YOUTH FOCUS INC.

ANNUAL CONTRACTOR UPDATE - 2016

There are certain expectations that Youth Focus has of all of our independent contractors each year with regard to training, safety and health. These expectations are outlined below. This form will be distributed April 1 each year. You must complete this UPDATE along with all relevant attached materials by July 1st in orderto remain a contractor.

Name:

Position:

For items listed below *write the date on which the item was completed* (for example the date of the live training or the date you read and completed the written training module). If you were not able to complete the live training course for that area you may complete the attached training modules as an acceptable substitute.

ALL CONTRACTORS MUST COMPLETE THE ITEMS LISTED BELOW:
Indicate the date the item was completed.

_____ Blood borne Pathogens and TB Prevention Training
_____ Safety Training
_____ Client Rights, Confidentiality and HIPAA Update Training
_____ Abuse Reporting; Recognition/Prevention/Reporting of sexual abuse
_____ Behavior Management and Discipline
_____ Drug Free Workplace Policy
_____ Harassment Policy
_____ System of Care Philosophy
_____ Personal Identifying Information Security and Disposal
_____ Annual Health Questionnaire
_____ Disclosure Affidavit
_____ RIL Form (complete "Employee" box in the upper right hand corner of the form.)
_____ OSHA Training
_____ Crisis Prevention and Intervention Plan Training

_____ Core Competency Form and Supervision Contract

OR

_____ Credentialing and Privileging Form in place of the Core Competency Form
(*Licensed staff should attach a copy of their current license)*

SEE OVER - 2 SIDES TO THIS FORM

ALL CONTRACTORS THAT WORK IN FAMILY PRESERVATION AND THERAPEUTIC FOSTER CARE MUST COMPLETE PART A OF NCI. However, LICENSED staff may sign the attestation form in lieu of Part A of NCI. ANY STAFF THAT PARTICIPATES IN A PHYSICAL RESTRAINT MUST COMPLETE PART A AND PART B OF RESTRAINT TRAINING (group home staff, RTC staff, day treatment staff).
Indicate the date the item was completed:

_____ Initial training in North Carolina Interventions Part A*
_____ Initial training in North Carolina Interventions Part B (Core Plus)*

Annual refresher training on NCI:
_____ Refresher course – Part A*
_____ Refresher course – Part B (Core Plus)*

*Youth Focus offers this training on a regular basis. See Marshand Hager, 274-5909 for a schedule of NCI training.

_____ All contractors that drive a Youth Focus vehicle or transport a Youth Focus client must supply a copy of their driver's license.
_____ If you drive your own vehicle for Youth Focus business you must supply proof of current auto insurance.

Please sign below when all items are completed and give to your supervisor. If you do not know who your supervisor is give this form to your Program Manager or the Human Resources Director.

_____
Signature Date

PLEASE LIST YOUR CURRENT HOME ADDRESS AND PHONE NUMBER (Including cell # if applicable):

_____
_____
_____
_____

SUPERVISOR: It is your responsibility to verify that all of the items listed above have been completed. If a supervision contract is required the supervisor must complete and sign the supervision contract.

_____
Signature - Supervisor Date

ANNUAL UPDATE

BLOODBORNE PATHOGENS & TB PREVENTION TRAINING

A. Bloodborne Pathogens

1. Bloodborne diseases to which you could be exposed:

    a. Hepatitis B – (inflamation of the liver) flu like symptoms
    b. Hepatitis C – (inflamation of the Liver) similar symptoms – no vaccine to prevent.
    c. HIV – attacks immune system; no vaccine to prevent it; may carry it without developing symptoms for years.
    d. Syphilis
    e. Malaria

2. Hepatitis B and HIV are biggest threat to you as a healthcare worker.

3. Bloodborne pathogens may enter your body through accidental injury by a contaminated sharp object, mucous membranes of your mouth, nose or eyes.

4. You can become infected through contact with a contaminated environmental surface if the infectious material has become completely dried (for at least a week, without visible signs).

5. Standard precautions include;
    a. Engineering controls: Self-sheathing needles, Sharps disposal containers, Bio-safety cabinets.

6. Personal protective equipment:

    a. gloves
    b. Protective eyewear
    c. Mouthpieces

7. Every time you remove gloves you should wash your hands with soap and running water as soon as possible.

8. You should never eat, drink, smoke, apply cosmetics or lip balms or handle Contact lenses in work areas where exposure may occur.

9. Good housekeeping protects everyone and is everyone's responsibility.

    a. Clean all equipment and environmental working surfaces as soon as possible.
    b. Never pick up potentially contaminated broken glass with your hands.

Always use tongs, forceps or a brush and dust pan.

c. Place contaminated sharps and infectious wastes in designated sharps containers which are labeled or color-coded, leak-proof and puncture resistant.
c. Handle contaminated laundry as little as possible and with minimal Agitation.
d. Never use your hands or feet to compact trash or soiled linens. Never handle trash and laundry without gloves, and carry bags away from your body.

10. If you have an accidental exposure, immediately wash exposed skin with soap and water or flush exposed mucous membranes with water, and then report the incident to your supervisor.

B. TB Prevention

1. TB prevention begins with having a TB skin test as recommended by your doctor.

2. Covering the mouth and nose when coughing or sneezing is an important method of preventing the spread of TB because this helps droplets from becoming airborne. Staff and clients should follow this procedure.

3. Signs of TB infection are:

   a. Coughing
   b. Fever
   c. Fatigue
   d. Night sweats
   e. Weight loss

4. You are more likely to get TB if your immune system is weak due to:

   a. Stress
   b. Poor nutrition
   c. Substance abuse
   d. Sickness
   e. HIV (AIDS)

Employee Name: _____

Date you read this Training Module: _____

SAFETY

ANNUAL UPDATE

Youth Focus strives to maintain the safest possible facilities and environment for our clients, staff and visitors. The following general safety rules apply:

1. Each facility should have a monthly fire drill, disaster drill and safety inspection. If any employee sees an unsafe condition, however, they should report that to their supervisor immediately.
2. All staff should know where the fire extinguishers are and how to use them.
3. First aid trained staff should always be on duty and prepared to use their first aid training in the event of a medical emergency.

Please review the steps to take in the event of a fire:

1. Notify the Fire Department, (dial 911) and activate the fire alarm.
   Information to be given:
   - Where the fire exists, name of program,
   - Address, location of building.
   - What kind of fire or smoke conditions exist (if possible) – flammable liquid, electrical, how large, etc.
   - Your name
2. Rescue any persons that are in danger.
3. Staff should investigate and determine necessary action.
4. Extinguish fire with the fire extinguisher if possible.
5. Evacuate clients, residents, visitors, and guests to "Assembly Area".
6. Close doors. (Everyone should do this as they leave their room or area).
7. Staff should designate someone to check and evacuate the time-out rooms.
8. Meet the local Fire Department outside the building and show them to the fire.

NOTE: Some of the above actions can be done simultaneously.

ASSEMBLY AREA:

The purpose of the Assembly Area is a safe gathering place outside the building for residents and staff to gather to ensure that all individuals are present and accounted for.

PROVISIONS FOR ASSISTANCE TO RESIDENTS AND PERSONNEL:
In the event of a fire or fire drill, all staff and residents should check the areas that they are in for smoke. (If resident is in room, he should check the hall for smoke). If smoke is in that area, crouch down and go to the assembly area. If no smoke is in area, walk to assembly area. Residents should be led by staff to assembly area.

Please sign below to indicate that you have completed the annual safety update including a review of the procedures for operating a fire extinguisher (back side of this page):

_____ _____

Staff Signature Date

Use the correct extinguisher

For CLASS A fires in ordinary combustibles, such as wood, paper, cloth, upholstery, plastics and similar materials, use a water or dry chemical extinguisher with either of these symbols on the label.

For CLASS B fires fueled by flammable liquids and gases, such as kitchen greases, paint, oil, kerosene and gasoline, use a dry chemical or carbon dioxide extinguisher with either of these symbols on the label. NEVER USE WATER.

For CLASS C fires involving live electrical equipment or wires, use a dry chemical or carbon dioxide extinguisher with either of these symbols on the label. If possible, cut off power first. Once the power is turned off, the fire becomes class A or B. NEVER USE WATER.

Know your extinguisher

Before you invest in one or more extinguishers, consider where you need them. Identify hazardous areas where fires are likely to start and which type of fire would likely occur in each area.

Discuss your needs with your local fire department. Because not all extinguishers work on all types of fire, your fire department can assist you with the most effective choices for your home. You should also select an extinguisher which can be easily handled by all family members.

Extinguishers should be kept in a handy location. Everyone in the family should know where they are and how to use them. The best location is most situations is just inside a door or entrance, out of the reach of children. Avoid locating an extinguisher right next to where a fire could develop. In the event a fire occurs, you may not be able to reach the extinguisher due to smoke, heat or flames.

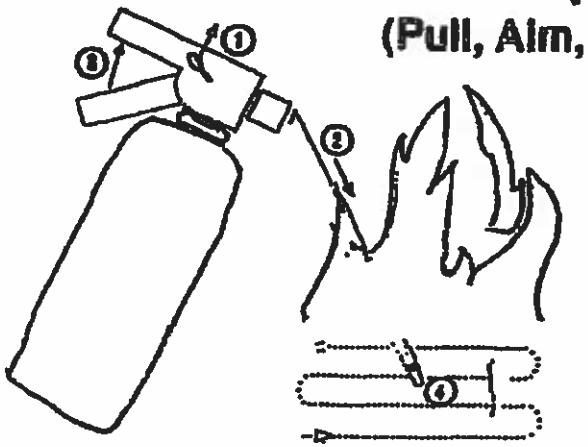
Only purchase extinguishers listed by a nationally accepted testing laboratory. Extinguishers rated ABC are effective on most types of fire.

- You have first called the fire department. An extinguisher is no substitute for the fire department.
- The fire is small and not spreading. A fire can double in size every two to three minutes.
- The fire is not between you and your exit. Make sure you can get out fast if you cannot control the fire.
- Your extinguisher is the correct type for what's burning. READ THE LABEL; know in advance what types of extinguishers you have in your home.
- Your extinguisher works. Inspect extinguishers once a month for signs of damage, corrosion, tampering and leaks. A partially discharged extinguisher is an empty one.
- You know how to use your extinguisher. It's too late to read the instructions when the fire is burning. Some fire departments offer extinguisher training classes. Attend one.

TO OPERATE AN EXTINGUISHER*

PASS

(Pull, Aim, Squeeze, Sweep)



1. PULL the pin
2. AIM the nozzle at the base of the fire
3. SQUEEZE the handle
4. SWEEP nozzle from side to side at base of fire

REMEMBER: SMOKE DETECTORS provide a first line of defense against fires. They will warn you of a fire while it's still small enough to put out with an extinguisher and, most importantly, they provide the time needed for you and your family to escape.

DEVELOP AND PRACTICE a home fire escape plan.

NEVER RE-ENTER a burning building for any reason.

I have read and understand the Fire Extinguisher Training. If I need additional information I can contact Marshand Hager, the Youth Focus Training and Quality Management Director.

Signature: _____ Date: _____

Annual Civil Rights Training

WHAT ARE CIVIL RIGHTS?

Civil rights are the nonpolitical rights of a citizen; the rights of personal liberty guaranteed to U.S. citizens by the 13th and 14th Amendments to the U.S. Constitution and Acts of Congress.

What is a Protected Class?

- Any person or group of people who have characteristics for which discrimination is prohibited based on a law, regulation, or executive order.
- Protected classes for the CN Programs are **race, color, national origin, age, sex, and disability.**

Title VI of the Civil Rights Act of 1964 states that *"no person in the United States shall be discriminated against on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity."*

People with limited English proficiency (LEP) individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English need to be served in other languages

- **Outreach in other languages is important**
- **Recipients of Federal financial assistance have a responsibility to take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency**

Title IX of the Education Amendments of 1972 states:

No person in the United States shall, on the basis of sex, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance.

The Age Discrimination Act of 1975 provides: *No person in the United*

States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.

Section 504 of the Rehabilitation Act of 1973 added disability to Title VI.

- **Title II and Title III of the Americans with Disabilities Act of 1990 extended the requirements to all services, programs and activities of State and local governments and prohibits discrimination based on disability in other public services.**

Client Rights

Annual Update

Respecting the rights of our clients is one of the most important parts of our jobs at Youth Focus. Please review the attached list of 20 of the most important rights that our clients possess. Your facility should have a complete list of client rights posted. Check to see that it is posted.

1. Youth Focus will not refuse to treat someone because of their sex, race, sexual orientation, religion, or because of a handicap unless that handicap prevents them from participating in the program.

2. You have the right to choose how you will spend money given to you as allowance or earned through a job program, as long as it is not prohibited by law.

3. You have the right to be safe from mental or physical abuse while you are a resident.

4. Physical restraining via therapeutic holding by staff can only be used to protect you from yourself or to protect others from you. Staff may ask you to go to a room by yourself for your protection or for the protection of others. You have the right to the least restrictive conditions adequate for your care. Your parents/guardian may request to be notified whenever therapeutic holding or time-out are used in the course of your treatment.

5. Your parents/guardian have the right to refuse any specific treatment recommended by Youth Focus. Youth Focus reserves the right to terminate the relationship with the resident upon reasonable notice, however, when such refusal does not permit adequate treatment by this facility.

6. You have the right to confidentiality in that confidential information gained through our treatment records will not be shared with anyone outside of the facility without the permission of your parents/guardian, as is required by law.

7. You have the right to privacy in the care of your personal needs and possessions. However, if at any time during treatment it is suspected that you have drugs, alcohol, weapons, or other dangerous items in your possession, you may be searched and your personal possessions may be searched (complete "strip" searches are not allowed).

8. You have the right to be visited by your parents/guardian, family and other approved visitors while staying in a Youth Focus program, unless the treatment team determines that is not in the best interest of your treatment.

9. You have the right to receive private telephone calls unless the treatment team determines that is not in the best interest of your treatment.

10. You have the right to send and receive mail, unopened. However, incoming mail may be opened by you in the presence of a staff member to ensure that the mail does not contain any unauthorized, injurious or illegal materials or substances. We cannot hold mail or prohibit you from sending or receiving mail.

11. You and your family have the right to have an interpreter to help you talk to staff if you or your parents cannot speak English or are hearing-impaired.

12. You have the right not to be required to perform work for Youth Focus unless the work is a part of your treatment plan (such as cleaning up a mess you have made or an age appropriate chore). You are responsible, however, at all times for making your bed, keeping your room an possessions neat, orderly and clean, and helping to keep common areas neat and orderly.

13. You have the right to be informed of the use of cameras, tape recorders, audiovisuals, etc. during your treatment at Youth Focus.

14. You have the right to participate in religious worship.

15. You and your parents/guardian have the right to voice your concerns or grievances and receive a response within a reasonable time period. You have the right to have this grievance procedure explained to you. You may access the proper grievance form at any time during your treatment, and may thereby file your grievance with your Program Director.

16. You and/or your parents/guardian may file complaints with the Youth Focus Executive Director regarding your treatment. You and your parents have the right to be told how Youth Focus will deal with these complaints. You and your parents/guardian are encouraged to recommend changes in the program to staff.

17. You have the right to be out of doors daily unless the treatment team determines it is not in your best interest.

18. You have the right to contact and consult with, at you own expense, legal counsel, private physicians, private mental health, mental retardation or substance abuse professionals of your choice.

19. You have the right to participate in a client self-government process (group session or community group) to have in-put regarding facility rules.

20. You have the right to have a safe place to store personal things.

Please sign below to indicate that you have participated in an annual review of clients rights:

Employee Signature _____ Date _____

Youth Focus

HIPAA PRIVACY ACKNOWLEDGMENT AND NON-DISCLOSURE AGREEMENT

Youth Focus is committed to protecting the privacy of all Clients and protecting the confidentiality of their health care information. The following specific principles are applicable to all of ***Youth Focus*** employees, independent health care professionals involved in the care of Clients at the Youth Focus, volunteers, students, faculty, vendors, and contractors regardless of their job classification or position. While working with Clients at or for Youth Focus, I realize that I may have access to or become aware of confidential Client medical information, whether or not I am directly involved in providing care to that Client. I understand that I must keep this information in the strictest of confidence. As a condition of my employment or work at ***Youth Focus***, I agree that I:

- Will not verbally or in any written form disclose confidential Client information to any unauthorized person.
- Permit any unauthorized person to examine or make copies of any Client's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at ***Youth Focus***.
- Will not examine, use, or disclose confidential Client medical information except as needed to perform the duties of my job.
- Will not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
- Will not remove or copy any record or report from the office where it is kept except in the performance of my duties.
- Will report any violation of this policy.

If I have access to computerized information or programs at Youth Focus, I understand that the information accessed through all ***Youth Focus*** information systems contains sensitive and confidential Client care, business, financial, and Youth Focus employee information that should only be disclosed to those authorized to receive it. I commit to:

- Respect the ownership of proprietary software.
- Respect the finite capability of the systems, and limit my own use so as not to interfere unreasonably with the activity of other users.
- Respect the procedures established to manage the use of the system.
- Prevent unauthorized use of any information in files maintained, stored or processed by ***Youth Focus***.
- Not utilize anyone else's authentication code or device in order to access any ***Youth Focus*** system.

- Respect the confidentiality of any reports printed from any information system containing Client/member information and handle, store and dispose of these reports appropriately.
- Not release my authentication code.
- Understand that all access to the system will be monitored.
- Understand that my computer system privileges hereunder are subject to periodic review, revision, and if appropriate, renewal.

I understand that a violation of this Agreement may result in corrective action up to and including discharge or termination of my employment or work at or for ***Youth Focus*** and that my obligations under this Agreement will continue after termination of my work at ***Youth Focus.*** By signing this, I agree that I have read, understand and will comply with the *Youth Focus*'s policies concerning confidentiality of information and use of computerized information systems and the statements made in this Agreement.

_____
Signature

_____
Printed Name

_____
Position at ***Youth Focus***

_____
Date

ABUSE
ANNUAL UPDATE

Any abuse should be reported to DSS. If you suspect abuse you must report it! Do not wait for someone else to report it and do not wait to have your supervisor report it. Call at once as soon as you suspect abuse. Waiting to report abuse that you suspect is a serious violation of the law, licensing rules and Youth Focus policies.

G.S. 7A-543 Duty to Report Child Abuse or Neglect
Child abuse is everyone' responsibility. In order to help maltreated children and their families, professionals and the general public by law must report suspected child abuse. You do not have to prove that a child is being abused or neglected, you only have to suspect maltreatment is occurring in order to report. When you report your suspicions to the county social services department, you should be prepared to provide information about the abusive situation and what has led to your suspicions.

DEFINITION – SEXUAL ABUSE

The National Center on Child Abuse and Neglect (NCCAN), which is the federal agency designated to research and fund child maltreatment research, has proposed the following definition:

Contacts or interactions between a child and adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another child. Eight percent of all reports of sexual abuse involve an abuser who is known and trusted by the child. The most prevalent of these reports are incestuous.

FACTS ABOUT CHILD SEXUAL ABUSE

- All sexual misuse or exploitation of children is abusive and consequences of childhood sexual victimization are both serious and long-lasting.
- Child abuse reporting statutes reflect a societal conviction that child sexual abuse is harmful and that society has a right to intervene.
- Child sexual abuse is found in groups from all socioeconomic, educational, religious and ethnic backgrounds – the poor and the rich abuse.
- The average age of incarcerated adult child molesters is 28 years; the average age of their first arrest for sexual crime is 16 years; the average age of their first committed offense to which they admit is 13 years. Offenders are both females and males of all ages. In one study of female children who molest other children, the age of the girls at the time their first offense occurred ranged from 4 to 9 years, with up to 15 victims each admitted. Child sexual abuse is recurrent and progressive in nature, often occurring over a period of weeks, months, or years before, if ever, being disclosed.
- Very young children rarely lie about sexual abuse but may be confused or repress facts. Older children may use accusations as a powerful tool of revenge, attention, or anger.

Specific examples of sexual abuse that should be reported:

- Any sex act by agency staff, regardless of child's willingness.
- Fondling a child, inappropriate touching.
- Genital exposure.
- Inappropriate kissing.
- Masturbating of a child or forcing a child to masturbate an adult.
- Overt acts of exhibitionism.
- Rape
- Intercourse
- Oral sex
- Forcing a child to watch others engage in sexual activities or exposing a child to pornography.

LAWS AND SENTENCES:

Any abuse should be reported to DSS:

G.S. 7A-543 Duty to Report Child Abuse or Neglect
Child abuse is everyone' responsibility. In order to help maltreated children and their families, professionals and the general public by law must report suspected child abuse. You do not have to prove that a child is being abused or neglected, you only have to suspect maltreatment is occurring in order to report. When you report your suspicions to the county social services department, you should be prepared to provide information about the abusive situation and what has led to your suspicions.

G.S. 14-27.7 Sexual Activity by a Custodian

- Substitute parent in out-of-home care, i.e., agency, institution, group home.
- No age or sex guidelines.
- Class G felony – maximum punishment 15 years imprisonment and/or fine.
- Presumptive sentencing – 4 ½ years is minimum punishment.

G.S. 14-27.7 Sexual Activity of Substitute Parent

- Offense occurs in the home, substitute parent assumes the position of parent in the child's own home.
- Victim under the age of 18, no sex guidelines.
- Class G felony – maximum punishment 15 years imprisonment and/or fine.

G.S. 14-27.2 Statutory Rape

First degree; intercourse that occurs under the following conditions even if the victim consents:

- Victim under age 13, perpetrator over age 12 and at least 4 years older than the victim.
- Victim forced to have sex by more than one person.
- Victim forced to have sex by use of deadly weapon.
- Class F felony – maximum punishment life imprisonment.

G.S. 14-202 Indecent Liberties with Children

- Fondling or any sexual act to gratify the perpetrator's sexual desires with the exception of intercourse.
- Victim less than 16 years old, perpetrator has to be 16 years old or 6 years older than victim.
- Class H felony – maximum punishment 10 years imprisonment.

Presumptive sentencing – maximum punishment 3 years imprisonment.

As a result of being incarcerated with a felony:

- Cannot vote.
- Forfeit citizen rights.
- Cannot serve as juror.
- Standing in military can be jeopardized.

SEXUAL ABUSE – VICTIM'S BEHAVIORAL MANIFESTATIONS

Victims of sexual abuse often display inappropriate sexual behavior. This behavior may be demonstrated through open masturbation, excessive sexual curiosity, frequent exposure of the genitals, and seductive behavior in adolescent females.

For an individual to confront this behavior, it is important to look at the underlying motives of the victim's behavior. When a young child has been sexually abused they have no cognitive understanding of adult sex. Children who act in an overtly sexual or sexually seductive manner have been taught to do so. An adolescent female has learned that seductive behavior is a method to obtain attention and love. She may look older or mature and even act more mature. However, this is all part of the attention seeking behavior and the impact of being sexually abused. Even though the child senses it is inappropriate behavior that is what has worked in the past. This is behavior that was learned, therefore it feels comfortable and familiar. The seductive behavior has little to do with sexual gratification but their primary objective is attention, nurturing and acceptance.

To safeguard your position as an employee, approach sexual or seductive client behavior with the following rules:

A. Do not be alone with clients of the opposite sex.
B. Tell the child's therapist.
C. Try to extinguish the behavior by ignoring inappropriate sexual behavior. Remember that the child is used to getting attention for inappropriate behavior. Negative or abusive attention is better than no attention at all. Therefore, to try to correct this behavior, reinforce appropriate behavior.

Please sign below to indicate you have read the annual update on abuse:

_____

Employee Signature

_____

Date

Youth Focus Inc.

Behavior Management - Plan 2016

Behavior management is a critical part of our services at Youth Focus. Effective behavior management allows to you intervene before a crisis has developed and therefore helps to keep a minor problem from escalating into a major problem. Major problems can require the use of **restrictive interventions** such as physical restraint and due to the dangers of using such interventions we want to avoid them whenever possible. Therefore, behavior management training is intended to help you learn **alternatives to restrictive interventions.**

- Youth Focus believes that behavior management begins by understanding the young person receiving services from our agency. Much behavior can appear to be inappropriate on the surface but understandable when the child's' prior history and psychological state of being is fully understood. Therefore, our behavior management philosophy starts by ensuring that we have a full understanding of the young person in our care. Accordingly, all Youth Focus programs are supervised by a licensed human service professional that conducts an initial assessment of each young person, develops a case plan or treatment plan and oversees and approves any specific behavior management interventions with each client.

- Clearly, behavior management begins with a well structured program that meets clients' needs such as adequate food, rest, recreation, medical care, free time, therapy, etc. Unstructured programs where clients are left unsupervised or minimally supervised or where their needs are not adequately met will quickly reach an out of control state with regular behavior problems. Each program supervisor at Youth Focus is responsible for instituting this structure and seeing that clients needs are met.

- A part of the basic structure of all Youth Focus facilities is a behavior modification program (usually a point and level system) that emphasizes rewarding positive behavior and regular individual, group and family therapy. No painful or aversive conditioning is allowed as apart of any behavioral program.

- Clients in our programs receive regular individual and group therapy that helps young people learn to solve their own problems, learn to modulate angry feelings and learn ways to express anger appropriately. As well, this therapy helps staff stay in touch with a client emotionally so that we know when they are having a difficult time and might need some extra guidance or supervision. All of these factors together help prevent behavioral problems and allow us to avoid the use of restrictive interventions like restraint.

- All staff that might need to restrain a client receives during pre-service orientation on North Carolina Interventions (NCI) which includes training on de-escalating potentially violent situations. Youth Focus has on its' staff an **NCI trainer** who provides initial NCI training and regular follow-up refresher courses. No staff member is allowed to participate in a restraint until they have completed the restraint training and have completed a regular update each year. No other Youth Focus client may participate in the restraint of another client. ***Staff at the RTC (our PRTF) must have restraint training TWICE a year.***

- Physical restraint will only be used as a last resort, never as a form of punishment and will end as soon as the young person is calm. Physical restraint will only be used when the client is at imminent risk of hurting themselves or others (see Policy 608). The decision making steps as to whether or not a restraint should occur will follow NCI guidelines. At the conclusion of the restraint episode a debriefing of the incident will occur with both staff and the clients as per NCI procedures. Restraints are not allowed in the Transitional Living Program, My Sister Susan's House or in therapeutic foster care.

- Physical restraint is the only intervention that Youth Focus uses as a planned intervention. When restraint is used as a planned intervention it must be reviewed by the Client Rights Committee.

- Isolation in a locked room (seclusion) is allowed only in our PRTF facility – the Youth Focus Residential Treatment Center. Voluntary time-out can be used in an unlocked room within hearing distance of a staff member and for a length of time appropriate to the young person=s age and developmental level. Exit from that room cannot be barred by staff. Staff should make a visual check on the client at least every 10 minutes.

IT IS CRITICAL TO NOTE:
Any type of corporal, physical or other inappropriate type of punishment is not allowed (see Policy # 609 and 906). In addition, the following procedures are prohibited:

1. Cruel, severe, or humiliating actions.
2. Discipline of one child by another.
3. Denial of food, liquids, sleep, clothing or shelter.
4. Denial of family contact including family time, telephone or mail contacts with family.
5. Assignment of extremely strenuous or punitive work or forced exercise.
6. Verbal abuse, ridicule or any degrading punishment.
7. Locked rooms (seclusion), except at the RTC.
8. Chemical or mechanical restraints or medication administered as punishment.
9. Group punishment for one person=s behavior.
10. The administration of noxious stimuli - e.g. hot sauce, lemon spray, electric shock
11. Excessive or inappropriate use of permitted behavior management interventions.
12. Deprivation of any other client right.

- All behavior management interventions will be discontinued if they produce adverse side effects such as illness, severe emotional or physical distress or physical damage. Behavior management techniques that are not deemed acceptable by prevailing community norms will not be utilized. The planned use of any behavior modification interventions should be documented in the client's record and should include the rational for its use, a schedule or timing of use and an assessment of the impact on the person served. Interventions that are ineffectual or detrimental to meeting treatment goals will not be utilized.

- Incident reports should be completed following Youth Focus policy (see Policy 504). At a minimum an incident report form should be completed when there is an accident or injury to a client, acts of serious physical aggression resulting in bodily injury or property damage, use of restraint, seclusion or a runway whose whereabouts are unknown after 3 hours.

- All incident reports will be reviewed internally by each program=s Quality Improvement Committee and by the Youth Focus Safety and Risk Management Committee.

- This Behavior Management plan will be reviewed with all new employees during new employee orientation and annually thereafter in annual updates.

- All behavior management will be done in full accord with the current best practice in the mental health field and in accord with all applicable statutory requirements and regulations including federal and state law.

- Youth Focus is committed to providing a safe and nurturing environment for the young people in our care and has made the commitment to devote whatever resources are needed to accomplish this goal.

If you have no direct client contact as a part of your job but observe out of control behavior on the part of a client appropriate action you might take includes: notify staff with direct care responsibilities, move yourself and others to a safe location, call emergency personnel, call Youth Focus on-call staff, dial 911.

I have read the above described behavior management plan and agree to follow all Youth Focus policies on behavior management.

_____ _____

Employee Signature Date

YOUTH FOCUS INC.
DRUG FREE WORKPLACE

In an effort to create a Drug Free Workplace Youth Focus has adopted the following policy:

Youth Focus will not tolerate the unlawful manufacture, use, sale, dispensing, or possession of illegal drugs, narcotics or alcohol on its premises or while conducting Youth Focus business off premises and employees involved in these activities may be subject to immediate dismissal. Violation of this policy will result in disciplinary action, up to and including termination of employment, and may have legal consequences. Youth Focus encourages employees to seek assistance for their problems which may affect their performance.

If you are convicted of any drug related crime you must notify Youth Focus of that conviction immediately.

Please sign below to indicate that you have read this policy:

_____

Harassment – Annual Update

Policy:
Youth Focus is committed to protecting the rights and dignity of each individual it serves and of every employee who provides those services. A fair and productive working environment shall be maintained, free of unlawful and improper harassment of any kind including harassment based on race, sexual orientation, gender, gender identity (or expression), religion, and national origin. Offenders are subject to disciplinary action.

Procedures:

1. Harassment may be defined as unwelcome or unsolicited verbal, physical or sexual conduct which:
   a. is made a term or condition of employment.
   b. is used as the basis for employment decisions
   c. creates an intimidating, hostile or offensive working environment

2. Examples of what may be considered harassment are the following:
   a. Verbal harassment - derogatory or vulgar comments including jokes, insults or slurs regarding a person's race, sex, religion, ethnic heritage or physical appearance.
   b. Distribution of offensive material - This includes the distribution of electronically transmitted or written graphic material having the same effects outlined in (a) above.
   c. Physical harassment (bullying) - hitting, pushing or other aggressive action or threats to take such action.
   d. Sexual harassment - unwelcome sexual advances or comments, gestures or physical conduct of a sexual nature. Harassment also includes the use of one's authority and power to coerce another individual into sexual relations or to punish the other for his/her refusal.

3. Harassment is misconduct which will not be tolerated. Any employee who believes that he or she has been subjected to or witnesses discriminatory harassment should report the conduct immediately to any supervisor to whom the employee feels comfortable speaking, the Executive Director or the Human Resources Director. All complaints and related information will be investigated promptly and appropriate corrective and disciplinary measures will be taken, up to and including immediate termination of employment of an individual who exhibits harassing behavior.

I have read the policy on harassment and agree to follow this policy:

_____ _____

Signature Date

PERSONAL IDENTIFYING INFORMATION - SECURITY AND DISPOSAL

Policy: Youth Focus, Inc. recognizes the significant risk of harm to individuals resulting from "identity theft" and/or the unauthorized use by third parties of an individual's Personal Identifying Information for personal gain. It is the policy of Youth Focus to eliminate the unnecessary collection and use of Personal Identifying Information, to take all reasonable measures to safeguard such information in the agency's possession and ensure secure disposal of such information.

Procedure:
Personal Identifying Information includes any of the following:

- Social security or employer taxpayer identification numbers
- Drivers license, state identification card, or passport numbers
- Checking or savings account numbers
- Credit or debit card numbers
- Personal Identification (PIN) Codes
- Electronic identification numbers, email names or addresses, Internet account numbers, or Internet identification names
- Digital signatures
- Biometric data
- Fingerprints
- Passwords
- Parent's legal surname prior to marriage
- Any information that can be used to access a person's financial resources

Collection of Personal Identifying Information – Collection of Personal Identifying Information must be limited to that information necessary for legitimate business needs and to comply with government reporting requirements. Employees are required to make efforts to reduce the amount of Personal Identifying Information collected and to use alternative information for identification purposes (e.g., assigned numbers) when feasible. Collection and use of Social Security numbers should be restricted to that required by law and/or for which no other identifying information may be substituted.

Access to Personal Identifying Information – Access to Personal Identifying Information is limited to those employees who have a need to know the information for legitimate business purposes.

Security of Personal Identifying Information - All records containing Personal Identifying Information, whether in electronic or physical format, are considered highly confidential and must be secured to prevent unauthorized access by third persons.

Appropriate security measures must be taken to prohibit unauthorized or unlawful access to Personal Identifying Information. Such measures include password-protected access to electronic data; utilizing locked desk drawers or file cabinets and storing sensitive data in rooms with controlled access and check out procedures.

Care should be taken to ensure that Personal Identifying Information displayed on computer screens is not visible except to authorized staff and that computer passwords are kept confidential. Computer screens should not be left unattended without password protected screen-savers. Manual records should not be left where unauthorized personnel have access to them. Employees must secure Personal Identifying Information in their work areas prior to leaving the office for the day. Employees may not remove Personal Identifying Information from the office or access such information remotely without approval from the Executive Director or Human Resources.

Disposal of Personal Identifying Information - Documents containing Personal Identifying Information must be disposed of in a manner that ensures that the information is not accessible to any unauthorized person. Employees are required personally to destroy hard copy or electronic documents containing Personal Identifying Information by shredding, burning or pulverizing the documents so that the information cannot be practicably read or reconstructed. Alternatively, employees may verify that such documents are placed in sealed bins specifically designated for the disposal of this information. Personal Identifying Information must never be discarded in unsecured trash bins, recycling receptacles, or other publicly accessible locations. Consumer reports, credit reports, background checks, drug screens, tax forms, bank statements, and financial records contain sensitive information that should be treated in accordance with this policy.

Electronic Data - Secure methods must also be used to dispose of electronic data, documents, disks, tapes or any other medium upon which confidential information is stored electronically. An employee using Personal Identifying Information in electronic

form is responsible for deleting the data when it is no longer needed. Disks or other medium containing Personal Identifying Information should be destroyed to the point of being rendered unusable.

Additionally, the agency is responsible for:
Removing or neutralizing the magnetic fields of computer tapes, discs, and data storage devices to prevent recovery of data
Removing confidential information from all data storage and computers being sold, replaced, donated, or discarded using appropriate utilities
Erasing computer discs and storage devices to be reused using the appropriate utilities to prevent recovery of data
Destroying discarded tapes and discs to prevent recovery of data

Specific Prohibition on the Use and Disclosure of Social Security Numbers - Employees shall not:

1. Communicate or otherwise make available to the general public an individual's social security number.
2. Require the transmittal of a social security number over the Internet unless the connection is secured or the social security number is encrypted.
3. Print an individual's social security number on any materials that are mailed to the individual.
4. Disclose an individual's social security number to a third party without obtaining the individual's written consent to the disclosure. Exceptions to this rule may only be approved by the Executive Director or Human Resources if after exercise of reasonable diligence the agency has reason to believe that the third party has a legitimate purpose for obtaining the individual's social security number.

Permissible Uses and Disclosure of Social Security Numbers - Social Security numbers may be disclosed without consent in these limited circumstances:
When a Social Security number is included in an application or in documents related to an enrollment process or to establish, amend, or terminate an account, contract, or policy
To confirm the accuracy of a social security number for purpose of obtaining a credit report or background check
Where the Company is legally obliged to release the social security number, such as pursuant to a Court order, warrant, subpoena, or other legal provision
When the Company provides the social security number to a federal, state, or local government entity, including a law enforcement agency, court, or their agents.
When a social security number has been redacted to include only the last four digits or less.

Employee Training, Supervision, and Compliance

Supervisors are responsible for ensuring that employees adhere to the policy.

Employees are required to sign a certification verifying that the employee has received, understands, and agrees to abide by the agency's "Personal Identifying Information Security and Disposal Policies and Procedures."

Failure to abide by the agency's "Confidential Information Disposal Policies and Procedures" will subject an employee to disciplinary action, up to and including discharge.

Youth Focus will conduct periodic audits to ensure compliance with this policy.

Unauthorized Disclosures or Security Breaches - Each employee has a duty promptly to report any unauthorized use, disclosure or disposal of Personal Identifying Information to his/her supervisor or the Executive Director. If the agency confirms that a security breach of Personal Identifying Information has occurred, Youth Focus will take steps to secure the information and provide notice to affected individuals as required by the North Carolina Identity Theft Protection Act or other applicable law.

By Signing Below I indicate that I have read and agree to follow Youth Focus policies on PERSONAL IDENTIFYING INFORMATION - SECURITY AND DISPOSAL :

_____ _____

Signature **Date**

Youth Focus, Inc.
Disclosure Affidavit

Our agency screens all prospective/current employees and volunteers to evaluate whether an applicant poses a risk of harm to the children and youth it serves. Information obtained is not an automatic bar to employment or volunteer work, but is considered in view of all relevant circumstances. This disclosure is required for all employees, volunteers and applicants in order to work for Youth Focus, Inc. Any falsification, misrepresentation or incompleteness of this disclosure alone is grounds for disqualification or termination.

Full Name (*Please Print*): _____ **Social Security No.** _____

Please check "NO" below if you **HAVE NOT** at **ANY TIME** (whether as an adult or juvenile) been convicted of; had any judgement order rendered against you (by default or otherwise); or had other adverse action taken against you for:

YES	NO	Check "YES" or "NO" and provide a brief explanation for a "YES" answer on back of sheet or attach additional sheet.
		Any felony
		Rape or other sexual assault
		Drug/Alcohol-related offenses
		Abuse of a minor or child, whether physical or sexual (includes: sexual Exploitation, annoying/molesting, endangerment, statutory rape, etc.)
		Incest
		Kidnaping, false imprisonment of abduction
		Sexual Harassment
		Lewdness, lascivious behavior, and/or indecent exposure
		Assault, battery or other offense involving violence or the threat of violence
		Any misdemeanor or other offense classification involving a minor or to which a Minor was a witness
		Unfitness as a parent or custodian
		Removing children from a State or concealing children in violation of a law or court Order
		Restrictions or limitations on contact or visitation with children or minors
		Similar or related conduct, matters, or things
		Substantiation of abuse or neglect by child protective services
		Abuse or neglect of a child, been a respondent in a juvenile court proceeding that resulted in the removal of a child from my home or had any child protective services involvement which resulted in a child being removed from my home
		Abuse, neglect or exploitation of a disable adult
		As a domestic violence perpetrator
		Accusation of any of the above

***Please turn over and complete back of sheet**

Explanations, if you answered "YES" to any of the preceding, please explain:

By signing below I certify that I have no criminal, social or medical history that would adversely affect my capacity to work with children and adults

I further certify that I have no ailment or condition that will prevent me from fulfilling my job duties at Youth Focus, Inc. Youth Focus will make "reasonable accommodations" in accordance with the Americans with Disabilities Act and all other applicable state and federal laws.

The preceding statements are true and complete to the best of my knowledge.

Signature and Date

Witness Signature and Date

*False or misleading information may result in termination of employment.

OSHA Training

All Employees:

The OSHA Division of the Dept. of Labor recently made modifications to the Hazard Communication Standard (HazCom) to conform with the United Nation's globally harmonized system (GHS) for classification and labeling of chemicals.
All employees, both full-time and part-time are required to review and sign this training.

Modifications to the Hazcom Standards include:

Hazard Classification: Definitions now provide specific criteria for classification of health and physical hazards.
Labels: Labels will now include a harmonized signal word, pictogram, and hazard statement.
Safety Data Sheets (SDS, formerly MSDS): Will now have a specified 16-section format.
The new label elements and Safety Data Sheet (SDS) requirement will improve worker understanding of the hazards associated with chemicals in their workplace. To help companies comply with the revised standard, OSHA is phasing in the specific requirement over several years.

Globally Harmonized System (GHS) Adoption Timeline

Now: Employer must train employees how to read GHS formatted label and SDSs. Since employees will begin to see the new labels and SDSs on the chemicals in their workplace it is important that employees understand the new label and SDS format in order to protect themselves from hazards during the transition period.
June 1, 2015: By this date, chemical manufacturers & distributors should have completed their reclassification of chemicals and be shipping GHS formatted SDSs and labels with their shipments.
December 1, 2015: By this date, all SDSs and labels in the U.S. should adhere to the new Hazcom provisions. Distributors should only send updated SDSs & labels.
June 1, 2016: By this date, employers should be fully compliant with new HazCom provisions. This includes: making any necessary updates to their HazCom program, training employees on any newly identified chemical hazards, updating safety data sheet libraries and secondary labels.

Labels on workplace chemicals will be required to include these elements:

Product Identifier: the chemical name, code number of batch number. The manufacturer or distributer can decide the appropriate product identifier. The same product identifier must be both on the label and in Section 1 of the SDS.
Signal Words: a single word used to indicate the relative severity level – **"Danger"** or **"Warning"** are the only two signal words. Danger = more severe hazard. Warning = less severe. There will only be one signal word on a label no matter how many hazards a chemical may have.
Pictogram: a symbol, plus other graphic elements, such as a border, background pattern, or color, intended to convey specific information about the hazards of a chemical. OSHA has designated eight pictograms under this standard.
Hazard Statement(s): a statement describing the nature and degree of the hazard(s). all applicable hazard statements must appear on the label.
Precautionary Statement(s): a phrase describing recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling.
Name, address and phone number of the chemical manufacturer, distributor or importer.

Sample Label

Includes: Product Identifier, Signal Word, Pictogram, Hazard Statement, Precautionary Statement & Name, Address and Phone Number of Manufacturer.

ToxiFlam (Contains: XYZ)

Danger! Toxic If Swallowed, Flammable Liquid and Vapor

Do not eat, drink or use tobacco when using this product. Wash hands throughly after handling. Keep container tightly closed. Keep away from heat/sparks/open flame. – No smoking. Wear protective gloves and eye/face protection. Ground contrainer and receiving equipment. Use explosion-proof electrical equipment. Take precuationary measures against static discharge. Use only non-sparking tools. Store in cool/well-ventilated place.

IF SWALLOWED: Immediately call a POISION CONTROL CENTER or doctor/physician. Rinse mouth.

In case of fire, use water fog, dry chemical, CO_2, or "alcohol" foam.

See Material Safety Data Sheet for further details regarding safe use of this product.

MyCompany, MyStreet, MyTown, NJ 00000, Tel: 444 999 9999

How might an employee use the label in the workplace? Examples...

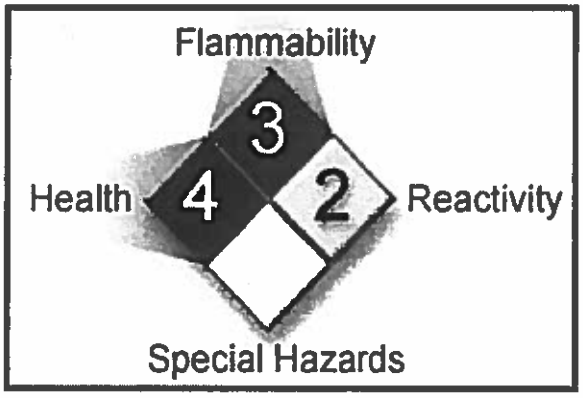
- Information on the label might be used to ensure proper storage of hazardous chemicals.
- Information on the label might be used to quickly locate information on first aid when needed by employees or emergency personnel.

How do the elements on the label work together? Examples.....

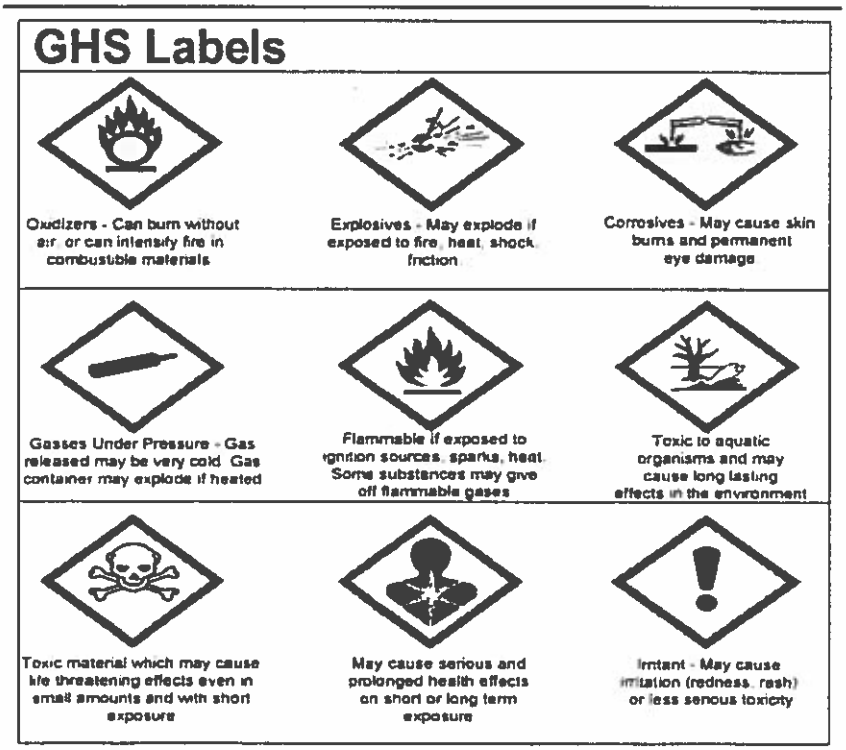
- When a chemical has multiple hazards, different pictograms are used to identify the various hazards.
- When there are similar precautionary statements, the one providing the most protective information will be included on the label

Pictogram and Hazard Class

This Hazard Diamond, in common use today, will eventually be phased out and replaced with the new global pictograms.



The new global pictograms (below) will replace the Hazard Diamond.



Safety Data Sheets (formerly known as Material Safety Data Sheets) must be divided into 16 sections. The SDS will be provided by manufacturers, distributors or importers. Employers must make readily available. Please note that information on the label is related to the SDS. For example, the precautionary statements would be the same on the label and on the SDS.

SDS Sections:

- Section 1 – **Identification:** includes product identifier; manufacturer or distributor name, address, phone number, emergency phone number, recommended use; restriction on use.
- Section 2 – **Hazard Identification:** includes all hazards and required label elements.
- Section 3 – **Composition:** includes information on chemical ingredients; trade secret claims.
- Section 4 – **First Aid Measures:** defines when medical attention is needed.
- Section 5 – **Fire-Fighting Measures:** lists suitable extinguishing techniques.
- Section 6 – **Accidental Release Measures:** emergency procedures; protective equipment; proper methods of containment and cleanup.
- Section 7 – **Handling and Storage:** precautions for safe handling and storage, including incompatibilities.
- Section 8 – **Exposure Controls / Personal Protection:** exposure limits, engineering controls, ways to protect yourself and PPE.
- Section 9 – **Physical and Chemical Properties:** list the chemical's characteristics.
- Section 10 – **Stability and Reactivity:** lists chemical stability and possibility of hazardous reactions.
- Section 11 – **Toxicological Information:** includes routes of exposure, related symptoms, acute and chronic effects; numerical measures of toxicity.
- Section 12 – **Ecological Information***
- Section 13 – **Disposal Considerations***
- Section 14 – **Transport Information***
- Section 15 – **Regulatory Information***
- Section 16 – **Other Information: includes the date of preparation of last revision.** *Note: since other agencies regulate this information, OSHA will not be enforcing Section 12-15 (29 CFT 1901.1200(g)(2))

Additional Information regarding the new global harmonized system may be found on the following websites:

- http://www.osha.gov/Publications/OSHA_3636.pdf
- http://www.osha.gov/dsg/hazcom/ghs.html

As Youth Focus adopts these new standards, the Safety Director will work with each program to ensure standards are met by the identified date within the GHS adoption timeline. Staff members should anticipate additional training through June 1, 2016. If you have any questions related to the new GHS format please contact Marshand Hager, Training and Quality Management Director at 336-274-5909.

My signature below indicates I have read the above HazCom Standard for the classification and labeling of chemicals.

_____ _____ Name

Date

Youth Focus Inc. - Contractor Health Questionnaire

Name_____ Date of Birth_____

Position_____ Program_____

Do you have any history of past or present? (check below) Yes No

	Yes	No
HIV/AIDS		
Bronchitis		
Chronic Cough		
Fainting		
Headaches (frequent)		
Hepatitis		
Jaundice		
Pneumonia		
Shortness of Breath		
Skin rash or skin infection		
Sore throat		
Strep throat		
Tuberculosis		

Please explain any "Yes" answers on the back of this form. If you develop any of the above listed symptoms or conditions during your work at Youth Focus you should report these to your supervisor so that we can explore your situation more thoroughly to ensure that you do not spread an infectious disease to our clients or other staff.

1. Do you have any other infectious diseases/conditions that could be spread to other employees or our clients? _____yes _____no If "yes" please explain on a separate sheet of paper.

2. Since you were hired have you developed any physical condition which limits your ability to perform any of your essential job functions? _____yes _____no If "yes" please explain.

_____ _____

Signature of Employee (By signing here I am attesting that the information listed above is accurate) Date

NUTRITION ANNUAL UPDATE

Busting the Sugar-Hyperactivity Myth

Are you convinced the reason for a child's rowdiness lies in a box of Milk Duds? You're not alone.

Are you convinced the reason for children's rowdiness or over activity lies in a box of Milk Duds? You're not alone. Many concerned parents and health organizations believe there is a link between a child's diet and behavior. The latest group to join the debate is the nonprofit Center for Science in the Public Interest, which recently released a report charging that the government, professional agencies and the food industry have been ignoring evidence that diet affects behavior. However, the majority of studies so far haven't found a connection, and **most in the medical industry maintain there is no known link between sugar and hyperactivity.**

Still, many concerned individuals feel certain they've seen a cause-and-effect relationship between sweets and over activity. Admittedly, more research would be needed to completely rule out the possibility of a link, but there are many plausible reasons other than sugar why a child may be bouncing off the walls.

Where Did the Sugar-Hyperactivity Theory Come From?

The notion that food can have an effect on behavior grew popular in 1973 when allergist Benjamin Feingold, M.D., published the Feingold Diet. He advocated a diet free of salicylates, food colorings and artificial flavoring for treating hyperactivity. Although Feingold's diet didn't call for eliminating sugar specifically, it did suggest to many parents that food additives might be better avoided. Little surprise, then, that refined sugar soon came under scrutiny.

Then a 1978 study published in the journal *Food and Cosmetics Toxicology* found that hyperactive children given glucose tolerance tests had results that suggested reactive hypoglycemia (low blood sugar). As yet, though, there are no good theories to explain the connection.

What We Know About Sugar

In the past 10 years, several studies have examined the effects of sugar on children's behavior. Here are the aspects of the studies that make them credible:

- Known quantities of sugar in the diets were studied.
- The studies compared the effects of sugar with those of a placebo (a substance without any active ingredients).
- The children, parents and researchers involved in the studies never knew which children were given which diets (this is known as a "double-blind" study and helps to prevent unconscious biases from affecting the results).

An analysis of the results of all these studies was published in the November 22, 1995 issue of the *Journal of the American Medical Association*. What were the researchers' conclusions? Sugar in the diet did not affect the children's behavior. The authors did point out, though, that the studies didn't rule out completely that sugar might be having a slight effect on a small number of children.

The evidence for a link between sugar consumption and hyperactivity is surprisingly slim. The most comprehensive study is a meta-analysis carried out in 1995, where the authors searched for the best-designed studies on the subject, combined the data and re-analyzed it. There are two main types of research: some studies gave children either sucrose or an artificial sweetener, such as aspartame, and then monitored their subsequent behavior without children or parents knowing whether they ate real sugar; others focus on children with a diagnosis of attention deficit hyperactivity disorder (ADHD), or another condition to see whether sugar affects them particularly.

Between them, the studies covered age ranges from two to thirty, and were well-designed though fairly small. All but one of the sixteen studies had fewer than fifty participants and one had just five. But the results of the meta-analysis were clear: sugar could not be shown to affect behavior or cognitive performance.

Expectations Can Affect Perceptions

In spite of this research, why do so many parents still believe sugar makes children hyperactive? Some researchers suggest that simply expecting sugar to affect your child can influence how you interpret what you see. A study published in the August 1994 *Journal of Abnormal Child Psychology* showed that parents who believe a child's behavior is affected by sugar are more likely to perceive their children as hyperactive when they've been led to believe the child has just had a sugary drink.

There are, of course, plenty of other reasons for children not to consume too much sugar, chief among them being rotten teeth and weight-gain. But it seems that the risk of over-excitement isn't one of them. That will happen anyway

Excerpted from WebMD and Yale Scientific.org 2014

Annual Update

Crisis Prevention and Intervention Plan Training

What is a Crisis Plan?

A Crisis Plan is a document designed to:

- Provide all the information necessary to help prevent a crisis from occurring.
- Provide information to guide an effective response when a crisis does occur.
- Make a plan for successful crisis resolution.

Who should receive a Comprehensive Prevention & Intervention Crisis Plan?

- The Comprehensive Crisis Prevention & Intervention Plan is designed to be one section of a Person-Centered Plan that can also be easily extracted as a stand-along document for the purpose of easy distribution. ALL Person Centered Plans MUST include the Comprehensive Crisis Plan.
- In addition, the Comprehensive Crisis Prevention & Intervention Plan is RECOMMENDED for all consumers who are at significant risk of crisis events – including those in basic benefit services. This would include persons who have, within the past year, been psychiatrically hospitalized or received inpatient treatment for a substance use disorder, who have been arrested, attempted suicide or used crisis services (i.e. mobile crisis team, facility-based crisis or non-hospital detox unit, walk-in crisis, NC Start, or use of a hospital's emergency department for reasons related to psychiatric illness of substance use).

Which provider working with a consumer should lead the process of developing the Comprehensive Crisis Plan?

- The Comprehensive Crisis Plan should be developed by the primary clinician or provider who completes the Person Centered Plan (PCP), in collaboration with the consumer, and perhaps with input from others who know the consumer well. Developing a comprehensive crisis plan requires a good working relationship with the consumer, and the in-depth knowledge of the consumer that a primary provider would have. Please note that general characteristics / preferences section of the crisis plan should not reflect only the views of the consumer or only the opinion of the clinician, but should be completed in a truly collaborative fashion, reflecting both the preferences of the consumer ***and*** the best clinical judgment and expertise of the clinician.
- Although mobile crisis teams are responsible for developing abbreviated one-page crisis plans, or "hot sheets," mobile crisis teams should not be charged with developing comprehensive crisis plans with consumers, unless the mobile crisis team is the typical and most constant provider of service for the consumer.

- Likewise, professionals in FBCs, inpatient psychiatric hospitals or emergency rooms should not have responsibility for developing comprehensive crisis plans.

When should the Comprehensive Crisis Plan be constructed?

- Constructing a Comprehensive Crisis Plan requires careful thought and knowledge of the person for whom it is being developed. The Comprehensive Crisis Plan should not be developed when the consumer is in the midst of a crisis, as thoughtful planning is often difficult to accomplish at such times. Although it does not need to be developed at the initial intake meeting with the consumer, it should be completed early in the treatment process, and if possible, within a month of intake.
- The Comprehensive Crisis Plan should be updated on the same schedule as the PCP, AND/OR shortly after any crisis episode occurs, AND/OR anytime there is a significant change in the course of treatment -- including medication changes.

Why are Crisis Plans important?

- Avert danger to the consumer or other's health and well-being.
- Prevent setbacks to an individual's recovery that results from the aftermath of a crisis, such as:
    - Loss of confidence and self-esteem.
    - Loss of job.
    - Loss of housing or placement.
    - Stress and burn out of family or care givers.
    - Damage to health of self or others.
    - Neurological damage resulting from reported psychotic episodes or mental health crises.
- Reduce the need for expensive resources, such as emergency room treatment or psychiatric hospitalization, thereby saving costs.

Who should have access to an individual's Crisis Prevention and Intervention Plan?

- With the individual and/or guardian's permission, the crisis plan should be uploaded to a computer and a paper or electronic copy made available to anyone likely to support the individual during a crisis episode:
    - Individual for whom the plan was developed.
    - Service Providers, including, but not limited to: Peer Support Specialists, First Responders, Mobile Crisis Teams, NC Start, etc.
    - LME-MCO Care Coordinators.
    - Emergency room personnel and the individual's physicians.
    - Legal Guardian(s)/Family.
    - Residential Providers.
    - Law Enforcement.

- Others as needed.

* *For individuals with a substance abuse diagnosis, the consent must meet the requirements set forth in 42 CFR Part II (Subpart C § 2.31).*

What are the Essential Values and Principles in Developing an Effective Crisis Plan and Responding to a Crisis Event? (Reference: www.SAMHSA.gov)

- Intervening in Person-Centered Ways - Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.
- Shared Responsibility - An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in, rather than a passive recipient of services.
- Addressing Trauma - It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available.
- Establishing Feelings of Personal Safety - Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (this should be included in the crisis plan) and what interventions increase feelings of vulnerability (i.e. confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.
- Based on Strengths - An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.
- The Whole Person – The individual may have multiple needs (i.e. Behavioral and/or medical) and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty.
- The Person as Credible Source – It is important for Responders to view the individual in crisis as a credible source of information—factual or emotional, rather than to be dismissive. It is important to understand the person's strengths and needs.

Guiding Principles include, but are not limited to: (Reference: www.SAMHSA.gov)

- Access to supports and services is timely.
- Services are provided in the least restrictive manner.
- Peer support is available.
- Adequate time is spent with the individual in crisis.

- Plans are strengths-based.
- Emergency interventions consider the context of the individual's overall plan of services.
- Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented.
- Individuals in a self-defined crisis are not turned away.
- Interveners have a comprehensive understanding of the crisis.
- Helping the individual to regain a sense of control is a priority.
- Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.
- Rights are respected.
- Services are trauma-informed.
- Recurring crises signal problems in assessment or care.
- Meaningful measures are taken to reduce the likelihood of future emergencies.

What are the Steps to Writing a Crisis Plan?

Writing a good crisis plan is a step-by-step process. Those specific steps are delineated below. **However, it is most essential that the crisis plan be constructed with the individual. The process must be a joint responsibility, and never carried out in the individual's absence or without his or her input.** The specific steps for developing a crisis plan are as follows.

Step 1 - Write the Date of the Initial Crisis Plan or the Date of the last Revision.

Step 2 - Write Basic Essential Information about the Individual, including:

- Identify the person needing a crisis plan.
- Date of birth.
- Address and phone number.
- LME-MCO information.
- Living Situation.
- Employment information/assistance.
- Communication barriers, language, preferences.
- Legally Responsible Person information.
- Insurance information.
- Diagnoses.
- Medications (including dosages, frequency, reason for change, date of prescription, the prescriber, and the pharmacy).
- Medical problems and allergies, if any.

Step 3 – Identify the Supports for the Individual

- List the individuals that should be called in the event of a crisis, indicate the calling order, provide contact information, and indicate if a consent to release information to that person exists.

Step 4 – Crisis Follow Up Planning

- Include which team member is the primary contact to coordinate care.
- Indicate who will be visiting the individual in the hospital (this should be the person's preference).
- Indicate who will organize and lead a review/debriefing following the resolution of the crisis, and within what timeframe that will happen.

Step 5 – Identify Additional Planning Documents

- If it is indicated that the individual has any of the planning documents, attach the documents(s) to the crisis plan.

Step 6 – Identify the General Characteristics/Preferences to include:

- A description of what the individual is like when feeling well.
    - Ask the individual what a good day looks like for him/her and provide examples of how he/she feels when they have a sense of overall wellness and wellbeing.
    - Describe how they interact, appear and behave when doing well.
- A description of situations and/or events that may be crisis triggers for the individual. (Make certain to include the person's perceptions of what causes him or her to be in crisis.) Examples may include:
    - Noise.
    - Change in routine.
    - Alcohol and/or drug abuse.
    - Non-compliance with medications or inability to express medical problems.
    - Family / marital conflict.
    - Particular environmental stresses such as noise, isolation.
- A description of the person's observable behavioral changes when s/he is entering a crisis episode, such as:
    - Not keeping appointments.
    - Change in hygiene/self-care.
    - Loud or rapid speech.
- A description of crisis prevention and early intervention strategies that have been effective. (NOTE: Describe ways that others can help the individual and what he/she can do to help him/herself.)
    - Focus on preventing the targeted behaviors.
    - Focus on the least restrictive measures.
    - Match the strategy to the behavior.

    - Consider what occurs just before, during and after crisis.
    - Be specific about relapse prevention strategy.
- A description of strategies for crisis response and stabilization. (NOTE: Describe ways that others can help the individual and what he/she can do to help him/herself.)
    - Describe how staff should interact with the individual when entering a crisis. For example: listening to music, going for a walk, having a conversation, not having a conversation, peer counseling, being touched, not being touched, etc.
    - Match the response to the level of behavior.
    - Focus on the least restrictive measure.
    - Make certain the strategy reflects the person's preference for intervention.
    - Include who should be notified of the crisis (guardians, family, etc.).
    - Consider the array of available responses (i.e. Back-up support, crisis respite, etc.)
    - Be sure to consider alternatives to hospitalization.
    - Consider and include (if appropriate) provision of support while inpatient, and coordination strategies with the inpatient team.
    - Include development of discharge plans. Plan this ahead, if possible.
    - Describe preferred and non-preferred treatment facilities.
    - Describe preferred and non-preferred medications.

Final Questions to Ask about Your Crisis Plans.

- Is there sufficient direction or guidance to be truly helpful to the person in crisis?
- Is the crisis plan truly an individualized plan that reflects the specific needs, preferences, strengths and challenges of that particular person? Probably the biggest temptation in developing crisis plans is to cut corners and develop "cookie cutter" plans that are generic and non-specific. To be useful, a crisis plan needs to fit the individual and his or her situation.
- Is the crisis plan up-to-date? People move, medications change, living situations and providers also change over time. Crisis plans need to be updated frequently so the information they contain remains relevant and useful.

If you have any questions regarding this Crisis Prevention and Intervention information please contact Marshand Hager, Training & Quality Management Director, at 336-274-5909.

By signing below you indicate you have read and understand the Crisis Prevention and Intervention requirements and will implement these requirements, when applicable.

_____ _____

Signature Date

Youth Focus, Inc.

Infection Control Annual Update

Policy: It is the policy of Youth Focus to serve AIDS patient without regard to the illness, provided all other established requirements for admission are met. Precaution procedures shall be in accordance with those recommended by the National Communicable Disease Center, the U.S. Department of Health and Human Services, State and local communicable disease laws, and Youth Focus Policies and Procedures. This policy and procedure document is based on current knowledge of the disease, AIDS, and is designed to protect patients and those responsible for their care.

Procedures:

General Information

1. Youth Focus considers all body fluids/secretions biohazardous. Consequently blood and body fluid/secretions precautions shall be observed for all patients. (Universal precautions)

2. Universal precautions eliminates the need for other categories of isolation procedures unless a concurrent airborne disease is also suspected or diagnosed in the AIDS patient. It must be remembered that Universal precautions are only as effective as those who use them. All body fluids/substances are to be considered biohazardous and warrant the use of these precautions.

3. Upon admission of a client with a confirmed diagnosis of AIDS or upon receipt of a positive HIV Laboratory Test results on a client, the Program Director shall immediately notify all supervisors of direct care staff.

4. The Program Director in consultation with supervisors of direct care staff shall review this policy and make recommendations regarding instructions/directions to direct care staff.

5. The Program Director shall insure that all staff are knowledgeable of universal body fluid precautions; and shall implement and enforce such universal precautions.

6. Staff providing direct care shall wash hands often and keep nails well-manicured. Vigorous hand washing for 1 to 3 minutes with soap, running water, and mechanical friction (rub hands together for at least 15 seconds under a moderate size stream of warm water) will remove most transiently acquired organisms.

Activities of Daily Living

1. The client may use the day room, classroom, and all other client areas, etc. The client may eat in the dining area with other clients and shall be encouraged to do so. No special precautions are needed for eating utensils or dishes.

2. Clothes may be washed in the normal manner. If visible particles of stool, vomitus, or other excretions are present, dispose in toilet prior to laundering the article of clothing.

3. For a client with bleeding gums or buccal (mouth) lesions, an individual disposable thermometer may be used at the discretion of the staff.

Protection of Skin and Mucus

1. Wear non sterile, latex gloves when restraining a client, and while working with potentially infectious materials and secretions such as soiled bandages, tissues and gauze used to control nose bleeds, urine and stool specimens, etc.

2. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or body fluids. Hands must be washed immediately after gloves are removed.

3. When restraining a client, take care to avoid being scratched, bitten, spat upon, or sustaining other such skin or mucous membrane injuries.

4. Keep small cuts and abrasions covered with a bandage.

Concurrent and Terminal Cleaning

1. Blood spills or areas of the physical environment soiled with blood or body secretions shall be cleaned up promptly by staff. Staff shall clean up such soils with a solution of 5.25 percent sodium hypochlorite, diluted 1:10 water (4 oz. clorox to 1 gallon clean cool water). Solution should be prepared daily or prior to use.

2. Use non-sterile, latex gloves when cleaning.

3. Staff should conduct a terminal cleaning of the bed and room when patient is discharged.

Emergency/Safety and Risk Management Considerations:

1. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

2. Any mucosal splashes or contamination of open wounds with blood or body fluids should be reported immediately.

3. Articles contaminated with body fluids/substance should be discarded or double bagged and labeled "infectious" before being sent for decontamination, reprocessing or disposal.

4. All paper tissues and other disposable items soiled with body fluid secretions should be placed in impervious bags and disposed of with trash.

5. Personnel who have exudative lesions or weeping dermatitis should refrain from all direct care until the condition resolves. The employee may also be requested to wear gloves.

6. Visitors should be instructed as indicated.

7. The same routine daily cleaning procedure used in other client rooms should be used to clean rooms of the AIDS client. Since environmental surfaces, unless visibly contaminated, are rarely associated with the transmission of infection, terminal cleaning should primarily be directed toward those items that have been in direct contact with the patient or the patient's infective material.

Supersedes _____ Distribution Prepared by ___M. Burton, RN_____

_____

Page ____ of ____ Dated _____ Approved by _____

SYSTEM OF CARE PRINCIPLES

System of Care is a philosophical approach to providing child and adolescent mental health services. Both nationally and at the state level it is considered to be a best practice procedure. Youth Focus has adopted the System of Care approach to the broad delivery of services. Please read the enclosed document and incorporate these principles into your delivery of care.

1. System of care is child centered and family focused with the needs of the child and family dictating the types and mix of services provided.

- Services offered should reflect the needs of the child and family and not what is most convenient for the "system" or provider.
- Review of progress notes and plan should provide evidence of child and family team meetings where different ideas are offered and the family has a choice in what service(s) to participate in.

2. Children with or at risk for serious emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by individualized person-centered plan.

- Review of multiple plans and progress notes provides evidence that the child and guardian had input in the plan and that their language is used as much as possible.
- The families and surrogate families of children with or at risk for serious emotional disturbances should be full participants in all aspects of the planning and delivery of services as evidenced by their signature on the plan and input on the plan from the family.

3. Family and other natural supports are utilized in the provision of services and services are provided that connect consumers to the community through meaningful involvement and participatory activities as much as possible.

- Review of multiple consumer progress notes and person centered plans provides evidence that family and other natural supports are: identified as resources, included in person centered planning, utilized in implementation for treatment interventions/actions and included as resources with professional services/supports.
- Review of multiple consumer records provides evidence that consumers' interests, aptitudes, strengths and preferences for community involvement are assessed and that interventions/actions are carried out to facilitate linkage to the community.

4. System of care is community based with the locus of services as well as management and decision making responsibility resting at the community level.

- Services should be offered at the least restrictive level on the continuum of services spectrum that meets the consumer's clinical needs. The level of care should not increase until lesser services at the community level have been exhausted.

- Review of multiple plans and progress notes provides evidence that the child is being served in the most appropriate setting and that his/her needs are being met.

5. System of care providers should be culturally competent with staff, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

- Services should be delivered without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

6. Children with or at risk for serious emotional disturbances should have access to a comprehensive array of services that are readily available and that address the child's physical, emotional, social, and educational needs.

7. Children with or at risk for serious emotional disturbances should receive services that are integrated with linkages between child-servicing agencies and programs and mechanisms for planning, developing and coordinating services.

- Children and their families should be provided with services to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

8. Consumers with co-occurring mental illness and/or developmental disabilities and substance-abuse disorders should have all disorders treated in an integrated manner.

9. Services provision yields desired outcomes.

- Review of multiple consumer records provides evidence that providers do not discontinue services until desired outcomes are reached.
- Services are assessed continuously and modified as needed to ensure that service provision meets individuals' evolving needs and review of multiple plans and notes provides evidence of this.

10. Children with or at risk for serious emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.

- The person-centered plan and progress notes should provide evidence of discharge planning and step-down plans for clients so that the transition to the adult service is appropriate.

11. The rights of children with or at risk for serious emotional disturbances should be protected and effective advocacy efforts for children and youth with emotional disturbances should be promoted.

- Progress notes and person-centered plans will be reviewed to ensure that the rights of the client are protected and that proper measures to ensure client safety are in place.

12. Crisis management plans are developed and used effectively for each child.

- Crisis plans provide evidence that they outline specific graduated interventions to be used during crises and delineate supportive persons who will implement those interventions.
- Review of multiple contact notes provides evidence that crisis plans are used consistently and that their provision/interventions are exhausted before hospitalization is sought.
- Review of multiple contact notes/crisis plans provides evidence that crisis plans are reviewed and updated as necessitated by evolving consumer needs and symptoms and as more effective interventions are developed.

Sign below to indicate you have read and agree to implement the System of Care approach.

_____ _____ Name

Date

North Carolina Division of Social Services
Responsible Individuals List (RIL) Information Request

Instruction for completing DSS-5268 (*please read carefully*):

G.S. § 7B-311 authorizes the release of information regarding substantiated cases of abuse and serious neglect from the Responsible Individuals List (RIL), for the sole purpose of determining current or prospective employment in certain situations, or fitness to provide case for children. This includes applications to foster or adopt a child. All sections of the DSS-5128 must be completed and signed by the agency and the prospective employee/applicant/volunteer.
Please print legibly or type all information. Incomplete or illegible forms will be returned via fax without the RIL check completed.

Requests for information may be submitted by:

Fax (919) 715-6714, Attn: RIL

Mail (must include SASE) N.C. Division of Social Services Attn: RIL
325 N. Salisbury St.
Mail Service Center 2408
Raleigh, North Carolina 27699-2408

Agency Requesting Information

Agency Name: Youth Focus, Inc.

Mailing Address: 715 N. Eugene St.

City/State/Zip: Greensboro, NC 27401

Phone: 336-274-5909

FAX: 336-274-3622

Type of Agency (Check One)

- ☑ Child Care Provider
- ☑ Child Placing Agency
- ☑ Group Home Facility
- ☐ Other Provider of Adoption
- ☐ Adoption Home Study
- ☐ Child Caring Institution
- ☐ County DSS
- ☐ Guardian ad Litem
- ☐ Other Provider of Foster Care
- ☐ Foster Parent Applicant

Agency License Number (if available)_____

Agency Certification: I herby request information from the North Carolina Responsible Individuals List. I certify that I am a person representing a child caring institution, child placing agency, group home facility, or a provider of foster care, child care or adoption services that needs to determine the fitness of individuals to care for or adopt children. I either currently employ the individual listed below, or am strongly considering the individual for an employment, contract, or volunteer position. I will only use the information requested to determine whether to hire or retain the individual.

Name and Title: (PRINT)

Becky Buchanan, Human Resources Director

Signature:

Date: _____

Employee (E), Applicant (A) or Volunteer (V).

Print E, A, or V's Full Name (including MI):

_____
First Name MI Last Name

E, A, or V's Date of Birth (MM/DD/YYYY):

_____/_____/_____

E, A, or V's Social Security Number (last four digits)

_____ _____ _____ _____

E, A, or V's Gender:
_____ Male _____ Female

Other names used (maiden, nickname, former married name etc.):

_____

_____

_____

Employee (E), Applicant (A), or Volunteer (V) Acknowledgement:
I acknowledge that I have been informed that the North Carolina Division of Social Services will disclose to the above named agency whether my name appears on the Responsible Individuals List, indicating that I am identified as being responsible for the abuse or serious neglect of a juvenile.

Signature: _____

Date: _____

NCDSS Office Use Only

☐ Form submitted incomplete

☐ Ineligible to request information

☐ As of _____ E, A, V's name is NOT on the RIL

☐ As of _____ E, A, V's name found on the RIL

Finding:

_____

_____

Completed by:

Staff Name (Print):

_____

Signature:

_____

Date: _____

The following form:

Youth Focus Core Competency Form

Is Used By:
Mental Health Technicians

Child Care Workers

Program Managers

Recreation Therapists

Teachers

Asst. Teachers

Therapeutic Foster Care Case Managers

BA level Intensive In-Home staff

Other direct care staff

Qualified Mental Health Professionals (i.e. a "Q") do not need to complete a supervision form *except for staff in Intensive In-Home*

YOUTH FOCUS CORE COMPETENCY FORM

Name: _____ Start Date: _____

Title: _____

Program: _____

Staff Definitions: Paraprofessional – HS Degree, no experience; **Associate Professional** – MA degree and less than 1 year of experience or college degree in human service area and less than 2 years of experience or college degree not in human services and less than 4 years of experience; **Qualified Professional** – Licensed (full or provisional) human service professional or MA degree plus 1 year of experience; college degree in human services and 2 or more years of experience; or college degree not in human services and 4 or more years of experience.

Staff Status: _____ Qualified Professional _____ Associate Professional _____ Paraprofessional

_____ Foster Parent

DURING THE HIRING/SELECTION PROCESS, DURING THE PRE-SERVICE TRAINING PROCESS AND DURING THE ANNUAL UPDATE/APPRAISAL PROCESS THE EMPLOYEE/FOSTER PARENT HAS BEEN DETERMINED TO HAVE THE CORE SKILLS AND COMPETENCIES CHECKED BELOW AND IS COMPETENT TO SERVE:

Populations (check all applicable): _____ Children _____ Adolescents _____ Adults

Core Skills and Competency	Check Below If Competent	Approved Service	Check If Approved
Adequate Technical Knowledge		Child and Adolescent Residential Treatment	
Cultural Awareness		Day Treatment	
Analytical Skills		Therapeutic Foster Care	
Good Decision Making Skills		Outpatient Services	
Good Interpersonal Skills		Targeted Case Management	
Good Communication Skills		Intensive In-Home Services	
Good Clinical Skills		Diagnostic Assessment	
Mental Health Treatment Skills		Restraint	
Substance Abuse Treatment Skills		Other – Specify:	

Staff responsible for hiring and training the employee/foster parent listed above have determined that they have the core competencies and skills indicated above. The signature of the supervisor verifies and documents that this assessment has occurred:

_____ _____

Supervisor Date

Youth Focus Inc.

Supervision Agreement

1. Name of Supervisee:

2. Name of Supervisor:

3. Functions of supervisee while under supervision will be outlined on their job description.

4. Supervision methods shall include the following:
   a. Discussion of client progress and implementation of treatment strategies
   b. Discussion of the treatment milieu;
   c. Professional and ethical issues;
   d. Review of documentation and Youth Focus Policies and Procedures;
   e. Discussion of seminars attended or assigned reading materials.

5. Brief description of supervision goals/objectives:

   GOAL 1.

   GOAL 2.

   GOAL 3.

6. Time Allocation:

   The supervisee will meet with the supervisor for up to one hour per month for individual supervision and/or for up to one hour per month for group supervision.

7. Length:

   This contract is in effect from _____ to _____.

8. Approval:

_____ _____
Employee Date

_____ _____
Supervisor Date

The following form:

Credentialing and Privileging and Core Competency Form

Is Used By:

Unlicensed or provisionally licensed counselors, social workers, substance abuse counselors or psychologists

Qualified Mental Health Professionals

Aka "Q's" do not need to complete a supervision form *except in intensive in-home where the service definition requires a supervision plan and documented supervision.*

YOUTH FOCUS CREDENTIALING AND PRIVILEGING AND CORE COMPETENCY FORM

Staff Name: _____ Start Date: _____

Job Title: _____ Program: _____

Highest Degree Attained:
School/University _____ Degree & Date: _____ Area of Study: _____

License/Certifications:
Type & Number: _____ Date Issued: _____ Expiration Date: _____ State _____

Staff Status: _____ Qualified Professional _____ Associate Professional _____ Paraprofessional

PRIVILEGED ACTIVITIES:
Populations (check all applicable): _____ Children _____ Adolescents _____ Adults

Activities	With Sup.	W/O Sup.	Provide Sup.	Activities/Competency	
Screening /Evaluation Diagnostic Assessment				NCI	
LOE/CAFAS				CPR	
Establish Diagnoses				First Aid	
Outpatient Treatment				Medication Administration	
Case Documentation				**Core Skills and Competencies Have Been Assessed Including (Check all that apply):**	
Case Consultation				Adequate Technical Knowledge	
Residential Service Planning, Implementation, Documentation and Treatment: Level II, Level III & PRTF				Cultural Awareness	
Intensive In-Home Services				Analytical Skills	
Targeted Case Management				Good Decision Making Skills	
Day Treatment Services				Good Interpersonal Skills	
Mental Health Treatment Services				Good Communication Skills	
Substance Abuse Treatment Services				Good Clinical Skills	
Other				Other:	

Staff Signature: _____ Date: _____
(as it will appear in client records)

Supervisor Signature: _____ Date: _____

Youth Focus Inc.

Supervision Agreement

1. Name of Supervisee:

2. Name of Supervisor:

3. Functions of supervisee while under supervision will be outlined on their job description.

4. Supervision methods shall include the following:
   a. Discussion of client progress and implementation of treatment strategies
   b. Discussion of the treatment milieu;
   c. Professional and ethical issues;
   d. Review of documentation and Youth Focus Policies and Procedures;
   e. Discussion of seminars attended or assigned reading materials.

5. Brief description of supervision goals/objectives:

   GOAL 1.

   GOAL 2.

   GOAL 3.

6. Time Allocation:

   The supervisee will meet with the supervisor for up to one hour per month for individual supervision and/or for up to one hour per month for group supervision.

7. Length:

   This contract is in effect from _____ to _____.

8. Approval:

_____ _____
Employee Date

_____ _____
Supervisor Date

The following form:

Credentialing and Privileging and Core Competency Form for LICENSED STAFF
such as licensed counselors, social workers, MD, nurse or psychologists

Licensed staff does not need to complete a supervision form *except for staff in intensive in-home where the service definition requires a plan and supervision.*

Please note: Not all licensed nurses are considered to be a Qualified Mental Health Professional. Nurses must have at least 2 years of full-time experience working with a mental health population to be a Q and therefore do NOT require supervision.

ATTESTATION FORM: Licensed staff who will not participate in restraints should sign the attestation form that is included. Licensed staff who will participate in restraints may sign the form but they will also need to complete both Part A&B of NCI and all refreshers.

YOUTH FOCUS CREDENTIALING AND PRIVILEGING AND CORE COMPETENCY FORM
LICENSED STAFF

Staff Name: _____ Start Date: _____

Job Title: _____ Program: _____

Highest Degree Attained:
School/University _____ Degree & Date: _____ Area of Study: _____

License/Certifications:
Type & Number: _____ Date Issued: _____ Expiration Date: _____ State _____

Staff Status: _____ Licensed Qualified Professional

PRIVILEGED ACTIVITIES:
Populations (check all applicable): _____ Children _____ Adolescents _____ Adults

Activities	With Sup.	W/O Sup.	Provide Sup.	Activities/Competency	
Screening /Evaluation Diagnostic Assessment				NCI	
LOE/CAFAS				CPR	
Establish Diagnoses				First Aid	
Outpatient Treatment				Medication Administration	
Case Documentation				**Core Skills and Competencies Have Been Assessed Including (Check all that apply):**	
Case Consultation				Adequate Technical Knowledge	
Residential Service Planning, Implementation, Documentation and Treatment: Level II, Level III & PRTF				Cultural Awareness	
Intensive In-Home Services				Analytical Skills	
Targeted Case Management				Good Decision Making Skills	
Day Treatment Services				Good Interpersonal Skills	
Mental Health Treatment Services				Good Communication Skills	
Substance Abuse Treatment Services				Good Clinical Skills	
Other				Other:	

Staff Signature: _____ Date: _____
(as it will appear in client records)

Supervisor Signature: _____ Date: _____

Name: _____

Training on Alternatives to Restrictive Interventions and Demonstration of Competency for Licensed Professionals

Licensed professionals, by virtue of their extensive training and experience, may elect to either take Part A NCI training, or they may attest to their competence in each of the nine areas outlined below by signing an attestation statement confirming that they have reviewed the nine competencies and that they are proficient and well-skilled in each of these areas.

Competency Area:	Check if Competent
1. Knowledge and understanding of the people being served	
2. Recognizing and interpreting human behavior	
3. Recognizing the effect of internal and external stressors that may affect people with disabilities	
4. Strategies for building positive relationships with persons with disabilities	
5. Recognizing cultural, environmental and organizational factors that may affect people with disabilities	
6. Recognizing the importance of and assisting in the person's involvement in making decisions about their life	
7. Skills in assessing individual risk for escalating behavior	
8. Communication strategies for defusing and de-escalating potentially dangerous behavior	
9. Positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe)	

By signing below I attest that I am competent in the areas listed above:

_____ _____

Signature Date

_____