically unwell, or if you or they have any concerns about their health, send them immediately for medical care. If a person is having *any* trouble breathing (or any other particularly concerning symptoms), they should be transported via ambulance directly to an emergency department.

If they are medically stable, the first step is to be transparent about the fact that you believe that they may have COVID-19. Do not use language that stigmatizes people who are COVID+. You should explain that your shelter needs to take precautionary steps to protect all residents and staff. Explain that they will not be denied shelter or services. Second, outline what will happen for them. The ideal scenario is that they can be sheltered in a hotel or motel where they will have a private room and private bathroom for up to 21 days. Patients who have mild illness need only isolation for 14 days but those with severe illness may continue to be infectious for longer periods of time. If they have children, their children can be sheltered with them in the same room; with the exception of infants, children tend to have less severe disease and it is highly likely that if a parent is infected then their children are as well. Meals should be delivered to them and left outside of the door. If your shelter does not have access to hotel/motel rooms, create a COVID+ floor, wing, or room for COVID+ residents. Ideally, COVID+ residents should have their own room and have meals delivered to them. They should not use common spaces like the kitchen, play room or common room. If they need to use a bathroom shared with other residents, a protocol for wiping bathroom fixtures and other hard surfaces (*e.g.*, the toilet flush handle, the sink faucet handles, the doorknob) should be outlined. They should also wear a mask when in any shared spaces such as a hallway or bathroom or when a staff member is delivering food or medicine into their room. Third, reassure them that these extra requirements will not last forever and that you are grateful to them for agreeing to do their part to keep other people safe from COVID-19. Finally, there are a growing number of sites that might be able to temporarily accommodate the client who is COVID+. Make sure that you are aware of the potential locations and whether these are right for your client.

(4) Should we isolate COVID+ people even if they aren't high risk for severe illness?

Yes. While not everyone with COVID-19 experiences severe symptoms, they still have the potential to infect others and make them extremely sick. People who feel well may be hard to convince to isolate for the recommended period of time, and it may be hard for some shelter staff to want to send a healthy-looking person into intense isolation. This is necessary. The goal is to

try to prevent the spread of the infection. Even if that person does not have any of the risk factors for more severe illness such as older age, hypertension, asthma, or chronic obstructive pulmonary disorder (COPD), there may be other people at the shelter with undisclosed risk factors or people in the community with such factors who could be very seriously affected. COVID+ people should be quarantined because it will prevent them from transmitting the disease to others. At a minimum, they should be quarantined for 14-21 days and reassessed. People with mild symptoms may be quarantined for 14 days whereas those with severe illness (e.g., needing hospitalization) may need to be quarantined for longer.

(5) When is it safe for someone to participate in communal living again?

People who have been in isolation because they were symptomatic for COVID or have tested positive for COVID can be moved back into communal living when they are disease free. There are two ways to know if someone is disease free. First, they may have two COVID-19 nasal-pharyngeal swab tests 24 hours apart. These must occur at least 7 days from when their symptoms began and after at least 3 days of being free of symptoms, including fever without use of fever-reducing medications. Second, they are considered disease free if they have been symptom free for three days AND it is also more than seven days since they first got sick. In other words, if someone got sick on a Monday, and they felt fine on Tuesday, Wednesday and Thursday, they would not be OK to move back to the shelter on Friday. Why not? Because if they got sick on a Monday, they would need to wait seven days after Monday—and also have three days in a row with no symptoms—before they could be considered disease free.

Importantly, when someone moves back to a shelter or comes out of a quarantine living situation, they should be wearing a mask that covers their mouth and nose for at least 7 days after they were last symptomatic. If a mask is not available, use a scarf or something similar to cover the nose and mouth, which can help limit the spread of the disease. Frequent hand washing with soap and water for at least 20 seconds is also important.

(6) Can our shelter continue to hold support groups in person? When can we re-start offering in-person groups?

At the current time, we do not recommend holding in-person support groups. Shelters can look into the possibility of holding groups using technologies such as zoom, that allow people to connect but be in separate spaces. We do not recommend starting to offer in person groups until we have either much wider spread testing such that we understand if people have COVID or until there is a vaccine or effective therapeutic available.

(7) Is our program justified in spending funds on technology—ipads and phones capable of running video conferencing software—for their safety and health?

Yes. Without access to technology that is dependable and sufficiently upgraded to allow for conversations with advocates, participation in support groups, and social connecting, survivors will suffer. It is essential that programs be ready to (and allowed to) expend funds on technology upgrades or equipment for survivors and advocates who need it during this period of time to ensure access to supportive services.

(8) How can we best protect our staff?

Any staff who are have symptoms or are not feeling well should not be at work. Organizations should reconfigure staffing patterns to reflect in-person staffing only as needed and shift to remote services whenever possible.

Further, we recommend the following steps to protect staff. First, staff (and clients including children over 2 years of age) should wear masks at all times. The Centers for Disease Control and Prevention have guidelines about sewing masks or using bandanas if masks are not available (<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>). Second, staff should practice physical distancing. Offices and desks should be reconfigured if possible to ensure at least 6 feet of distance between staff members, and consultation rooms should place chairs for conversations at least 6 feet apart. Staff should avoid touching their faces and should wash their hands after contact with communal surfaces. If staff break rooms are available, a limited number of staff members should be allowed in at each time and furniture should be reconfigured such that staff are able to sit at least 6 feet apart. If food is donated or brought in, it should be individually wrapped.

(9) What do we need to know about the emotional and mental health impact of COVID-19 on survivors and their children? And about vicarious trauma and stress for staff?

Domestic violence survivors and their children have faced significantly stressful and traumatic situations, and generally come into shelters during times of crisis. In addition, many people--survivors, children and staff--also are now facing significant stress, anxiety and trauma related to the pandemic. Loved ones may be sick, jobs have been lost, schools and day cares have closed. People's routines have changed, and that type of change can be particularly stressful for children. Some children and parents may worry about becoming sick themselves and may experience anxiety. Right now, it is not clear when life will resume more normally. The additional behavioral and mental health needs of shelter clients during this unusual and difficult time are therefore important to consider. National and local groups (for example, the National Child Traumatic Stress Network: https://www.nctsn.org/sites/default/files/resources/factsheet/outbreak_factsheet_1.pdf) are coming out with resources that may be helpful to provide to clients if they are struggling. Connecting clients with community mental health resources may also be particularly important.

Glossary

In this document the term physical distancing is used to refer to the practice of maintaining six or more feet between individuals who are not isolating or quarantined together. This term is preferred to the term social distancing, because social connectedness is encouraged and is possible to maintain even when physical distance is necessary.

Isolating is the term used to refer to the practice of voluntarily staying in a room, apartment, house or other space for an extended period of time in order to reduce one's risk of acquiring COVID-19 or to reduce risk of spreading it to someone else.

A pandemic is a disease outbreak that affects the world. COVID-19 is a pandemic.