INITIAL L.P.S. DESIGNATION TRAINING AND TESTING

DATE & TIME: **November 19, 2014** **9:00 AM - 5:00 PM**

All registration is completed on the Learning Net prior to the training. Sign-in begins 30minutes prior to the training time. All participants must arrive during the sign-in period. Late arrivals will not be admitted.

PLACE: **DMH Headquarters**
550 S. Vermont Ave, 2nd Floor Conference Room
Los Angeles, CA 90020

PARKING: **523 Shatto Place - Parking structure (floors 3-8) OR metered parking lot Southwest corner 6th & Vermont**

This training will provide an introduction to mental health law and an overview of ethical issues as they relate to involuntary detention. It will include a clinical component that encompasses several learning modalities such as small group discussion and active participation. The participant is expected to spend a minimum of two hours in self study prior to the class and exam. (Please download and review the study guide before attending the training).

TARGET AUDIENCE: **Licensed Clinical Staff requiring authorization for LPS Designation**

OBJECTIVES: **As a result of attending this training, participants should be able to:**

1. Describe the fundamental law and criteria involving involuntary detention.
2. Define the impact of the Lanterman-Petris-Short Act on the rights of the mentally ill.
3. Identify who has authority to initiate an involuntary detention form and understand the scope of that authority.
4. Identify the responsibilities inherent in initiating involuntary detention and the ramifications of that responsibility.
5. Operationalize and problem-solve clinical and behavioral issues that may arise while conducting 5150 assessments in the field.
6. Discuss how different cultures and subcultures are considered when assessing consumers in crisis.

CONDUCTED BY: **Staff from Patient's Rights Bureau, and Emergency Outreach Bureau**

COORDINATED BY: **Lisa Song, LCSW Training Coordinator**
Email: lsong@dmh.lacounty.gov

DEADLINE: **October 3, 2014; or when maximum capacity is reached**

CONTINUING EDUCATION: **None**

COST: **None**

DMH Employees register at:
http://learningnet.lacounty.gov
And complete attached LPS Application

Contract Providers complete attached LPS Training Application

❒ Cultural Competency ❒ Pre-licensure ❒ Law and Ethics ❒ Clinical Supervision ☒ General

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
LANTERMAN-PETRIS-SHORT (LPS) ACT
INITIAL AND RENEWAL AUTHORIZATION APPLICATION

(Please Print or Type)

TO BE COMPLETED BY CANDIDATE'S SUPERVISOR (Failure to complete all items may result in the application not being processed.)

Training ID		**Date of requested training (initial only)**	
☐ **Initial Application** ☐ **Renewal Application**	☐ **Work Location Change From:**	**Training or testing date previously completed (if applicable)**	
County Employee Number (non-county employees supply the last four digits of the SSN)			
Candidate's Name		**Job Title**	
☐ **Resident**	☐ **Professional Staff with Admitting Privileges**	☐ **Professional Staff without Admitting Privileges**	☐ **County/DMH or Contracted Facility Staff**
Name of Agency, Program, or Hospital			
Work Address		**City**	**Zip Code**
Work Telephone	**Fax**	**E-mail**	
Number of years experience as a licensed MH professional		**List all other current facilities at which LPS Authorized (if applicable)**	
Start Date with LACDMH or Contracted Agency:		**Required: Completed initial 6 month probationary period with LACDMH or Contracted Agency?** ☐ **Yes** ☐ **No**	

Current job description of candidate which requires that he/she be authorized (please check one):

On-Site
- ☐ **County Clinic/County Contracted Clinic Employee**
- ☐ **LPS Designated Facility (inpatient) Employee**
- ☐ **LPS Designated Facility (inpatient) MD**

Mobile
- ☐ **Hospital Employee**
- ☐ **County Clinic/County Contracted Clinic Employee**

Field Based Services
- ☐ **FSP Specify:**
- ☐ **FCCS Specify:**
- ☐ **Other, Specify:**

Credential	☐ **LPT**	☐ **LMFT**	☐ **LCSW**	☐ **RN**	☐ **NP**	☐ **LVN (clinics only)**
	☐ **PhD/PsyD**	☐ **MD/DO**	☐ **Unlicensed Resident**	☐ **Other, Specify:**		
License No.		**License Expiration Date**				

I attest that all statements made in the application are true and correct.

Applicant **Signature**_____ **Date**_____	**Professional clinically in charge of Designated Facility or Agency** *(If applicant is clinically in charge then immediate supervisor must sign.)* **Print Name** _____ **Signature** _____ **Date**_____

Office Use Only: This section to be completed after training and examination.

Test Score:	**Pass:**	**Fail:**	**Test Date:**	**Designation Expiration:**
DMH Regional Medical Director (Signature):				**Date:**

RETURN **INITIAL LPS TRAINING APPLICATION** to:
County of Los Angeles - Department of Mental Health
Workforce Education and Training (W.E.T.) Division
695 S. Vermont Avenue, 15th Floor, Los Angeles, CA 90005
Phone No. (213) 251-6854 **Fax No. (213) 252-8776 / 8775**

Note: *The initial LPS Training Application should be submitted at least one month prior to selected scheduled training date.*

EMAIL **RENEWAL APPLICATION & NOTICE OF CHANGES for Hospital/Facility Staff, Directly Operated and Contracted Staff, or Questions** to:
LPSCoordinator@dmh.lacounty.gov

Submit this form as an application for LPS training, renewal authorization and change of work location. Form must be completed for each facility at which individual desires authorization. The application will be forwarded to the Medical Director's Office for final LPS authorization, once training has been completed and test score added.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ATTESTATION FOR LPS AUTHORIZED APPLICANTS

Certificate of Applicant:
I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here or an omission of material fact will result in my disqualification. I further acknowledge that I have reviewed the LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Sixth Edition (revised March 2013), and that I have read and understood this document, and will uphold all applicable legal, ethical, regulatory and reporting principles contained therein and in the standards of my professional license(s). Further, I will uphold basic ethical standards essential to the fulfillment of my responsibilities carried out in the application of my authority for involuntary detention, including but not limited to the following:

- Avoidance of circumstances where work based action may affect or appear to affect private financial interest or personal gain, financial or non-financial.
- Avoidance of any participation in a personal arrangement or business transaction which would generate potential or perceived conflict of interest or compromise my ability to provide treatment fairly and objectively.
- Avoidance of any circumstances that would hinder my ability to provide or refer to service that is of highest quality and effectiveness.
- Recognition and avoidance of any personal situation, habits or behaviors that might impair ability to provide competent care.
- Respect and protection of client confidential information, in accordance with applicable legal and regulatory standards.
- Performance of all duties in a manner that demonstrates an understanding of each client's personal dignity.
- Demonstration of highest standards of personal integrity in all work related activities carried out in the application of my authority for involuntary detention.

I acknowledge that, if I am given authority for involuntary detention, my failure to comply with the above principles and all laws, policies, by-laws or regulations related to involuntary detention, or with those portions of the LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Sixth Edition (revised March 2013) related to individuals (including any revisions thereafter adopted), will result in withdrawal of my involuntary detention authority. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by the LACDMH Director.

Signature of Applicant | **Print Name** | **Date**

Credential, License No. | **Expiration Date**

Designated Facility or Directly Operated Program or Contract Site Approved to Initiate LPS Involuntary Holds

Address | **City** | **State** | **Zip Code**

Work Telephone | **Email Address**

Professional Clinically in Charge of Designated Facility or Approved Site (Print Name) | **Signature**