U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

SUICIDE PREVENTION AND CARE PROGRAM

IHSC Directive: 07-04
ERO Directive Number: 11808.2
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By Order of the Assistant Director
Stewart D. Smith, DHSc, FACHE

9/27/2023

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Dr. Stewart D. Smith
Assistant Director
Signed by: STEWART D SMITH

1. **PURPOSE:** This directive establishes policies and procedures to prevent noncitizens from inflicting self-directed violence, or committing suicide, while in custody within detention facilities owned by U.S. Immigration and Customs Enforcement (ICE) or contracting agencies.

2. **APPLICABILITY:** This directive applies to all IHSC personnel, including but not limited to, U.S. Public Health Service (PHS) officers, civil service employees, and contract personnel. It applies to IHSC personnel who support health care operations in ICE-owned and contracted detention facilities (CDFs) and to IHSC headquarters (HQ) staff. This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees who support IHSC.

3. **AUTHORITIES AND REFERENCES:**

   3-1. ICE Directive 11065.1, *Review of the Use of Segregation for ICE Detainees, September* 4, 2013.

   3-2. ICE Directive 11003.5, *Notification, Review, and Reporting Requirements for Detainee Deaths,* October 25, 2021.

4. **POLICY:**

   4-1. IHSC establishes care for detained noncitizens, hereinafter known as patients, to prevent self-directed violence (SDV) and death by suicide. IHSC-staffed facilities implement comprehensive suicide prevention and care programs (SPCP).

4-2. The core elements of the suicide prevention program at IHSC facilities includes the following:

4-2.1 Facility staff identify suicidal patients and immediately initiate suicide precautions.

4-2.2 Health services staff immediately evaluate suicidal patients with appropriate follow up.

4-2.3 Facility staff monitor acutely suicidal patients.

4-2.4 Facility staff intermittently monitor patients on suicide precautions.

5. RESPONSIBILITIES:

5-1. Behavioral Health Unit Chief or Designee.

5-1.1 Serves as the IHSC authority for suicide prevention and care program.

5-1.2 Oversees IHSC suicide prevention and care training requirements.

5-1.3 Coordinates psychological autopsy investigations after a suicide death.

5-2. Health Services Administrator (HSA) or Designee.

5-2.1 Communicates with ICE stakeholders.

5-2.2 Oversees sentinel event debriefing.

5-2.3 Maintains facility staff suicide prevention training files.

5-2.4 Chairs Multidisciplinary Suicide Prevention Committee (MDSPC).

5-3. Clinical Director (CD) or Designee.

5-3.1 Serves as the facility's clinical medical authority.

5-3.2 Directs and supports supervision and oversight of patient health care services.

5-4. Health services staff maintain compliance with mandatory orientation and annual suicide prevention training.

5-5. Registered nurses (RN) complete medical screenings on patients prior to their transfer to the housing area for suicide precautions.

5-6. Advanced Practice Providers (APP), Physicians and Behavioral Health Providers (BHP).

5-6.1 Conduct comprehensive mental health evaluation for suicidal patients.

5-6.2 Complete suicide risk assessment (SRA).

5-6.3 Notify CD if an acutely suicidal patient requires a higher level of care.

5-7. Behavioral Health Clinical Consultants.

5-7.1 Update segregation review management system (SRMS) for patients identified for risk of suicide.

5-7.2 Notify IHSC leadership of suicide attempts and transfers to inpatient settings due to the suicide care management needs of patients within IHSC staffed facilities.

5-8. Behavioral Health Case Managers (BHCM).

5-8.1 Monitor suicide prevention and care for patients within non-IHSC-staffed facilities and coordinates with field medical coordinators as appropriate.

5-8.2 Notify IHSC leadership of suicide attempts and transfers to inpatient settings due to suicide care management for patients in non-IHSC-staffed facilities.

5-8.3 Monitor and tracks patients in segregated housing for suicide precautions within non-IHSC-staffed facilities.

5-8.4 Notify IHSC leadership of all patients placed on and removed from suicide precautions within non-IHSC-staffed facilities.

5-9. Multi-Disciplinary Suicide Prevention Committee (MDSPC).

5-9.1 Review prevention, care program, and staff training involved with suicide prevention.

5-9.2 Includes, at a minimum, the following personnel:

5-9.2.a CD.

5-9.2.b HSA.

5-9.2.c Supervisory behavioral health provider or designee.

5-9.2.d Facility administrator or designee.

6. PROCEDURES:

6-1. Suicide risk screening.

6-1.1 The nurse, APP, physician, or BHP use the Columbia Suicide Severity Ratings Scale (CSSRS) to screen patients for suicidal ideation, plan, and intent at intake and as clinically indicated.

They place the patient on suicide precautions immediately if the CSSRS indicates.

6-1.2 The nurse, APP, physician, or BHP enables suicide risk global alert in the electronic health record (EHR).

6-1.3 The nurse, APP, physician or BHP documents screening results, disposition, and other relevant clinical information in the medical record.

6-1.4 Health services staff refer patients with suicidal ideation to a BHP to complete a SRA and comprehensive mental health evaluation.

6-1.5 Health services staff place patients with suicidal ideation on suicide watch until an SRA is complete.

6-2. Suicide risk assessment (SRA).

6-2.1 The APP, physician or BHP completes an SRA within 24 hours of placement on suicide precautions.

6-2.2 The APP, physician or BHP determines the level of clinical care needed, which can include:

6-2.2.a Mental health observation.

6-2.2.b Constant watch.

6-2.2.c Suicide watch.

6-2.2.d Crisis intervention, offsite emergency hospitalization, or other decision as clinically indicated.

6-2.2.e A BHP determines suicide interventions for patients on mental health observation, constant watch, or suicide watch.

6-3. Suicide Precautions.

6-3.1 Mental health observation:

6-3.1.a Facility staff monitor the patient at unpredictable, staggered intervals, not to exceed 15 minutes between checks.

6-3.1.b BHP completes re-evaluation and ongoing treatment, as clinically indicated.

6-3.1.c The RN, APP, or physician documents welfare checks at least daily.

6-3.2 Constant watch:

6-3.2.a Facility staff continuously observe the patient.

6-3.2.b BHP requests issuance of a safety smock and safety blanket if needed.

6-3.2.c BHP conducts a daily re-evaluation and continues treatment.

6-3.2.d The RN, APP, or physician documents welfare checks at least every eight hours.

6-3.2.e BHP identifies housing to monitor and observe a patient on suicide precautions.

6-3.3 Suicide watch:

6-3.3.a Facility staff continuously observe the patient.

6-3.3.b BHPs request issuance of a safety smock and safety blanket.

6-3.3.c BHP conducts a daily re-evaluation and continues treatment.

6-3.3.d The RN, APP, or physician document welfare checks at least every eight hours.

6-3.3.e BHPs identify housing to monitor and observe patients on suicide precautions.

6-3.4 Crisis Intervention:

6-3.4.a BHPs treat patients who engage in self-directed violence with or without injury or with suicide attempt.

6-3.4.b BHPs ensure that patients on suicide precautions are housed in segregation as a last resort.

6-3.4.c RNs conduct welfare check rounds for patients on suicide precautions.

6-3.4.d Other patients and noncitizens cannot substitute staff supervision as companions or suicide prevention aides.

6-3.4.e Supervision aids such as closed-circuit television, inmate companion, or watchers, can supplement, but never substitute direct staff monitoring.

6-3.4.f The APP, physician, or BHP completes IHSC 819, *Special Needs* Form, to detail conditions of suicide precautions, including but not limited to:

- Housing.
- Clothing.
- Food.
- Bathing or grooming items, etc.

6-3.4.g The APP, physician, or BHP conducts a daily SRA for patients on suicide precautions and determines the plan of care including continuation of or stepdown to:

- Suicide watch.
- Constant watch.
- Mental health observation.
- Return to custody.
- Other placement procedures, as clinically indicated.

6-4. Safety planning intervention (SPI).

6-4.1 BHP completes SPI with the patient to address the following areas:

6-4.1.a Recognizing warning signs of a suicidal crises.

6-4.1.b Identifying and using coping strategies.

6-4.1.c Contacting others to distract from suicidal thoughts.

6-4.1.d Contacting help to resolve the crisis.

6-4.1.e Requesting medical or behavioral health.

6-4.1.f Reducing the availability of means to complete suicide.

6-4.2 BHPs implement SPI during:

6-4.2.a Initial SRA.

6-4.2.b During follow-up SRA and as clinically indicated.

6-4.2.c The BHP documents ongoing prevention and care of patients with suicidal ideation in the medical record.

6-5. Suicide risk Structure Treatment Plan (SrSTP).

6-5.1 The BHP develops an SrSTP with the patient to address the following areas:

6-5.1.a Suicide risk treatment goals, objectives, and other areas to address, as clinically indicated.

6-5.1.b Specific suicide risk interventions.

6-5.1.c Stepdown procedures and criteria.

6-5.1.d When and how to seek help to resolve the crisis.

6-5.1.e Counseling on how to prevent access to lethal means.

6-5.2 BHP revises the SrSTP as clinically indicated to address:

6-5.2.a Updated treatment goals and objectives in EHR.

6-5.2.b Discharge of patient from suicide precautions or transfer to a higher level of care.

6-6. Discontinuation of suicide precautions and follow-up planning.

6-6.1 The physician or BHP completes a follow-up SRA.

6-6.2 The physician or BHP completes and reviews the discharge plan with the patient before discontinuing suicide precautions.

6-6.3 The physician or BHP provides instruction and specifies timeframes for treatment upon return to custody.

6-6.4 The physician or BHP documents clinical encounters in the medical record.

6-7. Multidisciplinary Suicide Prevention Committee (MDSPC).

6-7.1 The HSA collaborates with the facility administrator (FA), clinical director, and the supervisory behavioral health provider to approve and manage the facility SPCP.

6-7.2 The MDSPC convenes at least quarterly to provide input on the SPCP including staff training and policy review.

6-8. Sentinel event debriefing (suicide attempt or death by suicide).

6-8.1 HSA or designee coordinates with CD, BHP, FA, and ICE stakeholders to conduct sentinel event debriefing for all staff and patients 24 to 72 hours after the sentinel event.

6-8.2 BHP or designee conducts the sentinel event debriefing.

6-8.3 HSA or designee keeps a record of these debriefings.

6-9. Psychological autopsy and reconstruction (death by suicide).

6-9.1 IHSC medical director requests a psychological autopsy and reconstruction.

6-9.2 BHU chief assigns a BHP to complete a psychological autopsy investigation within 30 days of notice of suicide death.

6-9.3 BHP submits a complete psychological autopsy to BHU chief for further routing, approval, and dissemination as indicated.

6-10. Care Coordination.

6-10.1 The BHP collaborates with RNs, APPs, physicians, BHTs and ICE stakeholders to ensure patients receive follow up evaluations, monitoring, and wellness checks while on suicide precautions.

6-10.2 BHCM notifies IHSC leadership via the Unified Patient Tracking System (UPTS) of patients who attempt suicide within non-IHSC-staffed facilities.

6-10.3 BHCC coordinates with IHSC leadership and ICE stakeholders to manage patients with suicidal ideation placed on suicide precautions in special management units.

7. HISTORICAL NOTES. This directive replaces the archived IHSC Directive: 07-04, *Suicide Prevention and Intervention*, 30 April 2019.

7-1. Changed title from Suicide Prevention and Intervention Program (SPIP) to Suicide Prevention and Care Program (SPCP).

7-2. Revised authorities and references consistent with regulatory, federal, and state laws.

7-3. Revised language for the purpose and policy statements to align with accreditation standards and regulations.

7-4. Added behavioral health case managers' role under responsibility.

7-5. Added the Columbia Suicide Severity Rating Scale (C-SSRS) as IHSC's suicide prevention screening tool.

7-6. Added the safety plan intervention (SPI) to engage patients identified with suicide risk and incorporate into the treatment plan.

7-7. Replaced significant self-harm with self-directed violence.

7-8. Replaced critical incident debriefing with sentinel event debriefing and included this in responsibilities.

7-9. Added directive related definitions and links to applicable policies and guides.

7-10. Added references: The Surgeon General's Call to Action; About the Protocol the Columbia Lighthouse Project;

Stanley-Brown Safety Planning Intervention; and Psychological Autopsy Certification Training.

8. DEFINITIONS:

8-1. **Columbia Suicide Severity Rating Scale (C-SSRS)** – an evidenced-based suicidal and behavior rating scale used to screen and prevent suicide.

8-2. **Constant watch** (CW) – an intervention reserved for the patient who expresses suicidal ideation and/or has suicide plan but denies intent and is considered moderate risk for suicide. CW is less restrictive than suicide watch, but more restrictive than mental health observation.

8-3. **Continuous one-to-one observation** – monitoring of one suicidal patient by one staff member.

8-4. **Critical incident debriefing** – a practice that allows survivors to process and reflect on the traumatic events they experienced so they can gain personal control over the incident.

8-5. **ICE stakeholders** – includes U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations, field office director, facility administrator, custody officials, and officer in charge.

8-6. **Mental health observation** – an intervention to monitor patients who demonstrate emotional disturbance, mood dysregulation, cognitive impairments, or has a recent history of suicidality and who is considered at low risk for suicide or self-directed violence.

8-7. **Multi-disciplinary Suicide Prevention Committee (MDSCP)** – includes, at a minimum, the HSA, mental health, medical (or designees) and other ICE stakeholders.

8-8. **Psychological autopsy** – a written reconstruction of an individual's life with an emphasis on factors that preceded and may have contributed to the individual's suicide.

8-9. **Safety planning intervention (SPI)** – a collaborative effort between a treatment provider and a patient to mitigate suicide risk.

8-10. **Self-Directed violence (SDV)** – refers to any action that a patient takes to self-harm. It may or may not result in injury and may or may not be with intent to die and should be documented accordingly in the health record.

8-11. **Sentinel event** – any unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient that is not related to the natural course of the patient's illness.

8-12. **Step-down protocol** – written instructions to place a patient on a less restrictive plan of care after discontinuation of suicide precautions.

8-13. **Suicide** – death caused by self-inflicted injurious behavior with any intent to die, as a result of the behavior.

8-14. **Suicide attempt** – any non-fatal, self-directed, potentially injurious behavior with any intent to die because of the behavior. A suicide attempt may or may not result in injury.

8-15. **Suicide intent** – past or present evidence (implicit or explicit) that an individual wishes to die, means to kill themself, and understands the probable consequences of their actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.

8-16. **Suicide precautions** – continuous interventions (i.e., suicide watch, constant watch, or behavioral mental health observation) that provide a safe environment for patients exhibiting suicidal behavior, ideation; or other concerning behavior.

8-17. **Suicide risk assessment (SRA)** – a process to determine the extent of a patient's suicide ideation, plan, and intent and includes the following components, at a minimum: 1) risk factors; 2) protective factors; 3); acute and chronic risk determination; 4) current risk level; and 5) intervention.

8-18. **Suicide risk screening** – a process to determine if patient may be at acute risk for suicide using validated suicide risk screening instrument (e.g., the Columbia Suicide Severity Risk Screening (C-SSRS) tool).

8-19. **Suicide risk structured treatment plan (SrSTP)** – an individualized suicide care plan that is completed in conjunction with a current suicide risk assessment and incorporates safety planning intervention.

8-20. **Suicide watch** – the continuous visual observation of one patient by one custody staff member (one-to-one).

9. APPLICABLE STANDARDS:

9-1. **ICE Performance-Based National Detention Standards (PBNDS): 2011, rev. 2016:**

9-1.1 Part 4: Care; 4.6 Significant Self-Harm and Suicide Prevention and Intervention.

9-2. **ICE Family Residential Standards, 2020:**

9-2.1 Part 4: Care; 4.6 Significant Self Harm and Suicide Prevention and Intervention.

9-3. **American Correctional Association (ACA): Performance-Based Standards for Adult Local Detention Facilities, 4th ed.**

9-3.1 4 ALDF-4C-32-33. Suicide Prevention and Intervention.

9-4. National Commission on Correctional Health Care (NCCHC): Standards for Health Services in Jails, 2018.

9-4.1 J-B-05, Suicide Prevention and Intervention.

10. RECORDKEEPING: ICE uses detained noncitizen/resident health records and information maintained in accordance with the DHS/ICE-013, Alien Health Records System of Records, to provide for the care and safety of detained noncitizens/residents. IHSC limits access to detained noncitizen/resident health records and information to those individuals who need to know the information for the performance of their official duties, and who have appropriate clearances or permissions. IHSC secures paper records in a locked cabinet or room when not under the direct control of an officer or employee with a need for the paper record to perform their duties.

10-1. IHSC staff complete annual training on the protection of patient health information and Sensitive Personally identifiable information.

10-2. IHSC staff reference the Department of Homeland Security Handbook for Safeguarding Sensitive PII (Handbook) at OHS Handbook for Safeguarding Sensitive PII for additional information concerning safeguarding sensitive PII.

10-3. All relevant documents produced or provided in accordance with this Directive must be maintained in accordance with an applicable National Archives and Records Administration (NARA) General Records Schedule (GRS) or a NARA-approved agency-specific records control schedule. If the records are not subject to a records schedule, they must be maintained indefinitely by the agency. In the event the records are subject to a litigation hold, they may not be disposed of under a records schedule until further notification. Prior to the disposition of any records referenced in this directive, ICE Records Officer approval must be obtained.

11. NO PRIVATE RIGHT STATEMENT. This directive in an internal policy statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.

12. POINT OF CONTACT: Chief, IHSC Behavioral Health Unit (BHU).