DBHDS
Virginia Department of Behavioral Health and Developmental Services

DBHDS Office of Human Rights (OHR)

Reporting Peer-on-Peer Aggressions as Potential Neglect

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This guidance is intended to clarify the reporting requirements to the DBHDS Office of Human Rights (OHR) for peer-on-peer aggressions that occur in community provider settings licensed or funded by DBHDS. It is intended to supersede guidance dated June 15, 2017, entitled "Office of Human Rights Peer-to-Peer Reportable Incidents." The impetus for clarification was a comprehensive review of neglect data entered by providers in the DBHDS Computerized Human Rights Information System (CHRIS), and collaborative conversations with key stakeholders.

Defined Terms (See 12VAC35-115-30.)

"Complaint" means an allegation of a violation of this chapter [the *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services* ("Human Rights Regulations") or a provider's policies and procedures related to the Human Rights Regulations.

"Allegation" is not a defined term in the Human Rights Regulations; however, for purposes of this guidance and in practice, it is used interchangeably with the term "complaint" and refers to a claim or report of an alleged human rights violation.

"Individual" means a person who is receiving services. The term includes the terms "consumer", "patient", "resident", "recipient" and "client". In this document an individual is also referred to as a "peer." See § 37.2-100 of the Code of Virginia.

"Internal review" is not a defined term in the Human Rights Regulations; however, when used in this guidance, it refers to the provider's standard processes to review incidents to determine any further actions needed to identify and address potential harms to an individual and to reduce the likelihood of reoccurrence. Providers should have policies to address internal review procedures that include a reasonable timeframe for the review of incidents, the methodology used for the review, and a structure for documenting the outcome of the review.

"**Neglect**" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See

§ 37.2-100 of the Code of Virginia. Neglect directly impacts the health and safety of an individual receiving services and has the potential to result in significant harm to the individual.

"**Peer-on-peer aggression,**" for purposes of this guidance, means a physical act, verbal threat, or demeaning expression by an individual against or to another individual that causes physical or emotional harm to that individual. Examples include hitting, kicking, scratching, and other threatening behavior.
Note: Incidents involving peer-on-peer aggression may constitute potential neglect when provider staff fail to follow internal policies and procedures, do not deliver supervision consistent with an individual's individualized services plan (ISP), or do not act to prevent an individual from being harmed during the incident. Physical harm resulting from peer-on-peer aggression may be evidenced by open wounds, bruises, black eyes, lacerations, or broken bones. Emotional harm resulting from peer-on-peer aggression may be evidenced by an individual stating that they are feeling unsafe or afraid of certain peers, or documented changes in the individual's behavior (i.e., becoming more withdrawn, avoidance of peer(s), or clinical documentation from a qualified professional).

"**Provider**" means any person, entity, or organization offering services that is licensed, funded, or operated by the department. See § 37.2-403 of the Code of Virginia.

"**Serious injury**" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner. See 12VAC35-115-30.

"**Services**" means care, treatment, training, habilitation, interventions, or other supports, including medical care, delivered by a provider licensed, operated, or funded by the department. See § 37.2-403 of the Code of Virginia.

Background

Historically, the standard for reporting incidents of peer-on-peer aggressions to the OHR in CHRIS emphasized the occurrence of the incident in combination with either a complaint or provider suspicion of neglect. The rationale was that requiring providers to report incidents of peer-on-peer aggressions where they "suspect" neglect, even in the absence of an actual complaint alleging neglect, increased the department's ability to monitor provider trends and ensure appropriate actions to prevent and mitigate harm of individuals. However, the requirement to report on this basis did not fully validate the fact that incidents of peer-on-peer aggressions can and do occur when neglect is not present. It also deemphasized the fact that providers are ultimately responsible for identifying, monitoring, and mitigating risk patterns and trends. (See 12VAC35-105-520.)

In Fiscal Year 2022, licensed community providers reported a total of 8,708 complaints alleging neglect via CHRIS. Providers specifically coded 63% (5,542) of these complaints as alleged "Peer to Peer Neglect." Of these "Peer to Peer Neglect" reports, less than 2% (121) were ultimately determined to be a violation of an individual's right to

be free from neglect while receiving services. The high volume of reports compared to the low number of substantiated neglect violations is an indication that the vast majority of peer-on-peer incidents of aggression are not the result of neglect. During the same time period, data on serious incidents reported via CHRIS to the DBHDS Office of Licensing indicate there were 513 incidents (out of 22,424) where the cause of the incident was peer-on-peer aggression. In addition to the above, the OHR became aware of another 300-plus complaints alleging neglect that were brought to its attention through means other than provider self-report.[1] Of these other complaints, 15% should have been reported by the provider as alleged "Peer to Peer Neglect" under the current reporting guidance. This illustrates additional concerns about provider compliance with the existing reporting requirements.

The goal of the oversight provided by the OHR and the reporting requirements in the Human Rights Regulations is to enable the department to monitor compliance with relevant laws and regulations in order to help ensure the rights and safety of individuals receiving services. While notification to the OHR is a function of CHRIS, additional purposes include: 1) documenting alleged abuse, neglect, or exploitation, and other human rights complaints; 2) documenting a summary of the provider's investigation, findings, and any corrective action; and 3) allowing for review, monitoring, and verification of corrective action by the OHR.

Therefore, providers should only report incidents to the OHR in CHRIS that are alleged to have resulted in a human rights violation, whether that complaint is by an individual receiving services, by provider staff, or by other people outside the provider agency. Even when the outcome is known or predictable to the provider, a CHRIS report and investigation of circumstances is required for all complaints. A review of an incident where there is no complaint, identified pattern, or determination that a human rights violation may have occurred is not reportable to the OHR in CHRIS; however, these may still be reportable to the Office of Licensing if they meet the definition of a serious incident.

Internal Review of Peer-on-Peer Aggression

All incidents that meet the definition of "peer-on-peer aggression" in the Human Rights Regulations are to be reviewed by the provider, in accordance with the providers policies and procedures. This internal review of incidents involving peer-on-peer aggression is expected to consider, at a minimum, whether provider staff followed internal policies and procedures, delivered supervision consistent with individual(s) needs and the ISP(s), and acted to prevent individuals from being harmed while receiving services. In addition, the provider is expected to identify any programmatic issues that may have contributed to the opportunity for peer-on-peer aggression (e.g., policies, protocols, etc.). Upon completion of this internal review, providers are expected to implement any identified proactive measures that may reduce the number of peer-on-peer aggressions and lessen the possibility of neglect, resulting in a safer treatment environment overall. (See also 12VAC35-105-160 and 12VAC35-105-520 of the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and*

[1] These additional reports came to OHR's attention through local departments of Social Services, the Office of the State Inspector General, and via the Office of Licensing online complaint process.

Developmental Services [“Licensing Regulations”] that specify various review and reporting requirements.) Please note that the internal review is separate from the investigation that would occur if the review raised suspicion of abuse or neglect, or if the provider received a complaint.

The OHR may request to review provider information specific to their review of incidents involving peer-on-peer aggression because of identified trends, the possibility of neglect, complaints discovered by the OHR that were known to the provider but not reported, or in any situation that the OHR deems necessary to protect the rights of individuals receiving services from providers of mental health, developmental, or substance abuse services in Virginia. (See 12VAC35-115-260.)

Reporting Peer-on-Peer Aggression as Potential Neglect

Providers must report to the OHR all incidents of peer-on-peer aggression that are alleged to have resulted in or from a human rights violation, whether the alleged violation is discovered by the provider or through a complaint. These incidents of peer-on-peer aggression shall be entered in CHRIS within 24 hours of discovery of the incident or receipt of the complaint, in accordance with 12VAC35-115-230. These incidents should be coded under the category “Neglect Peer-on-Peer Aggression.”

Examples of incidents of peer-on-peer aggression that should be reported: :

- An incident that clearly occurred because staff were not engaged in appropriate supervision (e.g., provider staff willfully ignored the physical act, verbal threat, or demeaning expression of one peer to another; provider staff intervened but not in accordance with policy; provider staff failed to implement supervision or supports based on the specific needs identified in the ISP);

A pattern of three or more incidents of peer-on-peer aggression involving the same peers within a seven-day timeframe (e.g., Individual A was the victim of physical acts, verbal threats, or demeaning expressions by another individual or individuals during three or more separate incidents within the timeframe; Individual B performed physical acts, verbal threats, or demeaning expressions toward another individual or individuals during three or more separate incidents within the timeframe).

Entering Incidents of Peer-on Peer Aggression in CHRIS

Incidents of peer-on-peer aggression that are determined to be reportable after a review by the provider shall be entered in CHRIS within 24 hours of the date of this determination, which is the date of discovery. These incidents should be coded under the category “Neglect Peer-on-Peer Aggression” and the description must indicate the reason for the report. For instance, when the report is concerning three or more incidents of peer-on-peer aggression within a seven-day timeframe, the provider should indicate this as the “description,” along with a brief account of the three incidents. When the complaint alleges involvement of a known provider staff person, the provider staff name should be entered in the description of the incident on the Accusation Tab in CHRIS. If the complaint indicates a possible programmatic failure, the provider should select “Other” and enter the provider’s name (e.g., ABC Residential) under the Accusation Tab in CHRIS. Reports of peer-on-peer aggression should be entered in

CHRIS under the name of the individual who was the alleged victim of the aggression. If the aggression was mutual, a separate report must be entered for all individuals involved.

All incidents of peer-on-peer aggression that are reported in CHRIS must be investigated in full accordance with the Human Rights Regulations. (See 12VAC35-115-175.) The complaint shall be substantiated when the provider determines, as a result of its investigation, that the incident of peer-on-peer aggression: (i) was the result of acts or omissions by provider staff or a programmatic deficit; and (ii) resulted in an individual's physical or emotional harm. Providers are expected to take and document appropriate corrective actions for all substantiated complaints resulting in a human rights violation.

In addition to the provider's reporting requirements to the department as outlined above, if at any time the provider has reason to suspect that an incident may be a crime, or is otherwise reportable to another entity, the provider shall report the incident to all appropriate authorities. Such instances include but are not limited to an incident:

- Between peers involving sexual assault, which is a form of violence and includes forced groping and rape;
- Involving unwanted sexual activity between minors (e.g., intercourse, kissing, touching of private areas); or
  Involving sexual intercourse or other sexual activity, physical assault, or exploitation between adult peers in which at least one individual is deemed to lack capacity based on an existing assessment that indicated the individual was at risk of exploitation.