

**Report of the
Boston Bar
Association
Task Force
on
Children's
Mental Health**

January 17, 2002



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A S S O C I A T I O N

Executive Summary

This report sets out the analysis and recommendations of the Boston Bar Association's Children's Mental Health Task Force, which was commissioned in the Spring of 2001 by then BBA President Joan Lukey and President-elect Michael Keating. BBA members Michele Garvin, Michael Blau and Joshua Greenberg served as the appointed co-chairs of the Task Force.

The Children's Mental Health Task Force consists of roughly sixty members, representing every perspective relevant to the subject of children's mental health. Task Force members include the leaders of state agencies, and individuals representing diverse perspectives from the courts, academia, and the Legislature, as well as health care providers, payors, and advocates for children. The Boston Bar Association provides neutral ground on which these individuals can combine their experience, resources, and expertise to develop a comprehensive view of the problems that exist in the system of providing mental health services to meet children's needs, and to develop recommendations on how to improve that system.

The Task Force has organized its efforts under three basic topics: Early Detection and Treatment, Accessing and Coordinating Care, and Tracking Children and Outcomes. It has produced recommendations related to each of these topics, which it intends to carry out over the course of a year's time. In summary, the five recommendations of the BBA's Children's Mental Health Task Force are as follows.

Early Detection and Treatment

Assess the viability of outstationing mental health services in pediatric settings. Pediatric settings provide important opportunities to screen for, assess, and refer children for mental health services. In the past several years, several settings in Massachusetts have provided child development and case management services in pediatric clinics or private offices. These types of projects would make excellent test sites.

Developing a Client-Centered Focus: Accessing and Coordinating Care

Develop a guide to children's mental health services ("Guide"). The Guide is intended to be an easy to use reference tool for families of children in need of mental health services, pediatricians, other primary care providers, emergency physicians, schools, public agencies, and human and social service agencies and providers. The Guide will include: How to access child mental health screening and assessment services, a description of the types of available child mental health services and programs by funding source (public and private), contact information for categories of programs and services, and eligibility information for public programs and services.

Recommend protocols to coordinate care and cost of publicly funded children's mental health services. As a first step toward coordination, it is recommended that protocols be proposed to coordinate child mental health services, and cost allocation for those services, across all state agencies that furnish or procure any component of those services. The proposed protocols should delineate clear responsibilities for each agency, both with respect to services

and cost allocation, in the full range of foreseeable, real-life situations where the jurisdiction of more than one agency may be implicated.

Information Capture: Tracking Children and Outcomes

Develop a set of consensus measures for measuring and tracking children’s mental health indicators and outcomes. An Information Tracking working group should be established for the purpose of developing a set of indicators that include both systemic and clinical measures. Responsibility for data collection and reporting should reside with the Executive Office of Health and Human Services and its constituent agencies in collaboration with the Department of Education and private sector groups.

Establish a working group to develop model legislation for collecting data on children’s mental health care, access and outcomes. The BBA is already on record as supporting legislation enacted in December 2001 that requires the collection and reporting of certain information related to the delivery of mental health services to children in Massachusetts. A working group of the Task Force is to be established to develop model data collection legislation.

Other Topics for Future Discussion

Other specific topics of interest and concern raised within the Task Force are not addressed in the current Report, but are listed and described at the end, for the purpose of future discussions. The Task Force sincerely thanks the leaders and the members of the Boston Bar Association for their support. It is the shared hope of the many individual members of this Task Force that the Boston Bar Association will remain a committed partner in the work of meeting the mental health needs of the Commonwealth’s children for many years to come.

Background of the Boston Bar Association Children's Mental Health Task Force

Over the past few years, news reports have increasingly described children in Massachusetts being unable to access much-needed mental health services. Over a two year period, the Boston Bar Association's own Health Law Section hosted an extensive series of luncheon meetings, featuring a variety of speakers knowledgeable about the problems in the current system of delivering mental health services to children in Massachusetts. In the Spring of 2001, then BBA President Joan Lukey and President-elect Michael Keating commissioned the BBA Children's Mental Health Task Force, to provide a neutral environment for discussing the situation and proposing reforms.

BBA members Michele Garvin, Michael Blau and Joshua Greenberg were appointed as the co-chairs of the Task Force. They in turn assembled a group of distinguished representatives of every aspect of the field of children's mental health, ensuring that the membership of the task force would have the expertise and diversity it would require to meet its goals.

Building on the solid core of information generated by the BBA luncheon meeting series, the Task Force Co-Chairs conducted further research into the subject, and spoke with key stakeholders including state agency heads, legislative leaders, mental health advocates, private providers, and representatives of payor organizations.

Several themes emerged during the course of this preparatory work:

- The children's mental health care system lacks accountability and fails to coordinate care among the numerous state agencies, and between the public and private agencies, that deliver services. For example, one agency provides acute inpatient and outpatient treatment, while others are responsible for residential care. There is no active central coordinating body, nor any formal mechanism for resolving interagency disputes. Except in limited circumstances, there does not seem to be any central planning or case management system for individual children. As a result, advocates report that financial concerns among agencies often dictate determinations about care.
- Relevant, consistent data is difficult to come by. While there is some data on hospitalization and lengths of stay, for example, we found little information on the range, quality and/or appropriateness of community-based services. Furthermore, the existing data is not always consistent. The Massachusetts Behavioral Health Partnership, for instance, provides mental health services for a significant number of MassHealth recipients, but the four managed-care organizations participating in the MassHealth program each use a different vendor, and collect different data in different formats. There does not seem to be any mechanism for tracking any data elements across agencies.
- The problem is likely to worsen in coming years. The adolescent population in the state is projected to grow 25 percent between 1995 and 2005. The acuity of need also appears to be increasing, reflected in the growing numbers of younger children

needing services, as well as the more intensive services required by children. The shift to managed-care appears to have reduced the availability of more community-based initiatives, and has significantly undermined the ability of clinicians to make collateral contacts with relevant agencies due to the lack of reimbursement. Finally, almost every interviewee expressed frustration with the difficulty of hiring qualified staff, given the state's low payment rates for mental health workers. Numerous examples were cited of "funded" services being unavailable because staff could not be hired.

- Increasing the availability and capacity of community-based services was universally cited as a solution to the problem. However, most of the emphasis of the media, state policymakers, and provider organizations has been on children stuck in hospital beds or boarded in inappropriate settings because residential care is unavailable. As noted above, we were unable to find detailed information on the capacity and availability of the current community-based services.

Children's Mental Health Forum

Once the Task Force Co-Chairs had identified these issues, they produced a briefing book for the members of the task force, and brought the entire group together for an all day meeting, the Children's Mental Health Forum. The goal was to have concrete, achievable recommendations emerge from an intensive discussion by key stakeholders in three specific topic areas: early detection and treatment, accessing and coordinating care, and tracking children and outcomes (Copies of the briefing book are available from the Task Force Co-Chairs.)

Jack Shonkoff, Dean of the Heller School at Brandeis University, served as the Moderator for the plenary discussion sessions that took place at the beginning and end of the day. Barry Zuckerman, M.D., Chair of the Department of Pediatrics at Boston Medical Center, and Susan Ayers, Executive Director of The Guidance Center, Inc. led the discussion on the topic of Early Detection and Treatment; Marylou Sudders, Commissioner of the Department of Mental Health and Lisa Lambert, Assistant Director of the Parent Professional Advocacy League led the discussion on the topic of Developing a Client Centered Focus: Accessing and Coordinating Care will be; and Karen Hacker, M.D., Director of Children's Mental Health at the Boston Public Health Commission, and John Straus, M.D., Vice President of Medical Affairs of the Massachusetts Behavioral Health Partnership led the discussion on the topic of Information Capture: Tracking Children and Outcomes. The following is a synopsis of the concerns addressed at the Forum in each topic area:

Early Detection and Treatment

A variety of systems theoretically screen for mental health problems among children. These include pediatricians, childcare providers, schools and early intervention agencies. But the backlog of children awaiting treatment for serious mental illness suggests that the system is failing to identify those in need of treatment, failing to connect them with services at an early stage – or both. Pediatricians and school system professionals, for example, rarely conduct routine screenings because they lack the time and, in many cases, the training to do so. We need to strengthen the identification process and make it more uniform, to ensure that screenings are

culturally sensitive and that they take into account the multiplicity of factors that can affect a child's mental health, such as domestic violence and parental depression. Finally, once a child is identified, we must have a coordinated means of developing a more detailed, family-oriented assessment, and of following up.

But assessment will only hold value if treatment options are available. These should be community-based, so that the child can remain at home or in the least restrictive environment possible. We should also be equipped to address family needs, such as sufficient food and safe housing, as part of the treatment plan. It is unclear whether the problem is a failure of coordination and linkage to services, or a lack of sufficient services altogether. We must also determine how we can best allocate funding and make it more flexible, so that children receive appropriate treatment before their problems become severe enough to require out-of-home placement.

Developing a Client-Centered Focus: Accessing and Coordinating Care

The most publicized aspect of the children's mental health crisis is the "stuck" kids problem – children forced to wait in emergency rooms and hospitals because appropriate treatment facilities are full. This raises the question of whether there are a sufficient number of acute inpatient mental health beds in the system. Beyond capacity, however, we must ask whether enhancing front-end services would reduce the perceived need for inpatient and residential beds. Preliminary research findings from Massachusetts, as well as those referenced in the Surgeon General's Report on Children's Mental Health, indicate that such services can reduce hospitalization and placement rates. Although some programs offering intensive services and supports for children and their families exist, they are not widely available. Furthermore, we must effectively inform families of programs that can help their children. Parents often complain that they do not know where to turn when their children begin to exhibit mental illness, because the system is confusing and there is no written guide to help them navigate it.

Interagency disputes about funding responsibilities have negative consequences for children and families as well. Children often remain in hospitals longer than clinically necessary pending resolution of funding disputes.

Yet funding is not the only factor leading to fragmented care. The lack of interagency protocols to address children needing services from more than one source creates significant difficulties for families. This problem is compounded by poor communication between providers and the system's failure to take a comprehensive view of the needs of the child and family.

Finally, it will be difficult to address any of the above issues without solving the workforce problems of the children's mental health system. Many beds are currently left empty because facilities cannot hire or keep enough staff. Though Massachusetts has the highest concentration of licensed behavioral health professionals in the country, many are unwilling to accept all forms of insurance. In certain, principally rural, areas of the state, there are no child psychiatrists. Staffing shortages and alarming rates of turnover have led to increased utilization of inexperienced staff and reliance on relief and overtime. These issues directly correlate to quality and continuity of care for our children.

Information Capture: Tracking Children and Outcomes

One of the driving forces for this forum was the lack of reliable documentation about the state of children's mental health care in Massachusetts. Legislation signed into law in December 2001 seeks to address this concern, by requiring that state agencies publicly report on the children they treat each year. This new law will be a helpful start, but it will not provide any data about the availability of services and effectiveness of treatment. A systematic data collection process is necessary if we are to make better decisions about funding and care.

The nation's public health infrastructure has employed such a data collection process for decades; this should serve as a model for the mental health system. We must first determine the appropriate clinical measures of outcomes, and then decide how to collect and disseminate the data.

Conclusion

The Boston Bar Association's Children's Mental Health Task Force provides a neutral forum for discussion of the many complex issues associated with meeting the mental health needs of children in Massachusetts. Task Force members developed several recommendations, were subsequently refined and are described in detail in the next section of this report. The BBA hopes to continue facilitating dialogue on the children's mental health care system, with the goal of bringing about needed reforms.

Early Detection and Treatment

Recommendation 1 – Assess the Viability of Outstationing Mental Health Services in Pediatric Settings

Workgroup participants strongly felt that pediatric settings provided important opportunities to screen for, assess, and refer children for mental health services. In the past several years, several settings in Massachusetts have provided child development and case management services in pediatric clinics or private offices. Current projects include Department of Public Health Case Managers who serve children with special health care needs, and child development projects based at Boston Medical Center and Massachusetts General Hospital. In addition, the Massachusetts Behavioral Health Program is working with selected pediatricians to assess behavioral health conditions in their patient populations.

The Workgroup felt that these types of projects would make excellent test settings for integrating mental health screening, assessment and referral services. A small group of interested Task Force participants, including representatives from the Department of Public Health, the Division of Medical Assistance, the Massachusetts Behavioral Health Partnership and Boston Medical Center should develop a proposal that:

- Identifies potential clinical sites and currently operating programs;
- Defines the group of children in a given clinical setting that will receive mental health screening services;
- Defines the training needs of available outstationed public health and child development specialists;
- Creates a brief training curriculum for these workers;
- Identifies local resources for each clinical site for providing community based mental health services;
- Evaluates the success of the intervention.

Developing A Client Centered Focus: Accessing and Coordinating Care

Recommendation 1 – Recommend Protocols To Coordinate Care and Cost of Publicly Funded Children’s Mental Health Services

As a first step toward coordination, it is recommended that protocols be proposed to coordinate child mental health services, and funding cost allocation for those services, across all state agencies that furnish or procure any component of those services (“Coordination Protocols”). Initially, the public agencies involved should include the Department of Mental Health, the Department of Public Health, the Department of Social Services, the Department of Youth Services, the Office of Child Care Services, and the Division of Medical Assistance.

The proposed protocols should delineate clear responsibilities for each agency, both with respect to services and cost allocation, in the full range of foreseeable, real-life situations where the jurisdiction of more than one agency may be implicated. The protocols should be proposed for incorporation into an inter-agency memorandum of understanding (“MOU”), and administered by the Secretary of EOHHS (or his designee). Any blended funding of payment for services under the MOU should be administered in accordance with the MOU. Where appropriate, the MOU should designate a single case manager to coordinate care for the affected child or family (in relation to the child) across participating state agencies.

A Coordination Protocols Workgroup should be convened by the Secretary of EOHHS to develop the Coordination Protocols. The Workgroup should be comprised of the Secretary of EOHHS and the Commissioners of each of the above-referenced state agencies (or the Commissioner’s designee). The activities of the Coordination Protocols Workgroup should be monitored and reported on by the Co-Chairs of the BBA Children’s Mental Health Task Force (“Task Force”). The Coordination Protocols Workgroup should plan to meet at least monthly, its proceedings should be open to attendance (for observation purposes) by the Co-chairs of the BBA Children’s Mental Health Task Force (except for executive sessions determined by the Secretary), and it should complete its charge by December 1, 2002. The Task Force will be available to serve as a sounding board to the Coordination Protocols Workgroup, and will evaluate and comment on the protocols and MOU developed by the Workgroup.

It is further recommended that coordination planning should be conducted among the Coordination Planning Workgroup in consultation with the Department of Education, and public school superintendents, as well as with providers, private payors and mental health “carve-out” organizations to explore and promote coordination of care and cost of funding child mental health services among those agencies and organizations.

Recommendation 2 – Develop a Guide To Children’s Mental Health Services (“Guide”)

The Guide is intended to be an easy to use reference tool for families of children in need of mental health services, pediatricians, other primary care providers, emergency physicians, schools, public agencies, and human and social service agencies and providers. The Guide will include:

- How to access child mental health assessment services
- A description of the types of child mental health services and programs offered by public and private sources
- Contact information for categories of programs and services
- A description of populations served by public programs and services

It is recommended that the Guide be available to the public through various media (e.g., pamphlet, website, 1-800 number), and through the principal portals to child mental health services (i.e., schools, pediatrician offices, primary care physician offices, emergency departments, juvenile courts, public health and human service agencies, private health and human service agencies, public and private mental health facilities, and public and private mental health benefit payors).

It is further recommended that a Guide Planning Workgroup be established under the auspices of the BBA Children’s Mental Health Task Force for the purpose of developing the Guide. The Workgroup should consult with representatives of Parent/Professional Advocacy League and each of the referral sources identified above. The Workgroup should be charged with the responsibility to:

- Develop the Guide
- Develop a plan for funding, distributing, updating, and maintaining the Guide
- Develop a plan for having the Guide available through various media

The goal of the Guide Planning Workgroup should be to complete development of the Guide and related plan within one (1) year from the appointment of the Workgroup.

Information Capture: Tracking Children and Outcomes

Recommendation 1 – Propose a Set of Indicators for Measuring and Tracking Children’s Mental Health Care and Outcomes

It is recommended that the BBA Child Mental Health Task Force establish an Information Tracking Workgroup. The Workgroup will be responsible for examining system and clinical outcome indicators currently in use for children in the mental health field and for determining which among the available indicators would be most useful to track on an ongoing basis. The group is not to develop new outcome indicators and, as such, will coordinate with existing data collection initiatives such as the SAMHSA’s Carter Center Initiative that is focusing on children’s mental health care indicators. Members of the Workgroup should include representatives of the Executive Office of Health and Human Services (“EOHHS”) and its constituent agencies and the Department of Education (“DOE”) as well as providers, clinicians and public and private payors of health care. It is further recommended that the responsibility for data collection and reporting should reside with EOHHS and its constituent agencies in collaboration with DOE and private sector groups. Finally, it is recommended that EOHHS publish an annual report on the status of children’s mental health based on the Indicators.

The goal of the Workgroup is to collect data in order to better define who are children with mental illness, where are they being served and how acute are their needs. The purpose of the data collection is to better inform decision-makers in developing effective strategies for monitoring and tracking mental illness in children.

The Workgroup would be charged with reaching agreement on which Indicators the Group would recommend tracking. The Indicators would include:

- **ACCESS MEASURES**
 - Stuck kids/emergency room boarding duration
- **TREATMENT MEASURES**
 - Utilization of services
 - Use of pharmaceuticals for mental conditions
 - Number of days children are outside of the home
 - Ongoing treatment after hospitalization
 - Two clinical indicators
- **OUTCOME MEASURES**
 - To be determined
- **ADDITIONAL DATA**
 - Diagnosis, including depression, anxiety disorders, ADD, substance abuse
 - Demographics, including zip code

Indicators should be collected on a longitudinal basis.

Recommendation 2 – Establish a Workgroup to Develop Model Legislation for Collecting Data on Children’s Mental Health Care, Access to Services, and Outcomes

The BBA is already on record as having supported data collection legislation filed by Representative Ellen Story, which was signed into law in December 2001 as part of the state budget for fiscal year 2002. It is recommended that the Chairs of the Task Force appoint a subcommittee to work with the Information Tracking Workgroup to develop model data collection legislation, which will build upon the substantial accomplishment to date by Representative Story. The goal is to maximize our collective efforts and correct perceived deficiencies in the recently enacted legislation.

Other Topics for Future Discussion

In addition to drafting the recommendations described in the previous section of this report, Task Force members identified the following topics for future inquiry. The Task Force has not taken a position on each one, but participants may wish to assess the importance and viability of each suggestion in subsequent discussions:

Early Detection and Treatment

- Create a system to screen all mothers receiving public assistance, children in child-care facilities and foster homes and children believed to have been abused or neglected. These are all at high risk for mental illness and yet there is currently no system in place to identify such problems.

Developing a Client-Centered Focus: Accessing and Coordinating Care

- Create a common intake form so that every provider receives the same basic information. This will ensure that all of the important issues are addressed and will improve coordination by making all providers aware of the child's history. Furthermore, it will protect parents from having to repeat the same information at every visit.
- Set up a hotline that parents can call for help navigating the system, and another that children can call when they are experiencing mental health problems. Trained staff – possibly parents of children with mental health needs – would staff the line. Currently, parents report that one of the biggest problems they face is the dearth of information about mental health services. A hotline would serve as a much-needed roadmap.
- Consider requiring mental health practitioners to accept insurance as a condition of licensure in Massachusetts. Though the Commonwealth has the highest concentration of licensed behavioral health professionals in the country, many refuse to accept certain kinds of insurance. This creates a two-class system in which families who can privately pay for treatment have more options than families who must rely on insurance to receive care.
- Raise salaries and explore loan forgiveness programs for individuals willing to work in human services. Children's mental health is one of the most stressful and demanding fields, yet it is also one of the lowest-paid. Human services workers should not have to work two jobs to make ends meet, as many currently do. The high rate of turnover in mental health facilities has led to increased use of inexperienced staff and overtime – a situation that directly correlates with quality and continuity of care.
- Provide incentives for case managers by giving families on Medicaid case management vouchers. Case management is one of the services parents currently

complain about most and a voucher system, by generating competition among agencies that provide case management, may improve the quality of services families receive. It would also give parents more direct control over their children's care.

- Reform the current purchase of service ("POS") system to assure that qualified direct care workers who provide child mental health services are paid wages adequate to reduce the annual turnover rate for such workers. Procuring state agencies should also be prohibited from issuing requests for proposals for contracts for child mental health services that include a pre-specified maximum obligation amount or unit price, and multi-year procurement contracts should include a cost of living adjustment for inflation in wage and operating costs of reasonably efficient providers.

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