LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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LPS Facility Designation Team

Quality Assurance Unit
Quality, Outcomes, and Training Division
Health Access & Integration Bureau

Lanterman-Petris-Short Designation and Authorization Guidelines for Facilities within Los Angeles County

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LPS DESIGNATION GUIDELINES FOR FACILITIES WITHIN LOS ANGELES COUNTY

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Definitions

1. **Designated Facilities** who has the same meaning as defined in section 5008 of the Welfare and Institutions Code. Designated facility includes a facility, or a distinct part, unit , or area of a facility, who meet the criteria and process requirements set forth in this document **shall be designated** by Los Angeles County DMH and approved by the Department of Health Care Services to provide treatment pursuant to the Lanterman-Petris-Short (LPS) Act.
2. **Authorized Individuals** who meet the criteria and process requirements set forth in this document **may be authorized** by LACDMH to evaluate and treat persons involuntarily detained under the LPS Act.
3. LACDMH; Los Angeles County Department of Mental Health
4. DHCS; Department of Health Care Services
5. HAID; Health Access Integration Department
6. PRO; Patients' Rights Office
7. LPS; Lanterman Petris Short
8. "Behavioral Health" means mental health and substance use disorders.
9. "Behavioral Health Director" means the person responsible for the administration of behavioral health programs for the host county, or their designee.
10. "Behavioral Health Personnel" means staff who do not qualify as behavioral health professionals, but who through experience, training, or formal education, are qualified to participate in patient care. Behavioral Health Personnel includes, but is not limited to, Mental Health Rehabilitation Specialists, Other Qualified Providers, Peer Support Specialists, and Alcohol and Other Drug Counselors.
11. "Behavioral Health Physician" means a psychiatrist or addiction specialist physician.
12. "Behavioral Health Professional" means any of the following, acting within the scope of their license, waiver, or registration in accordance with applicable State of California requirements: (1) Psychologists. (2) Clinical social workers. (3) Professional clinical counselors. (4) Marriage and family therapists (5) Nurse practitioners fulfilling the requirements of section 2837.103 or 2837.104 of the Business and Professions Code and holding a certification in the psychiatric-mental health category specified in section 1481 of title 16 of the California Code of Regulations. (6) Registered nurses with a master's degree in psychiatric-mental health nursing and at least two years of nursing experience in a behavioral health setting, or registered nurses with a bachelor's degree and at least four years of nursing experience in a behavioral health setting.
13. "Behavioral Health Personnel" means staff who do not qualify as behavioral health professionals, but who through experience, training, or formal education, are qualified to participate in patient care. Behavioral Health Personnel includes, but is not limited to, Mental Health Rehabilitation Specialists, Other Qualified Providers, Peer Support Specialists, and Alcohol and Other Drug counselors.
14. "Clinical Social Worker" means a person who is licensed as a clinical social worker by the California Board of Behavioral Science, is waived, or is a registered clinical social worker. A Waivered or registered clinical social worker shall work under the necessary supervision required by the terms of their waiver or registration.
15. "Licensed Nursing Staff" means a nurse practitioner, registered nurse, licensed vocational nurse, or licensed psychiatric technician.
16. "Locked facility" means entrances, exits, and windows in a facility, or in the designated area of a facility, are controlled with locking mechanisms inaccessible to patients. Any outside spaces and recreational areas shall be similarly enclosed to preclude egress or ingress from the premises.
17. "LPS Act" means the Lanterman-Petris-Short Act, Part 1 of Division 5 (commencing with Section 500) of the Welfare and Institution code.
18. "Mental Health Rehabilitation Specialist" means a person who has a baccalaureate degree and four years of clinical experience in a behavioral health setting. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis: up to two years post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a behavioral health setting.
19. "Other Qualified Provider" means a person at least 18 years of age with a high school diploma or equivalent degree and two years of related paid or non-paid experience in a behavioral health setting, including experience as a service recipient or caregiver of a service recipient, or related secondary education.
20. "Peer Support Specialist" means a person with a current State-approved Medi-Cal Peer Support Specialist certification Program certification that meets all ongoing education requirements.
21. "Alcohol and Other Drug (AOD) Counselor" means an individual who is registered or certified by a certifying organization in accordance with chapter 8 (commencing with section 13000), division 4, title 9 of the California Code of Regulations.
22. "Professional Person in Charge of the Facility" means a person who is a behavioral health physician or a licensed behavioral health professional and appointed in by writing by a designated facility as the person who is clinically in

charge of the facility for purposes of the LPS Act and responsible for facility compliance with the LPS Act and regulations.

Objectives:

1. To enhance the capability and overall quality of the mental health delivery system in Los Angeles County (LAC).
2. To ensure proper utilization of the designation authority by granting it to only those facilities which meet specified LPS Designation Guidelines.
3. To establish the terms of and conditions pertaining to the delegation of authority by which individuals are taken into custody under the LPS Act.

I. LPS DESIGNATION GUIDELINES FOR FACILITIES

A. Delegation of Authority to Involuntarily Detain and Treat

1. The authority under the LPS Act to take individuals into custody and to involuntarily treat mental health patients is vested by state law in the Local Mental Health Director.
2. In LAC the size and diversity of the community are such that the Director of LACDMH, in capacity as Local Mental Health Director, delegates authority to involuntarily detain and treat.
3. Involuntary detention under LPS Act constitutes a significant deprivation of civil liberties that is supported under limited circumstances described in law and regulation.
4. Involuntary detention and treatment is deemed necessary to protect the safety of certain individuals and the community in circumstances permitted by law.
5. These LPS Designation Guidelines describe the nature, extent, and processes by which the authority to involuntarily detain and treat under the LPS Act is delegated to others by the Director of the LACDMH.

B. Facility Operations Guidelines

1. A designated facility provides evaluation and treatment services for persons who, as a result of a mental disorder, are judged to be dangerous to self or others and/or gravely disabled due to a mental health disorder and/or severe substance use disorder. It adheres to those regulations and statutes relevant to the clinical, health and safety needs of those persons.
   - **a.** The facility must comply with applicable constitutional, statutory, regulatory, and decisional law, including but not limited to:
     - **i.** Department of Health Care Services LPS Interim Regulations, Articles 1 thru 5
     - **ii.** California (CA) Welfare and Institutions Code (WIC) Division 5, Part 1, The Lanterman-Petris-Short Act
     - **iii.** The requirements governing mental health facilities and/or treatment of Titles 9, 22 and 24 of the CA CCR for specific facility license type
     - **iv.** The Civil Code;
     - **v.** Health and Safety Code (HSC);
     - **vi.** The CA Penal Code, §§ 11164-11174.3;
     - **vii.** CA WIC, §§ 5404, 15630 and 15610-15610.65 governing mandated reporting;
     - **viii.** All applicable guidelines governing LPS Designation established by LACDMH.
   - **b.** The facility maintains all applicable current licenses as appropriate for its type. No designated facility may show any gross violation of patients' rights, clinical practice, quality of care, and/or safety provisions relevant to the class of persons for whom the designation applies, although the violations may not be explicitly covered by licensing standards. Any such gross violations, as determined by the LAC Health Director, can result in discontinuation of the facility designation.
     - **i.** Facility must notify LACDMH LPS FACILITY DESIGNATION TEAM the following:
       - (i) No later than 24 hours after the suspension, revocation, termination of its license, certification or accreditation
       - (ii) Within 10 calendar days of any change to the facility's license, certification, or accreditation, including but not limited to the facility's name, location, or mailing address
       - (iii) Within 10 calendar days of a change of the professional person in charge of the facility
       - (iv) This section does not apply to Jail LPS units subject to oversight by the Board and State and Community Corrections.
     - **ii.** Any termination of LPS Designation by LACDMH will be submitted and reported to DHCS. The Department

will provide final approval of any termination of LPS Designation by LACDMH. Termination is subject to review.

iii. Notifications shall be made to FacilityDesignation@dmh.lacounty.gov

c. An inpatient facility remains accredited by The Joint Commission (TJC) or by an approved equivalent agency and complies with Centers for Medicare & Medicaid Services (CMS) Medicare Conditions of Participation.

i. Acute Psychiatric Hospitals (APH), Psychiatric Units within a General Acute Care Hospital (GACH), Skilled Nursing Facilities with Special Treatment Programs (STP) and Psychiatric Health Facilities (PHF) shall comply with all provisions of Title 22 of the CA CCR and shall comply with all laws, regulations, CMS Conditions of Participation, and standards of care as applicable to them.

ii. Mental Health Residential Centers, Crisis Stabilization Units/Urgent Care Centers (CSU/UCC) Urgent Care Centers shall comply with all provisions in Title 9 of CA CCR, laws, regulations, and standards of care as applicable to them.

iii. Jail Inpatient Units shall comply with all laws, regulations, and standards of care as applicable to them, e.g., Title 9 §§ 541(g), 663 and 821, WIC 5150 et seq and WIC 5404.

d. The facility maintains a current Medi-Cal Fee For Service contract with LACDMH as a condition of LPS facility designation for LACDMH contracted facilities.

i. The facility abides by all terms of their contract, agreement and/or MOU.

e. Applicable to Crisis Stabilization Units or any other type of outpatient facility, these types of facilities may only be Designated to provide evaluation and treatment in accordance with Article 1 of Chapter 2 of the LPS Act, Commencing with section 5150**.**

f. The facility assumes the full responsibility for assuring appropriate patient care and safety and accepts all attendant legal obligations.

g. The facility has 24 hour a day, seven day a week mental health admission, evaluation, referral, and treatment capabilities, and provides whatever mental health treatment and care involuntarily detained persons require for the full period they are held (WIC 5152).

h. All areas of a medical facility may be designated, providing:

i. The facility has one or more inpatient mental health units under the same licensure unless a specific exception is made by the LACDMH Director

ii. Involuntarily detained patients are treated in areas other than the mental health unit only if their medical condition requires it.

iii. Appropriate mental health staffing, assessments, programs, and treatment are provided to all involuntarily detained patients regardless of their physical location within the facility.

iv. All rights guaranteed to mental health patients by statutes and regulations are observed.

v. All rights to administrative and judicial review to which patients may be entitled, including but not limited to certification hearings, medication capacity hearings, and writs of habeas corpus, are properly initiated, implemented, and conducted.

vi. Seclusion and restraints are not used to compensate for inadequate staffing, lack of program or building security. Seclusion and Restraint may be used only as a measure to prevent immediate injury to the patient or others only when less restrictive measures are not sufficient to protect the client or others from injury. Use of seclusion and/or restraints complies with all Title 9, Title 22, HSC, CMS, DHCS LPS Regulations and TJC or equivalent accreditation standards.

vii. The involuntary treatment provisions of the LPS Act are not used to authorize or deliver medical treatment. Consent to medical treatment must be obtained as otherwise provided in law.

i. Transfer of patients involuntarily detained under LPS:

i. Transfer from a psychiatric unit to a medical unit within an LPS designated facility licensed as a General Acute Care Hospital:

(i) The patient remains subject to LPS detention.

(ii) Care must be provided in a fashion consistent with prevailing standards of inpatient psychiatric care and the LPS Guidelines of the LACDMH.

(iii) This includes regular assessment by a psychiatrist and the adherence to all LPS patients' rights and due process requirements.

ii. Transfer from an LPS designated psychiatric facility to another accepting LPS designated facility.

(i) The actions at the receiving facility must comport with all LPS requirements, State and Federal guidelines.

(ii) The receiving/accepting facility may accept involuntary holds with applications written to other LPS Designated facilities if the original detainment destination occurred at another LPS Designated Facility.

(iii) The receiving facility must notify the Mental Health Court of the change of the patient's location (for

example, hospital name, unit, room number) and should be prepared to attend any scheduled Writ, Probable Cause and Conservatorship hearings.

(iv) Care must be provided in a fashion consistent with prevailing standards of inpatient psychiatric care and the LPS Designation Guidelines of LACDMH.

iii. Transfer from an LPS designated facility to a general medical facility that is not LPS designated:

(i) The LPS designated facility must properly discharge the patient from the LPS designated facility prior to transfer, as LPS detention cannot continue at non-LPS-designated facilities.

(ii) If the patient is later discharged from the non-LPS designated medical facility and readmission is sought to a designated LPS facility, the patient will again be assessed to determine whether a subsequent 5150 hold and admission is deemed appropriate.

j. Referring parties are made aware that the facility's off-site evaluation program is a private service that is not authorized to hospitalize persons on an involuntary basis anywhere but at their designated facility.

k. The facility ensures that once patients are discharged from custody detention of assessor, they are provided with the appropriate means to return safely to the area where they were taken into custody, if that is their request.

l. The facility ensures that, of the time patients spend in a non-designated medical facility emergency room to which they have come for medical treatment and wherein identified staff believe there is a need for 5150 evaluation, any detention time (up to 24 hours) awaiting placement into a designated facility is deducted from their subsequent 72 hour detention period, pursuant to HSC § 1799.111.

i. Applicable credit shall be applied with consideration of AB2275 requirements.

m. In situations when assessment pursuant to 5151 at an out-of-county LPS designated facility results in determination that an individual detained under WIC 5150 cannot be properly served without being detained, that individual may be directly transferred from the out-of-county LPS designated facility to an accepting LAC LPS designated facility, provided that documentation of an acceptable 5151 assessment by a member of the attending staff of the sending designated facility accompanies the transported individual. An acceptable 5151 assessment is one which contains the conclusion that the individual requires detention or requires admission for evaluation and treatment of a mental disorder.

n. Prior to admitting a person to a designated facility pursuant to section 5150, the professional person in charge of the facility or their designee assesses the individual in person to determine the appropriateness of the involuntary detention, as specified in WIC § 5151.

o. A designated facility that admits adults and minors shall house minors and adults in separate areas, utilize separate treatment staff, and implement treatment programs specifically designed for minors.

i. LACDMH will require separate treatment staff, treatment programs specifically designed for minors, however alternative plans may be proposed by facility and reviewed by LPS-FDT for approval.

p. When a county-operated LPS designated facility has determined under WIC 5585 that acute psychiatric inpatient admission is necessary for an LPS-detained adolescent, and determines that no acute psychiatric inpatient adolescent beds are available in non-publicly operated LPS designated facilities, the county-operated LPS designated facility must transfer the adolescent to an LPS designated acute inpatient adolescent bed in a Department of Health Services (DHS) facility, with priority for admission based upon the time the adolescent has been detained prior to admission.

i. County-operated LPS designated facilities must document regular efforts to identify and access available county- operated acute psychiatric inpatient beds in instances in which there are no acute psychiatric inpatient adolescent beds available in non-publicly operated LPS designated facilities for an LPS-detained adolescent.

q. LPS designated public facilities contracted with LACDMH with acute psychiatric inpatient beds must:

i. Provide a verified daily census to Managed Care Operations Division of LACDMH.

r. The clinical record associated with a 5151 assessment in an LPS designated facility that results in the release of an individual initially detained by LACDMH Psychiatric Mobile Response Team (PMRT) or authorized staff of LACDMH directly operated or contracted programs, must include necessary documentation related to the probable cause for detention recorded on the 5150 detention application, and the reason the 5151 evaluator felt that the cause (and other written clinical information provided with the 5150 application by the PMRT or program staff) did not suffice to require a clinical decision to continue involuntary detention.

s. Upon transport of an individual detained under WIC 5150 to an LPS designated CSU/UCC from a non-LPS designated location, a reassessment for probable cause should be conducted. The CSU/UCC pursuant to HSC § 1799.111, should apply credit if applicable.

t. Transport of an individual detained under WIC 5150 to an LPS designated CSU/UCC from an LPS designated facility may occur only when the WIC 5150 will not expire within 24 hours of the time the detainee arrives at the UCC.

u. LPS designated CSU/UCCs accepting patients detained on a 5150 must complete a risk assessment for each

patient.

i. LPS designated CSU/UCCs receiving patients on 5150s must refer to all documentation received with the 5150 in the risk assessment, reflect the consideration of the documentation received in the decision to admit the client, contact the 5150 originator if a decision is made not to admit the client, and document the basis for determining the release of clients who were detained as a danger to self or others.

v. LACDMH considers detention status under WIC 5150/5151 to be independent of any previous episodes of 5150 regardless of contiguity.

w. LACDMH considers the seventy-two hours of detention under WIC 5150 to begin at the time of the individual initially detained.

x. The LPS Designated facility will have procedures in place to for any clients who were detained pursuant to WIC 5150 and has not been certified for WIC 5250 but remains detained pursuant to WIC 5150, process for informing patients whose hearings have been upheld WIC 5256(b) and credit time to the patient upon admission to the LPS Designated Facility. The LPS Designated facility if accepting a patient who was certified under 5256(b) must request a copy of the certification hearing results indicating the continuation of the detainment.

i. Upon admission to facility of a patient with an upheld WIC 5256(b) hearing, from detainment of WIC 5150 beyond the 72 hours, the Designated facility will ensure copies of the original WIC 5150 and WIC 5256(b) hearing results is maintained in the patients record. A 5250 will be initiated if deemed appropriate, and follow the hearing process.

ii. When determining the maximum amount of days to detain, Designated facilities must abide by WIC 5258, 5352.3, 5270.55(c).

y. Once a facility accepts the patient for treatment by either conducting an assessment or otherwise intervening in the community, or by admitting a patient brought to the facility, the facility assumes the responsibility for seeing the case through and formulating as clinically indicated and making the appropriate referral or placement that best meets the clinical needs of the patient.

z. The facility makes arrangements for interpreters or ensures the use of other communication mechanisms to ensure adequate communication between patients and personnel, if language barriers exist between facility staff and patients.

aa. The facility allows the LACDMH to review the facility for initial designation, follow-up needed, and for the continuation of such designation.

bb. The facility allows the LACDMH LPS Facility Designation unit and Patients' Rights Advocate access to all staff and patients to conduct investigations related to patient complaints and unusual occurrences to resolve such patient issues in a timely manner. Also, the LPS designated facility shall ensure that patients are allowed access to the Patients' Rights Advocate if requested and when appropriate.

cc. The facility allows the LACDMH LPS Facility Designation unit and Patients' Rights Advocate access, upon request, to all patient treatment records, logs, hospital policy and procedure manuals, contracts, credentials files and/or personnel records of staff empowered to initiate 72 hour holds, and other professional staff to conduct investigations and assess compliance with LPS Designation Guidelines and Patients' Rights statutes and regulations (WIC 5500-5550):

i. *WIC § 5520-Each local mental health director shall appoint, or contract for the services of, one or more county patients' rights advocates. The duties of these advocates shall include, but not be limited to, the following:*

(i) *To receive and investigate complaints from or concerning recipients of mental health services residing in licensed health or community care facilities regarding abuse, unreasonable denial or punitive withholding of rights guaranteed under the provisions of Division 5 (commencing with § 5000).*

(ii) *To monitor mental health facilities, services, and programs for compliance with statutory and regulatory patients' rights provisions.*

(iii) *To provide training and education about mental health law and patients' rights to mental health providers.*

(iv) *To ensure that recipients of mental health services in all licensed health and community care facilities are notified of their rights.*

(v) *To exchange information and cooperate with the patients' rights program. This section does not constitute a change in but is declarative of the existing law.*

dd. The facility abides by the procedures established and set forth by the Superior Court and the LACDMH for all mental health-related court hearings that are facility-based (including but not limited to certification review hearings, medication capacity hearings, Roger S. hearings and clinical reviews), court-based hearings- Writ of Habeas Corpus, Medication Capacity appeals, and all Conservatorship proceedings are completed accordingly.

i. The designated facility is responsible for transport and escort of patients to and from, and supervision of the patient at all times during mental health court related hearings.

ee. In instances in which an involuntarily admitted individual meets all the following criteria, an LPS designated facility must either request an LPS conservatorship investigation by the LAC Office of the Public Guardian, or explicitly state in the clinical record the reason for not doing so:

- **i.** Current detention under 5250 or 5270 by reason of grave disability;
- **ii.** Finding of probable cause for detention by the Court;
- **iii.** Three or more previous psychiatric hospitalizations under 5250 or 5270 within the last twelve months by reason of grave disability; and,
- **iv.** Current diagnosis of schizophrenia, schizoaffective disorder, or mood disorder with psychotic features.

ff. The facility abides by all requirements, policies and procedures by Los Angeles County Superior court regarding the application of the 5270.55. The LPS Designated facility will work directly with the court and facilities legal counsel regarding the process for applying of the 5270.55.

gg. The inpatient facility abides by all Patients' Rights Conditions of Participation as set forth by CMS in 42 CFR part 482 inclusive of seclusion and restraint requirements and ensures that a physician or clinical psychologist with appropriate privileges (or trained registered nurse or physician assistant) sees and face-to-face evaluates the patient need for restraint or seclusion within one hour after the initiation of the intervention. The time limits of orders for restraint or seclusion are within CMS and TJC specifications. Patients in restraint or seclusion are continually monitored and reassessed appropriately, as per CMS, Title 22, Health, and Safety Code (Div. 1.5 commencing with § 1180-1180.6), and TJC requirements. Skilled Nursing Facilities, Psychiatric Health Facilities, and UCCs must abide by Title 22, HSC, Division 1.5 commencing with § 1180-1180.6, and LACDMH LPS Designation Guidelines referencing seclusion and restraint.

- **i.** The facility's process for using restraints or seclusion with mental health patients in an emergency situation has clinical integrity and is the principal responsibility of trained clinicians who routinely promote de-escalation and prevention of unwanted psychological effects.
- **ii.** "Behavioral Restraint" means "mechanical restraint" or "Physical restraint" as defined below, used as an intervention when a patients presents an immediate danger to self or others
  - **(i)** "Mechanical Restraint" means the use of a mechanical device, material or equipment attached or adjacent to the patient's body that they cannot easily remove and that restricts freedom of movement of all or part of patient's body or restricts normal access to the person's body, and that is used as a behavioral restraint
  - **(ii)** "Physical Restraint" means the use of a manual hold to restrict freedom of movement of all or part of a patient's body, or to restrict normal access to the patient's body, and that is used as a behavioral restraint. "Physical Restraint" is staff-to-patient physical contact in which the patient unwillingly participates. "Physical Restraint" does not include briefly holding a patient without undue force in order to calm or comfort, or physical contact intended to gently assist a patient in performing tasks or to guide or assist a patient from one area to another.
  - **(iii)** "Seclusion" means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving
  - **(iv)** "Seclusion" in a jail LPS unit means placement of an inmate patient in a safety cell in accordance with section 1055 of Title 15 of the California Code of Regulations.
- **iii.** A Designated facility shall not allow pro re nata (as needed) orders for seclusion or behavioral restraint.
- **iv.** Each episode of Seclusion and/or Restraint must be documented in the patient's record each time Seclusion and/or Restraint is applied.

hh. The facility has a system and procedures in place to ensure the confidentiality, security, integrity, and accessibility of patient health information, inclusive of a contingency plan for the storage and protection of filed medical records against unauthorized intrusion and/or damage.

ii. The facility submits required reports by established deadlines to the LACDMH via the Patients' Rights Office regarding involuntary detentions, patients' rights denials, seclusion and restraints, electroconvulsive treatment, psychosurgery, detailed demographic data, clinical outcomes, waiting periods, and number of county contracted beds, as required by WIC 5402, 5326.1, 5326.15, and CCR, Title 9, § 866, and Title 22. The facility reports data collected (including any revisions thereafter adopted) by established deadlines.

jj. The facility must notify the LACDMH of any changes that may significantly affect the facility's conformance with the criteria for designation, including modification of physical structure, number of beds, demographic or diagnostic aspects of patient population, therapeutic services, or policy or procedure concerning staffing, program, or operations. Based on receipt and analysis of such information, LACDMH may require a focused review as a condition of continued facility designation. Upon review, changes to bed capacity of total number of designated beds will be sent to DHCS to review and final approval. Notification to DHCS must be made by LACDMH LPS FACILITY DESIGNATION TEAM (5) calendar days before the date on which a facility's bed capacity is scheduled to change.

kk. The facility indemnifies, defends, and will hold harmless LACDMH, LAC Board of Supervisors, and the State Department of Health Care Services, and their officers, agents and employees, from and against any and all claims, losses, liabilities, or damages arising out of, or resulting from the facilities or its designees' exercise of county-granted LPS authority to detain and treat patients on an involuntary basis.

C. Staffing Guidelines

1. The facility has adequate 24-hour professional supervision to meet the clinical needs and ensure the safety of patients judged to be dangerous to themselves or others or gravely disabled.
2. The designated facility shall employe the following staff on a full-time basis:
   a. Professional Person in charge of the facility who is either a behavioral health physician or licensed behavioral health processional; and
   b. A nursing head of service who is a registered nurse with at least one year of experience in psychiatric nursing supervision within the last six years.
      i. The nursing head of service cannot be counted in the staff to patient census ratio nor have any charge nurse responsibilities
   c. The professional person in charge of the facility and nursing head of service or their designee, shall be present and on duty in the designated facility at least 40 hours per week.
   d. Any designee of the professional person in charge of the facility or nursing head of services for purposes of meeting the requirements above shall be another member of the facilities staff who meets the respective qualification listed in C.2.a-b.
3. The Designated facility shall meet the following full-time equivalent staff-to-patient census ratios in any 24-hour period. Required staff shall be present and on duty at the facility in accordance with the patient census.

			Minimum Number of Required Full-Time Equivalent Staff							
Patient Census	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Behavioral Health Physicians	1	1	2	2	3	3	4	4	5	5
Behavioral health Professionals	1	2	3	4	5	6	7	8	9	10
Licensed Nursing Staff	4	5	6	8	10	12	14	16	18	20
Behavioral Health Personnel	3	5	8	10	13	15	18	20	23	25
Totals	9	13	19	24	31	36	43	48	55	60

4. A designated facility with capacity for more than 100 patients shall staff the facility in according with the staff-to-patient census ratios listed above. For a facility with capacity of 150 patients, the facility shall add the required FTEs in the column 91-100 and the column 41-50.
5. Staffing requirements will follow the requirements set by the facility type (i.e. GACH, APH, PHF, SNF, MHRC) and the staffing regulation that applies to that facility type. Staffing must meet both license requirements and LPS requirements.
6. Facilities involved in involuntary treatment under the LPS Act must meet staffing requirements listed above and staffing regulations that apply to their facility type.
   a. GACH: Title 22, § 70217
   b. APH: Title 22, § 71215
   c. PHF: Title 22, § 77061
   d. CSU Title 9, § 1840.88
   e. STP in SNF: Title 22, § 72329
   f. MHRC: Title 9, § 785.15
   g. In addition, the facility must have methods for determining staffing requirements based on assessment of patient needs, The facility, upon request, makes available for review documentation of the methodology used in making staffing determinations, and provides verification that actual staffing meets the specified requirements.
7. Staff must hold current and valid CA professional licenses where required.
8. All staff involved in the evaluation and treatment of involuntary patients must be fully conversant with the involuntary detention statutes (WIC § 5150 et seq), WIC § 5500-5500 et seq and with patients' rights statutes outlined in WIC § 5325 and 5325.1 and related regulations (CCR § 860 et seq), inclusive of residents, attending physicians and psychologists, allied health professionals, and clinical employees. The Designated facility must

provide orientation to all newly employed and contracted staff who will provide treatment pursuant to the LPS Act prior to direct contact with patients. This orientation must be provided at least annually.

a. The facility makes available for review required documentation of attendance of staff at in-service training concerning LPS and Patients' Rights statutes and regulations (i.e., evidence of orientation at time of hire and of annual updates).

b. Initial Orientation and Annual training should include but not be limited to De-Escalation, crisis intervention, positive behavior management techniques, and prevention and management of assaultive and self-injurious behavior, safe use of restraint and seclusion, including the ability to recognize and response to signs of physical distress in patients who are in restraint or seclusion, suicide prevention techniques, Medications for Addiction Treatment and assessment and observation in facilities that admit patients who are presently intoxicated or experiencing withdrawal symptoms, or at risk of experiencing withdrawal symptoms.

c. A designated facility shall provide full-time staff with at least 20 hours per year of continuing training. The designated facility may prorate the required number of hours for part-time staff.

d. The designated facility shall document all staff orientation and training sessions by maintaining a record of the trailing title and date, syllabus or curriculum, training materials and sign-in sheets of attendees. These records may be retained in personnel files and must be retained for a minimum of three years from the last date the staff worked at the designated facility.

9. All staff involved in the evaluation and treatment of involuntary patients must be fully conversant with all mandated reporting statutes (including Penal Code §§ 11164-11174.3 and WIC §§ 15630, 15610-15610.65, and 15659), inclusive of residents, attending physicians and psychologists, allied health professionals, and clinical employees.
10. The facility meets requirements of TJC or of an approved equivalent agency for orientation and training of agency personnel, if utilized.
11. LACDMH may require a Designated facility to provide additional staff or add to the level of required staff experience, if it determines that additional staff are needed to provide for the health, safety, or behavioral health care needs of clients. In making this determination, LACDMH may consider the designated facility's client census, experience and education of current staff, frequency of deficiencies, severity of deficiencies, as well as any other relevant considerations, including the behavioral health conditions, acuity, and needs of the clients.

D. Policies and Procedures

1. The facility has acceptable policies and procedures, plans, and contracts (without compensation or inducement for referring patients) which comport to the WIC, the CA CCR, and the CA Business and Professions Code related to the legal, ethical, fiscally sound, and clinically appropriate psychiatric treatment of both voluntary and involuntary patients.
2. The Designated facility in accordance with the DHCS LPS Guidelines, must maintain a Facility Program Statement that addresses the following;
   a. Job Descriptions, daily staffing schedules, professional licenses and credentials, as applicable for the professional person in charge of the facility, nursing head of services, behavioral health physicians, behavioral health professionals, licensed nursing staff, behavioral health personnel.
   b. Statement must indicate that the professional person in charge of the facility, nursing head of service and their designees are qualified in accordance with DHCS LPS Guidelines.
   c. Organizational chart listing facility staff and staff-to-patient census ratios demonstrating compliance with DHCS LPS Guidelines.
   d. Description of the population admitted by the facility, including age and genders.
3. These policies and procedures, plans, and contracts are made available for review and must include, but are not limited to, the following:
   a. Legal Issues:
      i. Initiation of 72-hour detentions, 14-day certifications (1st and 2nd), additional certifications for gravely disabled persons (30 day), 180-day post certifications, and LPS conservatorships, and how the facility will assure proper implementation of these holds;
      ii. Patients' due process rights, including procedures relating to certification hearings, writs of habeas corpus, medication capacity hearings, expedited medication capacity hearings and five-day notice requirements prior to establishment of temporary LPS conservatorships, and how the facility will ensure that all requirements are met regarding these rights;
      iii. Patients' rights and denial of rights including required documentation and reporting;
      iv. Use of seclusion and/or restraints;
      v. The dissemination of information on the risks and benefits of medication and procedures used for obtaining informed consent for medication;

vi. Confidentiality;
vii. Plan for storage and security of medical records;
viii. Required patients' rights notification and advisements;
ix. Providing information to and accepting information from family members and significant others, including staff training on required communications with family and others concerned with patient care and documentation of information provided and received;
x. Required notification to patient of prohibition from owning, possessing, receiving, or purchasing firearms for a period of five years, including provisions for petition to Superior Court for relief of firearms prohibition, and provision of power of attorney declaration for firearms transfer and disposal;
xi. Required notifications of next-of-kin;
xii. Consents for treatment;
xiii. Electroconvulsive treatment, psychosurgery, or deep brain stimulation (if performed at the facility);
xiv. Absent Without Official Leave AWOL, Against Medical Advice AMA, and approved discharges, including discharge planning that appropriately uses resources in the county (or counties) of initial LPS detention and residence; discharge policy includes a written homeless patient discharge planning policy and process;
xv. Admissions criteria and procedures, including those pertaining to minors in applicable facilities;
xvi. Personal searches (types, justification for each type, and personnel and documentation required for each type of search);
xvii. Room searches;
xviii. Contraband;
xix. Time out;
xx. Tarasoff procedure;
xxi. Mandated reporting.
xxii. Substance use treatment and monitoring
xxiii. Suicide Risk Assessment and Monitoring

b. Ethical, Community Service, and Fiscally Sound Practices:

i. Facility Code of Ethics;
ii. Conflict of Interest;
iii. Process for resolving patient complaints, including (if applicable) Local Mental Health Plan (Medi-Cal) Beneficiary/Client Grievance and Appeal procedures;
iv. Criteria for identifying potential abuse;
v. Procedures for management of alleged physical and sexual abuse;
vi. Criteria for identifying issues of child endangerment or abandonment. This includes making efforts to determine upon admission whether the patient is a custodial parent or caregiver of a child or an elder or dependent adult and if so, whether a report should be made pursuant to Penal Code § 11164 et seq or WIC 15630 et seq;
vii. Advance Directives;
viii. Hospital plan for patient care;
ix. Strategic Plan (goals for psychiatric services) with community needs, services, and priorities identified;
x. Program services and schedules, and handouts for patients;
xi. Staffing Plans for patient care areas;
xii. Intake/admissions policies and procedures, including procedures for accepting transfer to the hospital of individuals detained pursuant to WIC § 5150 in a different county (e.g., verifying conditional LPS authorization by LAC of the professional who detained the individual out-of-county);
xiii. Contracts or Agreements for providing or receiving PMRT services to non-designated facilities, and/or with individuals providing emergency evaluations; and,
xiv. Safeguarding of belongings throughout hospitalization and during transfer and discharge.

c. Clinical Appropriateness:

i. Utilization Review Plan with mechanism for over- and under-utilization oversight and implementation of admission, continued stay, and discharge criteria;
ii. Mechanism for identification and management of critical incidents;
iii. Safety and Disaster Plans;
iv. Performance Improvement Plan with performance measures for professional staff (i.e., 72-hour hold proctoring and monitoring criteria); and,
v. Governing Body and Medical Staff Bylaws and Rules and Regulations.

E. Physical Environment

1. The facility has a safe, clean, and comfortable physical plant which ensures the safety of, and which meets the clinical and physical needs of patients identified as being dangerous to self or others or gravely disabled, and which is in compliance with all applicable statutes and regulations.
2. At the conclusion of construction and/or conversion to a psychiatric program, the physical plant operated by the facility meets the structural standards as provided in CCR Title 24 and has had its plans and construction approved by all legally dictated authorities.
3. The psychiatric program is housed in a separate and/or distinct unit within the facility's physical structure.
4. Each mental health unit has a separate observation room near the nursing station that provides a safe environment for those patients placed in seclusion and/or restraints and that supports the dignity of the individual to the extent possible.
5. ~~5.~~ The facility's physical plant has fire clearance from the approved by the local fire authority~~.~~
6. The facility's physical plant is structured and equipped to meet patients' rights requirements pursuant to WIC §§ 5325 and 5325.1.
7. The facility provides designated smoking areas with adequate ventilation to ensure healthful air quality or alternate nicotine replacements for patient comfort.
8. A facility treating minor inpatients ensures they are housed in a separate unit away from the adult population absent a waiver from the Patients' Rights Office (WIC, §§ 5585.55 and 5751.7).
9. The facility provides adequate, safe, and appropriately secure space, and any necessary security personnel or staff acting in a security role, to meet the clinical and safety needs for all facility-based hearings, such as Probable Cause, 5270, Riese hearings, Roger S., and Clinical Reviews.
10. A Designated facility must be a facility that is a locked facility, except if the facility is a crisis stabilization unit, it shall be:
    - **a.** A locked facility;
    - **b.** A Staff-secured with delayed egress facility; or
    - **c.** Both a locked and staff-secured with delayed egress facility.
11. LACDMH shall not designate a facility that does not continually satisfy all of the LPS Guideline standards referencing the DHCS LPS Guidelines in Article 3. If the entire premises of a facility will not continually satisfy all of the standards, LACDMH shall only designate the distinct part, unit, or area of the facility that continually meets those standards.

F. Documentation and Treatment Guidelines

1. The designated facility participates in quality improvement activities, including monthly and quarterly reporting, documentation, and data collection as specified by the LACDMH, inclusive of the following:
    - **a.** Per Behavioral Health Information Notice No: 23-015-Dated April 6, 2023 (Supersedes BHIN No: 23-011): There is a new process for quarterly reporting of involuntary treatment, and conservatorships. W&I Code § 5402 now requires counties and designated and approved facilities to report additional data elements including more detailed demographic data, clinical outcomes, waiting periods, and number of county-contracted beds. DHCS will be responsible for an overall analysis and evaluation of the services data reported to the Department to make recommendations for improving services.
    - **b.** Counties shall begin to report quarterly data to the Department using the online survey tool described in this information notice for the January 1, 2023 - March 31, 2023, third quarter reporting period. The first due date is April 30, 2023. It is the responsibility of the county in which a treatment facility or any other entity involved in implementing W&I Code § 5150 is located to include all the required information about the individuals held or treated in its report. This includes data from all facilities, public or private, and the persons served in those facilities receiving services reimbursed by private or public funds. DHCS requires that counties collect and report the data, since the counties are responsible for designating the facilities that serve persons on an involuntary basis and are knowledgeable regarding the entities in the county that are involved in implementing W&I Code § 5150.
        - **i.** Department of Health Care Service Involuntary Detention site posts the following forms and correlating instructions:
        - **ii.** DHCS 1008 Quarterly Report for Services Provided to Persons Detained in Jail
        - **iii.** DHCS 1009 Quarterly Report of Conservatorships established by the Superior Court
        - **iv.** DHCS 1010 Quarterly Report on Involuntary Treatment

2. Electronic Records: For purposes of detention in an LPS designated facility, documentation of the "APPLICATION FOR UP TO 72-HOUR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT (DHCS 1801) and the "INVOLUNTARY PATIENT ADVISEMENT (TO BE READ AND GIVEN TO THE PATIENT AT TIME OF ADMISSION DHCS 1802) " including documentation that is generated by electronic means, must contain all of the required elements and verbiage of the current DHCS 1801, DHCS 1802 or LAC MH302.
3. The facility ensures that initial assessments of referred patients are completed regardless of ability to pay.
4. Comprehensive mental health assessments of voluntary and involuntary patients include documentation substantiating the need for current treatment and level of care and are completed by the attending practitioner within 24 hours of admission.
5. Authorized members of the professional staff who initiate involuntary detentions participate in the care and treatment of the patients for whom they initiate 72 hour holds (inclusive of participation in treatment planning), pursuant to WIC § 5150 and CCR Title 9 § 823.
6. The facility ensures that patients are appropriately involved in planning their care and treatment, as evidenced by documentation of patient participation in treatment planning.
7. The facility ensures that patients' medical problems are identified, addressed, and documented in treatment plans.
8. The facility shall maintain a suicide prevention policy addressing all of the following elements of care for patients expressing suicidal ideation or engaging in self-harming behavior
    a. Risk Assessments
    b. Safety Precautions
    c. Visual Observation policies and staffing to maintain compliance with visual observation policies
    d. Incident documentation requirements
    e. Methods by which hazardous objects, including plastic bags and trash can liners, are kept inaccessible to patients.
9. The Facility shall directly provide all medications for addiction treatment to patients on site, as indicated.
    a. The facility shall implement an effective process for initiating or continuing a client's treatment with methadone. The facility's process shall include all of the following:
        i. Procedures for initiating or continuing a client's treatment with methadone while admitted to the facility, which shall include a documented formal affiliation with a narcotic treatment program, unless locally unavailable
        ii. Procedures for transporting clients to a narcotic treatment program, if patient care transported offsite, or procedures for obtaining and distributing methadone in the facility: and
        iii. Procedures for referring discharged patients to narcotic treatment programs, community health centers, or other providers of medications for addiction treatment.
10. The facility who admits client's who are presently intoxicated or experiencing withdrawal symptoms, or at risk of experiencing withdrawal symptoms, shall do the following:
    a. Asses a patient's need for observation at admission; and
    b. Conduct patient observation checks in accordance with the patient's assessed need for observation
    c. Facility shall document the name of the staff conducting client observation checks and the date and time of each observation in a client's chart.
11. The facility must ensure full compliance with WIC § 5328.1, which pertains to provision of information to family members, and must have internal policies and clinical documentation that reflect these practices.
12. The facility meets LACDMH requirements for application and referral of clients to LACDMH for petition for establishment of LPS conservatorships.
13. The facility ensures that the attending practitioners are present and testify at all appropriate hearings (e.g., Writs, LPS Conservatorship hearings, and Medication Capacity Hearings), and that treating physicians meet all expectations related to communication with, and testimony in the designated department of the Los Angeles Superior Court.
14. A designated facility may provide tele psychiatric testimony for conservatorship hearings at the discretion of the court. Use of tele-testimony by LPS designated facilities should be compliant with applicable standards for tele-mental health services.
15. The facility ensures that, should an involuntarily detained person elope, appropriate measures are taken to protect the individual and the public, which include proper efforts to apprehend the person, and notifications or the use of a form transmitted to law enforcement agencies.
16. The facility responds timely to all inquiries from LACDMH outpatient providers of service responsible for the care of any individual hospitalized at the facility and collaborates with the providers to establish effective transition to outpatient care.
17. The facility ensures that, upon discharge, patients receive practical, realistic, and appropriate referrals to community agencies, suitable placement, and necessary transportation and transfer of care, as evidenced by documentation in the Discharge and Aftercare Plans and other easily identifiable records, regarding these elements and associated

interagency communication to facilitate appropriate transition of care.

a. Uninsured, non-Medi-Cal patients who need further psychiatric medication are discharged with prescriptions for psychiatric medications that are available through the LACDMH uninsured formulary and consistent with LACDMH parameters for prescription of psychiatric medication.

18. The facility has a mechanism to review medical records on an ongoing basis for completeness and timeliness of information and takes action to improve the quality and timeliness of documentation that impacts the care of voluntary and involuntary patients.
19. The facility establishes and maintains a mechanism for appropriately resolving complaints, grievances, and appeals.
20. The facility's professional staff establishes and maintains a mechanism for proctoring and ongoing peer review of knowledge and competencies of 5150 detention authorized professional staff members with involuntary detention procedures and 5150's. Criteria and outcomes of monitoring are made available for review by the LACDMH Director and/or designees.
21. The facility notifies the LACDMH via the Health Access & Integration Division (HAIDAdverse@dmh.lacounty.gov) of all deaths and critical incidents, including suicides, homicides, and physical/emotional abuse, taser use, or serious injury involving a psychiatric patient by appropriately transmitted document within 24 hours of occurrence or by the next business day if event occurs on a weekend or holiday.

    a. The facility shall also report an unusual occurrence that involves suspected criminal acts to the local law enforcement authority as soon as possible, and in no case later than 24 hours after the act.

22. The facility establishes and maintains a mechanism for determining patient perception of the quality of the clinical treatment process and the satisfaction of individuals served. Outcomes are made available for review by the LACDMH Director or designee(s).
23. Involuntary detention forms can be found on the LACDMH Website, Quality Assurance – Clinical forms page.

G. LACDMH Oversight and Enforcement

1. LACDMH will ensure that a Designated Facility maintains compliance with the LPS Act and the standards set forth in the DHCS LPS Guidelines.
2. LACDMH will investigate complaints received about designated facility compliance with the LPS Act and the standards of the guidelines, and take any action deemed necessary to resolve those complaints, including, but not limited to, imposing a corrective action plan or terminating the facility's designation.
3. LACDMH LPS FACILITY DESIGNATION TEAM along with the Patients' Rights Office will investigate any alleged patients' rights violations pursuant to section WIC 5326.9 and comply with the complaint resolution process for patients' rights violations in section 864 of Title 9 of the California Code of Regulations.
4. LACDMH will provide DHCS with a report on the resolution of all complaints received within 30 Calendar days of resolving a complaint.
5. Investigate all unusual occurrence reports received pursuant to Section 17 of the DHCS LPS Guidelines.
6. At any time, with or without prior notice, the Department of Health Care Services and/or LACDMH may inspect a designated facility's site and its records, including medical records, to determine compliance with the LPS Act and the standards listed in the LPS Guidelines.

II. AUTHORIZATION TO TAKE INDIVIDUALS INTO CUSTODY PURSUANT TO THE LPS ACT

A. General Guidelines Related to Designated Inpatient Facilities

1. Facility administration maintains a current roster and current credentials files of professional staff members who have been privileged and authorized to initiate 72-hour detentions (5150 detention authorization). The foregoing is made available on request to representatives of the LACDMH.
2. Continuation of the designation status of the facility requires that all professional staff of the facility comply with all applicable LPS requirements. These requirements include the limitation of involuntary detention to those individuals who meet LPS criteria and are taken into custody only by members of the professional staff with involuntary detention authority privileges.
3. The facility ensures that all individuals with 5150 detention authority, whenever exercising or otherwise communicating either orally or in writing about their 5150-detention-related activities, clearly identify their facility affiliation, and wear the mandated identification badge in face-to-face interactions.
4. The facility ensures that the completed original or copy of 5150 detention form is present in the medical record for all involuntarily detained patients. A completed form contains, in legible fashion, the signatory's professional discipline, assigned 5150 detention authorization number (i.e., the numerical hospital-provided identification number), and the

facility affiliation under whose authority the involuntary detention was initiated.

5. The facility ensures that the involuntary detention authority granted to a member of the professional staff of the designated facility is exercised at the facility only in relation to the professional staff member's responsibilities in conjunction with that facility.
   - **a.** Facility-based non-mobile professional staff without admitting privileges may be granted involuntary detention authority at multiple designated facilities, which may be exercised on-site only. Such staff must be an employee and authorized professional staff member of the designated facility(ies).
   - **b.** Facility-based Psychiatric Emergency Teams (PET) are limited to involuntary detention authority with only one LACDMH designated facility and must be an employee of the designated facility.
   - **c.** Authorized professional staff of designated facilities may exercise 5150 detention authority to any facility(ies) at which the professional staff member has admitting privileges.
   - **d.** Authorized professional staff with involuntary privileges at multiple facilities must request LACDMH LPS Authorization by submitting a request for additional work location through the LPS Dynamics Portal. Facilities are responsible for being aware of affiliations of professional staff at other facilities and ensure the standards of the guidelines are met.
     - **i.** **https://lacdmhlpsprod.dynamics365portals.us/**
6. In instances where an evaluation for possible involuntary detention is conducted off the facility premises, the authorized professional staff member with mobile response responsibilities must:
   - **a.** Be an employee of the designated facility.
     - **i.** Exception: 5150 Detention Authorized Physicians
   - **b.** Authorized staff must only write 5150 applications to the facility they are affiliated with, with current privileges granted by the designated facility. Authorized staff of the designated facility may not write 5150 applications written to "Any LPS Designated Facility"
     - **i.** Exception: Must be given permission to write a hold to another designated facility, on a case-by-case basis.
     - **ii.** There are exceptions made by the LACDMH under certain circumstances in which other arrangements may be made, such as 5150 detention authorized physicians in their private offices, a Memorandum of Understanding between parties which exist to serve atypical situations.
     - **iii.** Mobile evaluators and/or Law Enforcement/Peace Officers should write the name of the accepting Designated Facility on the application to where the detained individual is being transported to. In the event where the detained individual is being transported to a Non LPS Designated facility for other reasons, the application may be written to "Any LPS Designated Facility" for transfer purposes.
   - **c.** Defer evaluations for purposes of determining and executing involuntary psychiatric hospitalization (WIC 5585) for children and adolescents who are dependent under the Department of Children and Family Services (DCFS) and wards of the court (Juvenile Probation population) in LAC to LACDMH PMRT 5150 detention authorized staff. Restricted settings include, but are not limited to, hospitals, foster, group, and family homes, and schools.
   - **d.** Dress and travel in a manner that does not inappropriately attract attention to the individual being assessed.
   - **e.** Complete a face-to-face assessment of the client prior to initiating an involuntary detention for that client.
   - **f.** Conduct and document an assessment that considers the full range of available treatment modalities, sites, and providers, and results in the care that best meets the client's specific needs. Assessment of need is based upon condition, treatment needs, geography, and current fiscal and treatment relationships with providers. The care should be rendered without regard to profit or gain by the designee's parent facility.
   - **g.** Have available a facility-approved comprehensive and current referral source list and be well versed in all relevant treatment resources in the client's area.
   - **h.** Honor the preference of the client and/or the parent of a minor, conservator, or legal guardian for the type and location of the desired treatment facility if administratively feasible and clinically appropriate.
   - **i.** Unless prohibited by specific circumstances, seek information from and involve, current providers of mental health care to the client to support continuity of care.
     - **i.** If the client is receiving care from LACDMH and treatment information cannot be obtained from the client or significant other, evaluating professional staff must contact 1-800-854-7771 and request contact information to gather information from the clinic or program.
     - **ii.** If the client is currently receiving services from LACDMH, the clinic or program must be contacted within one working day of the evaluation, whether or not the client was hospitalized as a result of the evaluation.
   - **j.** Strongly consider the proximity of the designated facility to the patient's own community, family, and support system. Alternatives to taking a patient to a more distant facility should be considered and documented on the off-site assessment form.
   - **k.** Ensure that proper interventions and/or treatment are provided to the client for whom they have initiated LPS evaluation until appropriate disposition is affected, e.g., one-to-one monitoring, removal of sharp objects, and the

like.

l. Give detainment advisements to clients in a language or modality that the client can understand, pursuant to WIC § 5150 et. seq inclusive of the name of the facility to which the client is being taken, and notification that the person is not under criminal arrest but is being taken for examination by mental health professionals.

m. Follow all statutory requirements regarding client confidentiality.

n. Maintain an accurate log of all requests for their off-premises services, including:

i. Date and time of both request and response;

ii. Referral source;

iii. Name of client;

iv. Time of intervention and departure;

v. Completion of a written assessment of client, including consideration of least restrictive alternatives;

vi. Services provided and/or referrals made;

vii. Disposition of the client;

viii. Name of staff involved;

ix. A copy of the 72 hour hold if initiated; and,

x. Source of payment.

(i) NOTE: Such log is available for inspection by the LACDMH LPS Facility Designation, Patients' Rights Office and/or other designees of the LACDMH Director

o. Take reasonable precautions to preserve and safeguard the person's property, pursuant to WIC §§ 5150(e) and 5211.

p. Initiate 72 hour holds only within the boundaries of LAC unless special written 5150 detention authorization or an exception (e.g., VA) has been granted by the LAC Directors involved allowing for cross-county 5150 detention.

q. Represent themselves to the public as affiliated with the facility from which they derived their 5150-detention authority.

r. Initiate involuntary detentions only for persons who, based on the authorized staff member's professional assessment, are believed to be dangerous to self, or others, or gravely disabled because of a mental health disorder, severe substance use disorder or co-occurring mental health disorder and severe substance use disorder as defined in W&I Code section 5008(h)

i. Abide by all provisions in the WIC Division 5, and accompanying regulations, and department policies regarding treatment, evaluations, patients' rights, and due process.

s. When the client does not meet criteria for involuntary detention, provide the client with information, referral to appropriate community services, and/or other intervention as appropriate to his/her circumstances.

t. Report conditions of abuse or neglect at residential facilities, such as suspected or possible unsafe and unsanitary living conditions, involving elder or dependent adults and children, to the appropriate agencies - for example, Aging and Disabilities, DCFS, Patients' Rights, Community Care Licensing, etc. per WIC 15630 (a)-(h)

u. Report potential child endangerment or abandonment and make efforts to determine offsite and upon admission whether the client is a custodial parent or caregiver of a child or caregiver of an elder or dependent adult and if so, whether a report should be made pursuant to Penal Code § 11164. or WIC 15630 et seq.

7. Designated facilities that provide material support to members of the 5150-detention authorized professional staff during off-site assessments must provide full disclosure to the LACDMH regarding the nature, terms, and limitations of such support. Material support includes payments to the attending staff for such services, provision of vehicles, communication infrastructure, and patient transport. Full disclosure includes all applicable policies, procedures and contractual arrangements that relate to such support.

a. The designated facility that provides this support has an administrator who is knowledgeable and responsible for ensuring that the support is in accordance with all applicable designation regulations.

b. The designated facility will not subcontract for PET services.

8. The facility must have at least one privileged professional staff member with 5150 authority present within one hour for on-site assessment of individuals considered for involuntary detention and/or admission.
9. The designated facility must have the ability to safely detain an individual pending a 5150 assessment for up to one hour on-site pending the arrival of an authorized professional staff member.

B. Criteria for Approval of Inpatient Facility's Authorization of Individuals to Initiate Involuntary Detention

1. To be authorized under WIC § 5150 to initiate a 72-hour period of involuntary treatment and evaluation, please refer to the LACDMH Website: Lanterman-Petris Short (LPS) Training.

2. Individuals must meet all the following criteria:
   a. Must have received licensure and training as a mental health professional acceptable to the LACDMH. Disciplines registered with the Board of Behavioral Services or Waivered Psychologists are acceptable.
   b. Be a member in good standing of the facility professional medical staff with active membership or an employee of the facility with a minimum six months experience as a Licensed Mental Health Professional or Registered/Waivered discipline, in an acute mental health setting, or completion of or membership in an approved psychiatric residency training program, CCR, Title 9, § 822, in the LPS Designation Guidelines, and in facility bylaws, and meet all criteria for professional staff membership and clinical privileges set forth by the facility. Eligible staff to initiate 5150 detentions do not need to be members of the medical staff of the facility but approved by the Chief of Medical staff or designee to exercise 5150 detentions.
3. It is the designated facility's responsibility to:
   a. Obtain verification of relevant training, experience, and licensure of all individuals with 5150 detention authority, including Residents, if licensed;
   b. Ascertain if there are previously successful or currently pending challenges to any licensure or registration or any relinquishment of such licensure or registration;
   c. Make all reasonable written and verbal inquiries to determine if there has been voluntary or involuntary termination of professional staff membership, reduction, or loss of clinical privileges at another facility;
   d. Take all reasonable steps to determine if there have been final judgments or settlements involving the individual's practice in the mental health field.
   e. Ensure members of the 5150-detention authorized professional staff receive active peer review based on monitoring criteria established by the professional staff, and clinical supervision consistent with membership on the professional staff, including proctoring regarding the exercise of 5150 detention authority;
   f. Ensure non-medical staff have access to appropriate psychiatric consultation whenever exercising this authority;
   g. Provide members of the 5150-detention authorized professional staff with a facility identification badge as specified by LACDMH LPS Detention Authorization Agreement (formerly LPS Designation Agreement) and Checklist requirements;
   h. Notify LACDMH via LPS Facility Designation within one week of discovery of licensure suspension or revocation of authorized staff members, and of the occurrence of any termination, whether voluntary or involuntary, of professional staff membership or reduction or loss off clinical privileges at the designated facility by individuals with involuntary detention powers; and,
   i. Keep separate records or credentials files regarding the above for each individual with 5150 detention authority and make them available upon request to the LACDMH representatives. The facility is accountable for verifying and submitting for authorization only fully qualified individuals.
      i. Be trained in an LPS class (as specified for Categories I, II, and III: Residents, Professional Staff With Admitting Privileges, and Professional Staff Without Admitting Privileges and in LACDMH Guidelines) in involuntary detention laws and procedures, including patients' rights; be aware of any current changes in the law in this area; and be able to demonstrate such knowledge by achieving a passing score on a written examination administered by LACDMH representative(s).
      ii. Any voiding of the examination that results as a consequence of impropriety (e.g., talking to other examinees or consulting notes during the examination) automatically disqualifies the examinee from eligibility to retake the examination for a one-year period from the date of impropriety, with the right of appeal by the facility to the Local Director of Mental Health. The disqualification and reason are reported by LACDMH to the professional clinically in charge of the facility who requested approval of the examinee.
      iii. Be approved in writing as authorized by the Chief of the Medical Staff of the designated facility or designee, based on the need for the individual's 5150 detention authorization, the individual's professional skills, and verification of whether the individual meets all criteria stated herein.
      iv. Have responsibility consistent with the requirements of the professional staff bylaws and employment policies for the care and treatment of the patients for whom they initiate applications for involuntary detention and consistent with their function on the professional staff (per WIC § 5150 and CCR § 823).
      v. Abide by Business and Professions Code § 650 regarding compensation for referrals.
      vi. Admitting professional staff (i.e., individuals permitted by facility bylaws to admit psychiatric patients) of a designated facility must conduct a face-to-face assessment of an involuntarily admitted patient within 24 hours.

C. The Local Mental Health Director authorizes individuals for a specified period, after which time further authorization requires attendance at an LACDMH-approved LPS Training Course and testing session.

1. The LACDMH Director may at their discretion, use renewal of the professional staff 5150 privilege in lieu of training or re-testing as a basis for reauthorization for the next authorization period.

2. For an individual requesting new involuntary detention authorization after a lapse of no more than six months since the person's last LPS authorization period of at least three years duration, and whose involuntary detention authority was not withdrawn or suspended at any designated facility by LACDMH during the prior authorization period, no further LPS training or testing is required for re-authorization. Any lapse of six months or more will require applicant to re-apply for LPS Authorization and re-take course and testing requirements. Note: Contact the LACDMH LPS Coordinator for most current requirements.

D. LACDMH Authorization of Individuals to Initiate Involuntary Detention

1. The LACDMH Director may individually authorize professional persons to initiate involuntary detention (custody) as provided in WIC § 5150. All such 5150 detention authorized individuals shall meet the requirements described in Title 9 §§ 622 and following of the CA CCR.

E. Peace Officers

1. In accordance with WIC § 5150, peace officers as described in CA Penal Code § 830 are empowered to initiate involuntary detention (custody) under the LPS Act.

III. INITIAL FACILITY DESIGNATION

A. Procedures

1. The facility requesting designation notifies the Lead of the Lanterman-Petris-Short Facility Designation Team (LPS-FDT) of the LACDMH by submitting a request form.
2. The Lead of the LPS-FDT then sends an informational packet to the facility along with an application and agreement to be signed by the facility director, which stipulates that the facility agrees to abide by all LPS Designation Guidelines and criteria set forth by the county. LPS-FDT will notify LACDMH Stakeholders of facilities request for Initial Designation review. LACDMH Stakeholders must approve request before review can begin.
3. Once the facility Medical and/or Administrative believes that the facility meets the LPS Designation Guidelines, he/she submits the above application and agreement to the LPS-FDT. Subsequently, a site survey is arranged.
4. Representatives of the LACDMH, including LPS-FDT and Patients' Rights conduct a site assessment of the facility – including the physical plant, staffing, policies and procedures, and credentials files – for compliance with the LPS Designation Guidelines and criteria. If the facility is already accepting patients, the assessment also includes an examination of treatment charts selected by the representatives, and voluntary interviews with selected patients and staff. The representatives also review Health Facilities Licensing reports, patient complaint logs and the facility's denial of rights, seclusion and restraint, involuntary holds reports, and grievance logs on file with the LACDMH Patients' Rights Office. At the time of the visit (or prior to the visit), the facility provides the survey team with a copy of their current operating license, staffing plans by discipline and patient-to-staff ratios, Fire Marshall clearance, governing body and medical staff bylaws, Performance Improvement and Utilization Review Plans, a verification of 24-hour admitting capacity, type of management (directly operated or by contract), treatment schedules and program descriptions. The facility also provides the survey team with access to meeting minutes, manuals (Administrative, Nursing, Program, Safety/Risk Management), in-service records, and contracts/agreements related to off-site mobile response individuals and/or teams.
5. If the facility's physical plant has not yet opened at the time of the Initial Facility Designation site review, LPS designation authority may still be granted on the basis of physical plant, staffing, licensure, policies and procedures (inclusive of Bylaws, Manuals and Plans), and credentials evaluations. However, in this instance, reassessment shall be conducted six months after commencement of the facility's operation and encompasses examination of treatment records, patient and staff interviews, in-service records, contracts with off-site mobile response individuals and/or teams, minutes, and logs and reports on file with the LACDMH Patients' Rights Office.
6. If the facility is found to be in compliance with the LPS Designation Guidelines and criteria, the Lead of the LPS-FDT submits a written report to the LACDMH Director with the recommendation that the facility be designated.
7. If the LACDMH Director finds, based on all available information, that the facility meets all LPS Designation Guidelines and criteria specified for designation, the Director may, as delegate of the LAC Board of Supervisors and after review by LAC County Counsel, designate the facility for 5150 purposes.
8. The recommendation is submitted to the DHCS / Licensing and Certification Division liaison for final approval.
9. The DHCS / Licensing and Certification Division notifies the Facility Director in writing of the LPS Facility Designation decision.

10. During the Initial LPS Facility Designation site survey, if the LPS-FDT survey team finds that a facility is not in compliance with LPS Designation Guidelines and criteria, they inform the facility and the LACDMH Director and make specific recommendations for compliance. A Corrective Action Plan (CAP) is issued, and a return visit survey may be scheduled once the facility notifies the Lead of the LPS Facility Designation Team (LPS-FDT) that the CAP deficiencies have been addressed.
    a. If the LPS-FDT team determine that the facility is not in compliance with the LPS Designation Guidelines criteria, and the facility disagrees, it may, if it chooses, present information directly to the LACDMH Director.
11. Prior to the facility's exercising its designation authority, all individuals involved in the involuntary detention process:
    a. Must have made application to the LACDMH for approval to initiate involuntary evaluation and detention, with signed attestation by the professional person clinically in charge of the facility;
    b. Must have received Los Angeles county-approved training on LPS statutes and patients' rights and achieved a passing score on a written examination;
    c. Must submit a signed agreement to the terms of individual 5150 detention authority set forth by the LACDMH; and
    d. Be issued an identification card and authorization number by the facility to be carried whenever imposing involuntary detention authority.

B. Length of Designation

1. Initial designation is provisional for six months but is revocable at any time should the facility fail to comply with the LPS Designation Guidelines.
2. The facility is monitored by the LACDMH Patients' Rights Office (WIC § 5520) during the six months provisional period. If found to be in compliance, the facility is designated for three years from the time of the initial LPS Designation survey, unless such designation is subsequently suspended or withdrawn.

IV. FACILITY REDESIGNATION

A. Procedures

1. The facility requesting redesignation notifies the LACDMH LPS-FDT.
2. The Lead of the LPS-FDT sends an information packet to the facility, delineating the criteria and procedures for LPS redesignation, with an application and an agreement to be signed by the facility Director that the facility will abide by all LPS Designation Guidelines and criteria set forth by the county.
3. The facility Director submits the above application and agreement to the LPS-FDT. Subsequently, a site visit is arranged.
4. Under the auspices of the LACDMH Director, LPS-FDT and an advocate of the LACDMH Patients' Rights Office conducts a review of each LPS Designated facility seeking redesignation to assess compliance with LPS Designation Guidelines and criteria.
    a. Such review may include but is not limited to:
        i. A tour of the patient units;
        ii. A survey of open and closed treatment charts selected by the reviewers;
        iii. Voluntary interviews with clients;
        iv. Review of any employee records related to LPS Authorization or education requirements of any staff
        v. Examination of policies, procedures, manuals, plans, minutes, and contracts; and,
        vi. Discussions with facility staff.
    b. In preparation for the visit, the reviewers examine:
        i. The facility Policy and Procedures;
        ii. Recommendations from the prior LPS Facility Designation survey(s);
        iii. The patient complaint log, the facility Denial of Rights, Seclusion and Restraint, 72 hour hold, Minors' Due Process Hearings;
        iv. ECT administration if applicable, monthly and quarterly data collection, and any other relevant reports on file with the LACDMH Patients' Rights Office;
        v. Certification and Medication Capacity review records; and,
        vi. Accreditation Surveys and Health Facilities Licensing reports regarding the facility.
5. The reviewers apprise facility staff of their findings orally at the conclusion of the visit and in writing (via a final

survey report) within 2-6 weeks thereafter citing specific areas of compliance and noncompliance and making recommendations for remedial action where indicated. During the LPS Facility Redesignation survey process, reviewers may also ask for a specific CAP to address areas of noncompliance, to be submitted within thirty calendar days of CAP receipt or as otherwise directed.

6. The reviewers make a recommendation concerning the facility's continued designation to the LACDMH Designation Review Committee and the LACDMH Director. If the reviewers are unable to recommend continued LPS designation, they may elect to conduct a repeat site visit upon their determination that sufficient time has elapsed for the facility to correct identified deficiencies. Gross violation(s) of patients' rights, clinical practice, and/or safety practices relevant to the class of persons for whom designation applies can result in temporary suspension and/or withdrawal of the designation. (See Section V of this document for additional circumstances warranting conditional designation and/or withdrawal of designation.)
7. If the facility fails to correct identified deficiencies, the LACDMH Director takes appropriate remedial action up to and including termination of the facility's designation.
8. The facility is notified in writing of the above action. Temporary suspension of a designation or placement of the facility on conditional designation status is a departmental administrative action requiring no action by outside parties.

B. Length of Designation

1. (Re)Designation as a facility to evaluate and treat persons involuntarily detained under the LPS Act (WIC, Division 3) is valid for three calendar years from the time of the LACDMH LPS redesignation survey, unless such designation is subsequently suspended or withdrawn.
2. Designation ceases if the facility has not detained patients on an involuntary basis pursuant to the WIC § 5150 and/or 5152 for a period of two years.
3. Once LPS FACILITY DESIGNATION TEAM has determined the facility is compliant to maintain Designation, Renewal application will be submitted to DHCS. The approval and expiration date of designation will be provided by DHCS upon review and approval of application submitted.

V. WITHDRAWAL OF DESIGNATION, MONITORING PLAN, CONDITIONAL DESIGNATION, AND REINSTATEMENT OF DESIGNATION

A. Circumstances under which the LACDMH Director may withdraw their designation of a facility under these Guidelines in the following circumstances:

1. Gross violation and/or ongoing violations of patients' rights, clinical practice, quality of care, and/or safety precautions relevant to the class of persons to whom designation applies.
2. Failure to comply with the terms and ethical provisions of law and LACDMH LPS Designation Guidelines which includes constitutional, statutory, regulatory, and decisional law, including but not limited to WIC, Division 5, CCR Titles 9 and 22, and the Business and Professions Code, § 650, concerning compensation for referrals.
3. Repeated failure to verify and submit for authorization only fully qualified individuals; failure to assure that 5150 detention authorized staff are appropriately monitored and supervised, and/or that its representatives exercise the involuntary detention and treatment authority in accordance with established LACDMH Guidelines and legal requirements.
4. Failure to allow the LACDMH Director or designee to review the facility for designation or complaint resolution purposes, including access to specified patients, staff, and records to establish compliance with LACDMH LPS Guidelines and regulations (WIC 5520).
5. Failure to correct circumstances within specified timelines that previously led to conditional designation.
6. Failure to truthfully disclose the material support provided to members of the 5150-detention authorized professional staff concerning off-site evaluation and 5150 detention activities, or to ensure the support is in accord with all applicable designation regulations; and,
7. Closure, loss of licensure, or loss of TJC or equivalent accreditation; failure to comply with Medicare Conditions of Participation.
8. ~~8.~~ Failure to comply with terms and conditions of contract, agreement and/or MOU.
9. When in the judgment of the LACDMH Director, it is required by community needs.

B. LACDMH Director may place a designated facility on monitoring plan or conditional designation status under the following circumstances:

1. Failure to notify LACDMH of significant occurrence(s) or failure to submit reports to the LACDMH Patients' Rights

Office as required within 30 days after end of reporting period;

2. Failure to meet documentation and treatment guidelines, as specified In the LPS Designation Guidelines by established deadlines;
3. Improper use of seclusion or restraint, including failure to routinely utilize preventive alternative interventions and/or to follow CMS, Title 22, and Health and Safety Code (Div. 1.5 commencing with § 1180-1180.6) requirements for seclusion and restraint orders, use, and monitoring;
4. Failure to ensure that all patient's rights guaranteed to mental health patients by statutes and regulations are adhered to, including proper initiation and implementation of rights to administrative and judicial reviews, hearings, and writs;
5. Occurrence of significant patient's rights, quality of care or safety issue or critical incident requiring LACDMH investigation and prompt corrective action by the facility;
6. Failure to submit a timely or acceptable CAP as requested in writing for cited deficiencies;
7. Failure to provide whatever mental health treatment, care, and referrals involuntarily detained persons require for the full period that they are held; and,
8. Failure to notify the LACDMH of any changes that may affect its conformance with the criteria for LPS facility designation.

C. LACDMH Director may withdraw approval of a designated facility's authorization of an individual to exercise its delegation of authority under the following circumstances:

1. Transfer to an assignment where such authority is unnecessary;
2. Failure to abide by all provisions in the WIC Division 5 and accompanying regulations, and by LACDMH LPS Designation Guidelines concerning treatment, evaluations, patients' rights, and due process;
3. Inappropriate use or abuse of the involuntary detention authority, including improper conduct during evaluations initiated on or off facility premises;
4. For failure to meet criteria for professional staff membership and clinical privileges for involuntary detention set forth by the facility;
5. For failure to properly and competently implement, complete, and document evaluation activities, 5150 applications, and/or verbal or written advisements and logs for 72-hour detention as required in WIC § 5150(f)-(h) and/or in the LACDMH LPS Designation Guidelines;
6. For loss of professional license for any reason; and,
7. For leaving facility employment.
   a. In the event the individual is seeking 5150 detention authority at a single designated facility and involuntary detention authority has been previously withdrawn or suspended at that or any other designated facility, the LACDMH Director may, in their sole discretion, withhold approval of the individual's involuntary detention authority at the facility, and notify the facility of the action taken.

D. LACDMH Director may reinstate approval of a facility's authorization of a qualified hired, rehired, or returning individual to exercise its delegation of authority under the following circumstances:

1. Individual left facility/professional staff for reasons not related to any disciplinary action for which involuntary detention authority was suspended or withdrawn during the prior authorization period and the individual left facility/professional staff for no longer than six months and the individual's written and signed agreement with the facility and LACDMH has not expired, or individual left facility/professional staff for no longer than three years and the last authorization period was of at least three years duration.
2. If the written and signed agreement has expired, the individual left facility/professional staff for longer than six months, and the person's last LPS authorization was of less than three years duration, the individual takes the LACDMH- approved LPS Detention Authorization Training Course and written examination the next time it is offered. No reinstatement of 5150 detention authority will be granted until the individual has passed the written examination.
3. When in the judgment of the LACDMH Director, it is required by community needs.
   a. Note: Contact the LACDMH Director DMH LPS Coordinator for the most current LPS Authorization requirements.

E. Should the LACDMH Director withdraw their designation of a facility, or should the LACDMH Director withdraw the approval of a designated facility's 5150 detention authorization of an individual, the following procedures shall take place:

1. Except as described below in respect to emergencies, the LACDMH Director shall notify the facility of their intention not less than 30 calendar days in advance of taking the action. The notification will specify the reasons for which the action is being taken.
2. The facility may submit to the LACDMH Director a written demand for review within fourteen (14) business days of receiving the notice of intention. In support of its written demand, the facility may submit written documentation or other proof controverting the specification made in the notice of intention. If the facility wishes to make an oral presentation or present witness to controvert the specifications in the notice of intention, its 1written demand may also request a meeting at which such oral presentation can be made.
3. If a request for a meeting for an oral presentation is made, the meeting shall be held not less than five nor more than ten business days from the date on which the facility demanded the review. In no event shall the meeting take place more than twenty-five business days after the notice of intent to withdraw the designation was received by the facility.
4. The meeting at which the facility makes its oral presentation shall be attended by the LACDMH Director, or designee, and such other representatives as designated by the LACDMH Director in writing to the facility administrator. The meeting may be attended by the facility administrator and Chief Medical Officer and such others as they designate in writing to the LAC Director of Mental Health. The facility may make oral presentations that are pertinent to the specifications contained in the notice of intent. A reasonable period, as determined by the LAC Director of Mental Health or designee, shall be permitted for the facility's oral presentation.
5. The LACDMH Director shall consider all written, oral, and other information submitted by the facility. The LACDMH Director shall notify the facility in writing of their final decision not later than twenty-nine business days from the facility's receipt of the notice of intention.

F. If in the judgment of the LACDMH Director, an emergency or threat of harm to consumers exists, he or she may suspend the authority of the facility to involuntarily detain or treat under the LPS Act or the approval of a designated facility's authorization of an individual. Such a suspension may be made during the pendency of a notice of intention, as described above, or for such periods of time during which the LAC Director of Mental Health judges the emergency or threat to exist.

1. The facility may request a review immediately or within 14 business days of receiving the written notice of emergency suspension, such review to be held within 3 working days from the date on which the facility demanded the review, unless another mutually agreeable time, not to exceed 14 business days from the date on which the facility demanded the review, is set.