March 4th, 2026
2:00 PM – 4:00 PM
LOB, ZOOM
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TCB March Monthly Meeting Minutes

Attendees:				**TYJI Staff:**
Alice Forrester	Angel Quiros	Carolyn Grandell		Erika Nowakowski
Carrie Bourdon	Catherine Foley	Ceci Maher	Christina Ghio	Emily Bohmbach
Claudio Gualtieri	Edith Boyle	Gerard O' Sullivan	Giselle Acevedo	Stacey Olea
Howard Sovronsky	Javeed Sukhera	Jeff Vanderploeg	Jody Bishop-Pullan	
Kimberly Karanda	Lisa Morrisey	Lorna Thomas-Farquharson	Melissa Santos	
Melvette Hill	Michael Powers	Mickey Kramer	Sarah Eagen	
Sean King	Tammy Freeberg	Tammy Venenga	Tammy Exum	
Tara Vien	Yann Poncin			

Welcome and Introductions:
The Meeting was opened with a welcome to all attendees.
Acceptance of TCB February Meeting Minutes:

A motion to accept the minutes from the February meeting was put forward, the motion carried and was approved.

Administrative Updates:

a. The meeting opened with administrative and legislative updates from Transforming Children's Behavioral Health (TCB), highlighting continued progress across workgroups and their focus areas. Updates highlighted focusing on the System Infrastructure subgroups: Systems of Car and Data Infrastructure. The Systems of Care subgroup is planning an April in-person session, including a larger convening on April 29th, to develop a project plan, review national models, and guide future workgroups and a summer 2026 TCB presentation. This work is being coordinated in partnership with the Department of Children and Families (DCF), the Innovations Institute at the UConn School of Social Work, and the Annie E. Casey Foundation, with an emphasis on aligning with existing statewide efforts rather than duplicating work. Some members raised questions about prior engagement with the Innovations Institute and the effectiveness of past technical assistance, prompting acknowledgment of the Institute's national expertise, particularly in system of care development, and a commitment to continue discussions offline.
    a. Additional updates highlighted ongoing work across other TCB groups. The School-Based Workgroup has shifted toward more active working sessions, using breakout groups to advance key 2025 legislative studies, including school Medicaid billing and special education-related behavioral health efforts, as well as the development of a comprehensive school mental health infographic. The Prevention Workgroup will convene to hear a community-based presentation and further refine its work plan and medium-term goals.
    b. Members were also informed of an upcoming public forum, Understanding Eating Disorders: Prevention, Policy, and Pathways to Care, scheduled for March 25, which will feature both subject matter experts and individuals with lived experience.

c. Finally, administrative materials, including updated work plans and the 2026 TCB agenda, were made available, and it was noted that the TCB legislative proposal, House Bill 5447, has been introduced and will proceed through the legislative process with updates to follow.

Congregate Care Overview/ History:

a. The first presenter provided critical historical and system-level context to frame the discussion on Psychiatric Residential Treatment Facilities (PRTFs). The presenter began with an overview of Connecticut's behavioral health continuum, noting that PRTFs are positioned alongside inpatient psychiatric care as a distinct and highly specialized level of service. It was emphasized that despite the term "residential," PRTFs are not traditional residential treatment centers, but instead function as intensive, medically supervised psychiatric settings. The presentation highlighted Connecticut's significant shift away from congregate care over the past decade, driven by state efforts and federal policy, including the Family First Prevention Services Act. Data showed that congregate care placements decreased substantially, from approximately 30% of youth in placement in 2011 to less than 10% by 2019, while kinship placements increased significantly and foster care remained relatively stable. While this reflects progress toward family-based care, the presenter noted that system capacity has declined sharply during the same period. At the same time, the number of licensed foster homes, particularly non-relative placements, has also decreased. This dual reduction has created a significant gap in the system, making it increasingly difficult to place youth who require structured, 24/7 care. As a result, children are often placed based on bed availability rather than clinical need, which can lead to mismatched placements and challenges in maintaining the least restrictive level of care. The presenter emphasized that while reducing congregate care remains an important goal, there continues to be a population of youth with complex behavioral health needs who require intensive, short-term treatment in 24/7 settings. This context is essential to understanding the role and current pressures on PRTFs, which serve as a critical level of care for youth whose needs cannot be met in lower levels of the system.

Psychiatric Residential Treatment Facilities (PRTFS) Level-Set and Overview Facilities:

b. The next speaker provided a detailed overview of Psychiatric Residential Treatment Facilities (PRTFs), further clarifying their role within the continuum of care. The speaker reinforced that despite the term "residential," PRTFs are not residential treatment programs, but instead function as inpatient psychiatric care delivered in a community-based setting. They described PRTFs as "inpatient beds in the community," operating under Medicaid and following many of the same clinical and regulatory expectations as hospital-based psychiatric care. The speaker explained that PRTFs are physician-driven programs requiring intensive clinical oversight, including 24/7 registered nursing, multidisciplinary treatment teams, and on-site educational services. These facilities are governed by extensive federal Medicaid regulations, which outline staffing requirements, treatment expectations, and strict safety protocols such as restraint and seclusion. These regulatory demands, along with ongoing workforce and funding challenges, make PRTFs both complex and resource-intensive to operate and expand. PRTFs are intended to serve youth who have not responded to community-based services and require intensive, structured care. However, the speaker noted that many referrals do not meet the strict medical necessity criteria for admission, despite facilities often operating at or near full capacity. Most referrals originate from inpatient hospitals and are reviewed by Carelon, which determines eligibility before sending approved cases to PRTFs for further evaluation. Admission decisions also require demonstrating that the youth is likely to benefit from treatment. The speaker also highlighted the complex oversight structure, noting that PRTFs operate under Medicaid through the Department of Social Services, with regulatory review from the Department of Public Health and licensing through the Department of Children and Families. This multi-agency involvement adds to the operational complexity. Overall, the presentation emphasized that while PRTFs are a critical level of care for youth with the highest needs, they are difficult to sustain and expand, contributing to ongoing system challenges.

PRTFS Carelon Data:

c. The presentation continued with an overview of data and system trends related to Psychiatric Residential Treatment Facilities (PRTFs), presented by representatives from Carelon Behavioral Health. Connecticut currently operates

five PRTF providers with a total of 119 beds, including 52 for adolescent males and 37 for adolescent females, highlighting a clear capacity gap for female youth. In 2025, 299 Medicaid-only youth were approved for PRTF care but wait times from referral to admission ranged from 37 to 86 days, with the longest delays for adolescent females due to limited bed availability. Length of stay averages remained relatively stable at five to six months, with most youth staying between 121 and 180 days. However, discharge delays, referred to as "overstay" significantly extended stays, often exceeding 300 days when appropriate follow-up placements were unavailable. Most youth were discharged to intensive in-home services such as IICAPS or MDFT, and about 65% returned home, though discharges to foster care have increased. A major cause of delays was the lack of therapeutic foster care and other step-down options, which resulted in thousands of occupied bed days and reduced system capacity. Providers also described their trauma-informed, family-centered treatment models, emphasizing early family engagement, multidisciplinary care, and skill-building to support reintegration. At the same time, they highlighted ongoing challenges, including workforce demands, funding and reimbursement issues, limited aftercare resources, and the difficulty of balancing safety requirements with creating supportive, home-like environments. Overall, while PRTFs play a critical role in stabilizing high-acuity youth, system-wide gaps in community-based services continue to impact access, flow, and long-term outcomes.

PRTFS: Facility Overview and Current Challenges:

d. The next set of speakers provided deeper context on both service delivery and system-level challenges within Connecticut's Psychiatric Residential Treatment Facility (PRTF) network. The Solnit programs operate two campuses, North (serving boys ages 13–17) and South (serving girls), with a combined capacity of 51 beds, and function similarly to private PRTFs in terms of referral pathways, trauma-informed care, and interdisciplinary treatment models. Approximately 60% of youth admitted come directly from inpatient hospital settings, underscoring the high acuity and clinical complexity of the population served. Both campuses provide fully integrated, on-site services, including education, psychiatry, medical care, individual and family therapy, and recreational and rehabilitative programming, allowing youth to receive comprehensive, coordinated care without leaving the facility. Despite this robust model, average lengths of stay, ranging from approximately 169 to 200 days, consistently exceed

the target of 120 days, largely due to delays in identifying appropriate discharge placements such as foster homes, therapeutic group homes, or other community-based supports. Speakers emphasized that youth entering PRTFs often present highly complex and layered needs, including significant psychiatric conditions, medical comorbidities, and social challenges. Many have cycled through multiple levels of care, including inpatient hospitalization, intensive outpatient programs, and in-home services, prior to admission, often with limited sustained success. In addition, many youths have experienced disrupted family relationships, trauma, or instability in their living situations, and some enter care without a clear or permanent home placement. This makes both treatment and discharge planning significantly more difficult. While PRTFs provide a unique opportunity for longer-term, intensive therapeutic engagement, including meaningful family involvement and skill-building, the expectation to stabilize youth and prepare them for reintegration within a relatively short 4–6-month timeframe can be ambitious given the severity and chronicity of their needs. Providers highlighted that much of their work involves not only clinical stabilization, but also rebuilding family relationships, identifying appropriate placements, and preparing both youth and caregivers for transition. A central theme throughout the discussion was the disconnect between clinical readiness for discharge and system capacity to support transitions. Even when youth have made significant progress and are ready to step down to a lower level of care, they frequently remain in PRTFs due to a lack of available foster homes, therapeutic group homes, or community-based services. These delays contribute to extended stay and can have negative impacts on youth, including increased frustration, stagnation in treatment, and reduced motivation. Providers also noted the complexity of navigating multiple regulatory frameworks, including state and federal requirements, licensing standards, and oversight from various agencies, which can sometimes be duplicative or conflicting and add administrative burden to already intensive clinical environments. Despite these challenges, speakers underscored the critical role that PRTFs play within the broader behavioral health continuum. They highlighted that when youth receive individualized, trauma-informed treatment combined with strong family engagement and coordinated discharge planning, meaningful and sustained improvements are possible. The discussion reinforced that PRTFs are an essential level of care for youth with the most complex needs; however, broader system limitations, particularly gaps in post-discharge placements, workforce capacity, and community-based supports,

continue to impact efficiency, access, and long-term outcomes across the system.

Q&A:

e. After the presentations, the discussion transitioned into a robust question-and-answer session, where members sought clarification, raised data gaps, and explored broader system implications related to PRTFs and Connecticut's behavioral health continuum. A key area of clarification focused on coverage and population served, confirming that while some data presented reflected Medicaid populations (due to data access through Carelon Behavioral Health), PRTFs also serve youth with other forms of insurance. Members also explored distinctions between treatment placements and child welfare placements, particularly the role of therapeutic foster homes versus traditional foster care. It was emphasized that while therapeutic foster care can provide a treatment environment, it is not interchangeable with the level of clinical intensity offered in a PRTF. Additionally, not all youth in PRTFs are involved with the Connecticut Department of Children and Families (DCF), though DCF involvement may occur during a youth's stay, sometimes prolonging discharge timelines. Participants raised important data-related questions and gaps, including the lack of available information on PRTF denial rates, discharge outcomes, and the proportion of youth experiencing extended stays who are DCF-involved. Questions were also posed about what happens when youth turn 18, given that PRTFs can technically serve individuals beyond that age, but available data largely reflects youth under 18. There was also discussion about high utilization of intensive in-home services (IICAPS), with clarification that these services are often used not due to lack of residential options, but because they provide critical, high-intensity, home-based support, including crisis response and family-centered intervention.
    a. A significant portion of the discussion centered on system-level capacity and infrastructure challenges. Members reflected on the reduction in congregate care beds over the past decade and questioned whether there had been sufficient, parallel investment in community-based services to meet the needs of youth transitioning out of higher levels of care. Concerns were raised that while programs such as IICAPS, Multisystemic Therapy (MST), and Functional Family Therapy (FFT) have been expanded, overall system capacity, particularly workforce availability, has

not kept pace with demand. This has resulted in gaps where youth require more comprehensive, wraparound support than currently available, especially during transitions from PRTFs back into the community.

b. The conversation also highlighted complex clinical and family dynamics contributing to placement challenges. Speakers noted that youth in PRTFs often have experienced multiple disruptions, including foster placement breakdowns, hospitalizations, and strained family relationships. In some cases, caregivers may feel unable or unwilling to have young people return home after extended placements, further complicating discharge planning. Participants emphasized the need for more graduated and flexible step-down options, as the transition from a highly structured PRTF environment directly to in-home services represents a significant gap in the continuum of care.
c. A critical theme throughout the discussion was the need for a more nuanced, balanced system design. While Connecticut has made intentional progress in reducing reliance on congregate care and prioritizing family-based settings, members acknowledged that this shift may not have been fully matched with sufficient infrastructure to support youth with the highest needs. State representatives emphasized that investments in community-based services have been substantial but also recognized ongoing gaps and the need for continued system refinement. The discussion underscored that solutions are not linear and require coordinated, cross-agency planning, data-driven decision-making, and sustained investment across the full continuum of care.
    i. Finally, participants raised equity and population-specific concerns, particularly regarding limited capacity for girls and youth with complex needs. It was noted that there are fewer placement options for girls, longer lengths of stay, and challenges engaging providers to expand services for this population. This prompted broader reflection on how the system can better respond to underserved groups and ensure that future planning efforts address these disparities. The discussion concluded with recognition that these issues will require ongoing, in-depth exploration, with future meetings focused on specific populations, agency roles, and opportunities to strengthen Connecticut's behavioral health infrastructure.

Complex Case Workgroup Final Report Findings and Recommendations:

a. The final presentation of the day highlighted findings from the Office of Policy and Management's (OPM) Complex Case Workgroup report, which examined the feasibility of establishing a more coordinated, interagency approach to serving high-need youth in Connecticut. Conducted in partnership with the Governor's Kids Cabinet, the work focused on youth ages 17–22 with intellectual or developmental disabilities (IDD) and co-occurring behavioral health needs who face significant barriers to timely placement and service access. The report outlined persistent system challenges, including prolonged hospitalizations, limited safe discharge options, fragmented service coordination, and insufficient placement capacity. Over several months, the workgroup reviewed national models, engaged stakeholders, and assessed gaps before submitting its findings to the General Assembly.
    a. The analysis found that successful approaches in other states are grounded in strong interagency collaboration, executive-level leadership, and dedicated funding structures. Models such as Ohio's Ohio RISE program, Pennsylvania's county-based technical assistance approach, New Jersey's integrated system of care with a single point of access, and Massachusetts' interagency review team demonstrated the importance of centralized coordination, clear accountability, and aligned financing. Among these, Massachusetts' model most closely aligned with Connecticut's current landscape, particularly in its use of a structured interagency team to review and resolve complex cases. Building on these findings, the workgroup recommended formalizing Connecticut's existing interagency efforts through a memorandum of understanding (MOU) to establish a clear referral process, accountability structure, and follow-through for complex case reviews. The group emphasized the need first to collect data and maintain flexibility before pursuing statutory or funding changes. Additional recommendations focused on addressing system gaps, especially during transitions into adulthood, by improving coordination, clarifying whether youth needs are driven by treatment or long-term placement, and reducing unnecessary disruptions. The report also identified a critical lack of specialized

treatment capacity for youth with IDD and autism, noting that current providers often lack the expertise or flexibility to meet these needs. As a result, the work group recommended exploring the development of a specialized level of care, potentially a PRTF-like model adapted for this population, supported by enhanced clinical expertise and more flexible, evidence-based treatment approaches.

Q&A:

b. Following the presentation, members raised questions about demographic trends, noting that while autism diagnoses are more prevalent among males, females are often underdiagnosed, highlighting potential gaps in identification and access to services.
    a. The discussion broadened to examine system capacity challenges beyond behavioral health, particularly within the education system. Participants noted that limited in-state resources have led to many youths with complex needs being placed in out-of-state residential educational programs. Over a recent three-year period, 224 children were sent out of state for special education placements, raising concerns about oversight, continuity of care, and safety, as Connecticut's protections do not fully extend to these settings. Members emphasized the need to address capacity issues holistically, noting that gaps in community-based services and specialized programs often result in youth being placed in higher levels of care than necessary or sent out of state. Additional concerns included limited treatment options for specific populations, such as disordered eating services, particularly for males, and the growing reliance on private providers during crises. Overall, participants stressed the importance of developing more flexible, in-state options that better meet evolving needs.
    b. Additional discussion highlighted populations that are often overlooked, particularly youth with complex medical and co-

occurring psychiatric conditions. These individuals face significant barriers to placement, as many behavioral health programs are not equipped to manage medical complexity. Even when specialized inpatient settings are available, securing appropriate step-down or community-based care remains a challenge. Members emphasized that discharge planning remains a critical weakness across the system, underscoring the need for stronger coordination and expanded capacity to support successful transitions.

The next **TCB Monthly Meeting will be on April 15th, at the LOB from 2:00 – 4:00 PM on Zoom.**