Guidelines for the family violence and sexual violence workforce supporting clients during COVID-19 Alert Level 3

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Purpose

The purpose of this document is to provide guidelines for the family violence and sexual violence workforce supporting clients (victims/survivors, perpetrators and (if applicable) whānau) during COVID-19 Alert Level 3. The guidance covers how providers should operate during Alert Level 3 while meeting health and safety expectations that will keep staff and clients safe.

Document development

The Joint Venture for Family Violence and Sexual Violence requested the development of this document as a response to feedback from sector representatives. The document is a collaboration of the Family Violence and Sexual Violence Pandemic Working Group and was collated by the Ministry of Social Development. The document has been reviewed by lead agencies and key sector representatives throughout its development. This is a 'living document' which was last updated 12 August 2020.

What is COVID-19?

COVID-19 is a virus that can affect your lungs and airways. It is caused by a type of coronavirus. COVID-19 is spread by droplets. When an infected person coughs, sneezes or talks, they generate droplets that contain the virus. These droplets are too large to stay in the air for long, so they quickly settle on surrounding surfaces. People may become infected by the virus if they touch those surfaces or objects, and then touch their mouth, nose or eyes.

The symptoms of COVID-19 are similar to that of a cold or flu and can range from non-specific respiratory symptoms such as cough, fever and sore throat, to shortness of breath and symptoms of pneumonia and severe acute respiratory infection. When referring to 'respiratory symptoms' throughout this document, it is with the caveat that it is symptoms of an acute respiratory illness. It is not referring to someone with asthma, chronic obstructive respiratory disease or another chronic condition. However, they may have worsening of symptoms of such a condition (e.g. a worsening cough).

If you think someone has COVID-19 or may have been in contact with someone who has the virus, encourage them to call the free COVID-19 helpline on 0800 358 5453 (open 24 hours a day, 7 days a week).

Key message

At a time like this, it is important we unite as a sector to support clients. We must assure people seeking help that:

we are still open to deliver support and services in line with the Government's guidelines; give us a call and we can help you.

Alert Level 3

Under the New Zealand's COVID-19 Alert Level 3 there are significant restrictions in place to reduce the risk of transmission of COVID-19. In Alert Level 3 all social services can continue to operate if they can do so safely. For an update on the current Alert Level and more information on what the measures of Alert Level 3 are, visit the COVID-19 website.

Health and safety practices

In some instances, frontline family and sexual violence providers will need to meet with clients (refer to Face-to-face support for clients) or work from an office (refer to When working from home isn't an option). To ensure staff and clients are kept safe, strict hygiene practices must be followed. It is important that staff stay home and call the COVID-19 helpline or their GP if they are feeling unwell.

Providers should make sure there is enough soap, paper towels, hand sanitiser, cleaning products, disinfectant and personal protective equipment within their facilities as necessary. Further advice on hygiene practices can be found at the COVID-19 website.

Hand hygiene

Hand hygiene practices for all to follow are:

- Wash your hands for at least 20 seconds with soap and water and dry them thoroughly:
    - before eating or handling food
    - after using the toilet
    - after coughing, sneezing or blowing your nose
    - after touching a surface outside of your home/workspace where you aren't sure of the cleanliness
    - after visiting a public space
    - after caring for sick people.
- Dry your hands completely following washing. Paper towels or clean cloths are the most effective way to remove germs without spreading them to other surfaces. Ensure towels and cloths are properly disposed of after use.
- Avoid touching your eyes, nose or mouth if your hands are not clean.
- Cough or sneeze into your elbow or by covering your mouth and nose with tissues.
- Immediately put used tissues in the bin or a bag.

If soap and water are not available, clean your hands with an alcohol-based hand sanitiser that has at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.

In cases where immediate hand washing is not practicable and there is no hand sanitiser, staff should use disposable gloves.

Personal protective equipment (PPE)

When wearing personal protective equipment (such as masks and face coverings or gloves), hand hygiene measures must still be followed – hands should be washed with soap and water as soon as gloves and masks are removed. Staff must not touch their face/the mask while wearing PPE. The use of hand sanitiser or gloves are recommended only if there is no access to handwashing facilities.

Masks and face coverings

The Ministry of Health has updated its guidance on using masks and face coverings as part of the response to COVID-19. Information and guidance for wearing and disposing masks can be found on the COVID-19 website.

Please note that the use of masks and face coverings is in addition to the general health advice. Staff must regularly disinfect surfaces; wash and dry their hands, cough and sneeze into elbow and avoid touching their face. If a staff member has cold or flu symptoms, they must stay at home and ring the COVID-19 helpline or their GP.

At Alert Level 3:

- Medical-grade masks are compulsory when physical distancing is not possible.
- Non medical-grade masks (including homemade masks) are strongly encouraged whenever people are out of their house.
- Staff should only have face-to-face contact with clients in exceptional circumstances, such as when a client is in crisis or within a refuge.
- Staff must undertake a triage/risk assessment before face-to-face engagement.
- Where COVID-19 is suspected or confirmed,
    - Where 'aerosolised' procedures (such as where there is risk of spitting) are unlikely, medical-grade masks level 1 or level 2 are recommended.
    - When there are 'aerosolised' procedures, N95 or P2 face masks are recommended. More information is available on the Ministry of Health website.

Please note that:

- PPE can give workers and clients a false level of assurance – they should act as if they are not wearing PPE to prevent this.
- If a client has COVID-19, discuss with the local public health unit the best way to interact with them.

Further information on PPE specifically for social services can be found on the Ministry of Social Development's website.

If a provider needs PPE and has not been able to access what is required, they should contact their Relationship Manager.

Cleaning

COVID-19 can remain on some surfaces for up to three days. Cleaning practices are to:

- be extra vigilant when cleaning surfaces
- if a surface looks dirty, clean it first before disinfecting
- disinfect frequently-touched surfaces and objects, such as handles, handrails, lift buttons, and switches
- use a disinfectant that is antiviral and follow the instructions on the label.

If a staff member/client has tested positive for COVID-19, please contact the COVID-19 helpline to discuss the appropriate cleaning methods.

If staff are unable to work from home, they should be using the same workstation each day where possible, and keeping it clean as part of their daily routine.

Regular hand hygiene is also important.

Contact tracing

Contact tracing allows health officials to quickly track down and test people who may have been exposed to COVID-19. The key things to know about contact tracing are:

- Providers need to maintain a record of close contacts that occur:
    - within the workplace
    - between your staff and others (e.g. clients) while working outside of the workplace.
- Close contact is defined as face-to-face contact with someone in any setting that occurs within two metres, for 15 minutes or more.
- Providers should keep this record in either paper or electronic format.
- This information needs to be kept by providers and needs to be easily accessible if requested by the Ministry of Health. It will not be used for any other purpose.

Visibility

Please ensure hygiene advice and the additional health precautions required are visible in all areas of a workplace including the reception area, meeting rooms, secure office area, kitchen and bathrooms. Printable resources can be found here.

Physical distancing

Physical distancing is about keeping a safe distance from others. Ideally, it involves maintaining a distance of **at least one metre from another person**. Do not physically greet or touch people (e.g. no handshakes, hongi or hugs. Use alternatives such as a wave or smile).

If applicable, each provider should audit their premises and identify rooms that are suitable for face-to-face support. These rooms should be big enough for people to sit at least one metre apart from each other to reduce the risk of contagion. If a provider has more than one room that can be used, it is recommended to alternate between the rooms, allowing time in between sessions and cleaning surfaces between use. Providers need to have clear protocols in place for tracking which rooms have been in use, including the date, time of use, who was in the rooms and cleaning protocol.

If a group of staff members within an organisation are unable to work from home and the group is big enough, create a roster to split up the team so there is consistent limited contact between each other.

Ideally, staff should be working from home. If working from a workplace or office:

- space staff at desks so they are not working in close proximity of anyone else
- staff should deliberately distance themselves at least one metre away from someone when speaking with them
- limit being in shared spaces such as kitchens by splitting break times.

Hygiene practices and physical distancing should be normalised in all areas of the facility.

Face-to-face support for clients

Family violence and sexual violence service providers must change the way they work to keep staff and clients safe from COVID-19. This includes flexible or creative ways of delivering services that are not face-to-face.

If a client is in immediate danger (e.g. crisis) or is unable to access help remotely and it is affecting their wellbeing, they can receive face-to-face services (e.g. counselling) until their immediate risk is resolved.

Clients can leave their 'bubble' to seek help if they feel unsafe. All other services should be carried out remotely. The table below is a guide to ascertain what level of face-to-face support a provider should be offering during Alert Level 3 in relation to the size of the provider.

Provider size	**Number of frontline staff**	**Approach**
Small	1-2	It is essential to plan for business continuity once Alert Level 3 is lifted. It is recommended these providers offer no face-to-face support.
Medium	3-9	Some essential face-to-face support can be provided. Providers need to consider the minimum viable workforce and have robust hygiene protocols in place. If staffing levels change due to sickness it is recommended medium sized providers start operating at the level of a small provider. Management support for frontline staff needs to be considered as part of the minimum viable workforce; providers' normal management and supervision processes should be in place during Alert Level 3.
Large	10+	Large providers have the capacity to provide essential face-to-face services in line with recommendations at Alert Level 3. Providers need to consider the minimum viable workforce and have robust hygiene protocols in place. It is recommended to split the team to limit the number of people who would need to self-isolate if a staff member meets a person who tests positive for COVID-19. It will also enable there to be a second team available to continue service delivery. If staffing levels change due to sickness, it is recommended large providers start operating at the level of a medium provider. Management support needs to be considered as part of the minimum viable workforce; providers' normal management and supervision processes should be in place during Alert Level 3.

(note: frontline staff includes those who have **direct** contact with clients such as social workers, counsellors, crisis support workers, advocates etc. Reception staff are not

considered 'frontline' but, depending on a provider's processes, may be essential to keeping the service running.)

Providers are responsible for ensuring all staff understand what an essential face-to-face service is. The decision to provide face-to-face support with clients must be made in consultation with a team leader or manager.

A decision-making matrix has been developed (appendix three), that provides practical guidance for crisis family and sexual violence providers working with victims/survivors to work through whether it is appropriate to attend face-to-face call outs. Non-crisis services may use the decision-making matrix as a guide to adapt for their own services.

Where possible, a client should be seen by the same staff member for any further face-to-face contact to reduce the risk of further transmission.

Remote support for clients

Excluding residential facilities (e.g. safe houses), clients are not allowed on-site of a provider's premise during Alert Level 3 unless it is considered essential to their wellbeing, and physical distancing and hygiene practices are strictly followed. Providers should only have clients in offices when there is no alternative option and there is an imminent safety risk. No face-to-face group programme delivery is permitted in Alert Level 3.

Where possible, services should be carried out remotely; consider using text, audio and video to communicate with clients. Ensure inboxes (including spam mail) are monitored regularly as clients may be more likely to seek help through alternative methods during this time.

Te Ohaakii a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST) have developed guidelines on remote therapy, this can be accessed through their website. If an organisation doesn't have technological capability, raise this with managers, national bodies and/or the provider's Relationship Manager. Sexual and family violence helpline numbers should always be provided to clients.

Providers must be mindful that clients may be in an unsafe environment when contacting them and it may not be appropriate for them to be speaking on the phone while in lockdown with others (including a client in the same household as a perpetrator, for example). Usual safe practices of communicating with clients remotely should be followed during this time.

It is normal to feel anxious about COVID-19. Staff will need to validate, acknowledge, and normalise clients' responses to stress, anxiety, and loneliness that may be exacerbated by physical distancing or self-isolation. Supporting clients to adjust to restrictions is important to support the journey of recovery.

Some clients' usual coping and self-regulating practices may not be possible/available during Alert Level 3. Help them to explore other coping and self-regulating practices if this is the case.

Staff should not be visiting client's homes, unless it is with the Police and absolutely necessary, such as where there is imminent risk to the safety of the client.

It might be normal practice for providers to offer transport to/from services. In the current environment, request taxi or ride-share services instead. The client will need to sit in the back seat of the vehicle to ensure physical distancing measures are followed. In some cases, staff can provide the client with taxi vouchers, such as to transport them to a safe house.

Triage: COVID-19 specific

All clients should be triaged for COVID-19 remotely before engaging in face-to-face contact with staff. The Ministry of Health has provided guidance on how to do this.

Depending on the case, this may have already been done by other stakeholders such as police, counsellors or medical staff. If triage cannot be done remotely, be aware of the guidelines around physical distancing (see below).

Avoid having face-to-face contact with someone who is suspected to be unwell or has respiratory symptoms, unless this is **critical and urgent to their or other's safety**.

Within the triage process, collect all relevant contact details of the client for contact tracing purposes.

Staff wellbeing

The effects of COVID-19 might put a lot of pressure on providers. Processes within organisations should be in place to keep staff safe and healthy from burn-out or vicarious trauma.

If a staff member cannot maintain the appropriate level of support required for a client, then the case should be passed on to a colleague or provider with more capacity. Clients can be advised to contact a helpline after-hours in the first instance to reduce pressure on providers.

Helplines are there to support everyone, including staff, throughout this time. For support with anxiety, distress or mental wellbeing, staff can call or text 1737 anytime to talk with a trained counsellor.

Management

Measures that are in place to keep staff safe in day-to-day life should continue. Working through a pandemic is a tense time and it is important to look out for the wellbeing of others. Management needs to ensure their staff are appropriately supported and safe throughout this time so they can return to work following the COVID-19 pandemic. Managers should:

- Check in on the wellbeing of their staff regularly.
- Check that staff are able to work from home. Consider the staff member's home environment and work with them to develop a plan that will keep them safe, comfortable and able to differentiate their 'home life' from their 'work life'. For example:
    - staff in a flat with housemates may only be able to work from their bedroom and therefore do not have the opportunity to 'escape' work
    - staff may have children who are doing schoolwork from home, and therefore are not able to work, or are not able to work their normal hours

    - sometimes working from home can lead to staff working longer hours as they have less of a working routine than when they are in the office.
- Check that staff who are offering face-to-face support are in the position to do so and are comfortable with it. Consideration needs to be given for those who in the workforce that are considered vulnerable (e.g. over 70 years, immune compromised).
- Put their staff *and* clients at the centre of their work.

The Mental Health Foundation has developed wellbeing tips for both managers and staff working through the pandemic, these can be accessed on the Mental Health Foundation website.

Professional supervision should continue via remote communication methods.

Working from home

Working from home will be a new way of working for many staff members.

The following questions will help managers to confirm whether their staff should be working from home. These should be used as a guide only.

- Can staff work from home in a way which will keep them healthy and safe?
- Will staff be able to separate work and home life? (e.g. do they have a space that is away from other house members to work from).
- Can staff work in a way which keeps client information safe? Do staff have access to headphones, a secure laptop, and understand information management practices (e.g. locking computers when not in use, securing physical papers when not in use)?

Staff who have concerns regarding their home environment or existing pain, discomfort or injuries should raise this with their manager and discuss options (especially for those who have a unique work station set-up).

Staying connected

When working from home staff may feel the impact of the lack of social connections which may lead to them having difficulty separating home and work life. It's important to encourage staff to try and stick to their usual routines and keep in regular contact with their manager and team. Plan time for staff to virtually connect in a social way, such as doing a quiz together, lunch breaks or celebrating milestones.

When working from home isn't an option

In some cases, staff will not be able to do their work from home. In Alert Level 3, staff can access the office if it is more suitable for them to work from. Physical distancing, hygiene practices and thorough cleaning process should be followed. If workplaces are too small, or if it is more suitable, providers may consider working with their partners in their region to see if office space can be shared. This kind of community collaboration could lead to there being a central 'hub' where clients can access help, and is encouraged in the current environment and beyond.

Safe houses

Safe house access during Alert Level 3

Clients (in both male and female safe houses) **will not be admitted to a safe house if they are suspected to have COVID-19**, the provider should liaise with the local public health unit to identify the best place for the client. Some public health units may have agreements with hospitality providers to act as quarantine facilities.

Family violence providers may also choose to organise and pay for clients to stay in motels rather than safe houses with other people. It is recommended that the provider fosters and maintains relationships and agreements with local motels about client stays. A coordinated approach is needed to ensure different groups are in different motels, such as those bound by a Police Safety Orders and victims/survivors of family violence. This should be discussed and planned with local stakeholders in each region.

If motel accommodation is organised, the rooms should include a private kitchen and bathroom to ensure health, safety and isolation. A client's need for food, medication and essential travel (e.g. the supermarket or pharmacy) need to be addressed by the provider during their stay in motels, and Wi-Fi should be made available. Staff should ensure sanitation needs for self-isolation can be met; this includes hand sanitiser, toothbrush, toothpaste, laundry powder, and baby products and pads/tampons if applicable, etc.

If a client or staff member is suspected to have COVID-19 (e.g. has been in contact with someone who has COVID-19, or has symptoms) then their safe house will go into quarantine until a negative test result is received. In the first instance, the provider must contact the COVID-19 helpline or their local public health unit to discuss the situation and confirm how long the safe house will need to be in quarantine.

The house will remain in quarantine if a positive test is received. This means either:

- the house and all occupants go into quarantine
- clients who have been in the safe house with an infected person but who are not yet showing symptoms themselves may be moved to a motel (without using any shared transport and with the agreement of the motel owner) and will need to self-isolate.

Safe house supplies

The safe house/accommodation must have Wi-Fi and options for entertainment available for clients. It is important that people have the ability to contact family members and have ways of keeping themselves busy. If a provider does not have technological access, they should contact their relationship manager.

Ideally, school-aged children in safe houses will need to be supported to have devices and Wi-Fi access to do their school work, however schoolwork should be seen as a secondary priority to maintaining family wellbeing. If access to school is affected, children should be provided with alternatives to keep themselves occupied during lockdown. If a client has teenage children, they may require additional support to ensure they adhere to government advice regarding COVID-19.

The safe house/accommodation must have enough supplies (e.g. linen, food, clothing, cleaning products) for all clients. This will also ensure if there was a case of COVID-19 within the safe house, there is appropriate supplies to completely clean, sanitise and disinfect the whole house. Stockpiling is not necessary, supermarkets and pharmacies will remain open in all four alert levels.

If a provider cannot make their own arrangements or is having difficulty accessing essential household goods or services, they should contact their relationship manager.

Children in shared care

Providers may receive questions from clients on issues relating to children in shared care. Management of children from families who have shared care or contact arrangements in accordance with Family Court Orders, should be decided by parents in the best interests of their children, whilst also following guidelines on COVID-19. Guidance has been issued by the Principle Family Court Judge on children in shared care during COVID-19, this has been published on the Ministry of Justice website.

Appendix One

Mitigation strategy template - safe house precautions during Alert Level 3	
Task	**People responsible**
Screening and pathways	
Where possible, conduct intake assessments via phone rather than face-to-face. Include a triage process for COVID-19. Alongside the triage process, check for risk factors such as: • Do you have any underlying medical conditions? • Do you have any respiratory risk factors? • Do you have risk factors (e.g. over 70 years of age)? Ask clients COVID-19 specific questions (refer to triage process for COVID-19) at least once a week.	
Staff may choose to organise clients to stay in motels and pay for this rather than admit them to safe houses with other people, especially considering those that are considered at risk. During Alert Level 3 clients will not be admitted to a safe house if they: • have had any contact with a recently returned (within the past 14 days) traveller • are currently unwell with respiratory symptoms • have been contacted by the Ministry of Health and advised they have been exposed to COVID-19 • or have been in recent contact with someone who is suspected to have COVID-19, but has not yet been tested/is waiting results of a test. If any of the above apply, staff should contact the COVID-19 helpline and/or their local public health unit. In these instances, staff should facilitate access to motels.	
If a client has respiratory symptoms but has a negative test result for COVID-19, they can be admitted to the safe house.	
On intake/admission and at regular intervals, remind clients that kindness and compassion are essential. No one should be allowed to be the subject of mistreatment based on their health status.	
Cleaning and supplies	
Ensure there is enough dispenser soap, paper towels, hand sanitiser and disinfectant for all clients and staff. This will help to keep communal areas sanitised.	

Ensure there is sufficient linen for all clients staying in the safe house to have their own towel, facecloth, and sheet set.	
Remember that government advice is to not stockpile food. Pharmacies and supermarkets are essential services that will remain open throughout Alert Level 3, with some restrictions.	
Ensure thorough cleaning practices are in place for the whole house.	
Information and briefing	
Normalise hygiene practices and physical distancing in communal areas.	
Ensure all staff and clients are aware of the hygiene measures recommended by the Ministry of Health to stop the spread of COVID-19.	
Reinforce the importance of the 'no visitors' rule with clients. Speak with them about alternative ways of interacting with support people such as phone calls or video chat.	
Advise clients that staff will work predominantly from home and set out emergency and regular contact options with them.	
As part of the entry briefing for clients, reiterate the seriousness of COVID-19 and of the precautions taken, but reassure them of the safe environment and invite them to raise any concerns about isolation or quarantine.	
Incorporate the potential for COVID-19 transmission into individual safety plans (in consultation with the client).	
If the perpetrator becomes aware of the location and attempts to visit, the client should call the Police and the provider should seek an alternative location for them to ensure safety, as per usual practice.	
Managing physical proximity	
Switch to remote meetings (e.g. text, audio and video to communicate with clients) and arrange to be in contact with each client each day, including those in motels.	
Staff are advised not to transport clients. Using taxis and ride-share services is preferred, staff can provide taxi vouchers to clients.	
Advocacy with other agencies should be done via the phone (such as Work and Income) rather than in person.	
Unwell client (COVID-19 not yet confirmed)	

If a client is concerned they have COVID-19 or may have been in contact with someone who has the virus, support them to call the COVID-19 helpline.	
Advise clients that the safe house may go into quarantine and they will be unable to leave for 14 days if this happens. If they are uncomfortable with this prospect, staff can offer motel stays instead.	
If somebody becomes unwell with respiratory symptoms in the safe house, assume it is COVID-19 until it is confirmed as negative or advised otherwise by the COVID-19 helpline. Household close-contacts (e.g. other clients at the safe house) of a COVID-19 case under investigation are advised to quarantine until laboratory results are available, clients may choose to go to a motel.	
Responding to confirmed infection	
If a client is confirmed as having COVID-19, the provider must seek guidance from the COVID-19 and/or the local public health unit immediately.	
If clients disclose they have COVID-19 and need to be put into a motel instead of the safe house, arrange to drop off essential items outside their motel door. Liaise with the public health unit/COVID-19 helpline on the best way to manage the client.	
If a client or staff member who has been in the safe house tests positive for COVID-19, the safe house will go into quarantine. This means either: • quarantining all clients within the safe house • or, using motel stays for clients who have been in the safe house with an infected person but who are not yet showing symptoms themselves (if possible, without using any shared transport and with the agreement of the motel). Contact the COVID-19 helpline and/or the local public health unit to discuss the situation.	
Following the quarantine, if a person with COVID-19 has been living in the safe house, close it and do a thorough clean: • using hand hygiene and while wearing gloves and a mask, clean the safe house, including washing linen separately in hot water and then using a tumble dryer, and doing a full standard clean using bleach or disinfectant • clean your own clothes afterward in a hot wash and tumble dry • throw away and restock all toiletries (e.g. soap, shampoo bottles) Contact the COVID-19 helpline to confirm cleaning methods.	

Supporting clients' mental health and social wellbeing during the pandemic	
Staff will assess the whole family's needs and address safety and wellbeing in the first instance and then address access to other needs like schooling.	
Wi-Fi should be accessible to every client.	
Ensure every safe house has some options for entertainment available (e.g. books, DVDs, board games). Ensure clients are aware of the need for hygiene when sharing these items. If possible, supply sanitised entertainment options to those staying in motels.	
Provide clients with a phone for accessing remote support (e.g. helplines) if they don't have one.	
Validate, acknowledge, and normalise responses to stress, anxiety, and loneliness that may be exacerbated by physical distancing or self-isolation.	

Appendix Two

Mitigation strategy template - Sexual Harm Crisis Support Services precautions during Alert Level 3	
Task	**People responsible**
Workforce	
Ensure all staff are aware of the hygiene measures recommended by the Ministry of Health to stop the spread of COVID-19.	
Ensure all staff have up to date information about client assessments for crisis callouts. This should be a coordinated approach at a Sexual Abuse Assessment and Treatment Service (SAATS) level.	
If staff or people in their home are considered vulnerable to COVID-19 (e.g. over 70, underlying medical conditions) they must be supported to work without face-to-face contact.	
Any staff that will be providing a callout service, in cases of acute sexual assault, need to follow strict health and safety routines (cleaning and hand washing).	
Encourage any decision of face-to-face support with clients to be done in consultation with a team leader or crisis manager. This is to support appropriate professional decision making for this alert level.	
Managing physical proximity with clients and staff	
Switch to remote meetings (e.g. text, audio or video) and arrange to be in contact with each client according to their client management plan created by the Crisis or Clinical Manager.	
Advocacy with other agencies should be done via the phone (such as with Work and Income) rather than face-to-face.	
Each organisation should audit their premises and identify rooms that are suitable for physical distancing when providing face-to-face support	
If a client has received face-to-face support, they should stay with the same crisis support worker for any further face-to-face contact to reduce the risk of further contamination.	
An organisation's health and safety policy (e.g. not having staff alone in the office with clients) needs to be followed alongside the Government's advice on physical distancing, hygiene and cleaning.	
Where there might be contact between staff, if the crisis team is big enough, split the crisis support team in a way that there is consistent and limited contact between each other. This will limit the number of people needing to self-isolate if the team comes into contact with someone who tests positive for COVID-19.	

Managing risk of contagion during a callout	
If it is decided that face-to-face contact with a client is necessary, phone ahead to triage for COVID-19 if possible. If they have symptoms of COVID-19, avoid visiting and recommend they contact the COVID-19 helpline. A coordinated approach at a SAATS level will need to occur so the client is assessed once only, and all others in the SAATS response are informed of the outcome of the assessment.	
Responding to potential or confirmed infections	
If a staff member has been with a client who tests positive for COVID-19, all staff who were in contact with that client need to contact the COVID-19 helpline and go into self-quarantine according to the Ministry of Health guidelines.	
If a client is concerned they have COVID-19 or may have been in contact with someone who has the virus, support them to call the COVID-19 helpline.	
Supporting client's mental health and social wellbeing during the pandemic	
Provide clients with a phone for accessing remote emotional support (e.g. helplines) if they do not have one.	
Some client's usual coping and self-regulating practices are not possible/available during Alert Level 3. Help them to explore other coping and self-regulating practices if this is the case.	
Validate, acknowledge, and normalise responses to stress, anxiety, and loneliness that may be exacerbated by physical distancing or self-isolation.	

Appendix Three

Decision-Making Matrix: Face-to-face support for family violence and sexual violence crisis services during Alert Level 3

Overview

The purpose of this matrix is to assist family violence and sexual violence crisis staff members and their managers in deciding the level of risk and need associated with providing face-to-face support for clients during Alert Level 3. Non-crisis services may use the decision-making matrix as a guide to adapt for their own services.

The table outlines two areas of risk:

1. The first area outlines the risk of the client based on their support needs and their circumstances for which they are seeking support. In this area, one risk is that staff will not attend when support is necessary. This may result in higher levels of client distress and compound the harm they are experiencing through lack of service/system responsivity. The staff member is also at risk of feeling that they were unable to provide support to the required standard.
2. The second area outlines risks of transmitting or contracting COVID-19 while providing support.

Where area one risks are higher and area two risks are lower, face-to-face support is most viable. Where area one risks are lower *or* area two risks are higher, face-to-face support is less viable. Where area one risks are lower *and* area two risks are higher, face-to-face support is not viable.

Guidelines for use

This matrix is to be used in consultation between crisis support staff and their supervisor, team leader, or manager. Before making contact with a client, triage first for COVID-19, this should be done remotely where possible. Then, consider the factors in each column to determine the client's need and overall risk. Staff (including management/supervisors) should assess their comfort level with attending a callout. Consider all strategies to mitigate risk before engaging with a client.

Mitigation strategies

There are two categories of mitigation strategies around the transmission or contraction of COVID-19:

1. If a staff member and their manager decide together not to offer face-to-face support, other ways of supporting the client are available. This includes remote support via text, call, video, or some combination thereof before, during and after the call-out event, and helping the client to identify those in their social network who are equipped to support them. In some cases, if one provider is not able to provide face-to-face support, another provider may have the capacity to do so.
2. If you decide to offer face-to-face support, risk mitigation for all parties is dependent on maintaining physical distancing, good hand hygiene and, in some cases, the appropriate use of personal protective equipment (PPE). Ensure everyone understands the risks, is comfortable with those risks and, bearing these in mind, consents to face-to-face support

Decision-Making Matrix:

Area one: risks posed to the client based on their experiences of violence (interpersonal and structural)				Area one risk level	Area two: risks of transmitting or contracting COVID-19		Area two risk level
Severity of event/pattern of abusive behaviour[1]	**Client wellbeing and social connectedness**	**Assessment of meaningful access to resources and equity**	**Context of support**		**COVID-19 risk: staff member**	**COVID-19 risk: client**	
Critical: life threatening or likely to cause serious physical harm and/or mental health harm to them or others. Cumulative patterns of harm and/or very high levels of coercive controlling behaviours. High risk of life-threatening retaliatory violence from the person using violence against the client and/or others for seeking help.	Client has a high level of need for specialist FV/SV support to mitigate coping strategies they are using in relation to the event or pattern of abusive behaviour which makes their daily functioning very difficult[2]. Client has little personal and/or social/cultural supports that can assist them. The pattern of abusive behaviour has included intimidation and/or isolation from people and places that matter to the client.	Client's 'space for action'[3] is severely constricted and they request specialist SV/FV support. Client experiences many intersecting barriers to accessing/receiving help such as: language issues, government agency distrust, limited social network, solitary lockdown conditions, low tech skills, serious economic instability, pre-existing mental health vulnerabilities or conditions etc. Client cannot get their/their family or whānau's basic needs met without shame, danger or great difficulty. Client is experiencing structural violence or inequities (e.g. racism, classism, transphobia and xenophobia) and has experienced discriminatory responses from services, compounding the client's experiences of feeling or being unsafe (from people, systems and services). Clients and their family and whānau are already living lives of precarity and marginalisation will be at greater risk of further harm.	To respond appropriately to the client's experiences of harm there are limited or no alternatives to face-to-face support. Face-to-face support is required due to the imminent risk the client is in. Face-to-face support is important to uphold the client's dignity.	**High**	Staff member has few risks. E.g. no health issues, is under 70, has access to PPE and knows proper use, no risk to bubble, is comfortable with infection risk, organisation has sufficient staff to accommodate the risk to workforce should the staff member contract COVID-19.	Client has few risks. E.g. no age or health concerns, no recent contact with anyone high-risk, no symptoms, understands and is comfortable with risk of transmission, is adhering to lockdown and physical distancing advice.	**Low**
Moderate: likely to cause moderate injury, illness or distress to the client or others. There are moderate levels of coercive controlling behaviours present. Moderate likelihood of retaliatory violence.	Client has a moderate level of need for specialist FV/SV support to help mitigate coping strategies which make their daily functioning difficult[2]. Client has some key personal and/or social/cultural supports who can assist the client.	Client's 'space for action'[3] is constricted and they request specialist SV/FV support. Client experiences some barriers to accessing/receiving help. Client has limited access to essential material and economic resources. Client is experiencing structural violence/inequities and is at risk of experiencing discriminatory responses from services.	Face-to-face support is important to uphold the client's dignity and to respond appropriately to their experiences of harm.	**Moderate**	Staff member has some risk. E.g. concerns about bubble safety, low level of comfort in offering face-to-face support, not enough staff within the organisation to mitigate risk to workforce.	Client has some risk. E.g. minor health-related concerns, been in contact with a potential COVID-19 positive person, may not understand risks of transmission, may not be adhering to lockdown and physical distancing advice.	**Moderate**
Variable: limited injury and minimal distress is anticipated. There is limited ability of the person using violence to control the client. Low likelihood of retaliatory violence.	Client has a low level of need for specialist FV/SV support as the event or pattern of abusive behaviour is not significantly impacting their daily functioning. Client has a strong personal and social/cultural support network who can assist the client.	Client requests support and has multiple avenues to receive support. Client is does not have any barriers to accessing/receiving help and has access to essential material and economic resources.	Other options (besides face-to-face) are available and considered acceptable by the client and staff member.	**Low**	Staff member has significant risk. E.g. over 70 years, has health-related concerns, doesn't have the required PPE or not aware of how to properly use it, high-risk people in their bubble, low level of comfort attending, not enough other staff to mitigate risk to workforce.	Client at high risk. E.g. over 70, has health-related concerns, has been in contact with someone with COVID-19, does not understand risks of COVID-19, is not adhering to lockdown and physical distancing advice.	**High**

[1] It is important to note that risk is not fixed and a client may move from 'variable' to 'critical' quickly; flexibility of the staff member is required to change the response should there be a change in risk.
[2] Clients manage emotional distress and responses in different ways. Some coping strategies, such as substance use, self-harm, eating disorders and suicide attempts, pose significant risks to their safety and well-being. These coping strategies make daily functioning more difficult. Clients experiences which are often described as 'symptoms' or can be pathologised are often better understood as reactions to threat, or survival strategies. L. Johnstone et al, *The Power Threat Meaning Framework: Overview,* Leicester: British Psychological Society, 2018
[3] Experiencing violence constrains a client's ability to be self-determining, it shrinks their space for action. N. Sharp-Jeffs, L. Kelly and R. Klein, 'Long Journeys Toward Freedom: The Relationship Between Coercive Control and Space for Action – Measurement and Emerging Evidence,' *Violence Against Women,* vol. 24, no. 2, 2017, p. 182.