MHCA
Mental Health Corporations of America, Inc.
July/August 2000

ExecutiveReport

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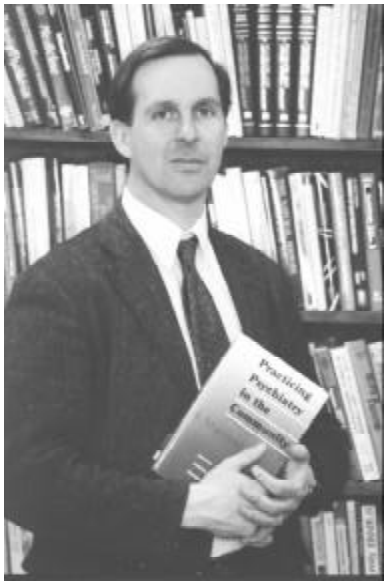

William Chandler Torrey, MD

Keynoting MHCA's Summer Meeting in Portland, Oregon on Wednesday, August 16, will be William Chandler Torrey, MD, Medical Director at West Central Services in Lebanon, New Hampshire. Dr. Robert Browne, Senior Research Associate at Eli Lilly, will introduce Dr. Torrey and make preliminary remarks about the current state of psychopharmacology. Dr. Torrey's presentation, "Psychopharmacology - New Medications and Implications for Services, Design and Delivery", will be followed by a panel of MHCA respondents offering "Trends and Innovations Related to the New Pharmaceuticals."

In addition to his responsibilities at West Central Services, Dr. Torrey is Associate Professor of Psychiatry, Dartmouth Medical School, Department of Psychiatry, and Director of The West Psychiatric Training Institute at Dartmouth Lebanon and Concord, NH. He is Medicaid Eligibility Reviewer in the Office of Medical Services, NH Division of Human Services and Medical Director, Care Management, Dartmouth-Hitchcock Behavioral Healthcare. Dr. Torrey received his undergraduate training at Dartmouth College and his medical degree from the Harvard Medical School. He served as Chief Resident in Psychiatry at Dartmouth Hitchcock Medical Center in 1988-89.

Dr. Torrey is widely published, having written and co-authored numerous articles, monographs and books. Since 1989 he has been continually funded by various sources as a research psychiatrist. In 1995 he was honored by the National Alliance for the Mentally Ill with "The Exemplary Psychiatrist Award". He is a sought after presenter and often lectures in the Northeast. He has also lectured in West Virginia, Georgia and Tennessee.

On Thursday, August 17, our General Session will include several presentations. Among them are "Successful Marketing Communications in Behavioral Health" which will present specific marketing communication information essential for maximum impact in this fast changing, competitive business. Presenters are Rebecca Carl and Tom Willey, Behavioral Healthmark, and Dennis P. Morrison, PhD, CEO, Center for Behavioral Health. Following will be "Lessons Learned: An insider's look at the behavioral health managed care industry" by Leslie Mariner, VP Public Solutions, Magellan Behavioral Health, and former MHCA member. In the afternoon we will hear about "Succession Planning for CEOs and Upper Management". This will be a presentation of succession plans adopted by MHCA members including Ann Borders, CEO, Cummins MHC; Howard Bracco, PhD, CEO, Seven Counties Services; David Feldman, EVP, Circles of Care; Mary Hiland, CEO, Alliance for Community Care; and Lloyd Sidwell, CEO, Family Resources, Inc. The afternoon session will conclude with a Member Showcase on "Operationalizing Core Values and Strategic Business Planning" by Jim Gaynor, CEO, Unity, Inc.

The dates are August 14-18 at Portland's Hilton Hotel...Monday and Tuesday will be devoted to Strategic Planning and Committee/Board meetings. Please join your colleagues for this great meeting! ❖

President's Column by Donald J. Hevey

Succession Planning - Starting Early

Donald J. Hevey

One of the presentations planned for Thursday, August 17 in Portland at our Summer Meeting is "Succession Planning for CEO's and Upper Management." Panelists Ann Borders, Howard Bracco, Mary Hiland, David Feldman and Lloyd Sidwell will discuss their models for succession planning. We are all aware of others in our group who have successfully implemented succession strategies. The following article, reprinted from The Chief Executive Group, L.P., web site **www.chiefexecutive.net,** provides a perspective and strategy on this process from outside our industry.

DANA CORP: Succeeding at Succession

Earlier this year, Southwood J. "Woody" Morcott stepped down as CEO of autoparts maker Dana Corp., while another company veteran, Joseph Magliochetti, took his place. Next year, Morcott will relinquish the chairman's title to Magliochetti as well. And if all goes accordingly, their 86,000 co-workers will hardly notice. "We're trying to make succession boring," quips Morcott, 61, an affable Georgia native who became CEO in 1989 and chairman the following year.

With many CEOs being shown the oak door before their time, or chasing career options in a quest for more lucrative stock options, corporate succession planning has never been so integral to smooth business operations. Toledo, Ohio-based Dana frankly hasn't had much experience with top-level succession. Morcott is only the fifth chairman since Charles Dana took the company public in 1916. But it does have a highly organized company-wide strategy. "Succession at all levels is a process, not an event," Morcott explains. "In 1989, when I became CEO, I started planning for my succession. When the event occurs, you don't go scrambling around looking. That should all be done in advance."

Managers of each Dana business division create what Morcott calls "depth charts" with the names of three or more potential replacements that the board reviews each December. These snapshots highlight an employee's strengths, weaknesses, and corporate experience. People on the depth chart know who they are, and their supervisors work with them to build their capabilities.

Additionally, Dana's five-member policy committee has its own depth charts to track the top few dozen division managers and other high-placed operatives. Dana tends to promote from within and gives continuous training, education, and managerial challenges that are designed to eventually produce several qualified candidates for the top job. Morcott, for instance, joined Dana in 1963; Magliochetti arrived three years later.

"Because we promote from within, we tend not to lose as many people," Morcott says. "They know nobody's going to be parachuted in above them. It's up to them to win it or lose it."

The succession system is so ingrained that Dana already is looking for people who can fill Magliochetti's shoes when the 57-year-old retires in about eight years-and beyond. "We're talking about who will be chairman in 2015," says Morcott. "I know the names of the players who have the potential if we move them around, train them, teach them, educate them."

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E-Sign ... Taking A Look at Its Application in Healthcare

Seeking to create uniform standards that will govern transactions in e-commerce, Congress has passed a new piece of legislation regarding electronic signatures. The Electronic Signatures in Global and National Commerce Act - also known as E-Sign - recognizes electronic signatures as having the same legal weight as handwritten signatures for most commercial transactions, and provides for certain technology-neutral approaches to the adoption of standards relating to electronic signatures. The Act was passed by both the House of Representatives and Senate in late June and signed by President Clinton on June 30.

E-Sign Overview

Set to go into effect on October 1, 2000, the Act provides that a signature or contract may not be found to be invalid or unenforceable solely because it is in electronic form. The Act, however, specifically does not require anyone (other than the government) to agree to use an electronic contract or to accept an electronic signature. Rather, if you want to transact electronically, the Act says you can, even if there is a statute on the books that says you need a writing in non-electronic form. E-Sign clearly wants to usher in electronic signatures gradually. It tries to effectuate a balance between the desire of industry to embrace e-business in its purest form and the technophobic consumer who is dubious of not having his or her agreement memorialized by a signed writing. Accordingly, E-Sign provides that where there is a law or regulation requiring that an agreement or other information relating to a transaction be in writing, an electronic signature or contract will not be valid unless the consumer has been provided with notice of his or her rights under that law and has affirmatively consented to doing business without a written agreement. In addition, E-Sign treats certain types of transactions as sacrosanct. Wills, codicils, testamentary trusts, and documents created in connection with adoption, divorce and other matters of family law are unaffected by the legislation, as are certain types of court orders, notices of cancellation of health and life insurance benefits and of utility service, and notices of foreclosure and eviction. The Act leaves the door open, though, providing for a review in three years to see whether these protections are still warranted. If in the next three years we as a society have embraced e-methods of doing business, then perhaps the statute will be amended to provide for e-wills, e-life insurance, and e-viction.

Interaction with **HIPAA** *Rules*

E-Sign's application in the healthcare context is similarly conciliatory, as it complements rather than conflicts with the electronic signature standard of the proposed HIPAA Security Rule. The HIPAA Security Rule, like E-Sign, does not require the use of an e-signature (although an electronic signature may be required by a given transaction standard adopted by the Secretary of Health and Human Services); and while the definition of the term "electronic signature" appears to be different in E-Sign and the HIPAA Security Rule, the two definitions are not inconsistent. E-Sign's definition of "electronic signature" is very broad, encompassing a range of technologies through which an electronic signature could be utilized, such as a sound, symbol or process that incorporates a digital, wireless, or magnetic format, for example. The HIPAA Security Rule's electronic signature definition is somewhat of a subset of the E-Sign definition, providing that when an electronic signature is used, it must be digital. Basically, the E-Sign legislation and the HIPAA Security Rule address two different, but related, concerns. The HIPAA Security Rule focuses on protecting the accuracy and security of a message transmitted by electronic means. For example, if a covered entity uses electronic signatures in its transactions, then the HIPAA Security Rule requires that the entity must assure (i) message integrity, i.e. unaltered transmission and receipt of the message; (ii) nonrepudiation, which would prevent the signer of a message from subsequently denying that he or she sent the message, and (iii) user authentication, which involves provid-

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From MHCA's ListServe...

A sampling of recent inquiries posted to MHCA's web-based General ListServe. These members each received numerous responses via email. For those of you who are still avoiding cyberspace, we thought you might be interested in seeing what your colleagues are doing "out there"! Log on . . . get in the conversation!

Jerry Mayo, Executive Director
Pine Belt Mental Health Resources

We are interested in preparing a handbook for our commissioners (governing board) that would contain policies and procedures particularly for them as well as general information about our agency. In particular they have ask that a glossary be included. I'm sure there are those among us that have such a handbook and I would appreciate receiving a copy of yours if possible so that we will have a guide. If a copy is too much trouble, if you would fax the table of contents that would be most helpful. Thanks for the help.

Address: P.O. Box 1030, Hattiesburg, MS 39401
Telephone: 601- 544-4641 Fax: 601-582-1607
email: jmayo@pbmhr.com

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Bob Williams, PhD, President/CEO
Quinco Behavioral Health Systems

Indiana Council is developing a model policy to present to our Division of Mental Health addressing the issue of consumer choice. Our long-term consumers tell us very clearly that "choice" to them means getting to work with the therapist and/or psychiatrist of their choice within our oranizations. It rarely means having the right to be seen by another provider organization.

Have any of you developed an internal "freedom of choice" policy and if so would you mind sending it along to me? Thanks in advance!

Address: 1455 N. National Road
Columbus, IN 47202-0628
Telephone: 812-348-7449 Fax: 812-376-4875
email: RJWilliams@QuincoInc.com

MHCA's List Server hosts the following groups:
Boards Discussion Groups
Committees Discussion Groups
General Discussion Group
SubLists Discussion Groups

Dan Ranieri, PhD, Executive Director
La Frontera Center

Our staff is requesting that we expand our health care benefits to domestic partners. Before bringing this to the Board, I'm trying to get information about the experiences of other organizations who offer this benefit (i.e., cost, staff morale, ability to determine eligility, escalation of requests for other benefit consideration, etc.). Any input would be appreciated.

Address: 502 W. 29th Street, Tucson, AZ 85713
Telephone: 520-884-9920 Fax: 520-792-0654
email: dranieri@azstarnet.com

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Sandy Stephenson, Executive Director
Southeast, Inc.

Southeast may have an opportunity to purchase an existing (specialty) pharmacy. Are any of you operating pharmacies that serve your clients as well as others in the community? I have a number of questions and would appreciate the opportunity to communicate with any of you who are operating a pharmacy or who have considered this venture.

Address: 16 W. Long St., Columbus, OH 43215
Telephone: 614-225-0980 Fax: 614-225-0986
email: StephensonS@southeastinc.com

• •

Bill Hogan, Chief Executive Officer
Lifequest

We are developing a Corporate Compliance program and would like suggestions on an internal monitoring/auditing system (i.e. specific activities) as well as disciplinary actions for non-compliant staff/managers. Any ideas?

Address: 230 E. Paulson, Suite #68, Wasilla, AK 99654
Telephone: 907-376-2411 Fax: 907-352-3222
email: bhogan@lifequest.org

Helen Ross McNabb Center and Quinco Mental Health Center Join MHCA

Ken Badal, CEO of the Helen Ross McNabb Center in Knoxville, Tennessee, and Barry Hale, CEO of the Quinco Mental Health Center in Bolivar Tennessee, have become our newest members, joining MHCA in late June and early July respectively.

Badal and his Board Chairman, Randy Miller, visited with us in Newport Beach, California at our 1999 Annual Meeting. Rick Haynes, the Center's COO, joined us for the recent Spring Meeting in Memphis. The Center's address is 1520 Cherokee Trail, Knoxville, TN 37920. Phone 865-637-9711.

Both Badal and Hale have been enthusiastically endorsed by fellow Tennessee members. We welcome them! The Quinco Center address is 10710 Highway 64, Bolivar, Tennessee 38008. Phone 901-658-6113. ❖

CARF Appoints Second National Director in Behavioral Health

CARF has announced the appointment of Steven F. Minner, Ph.D., as the accrediting body's National Director in the Behavioral Health Division. When Minner joins the CARF staff in mid-July, he will be dividing his time between marketing CARF' s accreditation products in the behavioral health field and overseeing CARF's work on the Opioid Treatment Program Accreditation Project.

Minner will share responsibilities with Nikki Migas, who has been a National Director in the Behavioral Health Division since 1997.

No stranger to CARF accreditation, Minner has been a CARF surveyor for eight years and a frequent presenter in the yearly CARF conferences that are sponsored by the Behavioral Health Division. He has more than 15 years of leadership experience in the behavioral health field, having worked in both the private and public sectors. Most recently he was the Accreditation and Corporate Compliance Officer for Counseling Associates in Conway, Arkansas. ❖

E-Sign, **continued from page 3**

ing an assurance of the claimed identity of an entity. E-Sign, on the other hand, does not impose specific requirements, but instead, strives to introduce uniformity into a wide range of e-commerce transactions while allowing consumers control over the use of e-signatures and e-records.

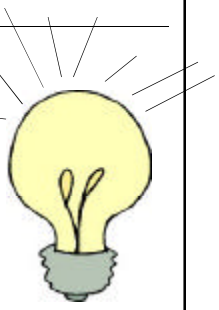
Though the approaches of E-Sign and the HIPAA Security Rule differ, their intention is the same - namely, to create an environment in which e-signatures may be more frequently used. The proposed HIPAA Privacy Rule will also be affected by the consent requirements of E-Sign, to the extent that the Rule requires that a consumer be given certain information in written form. For example, under HIPAA, consumers are entitled to written notice of a covered entity's information sharing practices, and to a written explanation when an entity denies a consumer's request to amend or correct his or her healthcare information. E-Sign would allow this written information to be transmitted to the consumer in electronic form, but only upon the consumer's consent.

If E-Sign is any indication, each new law and regulation governing e-commerce will need to be evaluated to determine whether and to what extent it will affect the e-health industry. Only time will tell if future e-commerce and e-health laws will be as compatible with each other as E-Sign and the HIPAA Rules appear to be. For more information, visit *www.ehealthlawtoday.com* ❖

Note: This Bulletin is intended as a general comment on certain recent developments in the law. It does not contain a complete legal analysis or constitute an opinion of Moses & Singer LLP or any member of the Firm on the legal issues herein described. It is recommended that readers not rely on this general guide in structuring or analyzing individual transactions but that professional advice be sought on with any such transaction.

Words to the wise . . .

If you haven't had a new idea or discarded an old one in the past six months, you'll want to check your pulse. You might be dead.



Scioto Paint Valley MHC - Risk Assessment for Violence Protocol

Winner of the 2000 Negley Awards for Excellence in Risk Retention - Chairman's Award

A collision of diverse realities: corporate leadership initiatives, adverse action incident, conflicting public policy mandates and legislation, incorporating evolving clinical research into clinical practice patterns and legal entanglements challenges the Center to continuously rethink how it views the universe of risk management. Yesterday's impossibilities and assumptions become today's opportunity and discipline. Risk management has become embedded in all aspects of the Center's operation.

Corporate Leadership

In 1993, the Center's Executive Director challenged the Center's clinical managers and professional staff to systematically develop and implement clinical protocols stipulating preferred practice guidelines. Shortly thereafter, the Center established a protocol development process *(Appendix 1)*. The procedure for initiating a protocol task group resides with any employee or group of employees regardless of status or credential. Once initiated the proposal is screened utilizing the following criteria: need and impact on effectiveness and efficiency. The next step in the development process is establishing a task group consisting of management and those professionals who are impacted. This process is consistent with the Center's mission, management philosophy and goals *(Appendix 2)*. The protocol implementation process involves the task group submitting their proposed protocol in compliance with the established format *(Appendix 1)* for management and executive staff review and their recommendation for approval. The Executive Director approves all protocols. The signature of the task group facilitator(s) and Executive Director are affixed on each protocol. This process ensures staff participation, ownership and utilization.Public Policy The State transferred to Community Mental Health Centers the responsibility for monitoring persons conditionally released who were found to be not guilty by reason of insanity and incompetent to stand trail due to mental illness. This increased responsibility exacerbated our risk potential exponentially.

Incident

Just prior to this change a severely mentally disabled client the Center had been serving for more than ten years, stabbed two persons, killing one and wounding the other.

Risk Assessment for Violence Protocol

Because of these realities the ensuing systematic process brought to light current research data and outcomes, conflicting mandates (public policy vs. legislation), the need for professional guidelines, training and continuous/vigilant monitoring of our diverse environment. The notice of a pending claim action coupled with the Ohio Supreme Court ruling in the case, Morgan v. Fairfield Family Counseling Center, stimulated the Center's Risk Assessment for Violence Protocol initiative. *(Appendix 3)*

The utilization of the protocol's Risk for Violence Inventory *(Appendix 4)* enables professional staff regardless of licensure status or discipline to identify high-risk patients who may potentially act out in violent or aggressive acts, facilitates appropriate supervisory involvement and monitoring, identifies appropriate and necessary level of care options and assures an efficient and effective manner for documenting assessment and actions in compliance with practice and legal guidelines and rules.

Prior to the Risk Assessment for Violence Protocol implementation the Center assumed managers and professional staff were cognizant of and effectively managing at risk clients. Once this assumption was subjected to the Center's established protocol development process, we became aware of the significant variance between the assumption and reality. Our Risk Assessment for Violence Protocol has enabled the Center to move from assumption to fact, from no data to a comprehensive array of data and from assumed risk management to disciplined risk management.

The implementation of the Center's Risk Assessment for Violence Protocol clearly demonstrates quality of care improvement. Enhancing our professional competence and confidence related to identifying and engaging high-risk clients

is viewed as a client and community benefit since the ultimate quality care criteria is strengthening client functioning. The client's perception of quality related to the Center's comprehensive system of care options as well as specific programs and services indicates exceptional outcomes *(Appendix 5)*. A cluster of the Center's client satisfaction survey outcomes indicate that we consistently exceed internationally benched marked outcomes. These results coupled with professional participation in targeted inservice training *(Appendix 6)* and increased utilization of the Risk Assessment for Violence Protocol instrument evidences increased quality of care.

The Center's professional staff have been and are intimately involved in all aspects of protocol development and most especially in the development of the Risk Assessment for Violence Protocol. The task group reviewed the literature and research, particularly the *MacArthur Violence Risk Assessment Study* (Monahan, 1998), the Ohio Supreme Court ruling, included professionals deposed in the Center's adverse action incident, and anticipated recent legislation: House Bill 71, 1999.

All professional staff participated in the inservice training and their suggestions lead to further refinements of the protocol. The task group produced an introductory video specific to the topic. The Risk Assessment for Violence Protocol was utilized 78 times in the first year of implementation and has been utilized 146 times so far this year. The protocol inventory has recently been amended in light of Ohio House Bill 71 to include Duty To Warn provisions. The protocols inventory is in compliance with all preferred practice and legal documentation standards. Risk tolerance expectations have been included in all staff job descriptions *(Appendix 4)*. Currently, professional staff have identified a need to amend and create a like protocol inventory to be focused towards children/adolescents. This is in the final stage of approval. Because of consistent and frequent referral to the Center's protocol manual, the Center is in the process of migrating from a paper protocol manual to copying the manual to a compact disk format.

Replication and Relevance

The Center has copyrighted their protocols and is willing to assist other behavioral health providers is whatever way possible. The Risk Assessment for Violence Protocol can be easily modified to fit any behavioral health organizations structure. Our Risk Assessment for Violence Protocol is both relevant and ideally suited for replication, since, the integrity of the Inventory incorporates both past and contemporaneous valid research, captures data in compliances with required practice and legal documentation guidelines and enhances efficient and effective professional utilization and clinical management oversight *(Appendix 7)*.

Existing Resources

The Center's Protocol development process was already operant; the Risk Assessment for Violence task group was established within these parameters. The Center's standing Inservice Training Committee facilitated the trainings utilizing members of the protocol task group as facilitators and accessing the Center's video production capabilities. ❖

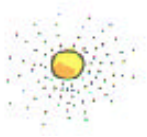
Attachments referenced in this article are available from MHCA. Phone 850-942-4900 or email: tboyter@mhca.com

History and Scope of Scioto Paint Valley MHC:

Scioto Paint Valley Mental Health is located in Chillicothe, Ohio and serves a five county rural area in South Central Ohio. They provide a comprehensive array of services to a diverse population with a decentralized management model that has enabled them to maintain a tradition of innovation. They have five outpatient clinics, a children's residential center, an adult residential center and a blend of staffed, supervised and unsupervised housing options. Service options at each outpatient site include: adult and children outpatients. community support: continuum of care for the severely mentally impaired. substance abuse. partial hospitalization, 24 hour crisis, employee assistance, critical incident stress debriefing, community education and consultation and forensic monitoring. Specialized program options include: DUI Intensive 48 hour group educational and assessment services; Poly Recovery Program intensive outpatient substance abuse treatment.; QA continuous improvement process; Forensic Services: court referred assessments, conditional release assessment and monitoring, sexual offender groups and shop lifting groups; and Transitional Services: facilitating and coordinating inpatient discharge planning related to internal and external continuum of care placements, assuring availability of community services.

At the time this program was submitted as a Negley Awards applicant, Scioto Paint's CEO was Diane Lewe. Since then Ms. Lewe has retired; the new CEO is Greg Kreuchauf (Phone: 740-775-1260). As winner of the Negley President's Award, the Center received an unrestricted cash gift of $5,000.

Calendar



MHCA 2000 Summer Meeting
Dates: August 14-18, 2000*
Location: Hilton Portland
Portland, Oregon
☎ 503-226-1611
Rate: $125/single or double
Registration Deadline: July 13, 2000
*Note the additional day - we'll begin MHCA's Strategic Planning Process on Monday!

MHCA 2000 Fall Meeting
Dates: October 31 - November 3, 2000
Location: Westin Riverwalk
San Antonio, Texas
☎ 210-224-8500
Rate: $160/single or double
Registration Deadline: October 8, 2000

MHCA 2001 Annual Meeting
Dates: February 20-23, 2001
Location: Westin Horton Plaza
San Diego, California
☎ 619-239-2200
Rate: $199/single or double
Registration Deadline: January 19, 2001

Succession Planning, continued from page 2

There's also another name in the top circle, which Morcott genially refers to as his "hit by a truck" replacement, who would be able to take the reins in dire straits. For Morcott's first two years, that task went to his immediate predecessor, Gerry Mitchell. Morcott himself became Dana president in 1986 to fill a vacancy after a sudden death, setting the stage for his future role. "You have to tailor everything to circumstances," he advises.

Open communication and feedback are linchpins of Dana's succession process. Morcott insists that he's opposed to executive horse races, where intense personal rivalries can undermine teamwork. "Dana hasn't functioned that way," he asserts, noting that naming Magliochetti CEO made it clear to the entire organization that he also would become chairman. "So you take away all discussion," Morcott adds, "and you get on with preparing him, positioning him, and letting him absorb the job in a more orderly fashion than just dropping everything on top of him." At the same time, the process tends to be self-selecting. A hotshot executive who's big on titles and has difficulty conceding power would probably not feel comfortable around Dana's nonthreatening, unemotional succession philosophy.

Has Dana found the solution to poor succession planning? Morcott, who serves on three other boards, cautions that there's no perfect way. "We don't have the answer," he says. "We have the answer for us." ❖

Negley Awards 2001:

"Limiting Liability Exposure While Addressing Violence in the Workplace and School"

Violence in the **workplace** is reaching epidemic proportions today all across the country. Though dramatic headlines catch the public's attention, workplace violence more often is associated with behaviors such as harassment, domestic violence problems or substance abuse. Employers have a responsibility to help reduce the potential for these problems. From pre-employment screening techniques to conflict resolution training, organizations can take a proactive role in making the workplace a safer place.

Similarly, news-making scenes of **school** violence are much too raw and much too recent to be easily forgotten. But in truth, the day-to-day realities of school violence occur on a continuum from verbal fights in the hallways to outright physical aggression in the parking lot. Before the day-to-day escalates to nightmarish proportions, there is much that can be done to help our children handle their depression, their anger and their shame. They don't have to hurt themselves or others. That's the good news.

But how do **employers** go about providing protections against these forms of violence? Often they turn to their **community mental health centers** whose programs of intervention serve an invaluable role in assisting the employer do the right thing. In spite of everyone's best efforts, violence continues. People are hurt. Litigation follows. What liability exists for the CMHC whose advice was sought, whose program was followed, whose counselors were involved?

For the past ten years, **Negley Associates**, the management company for **Mental Health Risk Retention Group**, has offered an awards program recognizing excellence in risk management. Negley Award applications are sought which present a clear understanding of and response to the issue of *"Limiting Liability Exposure While Addressing Vioence in the Workplace and School."*

Three cash prizes will be awarded ... $15,000 President's Award, $5,000 Chairman's Award, and $5,000 Board of Directors Award.

Application forms were mailed June 16 to all members of MHCA and NCCBH as well as to all MHRRG Shareholders. Response deadline is November 17, 2000. If you failed to receive a form and are a qualified applicant, contact MHCA. ❖