



**National
Children's
Alliance®**

*The Force Behind
Children's Advocacy Centers*



Midwest Regional
CHILDREN'S ADVOCACY CENTER

Children's
MINNESOTA



Western Regional
CHILDREN'S ADVOCACY CENTER



COVID-19 Service Guidelines: A Pandemic-Era Guide for CACs

A guide for CACs to address health, physical safety, and psychological safety concerns in serving clients through the end of the COVID-19 pandemic

Updated February 2021



Children's Advocacy Centers (CACs) provide many essential services which have, until now, been conducted in person, and some of these services critical to children's health, safety, and well-being must continue despite the COVID-19 outbreak. This guide, provided in FAQ format, is provided to answer questions for CAC staff and multidisciplinary team members on how to maintain health and safety in the CAC setting, to balance the need for pandemic safety against the critical needs of children and families, and to ensure the psychological safety necessary for children to heal and for staff and teams to work effectively.

These guidelines are intended to be followed until community spread of COVID-19 has stopped permanently. As of January 2021, COVID-19 vaccine availability is still extremely constrained, while community spread is still uncontrolled in many areas. Vaccination of some or all CAC staff and partners does not change any safety guidelines, and CACs must vigilantly enforce safety guidelines whether professionals are vaccinated or not. These guidelines will be updated periodically as new information becomes available.

Information in this guide is for discussion and team-planning purposes only. References have been provided to CDC sites with formal recommendations. In cases where information from local public health authorities conflicts with CDC recommendations, we recommend to err on the side of additional safety precautions.

Contributors

We are grateful for the contributions of medical providers and experts from institutions in the CAC movement who consulted on this document.

Ernestine Briggs-King, Ph.D.

Program Director, Data and Evaluation

UCLA-Duke University National Center for Child Traumatic Stress (NCCTS)

Associate Professor in Psychiatry and Behavioral Sciences, Psychiatry, Child & Family Mental Health & Developmental Neuroscience

Duke University School of Medicine

Director of Research

Center for Child & Family Health

Child and Family Clinical Psychologist

Duke Health

Karen Farst, MD

Director

Center for Children at Risk, University of Arkansas for Medical Sciences (UAMS)

Associate Professor

College of Medicine, Department of Pediatrics, UAMS
Child Abuse Pediatrician
Arkansas Children's

Mark Hudson, MD

Executive Director
Midwest Children's Advocacy Center | Children's Minnesota
Medical Director
Midwest Children's Resource Center

Teresa Huizar

Executive Director
National Children's Alliance

Joseph Kurland, MPH

Vaccine Specialist / Infection Preventionist
Children's Minnesota

Kim Martinez, MPH, RN, APRN, CPNP, PSANE

Program Manager of Medical Academy and Peer Review
Midwest Children's Advocacy Center | Children's Minnesota

Suzanne Starling, MD

Child Abuse Pediatrician
San Diego, California

Kori Stephens, MPH, ACC

Project Director
Midwest Children's Advocacy Center | Children's Minnesota

Carole Swiecicki, Ph.D.

Executive Director
Dee Norton Child Advocacy Center
Assistant Professor, Psychiatry and Behavioral Services
Medical University of South Carolina College of Medicine

Blake Warenik

Director of Communications
National Children's Alliance

Delivering services safely

To continue delivering services, CACs will need to adhere to certain basic safety procedures indefinitely, until the community spread of COVID-19 is halted by the broad availability of an effective vaccine or other developments. Fortunately, these safety procedures are simple, knowable, and possible for CACs of all types and sizes. Expert medical doctors, infectious disease specialists, and other medical providers familiar with the community-based CAC setting have provided the following health and safety guidance to help you adapt your operations to the pandemic era.

NEW! COVID-19 vaccination safety and effectiveness

Is the COVID-19 vaccine safe?

Yes. Based on results of the largest clinical trials in American history, the COVID-19 vaccines approved by the FDA for distribution in the U.S. are safe.

[See the CDC's facts about COVID-19 vaccines for more information](#)

Will vaccines protect me, my team, and my clients, from getting sick with COVID-19?

Yes. While protection is not absolute, the Pfizer and Moderna vaccines first to reach the market in the U.S. are approximately 95% effective at preventing symptomatic COVID-19 infections. That means that while it is still possible to contract COVID-19, it makes infection 20 times less likely than without it, with both required doses and effectiveness waiting periods. Evidence shows that these 2 vaccines can reduce the severity of infection including need for hospitalization and risk of death even if you do become infected after vaccination.

[Learn how COVID-19 vaccines work](#)

Does being vaccinated allow us to change or loosen up our safety procedures, like to stop masking?

No. It is still critical to maintain safe and appropriate masking, PPE wear, social distancing, and other safety precautions and processes in this guide, whether those at your CAC have been vaccinated or not, because simply not enough people have been vaccinated to prevent community spread. Until we reach herd immunity through vaccination, which is a long way off, relaxing your vigilance is not an option.

[See more FAQs on the vaccines from the *New England Journal of Medicine*](#)

Do I need the vaccine if I've already been infected?

Yes. While prior infection with SARS-CoV-2 does provide some immunity from the strain that caused the initial infection, reinfection is still possible. It is still unknown how long recovered hosts are immune from the strain they were previously exposed to, and reinfections may still be dangerous to the host and infectious to others. The Pfizer and Moderna vaccines are not “strain specific” and work by building the body’s immunity against the virus’ method of getting inside of the body’s cells.

Is the vaccine effective against new strains of the virus, like the ones from the UK, South Africa, and Brazil that are supposed to be much more contagious?

Yes. Early studies indicate that variants of SARS-CoV-2, including the B.1.1.7 variant identified in the UK that appears to be much more infectious, will be neutralized by the existing Pfizer and Moderna vaccines. While these studies have not been peer-reviewed, there is currently no reason to believe that B.1.1.7 or any other variant will reduce the effectiveness of the Pfizer or Moderna vaccines.

It is worth noting that other versions of the vaccine in development at time of writing may have differing effectiveness, but any vaccine is better than none. The risk of contracting the virus, and of severe illness or death in the meantime, before any choice over which vaccine version is possible for recipients, is too great to merit waiting until the preferred vaccine version is available.

[Read news on the study that found the UK variant had not reduced vaccine effectiveness](#)

How can we get priority access to the vaccine like other frontline workers?

Bring the issue to your local and state health authorities, who make the decisions about which groups of workers get access to the vaccine early. This is also an opportunity for advocacy. Reach out to your Chapter leadership and ask about the status of priority vaccines for CAC workers and partners, and ask if they have connected with senior public health officials, lawmakers, or governors about it. Also, rely on your relationships with your MDT partners in law enforcement and medicine, and see if there is a way for your staff who want it to receive vaccines in your capacity as a first responder to child victims of abuse.

[See talking points for use in requests to authorities for priority vaccine access](#)

Should CAC staff be required to receive the vaccine once available?

We strongly encourage CAC staff, volunteers, and partners to receive the vaccine as soon as possible as a matter of workforce safety. As vaccination coverage among staff progresses, the decision about whether to make a vaccine mandatory to staff is one that should be made by individual organizations in consultations with human resources. There is legal precedent that

allows employers to, under certain circumstances, mandate vaccinations with certain exceptions. However, employers may find that they can obtain similar results and less concern about consent through voluntary programs with the use of incentives.

One important consideration is that clients may not have a choice on whether to appear at the CAC. Their level of safety and concern about infection during their visit is paramount.

While some staff may be hesitant to be vaccinated, and in the case of people of color with very valid historical reasons for hesitancy, there are ways to address this hesitation. Ensure that you are willing to have open discussions with staff.

[The best evidence for how to overcome COVID vaccine fears \(Scientific American\)](#)

[Is the vaccine safe? \(CDC\)](#)

[COVID-19 vaccine FAQ: Safety, side effects, and efficacy](#)

NEW! Reliable sources of information about the pandemic

What are good sources of COVID-19 information?

Currently, the best source of U.S COVID-19 information is the CDC. While not infallible, the CDC is still the authority on what the latest science tells us about pandemic, the vaccines, and effective safety measures.

[See a collection of CDC scientific explainer videos about COVID-19](#)

The science seems to go back and forth all the time. What's the truth? How can I convince others to take safety measures when we don't know for sure?

Science, by its nature, evolves when new facts are uncovered. While our understanding of the nature of the novel coronavirus, and the COVID-19 disease it causes, was fluid in the early days of the pandemic, we now understand much more about it, how it transmits, and how to stop it.

Suffice it to say that the virus transmits through the air when in close contact with the breath of infected people. No measure is 100% effective, but properly fitted masks, social distancing, and good ventilation limit the spread, while the vaccines provide highly effective immunization to prevent contracting and spreading the virus.

[See a collection of CDC scientific explainer videos about COVID-19](#)

What if the information I'm getting from our local or state public health authorities is different from what the CDC says?

Some public health authorities are giving good advice, and some aren't. While you should absolutely make every effort to follow local public health guidance, make sure you understand the rationale behind the guidance, and ask questions. Familiarize yourself with the CDC guidance, and where it differs from your local guidance, choose the less risky option based on the rationale.

[See CDC guidance on protecting yourself and others in the workplace](#)

NEW! CAC operational planning for health and safety

How can we make people adhere to our health and safety rules, especially partners in a position of authority?

Remind everyone who comes in the door of your health and safety practices, explain that these safety rules are for their protection, and that, unfortunately, the CAC can't provide services if safety rules are not followed. CAC leaders and staff must take ownership of the choices they make and feel empowered to stand behind their safety rules.

What if someone refuses to obey our safety rules, and we have no way to make them?

With partner agencies, several strategies can be applied.

- First, depoliticize and de-escalate the discussion over masking and safety procedures. Instead, talk about it from the position of child safety.
- Second, because families with an abuse allegation cannot decline an investigation, we have to be very aware that they do not have the ability to meaningfully decline to be interviewed in an unsafe environment. Therefore, CACs have an enhanced role in ensuring clients have a safe environment.
- Last, if line-level MDT partners are failing to follow safety guidance, this should be addressed with their supervisors, as with any issue that needs supervisory support.

You may not be able to control what a partner does, but you can control what your staff does. Someone may refuse to wear a mask, but you can require your staff to. You can request safe alternatives to in-person meetings.

What should we do if too many members of our staff or partners go out sick with the virus?

Have an effective continuity plan in place. Sit down with your team and staff (virtually if that is part of your safety planning), and have an explicit discussion about who does what in what case, with a goal of ensuring that illness does not spread through the CAC. If you don't have an explicit, detailed plan, you need one. This plan will look different for small CACs vs. large ones, and between CACs attached to larger organizations like hospitals vs. independent centers.

Once you've completed a plan, think through whether your plan is reasonable, and make sure it includes your steps to remain vigilant to prevent spread, even for staff and partners and their families who are at home.

Should we notify staff and visitors if they may have been exposed to an infection in our CAC?

Yes. It's important to notify anyone who may have come into contact with an infectious person at the CAC setting, as specifically as possible,

It's equally important to remain in compliance with HIPAA by not revealing, directly or indirectly, the private health information or the name of the person who fell ill. All people who may have been exposed need to know is that they may have been exposed, on what date, and what they should do next: get tested within the appropriate window and monitor for possible symptoms.

How will we know if someone who's been on the premises gets sick later?

Make it part of your screening mechanism. It's common for dentists and other providers to make visitors and patients fill out a screening questionnaire, which includes an agreement to notify the office if they fall ill later.

Ask your staff, team, and clients agree to notify the center if they fall ill within 14 days of visiting the CAC. Tell them it's important not to lie or conceal the truth. It'll be on the honor system for the most part, but it's better than not making this expectation clear.

Screening clients, staff, team members, and visitors

What health screening questions should CACs ask before a client is scheduled for services?

All clients, family members, community partners, and CAC staff should be screened **each time** before coming into the CAC for an appointment or shift.

Screening of clients should occur at the time that the appointment is scheduled and repeated when the client/family enters the CAC. Screening of staff should be performed daily in some format, but this will vary by setting. Many hospital-based CACs have their own staff screening methods, such as online screening, and these should be followed by all CAC staff, team members, and visitors. Staff should monitor their symptoms closely before leaving for work and have a low threshold for being evaluated for possible SARS-CoV-2 illness if any symptoms listed in the screening question below are discovered. Similarly, because the onset of symptoms occurs rapidly, CACs should put in place policies whereby employees feeling ill should leave work as quickly as possible.

Community-based CACs might have someone designated to screen colleagues, or there could be a screening station where staff and teams check-in when they arrive and attest that their screening questions are still negative.

All CAC directors should strongly consider some form of screening compliance in case there is an exposure in the CAC. Additionally, if a client or family inquires, the CAC will be prepared to describe their process.

Screening questions

- Have you recently been exposed to someone known or suspected of having COVID-19?
- Do you or anyone in your home currently have **any** of the following symptoms?
 - fever of 100°F or higher
 - loss of taste or smell
 - shortness of breath or difficulty breathing
 - cough
 - headache
 - sore throat
 - body aches
 - chills
 - muscle pain
 - diarrhea

Unless there is an emergent risk to health and safety in failing to provide services immediately, anyone answering “yes” to any of the screening questions should be rescheduled. If answering yes to any symptoms, clients and families should be advised to contact their own medical provider for care and follow-up. In urgent situations, a tele-forensic interview may be an option (see [NCA Guidelines for Tele-Forensic Interviews](#).) Keep in mind that some children sick with COVID-19 or other illnesses will be too ill to be interviewed by any method, and their health needs should be the priority until they recover.

Should unwell staff or MDT members with respiratory symptoms be allowed to come to the CAC?

Under no circumstances should CAC staff or MDT members with symptoms of illness be allowed to enter the CAC. Additionally, symptoms and severity vary widely from person to person. For the health and safety team members, children, and families, any staff or team member with symptoms of illness should not be allowed to come to the CAC, should leave if symptoms develop while present, and should not come in contact with other CAC staff or team members outside of the facility. Those who believe their symptoms are just allergies or a cold should be included in this policy, as those with such symptoms often have COVID. No degree of illness is acceptable to be present at the CAC.

This restriction should also cover those with recent exposure (within the last 14 days) to someone else sick or known to have laboratory confirmed COVID-19. Consider exploring ways that team members with sick symptoms or recent exposure to sick people could participate in CAC activities by videoconference.

Is it okay to use facility animals?

There is currently limited information for the safe use of therapy or comfort animals in a setting such as a CAC. Animals are definitely able to contract COVID-19 from humans. The risk of animals spreading COVID-19 to people is considered to be low, but information on this subject remains limited to date.

Use of therapy and comfort animals in CACs should be limited to situations where it would be deemed necessary for the situation. A therapy or comfort animal should not be allowed to roam the CAC without someone present to oversee interactions. This is to protect both the animal and the people in the CAC. The CDC has released some [information regarding the necessary use of therapy or service animals](#).

Guidelines for using service animals

- Anyone who interacts with the animal should wash their hands thoroughly immediately before and after.
- Service animals may need to be around other people and animals while working. When possible, both the handler and the animal should stay at least 6 feet away from others.
- If a service animal is sick, call a veterinarian, and do not go out in public with the animal.
- Do not take therapy animals to visits if the animals are sick or have tested positive for the virus that causes COVID-19.

- Therapy animal visits require some level of contact between clients and the therapy animal team. When possible, keep animals at least 6 feet away from people and animals not participating in the visit. Handlers and participants should wear a [mask](#) during the visit.
- Do not take a service animal into settings in which people are infected with COVID-19 or facilities where you cannot prevent interactions with people who may have COVID-19.
- Avoid contact between sick people and the service animal as much as possible. If contact cannot be avoided, the sick person should wear a mask when around the animal.
- CDC recommends that everyone wear mask in public settings where other social distancing measures are difficult to maintain (e.g., grocery stores and pharmacies), [especially](#) in areas of significant community-based transmission.
- Do not use items that multiple people handle, particularly if items are brought to multiple facilities between therapy visits (for example, leashes, harnesses, toys, or blankets). If items like leashes must be brought between facilities, [disinfect](#) them after each use or facility.
- Do not let other people handle items that go into the animal's mouth, such as toys and treats.
- [Disinfect](#) items such as toys, collars, leashes, harnesses, therapy vests and scarves, and food/water bowls frequently.
- Do not allow therapy animals to lick or give "kisses."
- Do not wipe or bathe therapy animals with chemical disinfectants, alcohol, hydrogen peroxide, or any other products not approved for animal use. There is no evidence that the virus can spread to people from the skin, fur, or hair of pets.
- Do not put masks on therapy animals. Covering an animal's face could harm the animal.

Cleaning, distancing, and other operational measures

How do we keep families healthy and safe in waiting areas?

Universal precautions to prevent the spread of SARS-CoV-2, the coronavirus that causes COVID-19, include social distancing, mask wearing, and hand hygiene and are the pillars of infection prevention.

Coronavirus is primarily spread through respiratory droplets. The risk of transmission increases with close contact in confined spaces (like many CACs) over extended periods of time. Conversely, precautions to limit proximity and number of individuals, the time they

spend in confined spaces together, and the spread of infected respiratory droplets through masks and strict cleaning procedures limits transmission risk.

CACs should first consider limiting the number of people entering the facility. If at all possible, it is best if only one person or caregiver accompanies the child to the interview. Limiting the number of caregivers and siblings present will limit the opportunity for transmission.

Generally, interviews should be scheduled in a staggered fashion. This will allow children and caregivers to move through the CAC while having no or minimal contact with other families. A staggered schedule also allows time for forensic interview rooms and all hard surfaces in the waiting area to be cleaned between families. If a staggered schedule is not possible, utilization of different waiting areas for different families may be an option.

If families arrive in personal vehicles, try to make arrangements for them to remain in the vehicle until space is ready to receive them. Consider developing a protocol to connect with families by phone or text to inform staff when they have arrived and to invite them in when the facility is ready to receive them. When families are waiting in vehicles during hot or cold weather, make sure to check with them on whether the vehicle has well-functioning climate control, and make arrangements to have them park in the shade or a garage, or to come inside as appropriate.

If the CAC cannot separate families into different waiting rooms, arrange distancing by placing groupings of two chairs each (one caregiver/one child) at least six feet apart in the waiting room, with clearance to move in and out of the rooms with safe distances. This is the least desirable option and should be used as a last resort.

In addition to physical distancing, all caregivers, children over the age of 2, staff, and team members should wear masks that **cover the nose and mouth**, and should be required to keep the mask on and covering the mouth and nose at all times. Masks limit the spread of infection by limiting the dispersion of droplets from coughs, sneezes, talking and breathing.

While these barriers provide some protection for the wearer, the additional benefit is to protect others. A secondary benefit is that masks likely remind the wearer to not touch their face, mouth, nose or eyes. When a mask is in place the wearer should try to minimize touching or constantly adjusting it. CACs should plan to keep a stock of disposable medical masks on hand to provide visitors who did not bring their own. See this [CDC one-page info sheet on masks](#) which may be posted in the facility or given to families to take home. See more information on the next page about masks and other personal protective equipment.

[More info on how to wear masks](#)

Children, caregivers, staff, and teams should have access to sinks, soap, and water and should be encouraged to wash their hands frequently, including immediately upon arrival. If handwashing sinks are not available, hand sanitizing liquids/gels can be used. Hand hygiene should be performed prior to eating or touching the mouth, nose, or eyes.

How should we keep client service areas clean?

All surfaces in waiting rooms, entrances, restrooms, exam rooms, interview rooms, and anywhere else clients or visitors have access should routinely be wiped by germicidal wipes or spray. Read the directions on the product, as many products specify the length of time a surface must be kept wet for maximum effect. Since asymptomatic individuals can transmit the infection, surfaces should be cleaned even if visitors “pass” the screening questions. Remove any toys with cloth or porous surfaces and consider limiting access to a small set of toys for each family that are easy to wipe down or wash in a dishwasher, setting out replacement batches for new visitors. Children should not play with toys used in prior appointments until those toys have been sanitized in a dishwasher or wiped down thoroughly with germicidal wipes/spray and allowed to air dry.

An alternative is to encourage families to bring their own toys to the appointment, which need not be limited to hard-surface items.

FAQs: Cleaning and sanitization

- **What areas of the CAC should we focus on for disinfection?** High-touch surfaces (doorknobs, chair armrests, countertops, computer keyboard and mouse, telephones, light switches) are the primary surfaces that should be disinfected on a frequent basis.
- **How often should areas be disinfected?** Disinfection of exam and treatment room should occur as between family visits, as part of the room turnover. Staff should disinfect their workspace supplies (phone, computer, desktop) at least once per shift, and more frequently if the space is shared by others. Common spaces (waiting rooms, check in desks, break rooms) should be disinfected on a regular basis throughout the day, and more frequently if individuals are present with symptoms of respiratory illness.
- **After clients have left a room, do they need to stay out of the room for a particular length of time to let droplets in the air settle?** Unless staff perform medical “aerosol generating procedures” such as endotracheal intubation, CPR, nebulizer therapy, or sputum induction, it is unlikely infectious aerosol droplets are to be a risk to staff and others. The room may be cleaned and used by the next family as per usual process.
- **What cleaning agents are effective against COVID-19?** Disinfectants and germicidal products that are listed as being effective against Coronavirus are recommended. Staff are advised to review the package’s instructions for use and be sure to abide the

recommended wet or contact time to achieve the stated disinfection. The CDC has a [recommended list for cleaning facilities, including a list of effective disinfectants](#).

- **Do UV lights or air purifiers help?** Specialized medical-grade UV light is effective as a surface disinfectant and may be used in some settings for “terminal cleaning” once primary cleaning and disinfection steps are complete. Air purifiers may work to filter and effectively increase air exchange rates in confined spaces. Note that HEPA-grade filters may be required to capture infectious respiratory droplets and require changing on a manufacturer’s set schedule. These measures should not be used as stand-alone cleaning treatments.

Masks and other personal protective equipment (PPE)

Should masks be required within the facility, even if we are practicing disinfection and social distancing?

Yes, masks should be required in addition to any other safety measures. The CDC recommends that employees of businesses wear a mask as a measure to contain the wearer’s respiratory droplets and help protect their co-workers and members of the general public. People can be infected with the virus without symptoms and therefore can spread the virus when they do not think they are sick. Requiring the use of masks by the staff of a CAC and MDT partners has several benefits:

1. Masking sets a good example for the clients the CAC is serving because it sends a message that you care about their welfare and are willing to wear a mask to protect them (since you are expecting them to wear a mask to protect you and your staff).
2. Masking provides a layer of workforce protection. Since asymptomatic spread is possible, if there ends up being an exposure in your CAC, the people who were wearing masks at that time are much less likely to develop the infection and much less likely to be required to self-quarantine by local health department contact tracing efforts.

The urgency and benefit of masking is greatest in areas with high levels of community spread and when consistent 6-foot distancing cannot be maintained in the workplace. However, due to the dynamic movement of clients and team members in a CAC, people should be required to wear a mask when in the common areas of the CAC (halls, shared offices, etc.) regardless of whether it is an area of high community spread. It would be reasonable for someone to not mask if they are working alone in their office, and their office has a door that can be closed.

Masking is not a substitution for social distancing. The two methods work best together.

What should I do if I get pushback about wearing masks in the facility from clients, partners, or even board members?

This is an important area for all CAC leaders and staff to show collaborative leadership. Whether or not a client, team member, or member of your governance structure believes masks or other methods to prevent the spread of COVID-19 are effective, there is no need to argue the facts. Your message to stakeholders who are hesitant to follow your CAC health and safety rules should be about protecting each other, your clients, and your families, regardless of whether your stakeholders are concerned about protecting themselves.

It is also about respecting each other, and for your team members, respecting the collaborative decision-making process that is at the heart of the CAC model. Your MDT and board leaders are role models for your clients and community in regard to abiding by public health recommendations on how to minimize spread.

This messaging may be more challenging in areas where local or state health guidance is unclear. Another reason we abide by public health best practices, no less important than preventing the spread of the virus, is for the psychological safety of clients who are medically vulnerable or even simply too worried about contracting the virus to benefit from services. NCA-Accredited CACs are required to be a child-focused environment, and all CACs strive to be a safe place for children. No child or family member deserves to feel unsafe at the CAC, and these concerns are more important than comfort or one's personal level of risk tolerance.

What personal protective equipment should staff and team members use if they must have contact with an actual or suspected COVID-19 positive client?

Any staff and providers in very close contact with the patient, such as medical providers, should wear full personal protective equipment (PPE), including a medical mask and a medically appropriate gown, face shield/goggles, and gloves. Washable cloth, disposable, and fluid-resistant gowns are all acceptable. Gowns should not be worn to see multiple families or patients (wear a new gown with each patient). Gowns and gloves should be removed upon exiting the exam room. Sterile or fluid-impermeable gowns are not required for COVID-19 protection.

Other personnel who will share a room with children who may have any positive COVID-19 screening criteria should wear, at minimum, a medical mask, gloves and eye protection, even if a proper six-foot distance is maintained. Universal masking and eye protection in the healthcare setting is strongly advised. In emergency, inpatient, and primary care, it has become standard practice to wear a mask and eye protection for all patients, including patients with no symptoms, due to the risk for unrecognized contagious illness.

FAQs: Masks and PPE

- **Are face shields or safety glasses useful?** Face shields and/or safety goggles are recommended when close contact is needed for an extended period of time (i.e., medical exam, interview with a young child who will not abide by distancing requests...). The virus can enter the body through the mucosal skin around the eye. Wearing regular glasses does not prevent air flow to the eyes through the sides. **Wearing a face shield does not negate the need to wear a mask as well.** Face shields typically have less issues with fogging compared to safety glasses with a mask.
- **Do plexiglas shields help?** Yes, as long as users still wear a mask. Plexiglas operates on the same premise as safety glasses/face shields in providing a barrier between the respiratory droplets of someone who needs to enter the 6-foot spacing. This is why you are seeing them go up at drive-through windows, checkout counters, etc.
- **How many times can a mask be used?** Cloth masks should be washed when it is visibly soiled, and after being worn for a day. If staff are unable to wash masks they take home, a hot iron may also be used to press and disinfect the mask. Masks should be replaced if they become soiled, visibly contaminated, damaged/torn, or wet.
- **At what age should children be required to wear masks?** Masks should not be placed on children younger than age 2 years. If Children under the age of 2 (or those that do not comply with mask wearing) have respiratory symptoms, families may be advised to cover the child's face or head with a blanket to minimize the spread of droplets.
- **Should we be asking families and children to wear any PPE other than masks?** Families and patients should not be asked to wear any additional PPE beyond masks. Please advise them to wash their hands with soap and water or use hand sanitizer often.
- **My CAC provides car seats and our staff sometimes get into a family's personal vehicle to install a seat. Is the risk similar to other tasks at a CAC, or is there greater risk?** If people with sick symptoms had recently been in the car, there would be a theoretical risk of exposure. If this is a concern, keep the doors to the vehicle open to aid additional air flow and minimize the risk for droplet accumulation in the confined space. Washing hands before and after the install and wearing a mask during the install should provide adequate protection.
- **Are masks effective during an interview in an enclosed room without windows or good ventilation?** Masks are recommended in every situation, especially indoors, and critically in which consistent 6-foot distancing cannot be maintained. They are not 100% protective, but do add a barrier for respiratory droplets that can be present during conversation. Ensuring that the client was screened for sick symptoms and having the client wear a mask if feasible would be important items as well. For

situations with prolonged contact of less-than-6-foot distancing (medical exam, forensic interview in a tight room, etc.) consideration should be given to wearing safety goggles or face shield to increase protection of the staff member as well.

- **Should we “double mask”?**

The important thing is that the mask you wear needs to be fitted snugly and should have a nose wire to prevent air leakage. (An added benefit to the nose wire and a tight seal for glasses wearers: less chance of fogging up lenses!) We recommend the [CDC’s guide to getting a proper mask fit](#), and one method they recommend is to wear a cloth mask over a medical mask, but you can also wear a multilayer cloth mask instead.

Prioritizing and triaging services

How should we provide services in the CAC setting for a child who may have been exposed to COVID-19, but doesn’t show any symptoms?

If a child or family member has answered yes to the screening questions, the best option would be to defer services until the child has completed the quarantine period recommended by the child’s healthcare provider, or tests negative for COVID-19. Alternatively, offer remote interviewing or other CAC services via videoconference. Please see NCA’s guides to [teleforensic interviewing](#) and [telehealth resources](#) on NCA Engage.

In the rare instance where services cannot be deferred due to immediate safety issues and no teleforensic interview (or telehealth) option is available, take all safety precautions you would take with a child who has a confirmed case. Here are some precautions you can take:

- Mandate that the child wear a medical mask that covers their nose and mouth and have them wash their hands upon entry to the CAC. [See our guide to different kinds of protective masks](#)
- Limit their activities in the CAC since you will need to disinfect all of the surfaces they had contact with once they leave.
- Limit the number of people that need to be in the same room with the child, maintaining an appropriate six-foot distance.
- Limit the timeframe of the appointment as much as possible. The risk of acquiring COVID increases with the length of time spent with an infected person.

- Ensure the interviewer and any other personnel working in the same space as the child are wearing a mask and eye protection (glasses, goggles or face shield).
- If the child is young or developmentally delayed and cannot cooperate with six-foot distancing, those in close contact with the child should wear either a gown (disposable or washable) or an oversized cover shirt, as well as a face mask and goggles.
- Once the contact has ended, take the top layer off inside out, avoiding contact with the face in the process. If it will be laundered, store it in a plastic bag until it makes it to a washing machine. Wash hands after transferring to the bag and after transferring to the washing machine. Do not hand-wash masks or other protective equipment.

If the child is being brought by a family member, the CAC should use the same screening and precautions for the caregiver who accompanies the child. Family members should not come to the CAC if their presence is not necessary—remember, the rule of thumb is one caregiver per child.

What protections would need to be in place to safely provide services to a child client suffering from COVID-19?

Children suffering from confirmed cases of COVID-19 should not be interviewed at non-hospital CACs. (Hospital-based CACs should consult their own hospital policy and safety procedures.) Moreover, unless driven by an urgent child safety issue, these interviews should be deferred until the child is well both for the safety of the staff and for the wellbeing of the child.

Current studies indicate the virus is no longer infectious starting nine days after the onset of symptoms in otherwise healthy individuals. Tests may remain positive in patients for more than eight weeks, even after they are no longer capable of infecting others. Therefore, CACs may permit scheduled appointments when:

- at least 10 days after confirmed COVID-19 symptoms began, **and**
- symptoms have improved, **and**
- the patient has to have been fever-free (without medications) for at least 3 days.

In those cases where one must proceed, and the child is well enough to be interviewed, allow the interviewer and sick child to communicate by video conference. [Please see our teleforensic interview guidance for CACs.](#)

Similarly, family members accompanying children should not have symptoms of infection.

Providing medical exams and services

Should medical exams still be offered at this time?

The decision of whether a medical evaluation should be completed will depend on weighing the risks and benefits of several different factors as well as the setting in which acute and non-acute exams typically occur. If the medical provider is not typically involved in the decision about who is referred for an exam, consider establishing a communication process with the provider to arrive at a team-based decision.

Cases in which the safety of a child would be difficult to ensure without a medical exam should be considered for exams. The medical provider will need to know basic case information, including:

- Age of patient
- Type of body parts involved in the abusive contact
- Time since last contact with the alleged offender
- Whether the patient has current obvious physical or mental distress.

The provider will also need to know whether the child is known to have COVID-19, has current sick symptoms (see above), or has been exposed to someone with COVID-19 or sick symptoms in the last 14 days.

What kinds of medical exams should still be offered to sick kids?

Even if a child is actively ill with COVID-19 or has had a recent exposure to someone known/suspected of having COVID-19, certain exams and treatments may not be deferred to ensure the safety of the child. These acute services include:

- Acute assault exams for evidence collection and STI/pregnancy prophylaxis
- Acute physical abuse exams for safety reasons
- Testing and management of risk for STI/pregnancy for non-acute cases
- Evaluation for current physical/emotional distress

Because the medical provider will be in very close contact with the patient, exams of sick children should occur in a setting where a healthcare provider has access to appropriate PPE. See our FAQ on masks and PPE on page 9.

If the medical provider does not have access to the correct PPE, the child could be referred to a medical facility which can coordinate the necessary care with the remote assistance of the CAC medical provider.

What kinds of exams should wait until the child has recovered from illness?

Non-acute exams should be deferred if the patient has any positive COVID-19 screening criteria. However, even in a single case, some exams may be acute while others are not. The investigator or team member who is aware of the disclosure should discuss the scenario with the medical provider for decision.

For example, the team and medical provider may decide that the patient/client should have testing for STI and/or pregnancy at the time of the report, and defer the actual physical exam until later, since pregnancy and STI could be present at the time of the disclosure or report without causing obvious physical symptoms.

Limiting exposure through telehealth

Another consideration for providing critical mental health services without bringing children and families into the CAC setting is to consider options for providing tele-mental health services through technology to kids. These measures were already widely practiced by CAC therapists before the pandemic, and many resources are now available for CACs on how to deliver mental health services effectively through telehealth.

[See NCA telehealth resources](#)

Forensic interviewing health and safety

NCA offers a separate guide on tele-forensic interviewing as a safe alternative to in-person interviewing. However, effective and safe tele-forensic interviews require significant planning and buy-in from community partners and families. See our guide to tele-forensic interviewing to begin your planning or compare your plan to national practices.

FAQs: forensic interviewing

- **What's the recommendation for wearing masks during face-to-face interviews?** The interviewer, client, and others present in the space should all wear masks. Avoid touching them, and perform hand hygiene if contact is made with the mask.
- **Will wearing masks affect the child hearing the interviewer, and vice versa?** They should not significantly affect the ability of children and interviewers to hear one another, though care should be taken to speak clearly and loudly, and to ensure questions and answers are clearly understood and repeated if not, just as in any other interview scenario. For children who lip-read, many masks with clear plastic panels that reveal the speaker's mouth are now available; otherwise, other interpretive methods may be required.

- **How do you respond to MDT members who insist masks should not be worn during interviews?** See the section of this guide on masks and PPE to respond to such concerns. They are simply the rules, and there is no evidence that masking during interviews causes adverse outcomes.
- **Will wearing a mask or conducting a tele-forensic interview hinder prosecution?** This guide cannot provide assurance that masking will not be used as a defense strategy, but the National District Attorneys Association and Zero Abuse Project have produced [an article on conducting and defending pandemic-era forensic interviews](#) to prepare interviewers and prosecutors to respond. Their position is that, with proper planning and context in evidence collection, it is unlikely that any of the extraordinary measures necessary to ensure safety during the pandemic will prove an effective defense tactic.
- **Is a Plexiglas panel between child and interviewer enough? Do they still have to wear masks during the interview?** Plexiglas provides some level of protection but is inferior to the more complete coverage provided by a mask and personal eye protection. Masking is still required to prevent transmission of viral particles around the side or above the edges of the glass.

How can I make the case for tele-forensic interviews when MDT partners are not on board with the idea? Research on the effectiveness of teleforensic interviewing is still underway, but the early results and early adoption of tele-FI in the CAC setting have shown promise and have not deviated significantly from in-person forensic interviewing in terms of outcome. However, additional planning and consideration is required to perform such interviews. [See more about the research and practice behind tele-FIs in our guide and webinar recording.](#)

Making kids and families feel safe

To be effective at providing services for the children and families that are our mission, CACs need to do more than just be safe—they need to feel safe. Psychological safety at CACs means that children and families can focus on getting justice and healing instead of worrying about getting sick. Creating a psychologically safe environment is part of the child-focused setting standard and is a core responsibility of the Accredited CAC.

Here are questions you may have about creating psychological safety for kids and families at your CAC, and answers that may be helpful as you work toward effectively providing critical services for kids at a challenging time.

Creating a psychologically safe environment for children and families

How can I help children and families feel safe receiving services at the CAC?

Understand first of all, that for some, the pandemic is a stressor, but for others, it's potentially a traumatic event. For kids and families who have directly experienced harm from the pandemic, witnessed the harm it's caused directly, lost a loved one or had someone close to them hospitalized or severely ill, or been repeatedly exposed to the details of the pandemic (like first responders and medical professionals might), the DSM-V considers this a traumatic event. Indeed, even for CAC staff exposed to the traumatic effects of the pandemic, this time could be triggering.

CACs must consider that clients may be experiencing traumatic responses. Our safety precautions are not only for keeping people safe, but also for letting people know and see that they are safe.

- **Follow the medical guidance about safety** in this guide and in other resources from public health authorities.
- **Communicate about your precautions** early, often, and in multiple formats with your clients, staff, and community partners. Help them understand (for kids, on an appropriate developmental level) what you're doing and that it is to keep them safe. Even at the time of setting the appointment—let the family know then what to expect and that it's being done to keep them safe. Tell them ahead of time not just what the CAC staff will be doing—such as wearing masks—but also if the family will be expected to do.
- **Expect varied reactions** from your clients, staff, MDT partners. Have compassion even if they are reacting differently than you are. That means both staff and partners who are more worried than you are, and also those who are less worried than you are. It's a good time to educate all your stakeholders about both the medical advice and to normalize their reactions. You can connect them with resources and stand strong for them, all without either overreacting to their worries or bending the safety rules to suit them.

Creating an equitably safe environment for kids and families

What's important to know about how COVID-19 is affecting communities of color/non-dominant cultures differently?

The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging; however, current data suggest a disproportionate burden of illness and death among racial

and ethnic minority groups. A recent [CDC MMWR report](#) included race and ethnicity data from 580 patients hospitalized with lab-confirmed COVID-19 found that 45% of individuals for whom race or ethnicity data was available were white, compared to 59% of individuals in the surrounding community. However, 33% of hospitalized patients were Black compared to 18% in the community and 8% were Hispanic, compared to 14% in the community. These data suggest an overrepresentation of blacks among hospitalized patients.

Black and Hispanic people appear to be disproportionately affected by COVID-19 deaths as well. Among COVID-19 deaths for which race and ethnicity data were available, [New York City](#) identified death rates among Black/African American persons (92.3 deaths per 100,000 population) and Hispanic/Latino persons (74.3) that were substantially higher than that of white (45.2) or Asian (34.5) persons. Studies are underway to confirm these data and understand and potentially reduce the impact of COVID-19 on the health of racial and ethnic minorities.

Black/African American families are also over-represented in regards to living in poverty and having poorly controlled chronic medical illnesses. When the CAC has an opportunity to interact with a family facing these challenges, take it as an added opportunity to address the social determinants of health that put this population at risk for poor outcomes from any public health crisis. Connect the parents to community health services for their own medical and mental health needs. Engage with legal aid if needed for housing disparities.

That's all to say: this crisis has almost certainly had an outsize impact on communities of color and non-dominant cultures in the U.S. Additional sensitivity and cultural humility in serving clients from these groups may not only be important but critical, as these groups are at a higher likelihood of bereavement, hospitalization, exposure, and illness, and these issues all contribute to a heightened trauma response during an abuse episode or in a trauma-exposed work environment like a CAC.

Ensure that all team and staff members are up to speed on the [cultural competency standard and the practices it entails](#), and that you consider how your staff and team members' behavior in serving clients and treating one another may require additional sensitivity and care during this time.

Additionally, please [see this guide to extra precautions from the CDC](#) in serving people from racial and ethnic minority groups during the pandemic.

Maintaining wellness among the CAC workforce

Key to providing a psychologically safe environment for children and families is creating a safe and healthy environment for staff and team members. In a trauma-exposed workplace like a CAC, the events of the COVID-19 pandemic can be magnified for workers and

community partners, both as an added stressor generally and as specific traumatic events. Some staff who are working from home also have few other social outlets during isolation, and may also experience stresses caused by the lack of normal workplace-based interactions.

This section offers ways you can help staff and team members can focus on being effective at their critical work during a time of increased stress at and away from work, during this time of increased health risk, disruption of healthy routines, and social isolation. Here are questions you may have about creating psychological safety for the workforce at your CAC, and answers that may be helpful as you work toward health and wellness for all your stakeholders at a challenging time.

Strategies to improve psychological safety for your CAC workforce

Transitioning back to the office will require some weighing of risks and benefits. As you consider some of the safety tips for physical space, please also consider strategies to improve psychological safety. Here are a few tips:

- Encourage staff, MDT members, and clients to talk about their safety concerns
- Communicate what steps are being done to address safety concerns
- Address current safety concerns and additional adversities
- Strengthen workforce engagement, wellness, and safety by implementing programs and policies that support self-care and foster well-being

What are some examples of programs and policies for wellness and engagement?

Most organizations have some type of employee assistance program or policies to support the health and well-being of employees in times of crisis. Many of these programs offer a limited number of support sessions to address life challenges that may adversely affect job performance. Most of these programs also have the ability to make referrals for additional resources and programs particularly when additional treatment services are warranted.

A growing number of programs have also started to emerge where staff have made a commitment to support each other by fostering self-care and other factors that promote resilience (e.g., nutrition and fitness programs, weight loss/healthy eating challenges; opportunities to connect and volunteer for a social cause). Granted these may look a little different now (e.g., virtual breakrooms, 2-minute dance parties, virtual happy hours) but they still play a valuable role in connecting staff and decreasing a sense of isolation.

What are some tips for self-care?

- **Pace Yourself.** This is a marathon, not a sprint!
- **Connect with colleagues, friends and family.** Spend time talking and listening with trusted people and share what you're going through. Ask for the help and support you need.
- **Practice behavioral activation.** Regular exercise can increase energy levels and decrease feelings of fatigue, reduce stress, and relieve muscle tension.
- **Do things that make you feel good and healthy.** Sleep, exposure to sunlight, healthy food, caring for a pet, practice relaxation techniques.
- **Access self-help apps.** There are a number of apps that may be helpful, such as Calm, Headspace, Breathe

Creating an equitably safe environment for your workforce

What recommendations do you have for ensuring our staff, team members, and families of color can engage with our systems safely?

What's true for your clients is also true for staff and partners from communities of color and other marginalized groups: these are especially challenging times for groups that are experiencing an added danger and psychological burden during the pandemic. See content from the previous section under the "**Creating an equitably safe environment for kids and families**" heading to find information and strategies to ensure your CAC is psychologically safe and actively considerate of all people in your workforce.

Additional resources

[General information on COVID-19 safety from the CDC](#)

[COVID-19 resources for businesses and employers from the CDC](#)

[Workplace, school, and home COVID-19 safety guidance from the CDC](#)

[When You Can Be Around Others After You Had or Likely Had COVID-19 \(CDC\)](#)