Behavioral Health Services Guide

September 2020

ICE

ICE Health Service Corps

Foreword

The U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) *Behavioral Health Services Guide* supplements IHSC Directive 07-02 *Behavioral Health Services Directive.*

The IHSC Behavioral Health Unit develops and maintains *Behavioral Health Services Guide*. The guide explains concepts, assigns responsibilities, and details procedures for the implementation of basic behavioral health services for all behavioral health patients within our facilities.
The guide applies to all IHSC health staff supporting health care operations within ICE-owned and contracted detention facilities.

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Date

ERO Assistant Director
ICE Health Service Corps

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I. OVERVIEW

IHSC is dedicated to promoting a healthy and safe medical clinic environment to ensure consistent, integrated, and comprehensive behavioral health services for the IHSC patient population. Behavioral health services encompass the diagnosis and treatment of mental illness, substance abuse, and associated physical disorders. It consists of the integrated delivery of care by psychiatrists, primary care physicians, social workers, psychologists, psychiatric advanced practice providers, and other health care professionals. This guide describes detailed information on the structure of services, types of services offered, and processes involved.

II. RESPONSIBILITIES

A. Behavioral Health Unit (BHU)

Develops, reviews, and updates policies and official clinical guidance to assist IHSC staff with implementing administrative and/or clinical procedures related to behavioral health services.

Provides oversight of administrative and clinical processes impacting behavioral health services.

Provides clinical consultation and guidance on patient's direct care management and treatment to health care staff.

Conducts clinical competency reviews and program inspections on behavioral health staff and programs.

Reviews this Behavioral Health Services Guide and IHSC Directive 07-02, Behavioral Health Services, annually, and updates these documents as necessary.

Conducts peer reviews of behavioral health providers in IHSC facilities.

Coordinates with the Medical Education and Development Unit (MEDU) to conduct annual training on behavioral health services and programs.

B. Clinical Director (CD)

Ensures all patients referred for behavioral health services receive evaluation in a timely manner.

In the absence of the behavioral health provider, evaluates patients who voice suicidal or homicidal ideation, exhibit symptoms of a psychotic or thought disorder, and need immediate behavioral health services and close supervision.

Determines the appropriate level of patient monitoring for suicide precautions, develops an individualized treatment plan, and discharges the patient from suicide precautions in the absence of a behavioral health provider.

Initiates community-based hospitalization for patients in need of acute stabilization in the absence of a behavioral health provider.

Collaborates with a behavioral health provider to address both the medical and mental health needs of victims of sexual assault.

Oversees the supervisory behavioral health provider, as well as behavioral health treatment and services, in collaboration with the regional behavioral health consultant at the designated IHSC-staffed facility.

C. Psychiatric Services Unit (PSU)

Prescribes, directs, and administers psychopharmacological treatments for patients living with mental, emotional, and behavioral disorders in ICE Custody.

Partners with BHU staff, the local behavioral health provider, health services administrator (HSA), and clinical director, as needed, to coordinate services such as, tele-psychiatry, psychotropic medications, and forced emergency psychotropic medications.

Collaborates with BHU staff to discuss patients who have significant medical and behavioral issues affecting continued detention, release, or removal.

D. Health Services Administrator (HSA)

Supports BHU through oversight of behavioral health services within IHSC-staffed facilities.

Supports BHU to develop and approve local operating procedures (LOPs) for behavioral health related services.

Ensures all health care staff receive annual training on all behavioral health related services and programs.

Ensures health staff maintain daily, weekly, and monthly reports and clinical documentation locally, and submits to BHU in accordance with official guidance.

Collaborates with the clinical director, local behavioral health provider, and the chief psychiatrist/PSU designee to approve the Suicide Prevention and Intervention Program in accordance with official guidance.

E. Behavioral Health Provider (BHP)

Completes all clinical competencies; maintains knowledge and clinical skills.

Performs comprehensive mental health evaluations and develops treatment plans for integrative care coordination.

Completes daily, weekly, and monthly documentation related to behavioral health services in accordance with official guidance.

Oversees chronic care management of patients with serious mental disorders and or conditions.

Maintains compliance with all state, federal and local laws governing licensure and credentialing.

Completes all IHSC annual and mandatory training requirements.

Observes safety and security regulations of medical clinics.

Ensures patients referred to behavioral health services receive assessments and access to care.

Oversees serious mental illness (SMI) caseload for patients identified with serious mental disorders.

Ensures other designated BHPs, such as psychiatrist and/or psychiatric advanced practice provider (psych app), perform psychopharmacological evaluation and management.

F. Health Staff (Non-Behavioral Health Providers)

Some specific behavioral health activities are discipline-specific, while other responsibilities are shared. See Appendix A for outline of the scope of practice for non-behavioral health providers by discipline.

III. Notification of Available Behavioral Health Services

A. Written Notification of Services

Upon a patient's arrival, facility staff use the National Detainee Handbook to inform all patients of accessibility to health services. The facility may also post sick call hours in common areas such as housing and the dining facility. Patients can initiate requests for health services daily.

An IHSC patient education brochures, translated into multiple languages, orient patients to the clinic and outline how to access mental health services. The brochures are available via IHSC SharePoint within the folder: Patient Education. IHSC staff should distribute the brochure to all patients within the first 12 hours of arrival. IHSC health care providers have access to a variety of behavioral health related patient education materials translated into many languages. Health care providers give these handouts to patients as appropriate. Topics include: *Staying Healthy, and Sexual Assault.*

B. Verbal Notification of Services

During the intake screening, IHSC health care staff inform patients how to access behavioral health care through the sick call triage process.

IV. Access to Care

A. Sick Call

Patients with behavioral health concerns, including those in segregated housing, may request care daily through the sick call process. Sick call staff triage the request within 24 hours and follow up in accordance with IHSC Directive 03-02, *Access to Care – Sick Call*, found within the IHSC Policy Library.

Health care providers may schedule behavioral health appointments, if necessary, in the Behavioral Health Resource Scheduling in the electronic health record (EHR) under the appropriate BHP's schedule, or may submit telephone encounters to the appropriate BHP to schedule their referred patients.

B. Physical Exam and Health Assessment

A registered nurse (RN), advanced practice provider (APP), or physician conducts a comprehensive medical/behavioral health assessment within 14 days of arrival, or sooner, if clinically indicated.

- The RN, physician, or APP documents the findings in the Progress Notes of the EHR. The Physical Examination/Health Appraisal form – IHSC 795 A & IHSC 795 B.
- The RN, physician, APP, or designee submits a referral to a BHP if findings indicate a need for an evaluation by a BHP. The appointment must be within 72 hours of the referral in accordance with the prioritization of referrals.

C. Referrals

Health staff, non-clinical ICE personnel, or contract security staff may refer patients in need of a behavioral health evaluation and treatment at any time.

Referring Staff:

- Referrals from medical providers and nursing staff. Medical providers and nursing staff initiate referrals through available functions in the electronic health record (preferred method), or through other verbal or written means, to include e-mails or locally developed referral forms.
- Referrals from non-clinical staff. Non-clinical staff (i.e., non-clinical ICE personnel or contract security staff) may initiate referrals verbally or in writing. If verbal, the health staff documents the referral in the medical record using the (b)(7)(E) documentation format and initiates the referral process.

Prioritization of Referrals for Behavioral Health Evaluations:

IHSC categorizes the priority of service delivery for behavioral health evaluations as either "Emergent," "Urgent," or "Routine." The HSA, CD, or designee ensures health staff evaluate all patients referred for behavioral health services in a timely manner.

- Emergent. Patients categorized as emergent are those who voice suicidal or homicidal ideation, exhibit symptoms of a psychotic or thought disorder so severe that they are unable to care for themselves or need immediate behavioral health services and close supervision. Facility or health staff must immediately refer the patient to the BHP who conducts an evaluation and documents a course of action. If no BHP is available (either on-site or through tele-behavioral health/tele-psychiatry), the CD or primary care physician may conduct the evaluation. Primary care advanced practice providers (APPs) may conduct an emergency psychiatric evaluation; however, this requires immediate consultation, either in-person or by telephone with a physician or BHP. If none of these providers are available, the RN or LVN/LPN should place the patient under observation, on one-to-one watch, and consult immediately with the psychiatrist, BHP, or on-call provider. If on-call consultation is not available, the RN should refer the patient to the local emergency department for evaluation and/or treatment and follow their discipline-specific guidelines. Health staff must not house patients who need emergent behavioral health services in general population; these patients require close supervision in a medical housing unit (MHU) or special housing unit (SHU) under constant watch until they are transported to the local ER for evaluation.
- Urgent. Patients categorized as urgent are those who show active psychiatric symptoms (e.g., psychosis, depression, etc.), but are not

harmful to self, others, or property. Health staff schedule patients in this category for an evaluation with a BHP within 24 hours. If no BHP is available (either on-site or through tele-behavioral health/tele-psychiatry), the CD or primary care physician may conduct the evaluation. Primary care APPs may conduct an urgent psychiatric evaluation; however, this requires immediate consultation either in-person or by telephone with a physician or BHP. If none of the providers previously mentioned are available, the patient must receive an emergency room evaluation. The primary care APP places an order to refer the patient to the emergency room for evaluation and treatment. Nursing staff coordinate the referral and follow their discipline-specific guidelines. The RN places the patient in the MHU or SHU for observation pending full evaluation by the BHP.

- Routine. A patient categorized as routine has symptoms of mental illness, however, is not actively suicidal, homicidal, or impaired in their ability to function in the general population. A qualified health care provider (BHP, APP, or physician) should schedule the patient for a mental health evaluation within 72 hours of referral from a medical provider or nursing staff. Primary care APPs may conduct a routine psychiatric evaluation; however, the APP should refer the patient to the BHP for further evaluation and/or consult, as indicated by the psychiatrist, physician, or Psych APP. The BHP evaluates the patient within the next business day.

V. Behavioral Health-Related Services

A. Suicide Prevention and Intervention

All IHSC facilities must implement an IHSC Suicide Prevention and Intervention Program (SPIP) to ensure patients receive screening for suicidal ideation, plan, and/or intent.

1. Behavioral Health Provider Care Coordination:

    - The BHP evaluates patients by completing an SRA within 24 hours of patient placement on suicide precautions.
    - The BHP develops an individualized treatment plan based on the SRA and documents the plan in the patient's health record.
    - The BHP designates the least restrictive housing for supervision of suicidal patients.

- The BHP completes daily mental health evaluations on patients on suicide precautions.

- The BHP completes a post-discharge plan upon discontinuation of suicide precautions. The aftercare treatment plan includes re-evaluation time frames.

- The BHP schedules appropriate mental health follow up with a patient returning from an emergency mental health hospitalization for actively suicidal, potentially suicidal, and/or self-harming behaviors.

- The BHP requests and reviews mental health records as required.

2. Critical Procedures:

   - Critical Incident Debriefing: The BHP or designee must offer a critical incident debriefing following a suicide or serious suicide attempt to all affected staff and patients within 24 to 72 hours after the critical incident.

   - Immediate Safety Response Procedure: Custody staff should immediately escort patients who are actively or potentially suicidal, and/or engaging in self-harm behaviors, to the clinic for an assessment by an RN or medical provider.

   - The RN or medical provider medically clears the patient for transfer to the designated facility housing location for suicide watch. The RN or medical provider refers the patient to the BHP immediately for a more thorough evaluation.

   - Custody staff place the suicidal patient in the designated facility housing unit.

   - The RN or medical provider, in collaboration with the BHP, places the suicidal or self-harming patient on suicide watch with full safety precautions. These precautions include an (b)(7)(E) (b)(7)(E) The patient undergoes continuous one-to-one observation in the designated facility housing unit.

3. Suicide Precautions:

   - All health and custody staff may identify patients who are at risk for self-harm or suicide at any time while in ICE custody.

   - Health services staff must screen patients for suicidal or self-harming thoughts or plans at designated times, including standard IHSC screening,

prescreening, initial intake screening, pre-segregation screening, and health assessments.

- The BHP, CD, or designee completes an initial SRA to determine the appropriate level of patient monitoring for suicide precautions. In the absence of the BHP, the RN and medical provider have the authority to implement full safety precautions. The three levels are described below:
  - Suicide Watch. (b)(7)(E)
    (b)(7)(E)
  - Constant Watch. (b)(7)(E)
    (b)(7)(E)
  - Mental Health Observation. (b)(7)(E)
    (b)(7)(E)

4. The BHP develops a treatment plan for actively, or potentially, or suicidal patients and communicates this plan in the electronic health record and to the health care providers. The plan considers and includes the following:

    - A follow up SRA for patients on suicide precautions, completed by a BHP, CD, or appropriate designee.
    - Secure housing accommodations that is least restrictive to manage patient's therapeutic needs.
    - Special needs requirements addressed in the treatment plan.
    - Individualized interventions and structured time frames for scheduled follow up with health care providers.
    - An established step-down protocol for patients to include a post discharge plan.

5. The BHP, Psychiatrist, CD, or designee are the only staff authorized to discharge a patient from suicide precautions. Discharge from suicide precautions first requires the following:

    - A documented SRA that includes a post discharge plan prior to termination of suicide watch.
    - Patient education on post discharge plan, to include step down protocol for termination of suicide watch.
    - Notification to health care providers and documentation in the electronic health record of a patient's post discharge plan prior to termination of suicide watch.

For additional information, see IHSC Directive 07-04, *Suicide Prevention and Intervention,* located in the IHSC Policy Library.

B. Substance Use Difficulties, Identification, and Services

Patients with identified substance use disorders or conditions receive services appropriate for maintenance and stabilization, while in ICE custody. These services may include drug education, counseling, and monitoring.

Health staff refer patients who experience withdrawal or intoxication to a medical provider for evaluation and treatment, or an appropriate facility if indicated. The medical director approves the clinical guidelines for drug and alcohol dependency used by the IHSC-staffed facility.

For more information, see IHSC Directive 03-13, *Patients Diagnosed with Substance Dependence or Abuse,* located in the IHSC Policy Library.

VI. Behavioral Health Evaluation, Treatment, and Programs

IHSC utilizes a variety of treatment options to help stabilize patients to include talk therapy, psychotropic medications, inpatient treatment, and crisis/emergency intervention. Prioritization for services is as follows, unless otherwise directed by the HSA, CD, or BHU chief.

A. Behavioral Health Evaluation

Any detainee referred for mental health treatment must receive an evaluation by a qualified health care provider (BHP, APP, or physician) no later than 72 hours after the referral, or sooner, if necessary. If the practitioner is not a mental health provider and further referral is necessary, a mental health provider must evaluate the detainee within the next business day.

B. Levels of Prioritization

Priority 1:

(1) Acute crisis intervention where the patient is suicidal, violent, or psychotic.

(2) Suicide prevention and intervention (prevention, intervention, and treatment). See IHSC Directive 07-04, Suicide Prevention and Intervention, found within IHSC Policy Library for more information on the Suicide Prevention and Intervention Program.

(3) Treatment of patients with mental illness.

(4) Diagnostic interview for referred patients.

(5) Special Management Unit rounds.

(6) Behavioral health sick call requests.

Priority 2:

(1) Individual or group psychotherapy and psychoeducational/psychosocial programs.

(2) Brief counseling activities.

(3) Staff training on psychological issues for medical, correctional, and ICE staff.

Priority 3:

(1) Consult with ICE staff on psychological issues concerning patients.

(2) Patient education on behavioral health, medical, and other issues related to detention.

(3) Program development, program evaluation, and research projects.

(4) Participation in seminars, conferences, and community programs.

C. Treatment Planning

Patients must have a treatment and/or management plan developed or approved by a BHP, psych APP, psychiatrist, or CD upon placement on suicide precautions and within 72 hours of discontinuation of suicide precautions. Additionally, patients must have a treatment and/or management plan approved by a BHP, qualified mental health provider, or CD to accompany a diagnosis from the DSM-5 Diagnostic and Statistical Manual of Mental Disorders within three business days. The treatment plan must include directions to health care staff regarding their roles in the care and supervision of the patient; frequency of follow up for medical and mental health evaluation and adjustment of treatment modality; the type and frequency of diagnostic testing and therapeutic regimens; and when appropriate, instructions about adaptation to the correctional environment and medication. The BHP, psych APP, psychiatrist, or CD reviews their respective discipline-specific treatment plan (b)(7)(E) (b)(7)(while the patient is in ICE custody.

(b)(5); (b)(7)(E)

Note: Documentation in Electronic Health Record. Health staff must document any education or treatment delivered to the patient in the health record.

D. Levels of Behavioral Health Care

IHSC provides appropriate and necessary levels of behavioral health care based on the patient's symptoms. Levels of care can include treatment while in general population, medical housing units, and community hospitalizations.

General Population:

Patients with behavioral health issues may remain in general population if the BHP determines the individual is stable and no longer needs a higher level of care.

Medical Housing Units:

Medical housing units, or MHUs, are available at designated ICE facilities and offers a secure environment where health care staff can provide care for behavioral health patients with an identified need for higher levels of care. (See IHSC Directive 03-17, *Medical Housing Units (MHU)*, found within the IHSC Policy Library for more information on MHUs.

Community Hospitalization (Inpatient Psychiatric Treatment):

IHSC health care providers attempt to stabilize patients with mental illness within the detention facility. If providers initiate treatment and cannot stabilize the patient within the detention facility, facility staff may transport the patient to an inpatient treatment facility. The BHP, psychiatric services provider, CD, or primary care physician may initiate hospitalization at any time. Primary care APPs and clinical pharmacist (CP) may initiate hospitalization after consulting with a BHP, psychiatric advanced practice provider (Psych-APP), or physician.

IHSC must comply will the state laws governing the facility for all involuntary hospitalizations.

The transfer occurs in a timely manner. Facility staff, in collaboration with health staff, safely house and adequately monitor the patient until transfer.

After the inpatient psychiatric hospital releases the patient, either a BHP, physician, or APP must evaluate the patient no later than the next business day. A psychiatric services provider, physician, or primary care APP must see the patient, if the patient requires continued psychotropic medications.

Columbia Regional Care Center (CRCC) and Larkin Behavioral Health Hospital (LBH):

CRCC is a private correctional hospital located in Columbia, South Carolina, that provides behavioral health services to acute/chronic mental health patients.

LBH Hospital located in Hollywood, Florida, provides behavioral health services to acute/chronic mental health patients.

Behavioral health clinical consultants at HQ review and coordinate the referrals to CRCC and LBH to determine appropriateness of the referral for inpatient hospitalizations.

Alvarado Parkway Institute (API) and Paradise Valley Hospital (PVH):

API is a community hospital located in La Mesa, California, that provides medical and behavioral health services to ICE detainees.

PVH is a community hospital located in National City, California, that provides medical and behavioral health services to ICE detainees.

Medical providers, field medical coordinators (FMCs), BHPs, and HSAs may refer patients to Paradise Valley Hospital and API by contacting the IHSC BHU at IHSC HQ.

Krome Behavioral Health Unit (KBHU):

KBHU is a (b)(7)(E) behavioral health unit, with double occupancy rooms, within the Krome Service Processing Center in Miami, Florida. KBHU provides psychiatric services to patients with sub-acute or chronic behavioral health conditions who cannot be placed in the general population, but do not require acute inpatient hospitalization.

Medical providers, FMCs, BHPs, and HSAs may refer patients by completing application materials provided by the IHSC BHU behavioral health clinical consultants, and by submitting to (b)(7)(E) @ice.dhs.gov for the western region and (b)(7)(E) @ice.dhs.gov for the eastern region.

VII. Continuity of Care for Behavioral Health Patients

IHSC provides appropriate standards of care to maintain and stabilize patients in preparation for repatriation or release. Behavioral health staff develop all behavioral health services to meet the patient's needs, utilizing an integrated approach to ensure both medical and psychosocial needs are met. Health care providers coordinate behavioral health, medical, and substance abuse services to appropriately integrate and manage patient care, meet medical and behavioral health needs, and address the impacts of one condition on any others.

A. Monitoring of Patients with Chronic Mental Illness

The BHP monitors the functioning of patients identified with acute and chronic mental illness. A BHP sees patients with chronic mental illness (b)(7)(E) or more frequently if clinically indicated, if they remain in detention.

A medical provider sees patients who take psychotropic medication (b)(7)(E) (b)(7)(E) A psychiatrist or psych APP sees patients who take psychotropic medication (b)(7)(E) Providers may use tele-psychiatry to meet these requirements.

The BHP reports all patients who meet SMI criteria to HQ on a weekly or recurrent basis, utilizing the eClinicalWorks (eCW) Segregation and SMI Smart Form (SF). The BHP completes a Mental Health Review Form (IHSC Form 883) for every SMI patient upon initial evaluation and once every 30 days for as long as the patient meets the SMI criteria.

B. Communication with ICE Staff Regarding Patients with Serious Mental Disorders or Conditions

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C. Chronic Care Management

The BHP uses clinical discretion and judgment in the management and treatment of identified mentally ill patients. A physician, psychiatrist, or Psych-APP sees the patient (b)(7)(E) they see patients identified as acute or unstable as needed, based on their symptoms and responsiveness to treatment.

VIII. Care for Specialized Population(s)

A. Segregated Patients and Patients with Limited Outside Access

The IHSC BHP conducts (b)(7)(E) rounds in the Special Management Unit (SMU) to evaluate the safety and mental health of all patients held in disciplinary or administrative segregation and reports the information to IHSC HQ on a weekly basis. This (b)(7)(E) round is in addition to the (b)(7)(E) rounds conducted by health care providers.

Report to IHSC HQ:

The BHP completes the Mental Health Segregation Smart Form within the electronic health record and assigns the completed form to the designated mental health coordinator at HQ for review and electronic signature.

B. Victims of Sexual Assault

A health care provider may detect sexual or physical assault, abuse, and/or neglect in patients during the intake screening process, or during other clinical encounters. Facility staff may refer suspected incidents of sexual or physical assault, abuse, and/or neglect, or patients suspected of being at high risk for victimization to a qualified health care provider at any time.

Referral Process: The health care provider refers identified patients to a BHP for mental health services, and immediate medical evaluation by a qualified health care provider (APP or physician). IHSC health care providers may also provide acute medical and mental health treatment prior to transfer to an appropriate facility for further emergency treatment.

Assessing Sexual Abuse and Assault: If the health care provider identifies the patient upon intake (utilizing both the mental health and trauma assessment) as having a history of sexual abuse or assault prior to coming into custody (within the past six months), the health care provider assesses and treats the patient by one of the methods listed below, if indicated.

- Any health or facility staff member refers the identified patient to medical and mental health providers for an evaluation in accordance with PBNDS 2011, revised 2016 and DHS Prison Rape Elimination Act (PREA).
- The BHP, or qualified health care provider, evaluates the patient within 72 hours or sooner, if reasonably practicable in non-residential facilities, and within 24 hours in family residential centers.
- The BHP must evaluate the patient's referral for a physical evaluation within two working days. (NOTE: Patients with a history of sexual abuse or victimization receive a full mental health evaluation by the BHP or physician within 60 days, and appropriate follow up is provided, if needed).

Recommendations for Patients at High Risk for Victimization: Upon completion of the mental health assessment, the BHP or physician provides a recommendation regarding alternative placement to the custody staff when appropriate. IHSC qualified health care providers and the HSA should recommend patient placement in the least restrictive housing available, appropriate to the facility.

Known Abuser Mental Health Evaluation and Treatment: A BHP, or physician if no BHP is available, should attempt to conduct a mental health evaluation of all known patient-on-patient sexual abusers, and provide treatment within 60 days of notification of such history of abuse and/or assault. If the provider successfully conducts an evaluation, the BHP or physician documents the evaluation and ensures it is placed in the electronic health record.

Post-Incident Response: Patients who had a recent (within past 30 days) incident, while in custody, involving sexual or physical assault, abuse or neglect, must receive a medical evaluation within two working days, and a mental evaluation within 72 hours. Please refer to IHSC Directive 03-01, Sexual or Physical Assault, Abuse or Neglect within the IHSC Policy Library.

Mental Health Care: Following a medical evaluation, the need for mental health care and continued services for post-abuse assault and neglect complications are assessed by the BHP, the CD or qualified health care provider and scheduled, as needed, based on the mental health status or condition of the patient. Off-site referrals for specialized services for victims of sexual assault or abuse are initiated, if indicated.

Follow Up Medical and Mental Health Care for Victims: The appropriate health care providers, as listed previously, provide a medical and mental health evaluation. Additionally, they provide treatment for all patients victimized by sexual abuse while in ICE detention, as appropriate.

Continuity of Care: In accordance with professionally accepted standards of care, the evaluation and treatment of patient victims include, follow-up services, treatment plans, as appropriate. When necessary, evaluation and treatment can also include referrals for continued care following their transfer or placement in other facilities, or release from custody.

Refusals: If a patient refuses a medical or mental health evaluation related to the PREA allegation, the patient must sign a refusal form. Before the patient signs the refusal form, the health care provider must explain the importance of having these evaluations in relationship to the allegation. After the patient signs the refusal form, the health care provider informs the patient of the opportunity to complete these evaluations in the future, either by appointment or the sick call process.

Confidentiality: ICE personnel must maintain information regarding a patient's possible sexual abuse, assault, and/or neglect is maintained by all of ICE personnel in accordance with applicable law and DHS policy; staff keep all information in the highest confidence. The HSA or designee must approve any release of information regarding sexual assault or abuse. The HSA or designee should only release information to ICE or IHSC staff on a need-to-know basis or to support ongoing patient treatment of the patient.

Community-Based Support: The HSA maintains a list and, when applicable, a copy of all memorandums of agreement (MOA) entered by the assistant field office director (AFOD) of community-based organizations and resources related to sexual assault crisis intervention and counseling services that provide support to victims of sexual assault.

Medical and mental PREA templates: All medical and mental health providers, who conduct a PREA medical or mental health evaluation on a detainee with sexual assault allegation, must use the medical and mental health template located on eCW.

Training and Support: The HSA, assistant HSA, local training coordinator, or other designated IHSC staff member documents all required training. IHSC has a zero-tolerance policy for sexual or physical assault, abuse, and sexual harassment. The BHP or designee trains all IHSC staff on the Sexual Abuse and Assault Prevention and Intervention (SAAPI) directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC. For more information, see IHSC Directive 03-01, *Sexual or Physical Assault, Abuse or Neglect*, within the IHSC Policy Library.

Assistance to Security Training:
The HSA designates an IHSC health care staff member to assist with the development of medical aspects of the facility's zero tolerance and prevention of sexual assault and abuse training program.

Patients at Risk for Sexual Victimization
Qualified health and mental health professionals may identify detainees who were allegedly sexually assaulted or abused during the intake screening process or during other clinical encounters. Facility staff may refer suspected incidents of sexual assault or abuse, or detainees suspected to be at high risk for victimization, to a qualified health care provider at any time. Either a BHP, physician, or Psych-APP then assess patients identified as 'high risk' for sexual victimization during the intake screening process. Upon completion of the assessment, the BHP recommends housing in a supportive environment that represents the least restrictive option possible. Custody staff consult a medical and mental health professional as soon as possible on assessment made for a transgender or intersex detainee. Custody staff should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee. (PBNDS 2011, revised 2016, Section 2.11, part j).

C. Transgender Population

Mental Health Assessment: Health staff must refer transgender detainees to a BHP for an evaluation. This mental health assessment must occur within two business days of intake or condition identification (i.e., when medical staff learns of a detainee who identifies as transgender while in ICE custody), whichever is later. See IHSC Directive 03-25, *Gender Dysphoria and Transgender Detainees,* within IHSC Policy Library for additional information. Health staff must refer patients diagnosed with Gender Identity Disorder (formerly Gender Dysphoria), per the Diagnostic Statistical Manual (DSM) criteria, back to the medical provider for evaluation of treatment options.

D. Children (ages 17 or younger)

Physical Exam and Health Assessment: Medical staff complete comprehensive medical/behavioral assessments within 7 days for children (age 17 years or younger).

Referrals: The BHP must complete mental health referrals for all children within 24 hours of the referral.

Treatment Planning: All children (age 17 or younger) must have a treatment plan in place, developed or approved by a BH provider or primary care physician within three business days of diagnosis. The BHP, psych APP, psychiatrist, or CD reviews their respective discipline-specific treatment plan (b)(7)(E) while the patient is in ICE custody

Wellness Checks: The BHP conducts wellness checks weekly on all children housed in family residential facilities. These checks are to address any adjustment issues the child experiences and/or concerns parents may have. The BHP provides a variety of psychoeducational groups at family residential facilities. These groups assist with overall functioning and coping skills.

Segregation: Segregation does not apply to resident children ages 17 and under.

Victim of Sexual Assault: Medical personnel must see all children, ages 17 and under, involved in sexual assault allegations within 24 hours of the incident. The health care provider, in collaboration with the CD and HSA, along with the BHP (when available). interviews the child and determines whether the assault, abuse, or neglect will result in an emergency/urgent mental health need. When a BHP is not on-site, a health care provider evaluates the patient's needs for mental health. When appropriate, facility staff, in collaboration with health staff, transfer the patient to an appropriate facility for appropriate clinical level of care and assessment and to complete a forensic evaluation. By law, health staff must file a report with police agencies and child protective services within the jurisdiction. In addition, the HSA must urgently notify the AFOD, the Chief of Juvenile and Family Residential Management Unit (JFRMU), the facility's administrator, and the appropriate IHSC chain of command.

Suicide Prevention/Intervention: Health staff should make every effort to refer and transfer any suicidal child (age 17 or younger) to the local hospital for evaluation and treatment as soon as possible. Any health staff should place the child in (b)(7)(E) continuous observation until the transfer takes place. Additionally, a BHP or physician should immediately assess the child. If a BHP or physician is not available to conduct the evaluation, the child should remain in (b)(7)(E) constant observation until transferred to a local hospital. The parent should accompany the child through the

admission process under the supervision of ICE. The hospital determines if the parent can stay overnight; otherwise, the parent may visit.

Health staff must place any potentially suicidal child (age 17 or younger) in the least restrictive setting, or in the MHU with (b)(7)(E) constant observation up to 24 hours, until referred to the hospital or released from observation by a BHP or physician. The parent is allowed in the MHU only if their presence is not a safety issue. Medical staff must document the status of the child in observation every two hours or more frequently as determined by the BHP. Custody staff must document observations every 15 minutes.

Mental Health Related Family Separations: Other ERO components may consult IHSC on a case-by-case basis to address family separations depending on the anticipated duration of separation and potential diagnosis. If deemed necessary, local ICE administration, in coordination with security staff, devise a plan of supervision to allow the juvenile to remain in residence during temporary separation. If circumstances suggest the juvenile meets unaccompanied minor criteria, the local ICE administration obtains concurrence from JFRMU and ICE Enforcement and Removal Operations (ERO) in order to proceed with Office of Refugee Resettlement (ORR) placement.

IX. CONSULTATIVE SERVICES

IHSC BHPs may serve as subject matter experts for ICE in the areas of their expertise. IHSC BHPs may also coordinate with community BHP designated teams when a determination of competence is required for treatment and commitment.

A. Tele-Psychiatry

If the facility uses tele-psychiatry for patient encounters, the psychiatrist or psychiatric APP must:

1. Ensure the patient consents and signs a written consent form;

2. Ensure the patient's confidential health information is protected;

3. Document their findings; and

4. Integrate the consultation report into the patient's health care record.

Process for Initiating Tele-Psychiatry: The BHP or medical provider makes referrals through the electronic health record or directly to the provider. Please follow eCW appointment scheduling procedures.

B. Psychotropic Medications

Initiation of Treatment: Mental Health Care Levels categorize medical provider prescriptive authority.

IHSC physicians, psychiatrists, and Psych-APPs may initiate psychotropic medications for both Mental Health Care Level 1 and Level 2.

IHSC clinical pharmacists may initiate psychotropic medications for Mental Health Care Level 1 +/- 2 medications only as authorized in their IHSC collaborative practice agreement.

IHSC APPs may only initiate psychotropic medications for Mental Health Care Level 1 in accordance with the IHSC collaborative practice and prescriptive authority agreement. When a primary care APP or CP prescribes psychotropic medication, they must refer the patient for an evaluation with a BHP as clinically indicated or within 90 days.

- Mental Health Care Level 1 – Evaluation, assessment, and treatment of mild/moderate depression without psychotic features, mild/moderate anxiety, adjustment, and secondary sleep disorders.

- Mental Health Care Level 2 - Evaluation, assessment, and treatment of more acute and/or complex mental health conditions, including but not limited to severe depression, depression with psychotic features, severe anxiety, schizophrenia, schizotypal, schizoaffective, bipolar, and post-traumatic stress disorders.

Continuity of Care: All IHSC medical providers may continue psychotropic medications to ensure continuity of care for mental health conditions. When a new patient presents to an IHSC facility with verifiable and current psychotropic medication prescriptions, the provider who performs the health assessment is responsible for continuing the medication.

If the provider performing the patient's health assessment is privileged to initiate care for the patient's reported mental health condition, the provider administers and obtains written informed consent for the medication(s) prior to prescribing the medication(s).

If the provider is not privileged to initiate therapy for the patient's reported mental health condition, the provider may enter an order for up to 30 days of the medication to ensure continuity of care. This provider must refer the patient to a psychiatrist or Psych-APP for evaluation within the next 30 days.

Informed Consent: IHSC medical providers must obtain a separate informed consent, including a description of the medication's side effects, prior to administering a

psychotropic medication to a patient. Health staff must ensure that appropriate medical personnel answer the patient's questions regarding treatment. Medical providers must document the informed consent utilizing the appropriate IHSC form for the medication(s) prescribed.

Psychotropic medication consent forms are available for the following medications and medication classes (b)(7)(E)

- IHSC 933: Consent to Use of Benzodiazepines
- IHSC 934: Consent to Use of Atypical Antipsychotics
- IHSC 935: Consent to Use of Lithium
- IHSC 936: Consent to Use of Tricyclic Antidepressants
- IHSC 937: Consent to Use of Typical Antipsychotics
- IHSC 938: Consent to Use of Monoamine Oxidase Inhibitors (MAOI) Antidepressants
- IHSC 940: Consent to Use of Miscellaneous Antidepressants
- IHSC 941: Consent to Use of Serotonin Reuptake Inhibitor Antidepressant Medication
- IHSC 944: Consent to Use of Mood-Stabilizing Medication
- Informed Consent for Continuity of Care: If the provider performing the patient's health assessment is not privileged to initiate care for the patient's reported mental health condition, a psychiatrist, Psych-APP, or APP/CP with expanded privileges must evaluate the patient within the next 30 days. The referral provider administers and obtains written informed consent.
- Signatures: The patient must sign the psychotropic consent form(s) using the electronic signature pad provided by ICE/IHSC. If the system is inoperable or unavailable, the patient and a health care provider must sign the appropriate paper consent form, then medical records staff should scan the form into the EHR. The manner in which the provider signs the consent form must match the manner in which the patient signs the form (wet ink vs. electronic). Providers should only utilize credential-based electronic signatures for telemedicine encounters.

- Witnesses: Witnesses are only required to sign the psychotropic medication consent form if the prescribing provider administers the consent form as part of a telepsychiatry encounter. A witness may be any health care staff member, such as a nurse, behavioral health technician, medical records technician, or medical assistant.

- Minors: If the patient is a minor, the parent or legal guardian must provide informed consent. Adolescents age 13-17 must provide written consent to receive psychotropic medications.

- Prescription Renewals: IHSC does not require a new informed consent each time the provider renews a prescription to continue therapy, or for changes to the dose and/or dosing schedule. The provider must administer and obtain a new written informed consent for medications discontinued then resumed.

- Transferability of psychotropic consent: If the detainee transfers to another facility within the IHSC system, and medication is continued at the receiving facility, a new consent for psychotropic medications is not required.

Pill Line: Patients receiving psychotropic medications via Pill Line may self-administer keep on person (KOP) or other medications in accordance with the prescribing provider's clinical judgement. Psychiatric providers may designate patients as unsafe to self-administer medications and must document this in the EHR, and directly communicate this limitation to the facility pharmacist for appropriate action. See IHSC Directive 09-02-G-01*, Pharmaceutical Services Guide,* within the IHSC Policy Library for more information.

Patient Education: Prior to the start of psychotropic therapy, the prescribing provider should counsel patients on the use, benefits, and potential side effects of the medications. The provider should document this patient education in the medical record.

C. Forced Emergency Psychotropic Medication

Involuntary administration of psychotropic medications: Involuntary administration of psychotropic medication requires authorization of a licensed clinician (CD or designee) prior to use. The licensed clinician's written order should specify when, where, and how the psychotropic medication may be forced. The licensed clinician must document the following in the patient's health record:

- The patient's condition
- Threat posed
- Reason for forcing medication

- Other treatments attempted
- Treatment plan for less restrictive treatment alternatives
- Appropriate follow up care

Nursing Checks/Documentation: Nursing staff must document follow-up checks in the health record within the first hour of psychotropic medication administration and again within 24 hours.

APP, CP, or RN Initiation in Emergency: If an APP, CP, or RN initiates an involuntary administration of psychotropic medication in an emergency, the provider must first obtain a verbal order from a physician prior to implementation. The APP, CP, or RN records the verbal order in the patient's health record within an hour of the order.

See OM 16-025, *Forced Emergency Psychotropic Medication,* found within the IHSC Policy Library for more information on involuntary administration of psychotropic medication.

D. Collaborative Practice Agreement (CPA)

Collaborative Practice Agreements: Psychiatric care provided within IHSC health care facilities through an interdisciplinary framework of health disciplines including psychiatrists, physicians, advanced practice providers, and pharmacists. Collaborative practice and prescriptive authority agreements for Psych-APPs, primary care APPs, and CPs are governed by psychiatrists and physicians. The agreements delineate the scope of practice and psychopharmacology prescribing privileges for the advanced practice provider and pharmacy disciplines supporting behavioral health care operations. CPAs and PAAs establish prescribing diversification aligned with IHSC's specified patient mental health diagnostic levels, defined below. CPA and PAAs enhance behavioral health care in the development of treatment plans including the initiation, management, modification and discontinuance of psychopharmacology interventions. The CPA and PAA structure ensure all acts of psychopharmacological ordering, or prescribing, adheres to IHSC standards of care, pharmacological and formulary guidelines.

Behavioral health practice includes psychotherapeutic interventions and psychopharmacology administered through the Collaborative Practice Agreement for prescribing diversification aligned with defined patient mental health diagnostic levels.

See IHSC Directive 07-02, *Behavioral Health Directive*, within IHSC Policy Library for more information.

E. Forensic Behavioral Health Evaluations

IHSC staff do not refer for forensic behavioral health evaluations unless ordered by a court of competent jurisdiction. (Note: The court may order an evaluation, but IHSC

staff do not perform the evaluation.) IHSC coordinates when appropriate. BHU must also notify the Psychiatry Services Unit chief or designee regarding all forensic evaluation requests. For more information see IHSC Directive 07-03, *Forensic Mental Health Evaluations* within the IHSC Policy Library.

X. Non-IHSC Staffed Facilities

In non-IHSC staffed facilities (i.e., intergovernmental service agreement [IGSA] facilities), the IHSC FMC works with facility medical staff to identify all individuals with behavioral health concerns within their area of responsibility. The FMC must immediately report any major change in stability for a patient with a serious behavioral health condition to the field office director (FOD) and OCC.

XI. Other Related Behavioral Health Responsibilities

A. Behavioral Health Training

The IHSC behavioral health staff, or designated medical providers, may provide the **annual** training topics outlined below, as directed by the clinic's HSA or ICE staff.

(b)(7)(E)

B. Procedural Meetings

(b)(5); (b)(7)(E)

(b)(5); (b)(7)(E)

C. Peer Review

IHSC BHU staff or designees conduct peer reviews on all IHSC BH Providers annually. BHU staff conduct peer reviews within the first three months for all new employees and yearly for all established employees. BHU staff review ten charts for both new and established employees as part of this process. The peer reviewer provides results of the peer review to the BHU chief, the HSA or FMC, IHSC Credentialing and Privileging Office, and the provider. See IHSC Directive 01-46, Multidisciplinary Peer Review, and IHSC Directive 01-46 G-04, Behavioral Health Provider Peer Review Guide, within the IHSC Policy Library.

D. Protection of Medical Records and Sensitive Personally Identifiable Information (PII)

Medical records staff keep all medical records, whether electronic or paper, secure with access limited only to those with a need to know.

Medical records staff train staff on the protection of a patient's medical information and sensitive PII during orientation and annually thereafter.

Only authorized individuals with a need to know may access medical records and sensitive PII.

Staff reference the Department of Homeland Security *Handbook for Safeguarding Sensitive PII* for guidance to safeguard sensitive PII.

XII. Appendix

Outlines the scope of practice for non-behavioral health providers by discipline. (Note: APP = Advanced Practice Provider; CP = Clinical Pharmacist; LVN = Licensed Vocational Nurses; LPN = Licensed Practical Nurses).

Behavioral Health Related Activity	Primary Care Physician	Primary Care APP and CP	Registered Nurse (non- psychiatric)	LVN and LPN	Other Requirements (e.g. follow-up with BHP within 24 hours)
Develop/ approve behavioral health-related training for IHSC and detention staff	Yes* (develop)	No	No	No	*Requires BHU approval.
Provide online/ PALMS behavioral health-related training to IHSC staff and facility staff	Yes	Yes*	Yes*	No	*Materials require BHU approval.
Conduct pre-screenings	Yes	Yes	Yes	Yes	None
Conduct initial screenings (12 hrs upon arrival to the facility)	Yes	Yes	Yes*	Yes*	*Any abnormalities require follow up at the next provider level.
Conduct transfer screenings	Yes	Yes	Yes*	Yes*	*Any questions require follow up with the next level provider.
Conduct physical exam	Yes	Yes*	Yes**	No	*CPs do not conduct initial or annual health assessments/physical exams **If trained to do this portion of physical exam (PE) (requires review by a physician).
Conduct behavioral health sick call triage	Yes	Yes	Yes*	No	*Per behavioral health and nursing guidelines.

Behavioral Health Related Activity	Primary Care Physician	Primary Care APP and CP	Registered Nurse (non- psychiatric)	LVN and LPN	Other Requirements (e.g. follow-up with BHP within 24 hours)
Conduct behavioral health sick call appointment	Yes	Yes	Yes*	No	*Basic stress coping mechanisms.
Conduct a routine psychiatric evaluation	Yes*	Yes**	No	No	*if tele-psych or on-site psychiatrist not available **APP and CP should consult with psychiatrist, physician, Psych-APP, or BHP.
Conduct an emergency psychiatric evaluation	Yes*	Yes**	No	No	If tele-psych or on-site psychiatrist not available. **APP and CP should consult with psychiatrist, physician, psych APP, or BHP.
Admit a patient to MHU for BH reasons	Yes*	Yes**	No	No	*If tele-psych or on-site psychiatrist or psych APP not available. **APP and CP should consult with psychiatrist, physician, psych APP, or BHP.
Discharge a patient from MHU for MH reasons	Yes	Yes*	No	No	*After consultation with psychiatrist, physician, psych APP, or BHP.
Recommend admission to Behavioral Health Unit/ Columbia Care	Yes	Yes*	No	No	*APP and CP should consult with CD, physician, psych APP, or BHP prior to recommendation.
Admit/recommend admission to other inpatient psychiatric facilities	Yes	Yes*	No	No	*In consultation with psychiatrist, physician, psych APP, or BHP.

Behavioral Health Related Activity	Primary Care Physician	Primary Care APP and CP	Registered Nurse (non- psychiatric)	LVN and LPN	Other Requirements (e.g. follow-up with BHP within 24 hours)
Initiate suicide watch	Yes	Yes*	Yes*	Yes*	* Anyone can initiate suicide watch. Immediate consultation either in-person or by telephone with physician or BHP is required. If not available, emergency room evaluation is required.
Discharge patient from suicide watch	Yes	No	No	No	Note: Only a BHP or physician may discharge a patient from suicide watch.
Update a BH treatment plan	Yes	Yes*	No	No	*In consultation with psychiatrist, physician, psych APP, or BHP.
Provide chronic care follow-up to seriously mentally ill or developmentally disabled patients	Yes	Yes*	No	No	*In consultation with psychiatrist, physician, psych APP, or BHP.
Prescribe psychiatric medications	Yes	Yes*	No	No	*May initiate psychotropic prescription per the IHSC formulary and the APP/CP CPA/PAA. May continue currently prescribed medications substantiated by current medical documentation for continuity of care purposes.
Monitor/follow-up appointments for stable patients on psychiatric medications.	Yes	Yes	Yes*	No	*Any abnormalities require follow up at the next provider level.
Monitor/ follow-up appointments for patients on psychiatric medications who are NOT stable.	Yes	Yes*	No	No	*As per the APP/CP CPA/PAA, and/or in consultation with psychiatrist, physician, psych APP, or BHP.

Behavioral Health Related Activity	Primary Care Physician	Primary Care APP and CP	Registered Nurse (non- psychiatric)	LVN and LPN	Other Requirements (e.g. follow-up with BHP within 24 hours)
Order Therapeutic Restrictive Care	Yes	Yes*	No	No	*In consultation with psychiatrist. Physician, psych APP, or BHP.
Order involuntary psychotropic medication in MH emergency	Yes	Yes*	No	No	*Must consult with psychiatrist, physician, or psych APP prior to order.
Administer involuntary psychotropic medication in MH emergency	Yes	Yes*	Yes*	Yes**	*Only after documented consultation with physician (on or off- site). **Only if physician is present (on-site) and gives written order.