April 15th, 2026
2:00 PM – 4:00 PM
ZOOM
Viewing Option YouTube or CTN

TCB April Monthly Meeting Minutes

Attendees:			**TYJI Staff:**
Howard Sovronsky	Vin Russo	Andrea Goetz	Erika Nowakowski
Kimberly Karanda	Edith Boyle	Alice Forrester	Emily Bohmbach
Melissa Santos	Mickey Kramer	Jeanne Milstein	Stacey Olea
Shari L Shapiro	Christina Ghio	Michael Moravacek	
Gerard O' Sullivan	Lorna Thomas-Farquharson	Claudio Gualtieri	
Nicole Taylor	Michael Powers	Miriam Miller	
Jody Bishop-Pullan	Melvette Hill	Tammy Venenga	
Yann Poncin	Cristin McCarthy Vahey	Sone-Moyano Sinthia	

Welcome and Introductions:
The Meeting was opened with a welcome to all attendees.
Acceptance of TCB March Meeting Minutes:
A motion to accept the minutes from the March meeting was put forward, the motion carried and was approved.

Administrative Updates:

1. The meeting continued with administrative updates, noting a full agenda for the session.
    a. Updates were provided across TCB workgroups, beginning with the System Infrastructure Subgroup, which will meet on April 21st from 3:00–4:30 PM via Zoom. The meeting will focus on a policy paper developed by one of the co-chairs, with discussion centered on key definitions, the history and evolution of the system of care, and priority policy focus areas to guide ongoing work.
    b. Updates were also shared on the School-Based Workgroup, which is scheduled to meet on May 4th from 3:00–4:30 PM via Zoom. Recent meetings have shifted toward more active working sessions, incorporating breakout groups to advance targeted priority areas. Current focus areas include school Medicaid billing and special education-related behavioral health efforts. During the most recent meeting, an informational RFQ session was held regarding the school billing initiative. Additionally, Tom Cosker from Disability Rights Connecticut, who has been contracted to support the special education scope of work, joined to provide an overview of his role and upcoming contributions. Both the school billing and special education subgroups will reconvene at the May meeting to continue progressing their work.
    c. The Prevention Workgroup will meet on April 20th from 3:00–4:30 PM and will include a presentation from the Office of Early Childhood on the Connecticut Pyramid Model. The workgroup is also awaiting results from the Connecticut Children's Behavioral Health Provider Survey, which will inform the identification and prioritization of action items within the work plan.
    d. The Services Workgroup, noting that the meeting has been rescheduled to May 27th. At that meeting, Jill Farrell from the Innovations Institute at the UConn School of Social Work will present findings from the Children's Behavioral Health Provider Survey. These findings are expected to be shared more broadly at the full TCB meeting in June to support cross-work group alignment and planning.

2. TYJI staff provided a brief legislative update regarding the TCB's H.B 5447. The bill was heard during a public hearing before the Appropriations Committee on March 12th and has since been filed as House calendar number 433, indicating continued movement through the legislative process. Members were informed that any additional updates will be shared with both the workgroups and the full committee as they become available. The conversation shifted to updates on the Office of the Behavioral health Advocate. Updates from the Office of the Behavioral Health Advocate, highlighting recent progress in establishing the office's presence and capacity. It was noted that the office's public-facing homepage launched the previous week, creating an initial online presence and improving access for the public to connect with the office. In addition, staffing updates with two new team members expected to begin onboarding. The office has hired an Assistant Behavioral Health Advocate and a Behavioral Health Associate, both of whom are licensed clinicians with experience across the behavioral health continuum, including direct service delivery and navigating insurance systems within private practice. Their addition is expected to strengthen the office's capacity as it continues to build out its operations. Both staff members will be introduced at a future TCB meeting.

3. Prior to transitioning into presentations, a brief recap of the previous meeting and an overview of next steps were provided. The March meeting focused on Psychiatric Residential Treatment Facilities (PRTFs) and included a presentation from the Complex Case Workgroup on its final report, which highlighted the service needs of individuals with co-occurring behavioral health conditions and intellectual and developmental disabilities, including autism spectrum disorder. As a follow-up to that discussion, the current meeting will include presentations from various state agencies outlining their roles, authorities, and service offerings for this population. Agencies will also highlight interagency coordination, as well as identify existing gaps and barriers, including age

restrictions, referral processes, and service access challenges. As a next step, the Tow Youth Justice Institute will work in partnership with the Children's Behavioral Health Implementation Advisory Board to synthesize information from these presentations and related efforts to develop an informational resource outlining the roles of state agencies serving this population. Additional details regarding this effort are expected to be shared at the May meeting. The floor was then transitioned to the next presenter to begin the session's presentations.

Overview of Agency Roles for Individuals with ID/DD/ASD:

4. **Department of Developmental Services**

    a. The presenter provided an overview of their agency, including its structure, eligibility requirements, and service array. It was noted that while DDS primarily serves adults, it also operates a smaller children's division designed to support youth with intellectual disabilities. The agency's mission is to partner with individuals and families to support lifelong planning and promote meaningful opportunities for individuals to fully participate as valued members of their communities. By statute, DDS is responsible for the planning, development, and administration of a comprehensive, integrated statewide system of services for individuals with intellectual disabilities and those diagnosed with Prader-Willi Syndrome. Eligibility is determined through statutory criteria, requiring an intellectual disability, defined as an IQ of 69 or below with significant limitations in adaptive functioning, with onset prior to age 18.
        i. A brief outline of the organizational structure was provided, including central office leadership, three regional offices (North, West, and South), and specialized divisions such as abuse investigation, business intelligence, and case management. DDS also continues to operate the Southbury Training School, which currently serves a small population with an average age of 75. Across the state, approximately 36,500 individuals are estimated to have an intellectual disability, with 17,411 individuals currently determined eligible for DDS services. However, it was emphasized that DDS is not an entitlement program, and services are limited by available appropriations. As a result, many individuals who meet

eligibility criteria do not receive services and instead rely on helpline support without access to case management or funded services.

ii. DDS services are delivered through three Medicaid waiver programs administered in partnership with the Department of Social Services, including the Comprehensive Waiver, the Individual and Family Supports (IFS) Waiver, and the Employment and Day Supports Waiver. These waivers fund a range of residential, day, and in-home supports, with more than 60% of individuals receiving services in their own or family homes. It emphasized that waiver services are subject to funding limitations and cannot be guaranteed to all eligible individuals. Additional support includes helpline services, which provide access to family support workers, transition advisors, and short-term clinical consultation. DDS also administers a family grant program that provides limited financial assistance to offset disability-related expenses, such as respite care, summer programming, and home modifications. Demand for these grants significantly exceeds available funding, with requests far surpassing the program's $3.7 million allocation, which has remained unchanged for over two decades.

iii. System capacity challenges were also highlighted, including significant waitlists for services. At the time of reporting, more than 6,000 individuals were on the DDS helpline, including those identified as having emergency needs for residential services. Additionally, hundreds of individuals remain on residential waitlists, either without services or seeking expanded support. Future demand is expected to increase, with a growing number of individuals transitioning from other systems, including the Department of Children and Families, voluntary care management programs, and educational placements. A planning list was also noted, consisting of individuals and families anticipating service needs within the next three to five years, further illustrating ongoing system pressures.

iv. A more detailed overview of the Children's Services Division was provided, describing it as a centralized unit serving youth ages 8 to 20 who demonstrate needs beyond what can be met through

existing community, state, or federally funded programs. As a payer of last resort, DDS requires that all other service options, including insurance and community-based supports, be exhausted prior to accessing DDS-funded services. The division focuses on stabilizing and supporting families, with the goal of preventing crises and avoiding out-of-home placements. However, DDS does not function as a child welfare agency, does not offer family-centered programming, and does not support individuals seeking out-of-home placement as a primary service request.

v. Eligibility for children's services requires DDS eligibility and demonstration of significant unmet need. The most utilized services include respite and in-home support, particularly for families engaged in intensive therapies such as Applied Behavior Analysis (ABA), where gaps in caregiver support remain. Key reasons for ineligibility include lack of consistent school attendance, active involvement with other systems such as child welfare or juvenile justice, or situations where families are only seeking financial assistance through grants. The division works closely with partner agencies, including child welfare, voluntary care management programs, Local Education Agencies (LEAs), and behavioral health providers, to support coordinated planning and transitions, particularly as youth approach adulthood. Case management plays a central role in assessing needs, developing individualized plans, and facilitating access to services.

vi. The overview concluded with key system observations and challenges. It was noted that the average age of individuals in DDS residential settings is significantly older, making placement of younger individuals more difficult. Additionally, a large proportion of children eligible for DDS services are not receiving ongoing support, with the majority relying solely on helpline resources. Ongoing access challenges for youth with intellectual disabilities within the broader behavioral health system were also highlighted, noting that these individuals are often excluded from programs due to functional or communication requirements, despite having significant behavioral health needs. It was emphasized that intellectual disability alone is not a reason for hospitalization, and that co-occurring behavioral health conditions are often the

primary drivers of service need. These challenges underscore broader gaps in system capacity and the need for more inclusive and coordinated approaches to serving youth with complex needs.

5. Birth to three – Office of Early Childhood

a. The following set of speakers provided a brief overview of the Office of Early Childhood's Birth to Three program, including its structure, eligibility criteria, and service delivery model. Birth to Three is Connecticut's early intervention system, established under Part C of the Individuals with Disabilities Education Act (IDEA), and serves infants and toddlers from birth to age three who have developmental delays or diagnosed conditions associated with developmental risk, including social-emotional and behavioral health needs. The system operates in coordination with multiple state agencies, including the Department of Social Services, the Connecticut State Department of Education, and the Department of Children and Families, as well as a network of community-based providers. Services are delivered through a multidisciplinary approach and guided by an Individualized Family Service Plan (IFSP), which is developed through evaluation, assessment, and family input, ensuring caregivers are active partners in the planning process.
    i. The referral process includes a centralized intake system that serves as a single point of entry, allowing families, providers, and community members to submit concerns. Following referral, children receive a comprehensive evaluation to determine eligibility. Those who qualify receive services guided by an IFSP, while those who do not are connected to community-based resources, including developmental monitoring supports, with the option to re-refer if concerns persist. Services are provided at no cost to families, with Medicaid and private insurance utilized, when available, to support the system.
    ii. Eligibility criteria in Connecticut are defined through specific developmental thresholds, requiring moderate delays across two developmental domains or a significant delay in one. Evaluations assess all areas of development to ensure a comprehensive

understanding of each child's needs. Certain diagnosed medical conditions associated with a high likelihood of developmental delay qualify a child for automatic eligibility, regardless of demonstrated delay. These determinations are made in collaboration with pediatric providers and informed by current research and clinical guidance. In limited cases, clinical judgment may also be used to support eligibility when developmental concerns are present but do not fully meet standard criteria.

iii. Data trends indicate increasing demand for early intervention services, with growth in referrals, evaluations, and eligibility determinations statewide. On average, children participate in the program for 11 to 12 months, often entering closer to age two. Efforts are underway to strengthen early identification, particularly for children under age one, to better support development during critical early periods. A key focus of the program is building caregiver capacity, recognizing that consistent, everyday interactions in natural settings are essential to supporting developmental progress.

iv. As children approach age three, transition planning is initiated to support movement into preschool special education services under Part B of IDEA or other appropriate supports. Many children transition into school-based services, while others exit after meeting developmental goals or no longer requiring services. For those who do not continue in formal support, families are connected to community resources to promote ongoing development. Overall, the program reflects a coordinated, family-centered approach that emphasizes early identification, collaboration across systems, and improved outcomes for young children and their families.

6. Unlocking Lifelong Potential – Connecticut State Department of Education

a. The next presenters provided an overview of the Connecticut State Department of Education's role in supporting students with disabilities, including its structure, responsibilities, and system-level approach. As the state educational agency, CSDE oversees public education statewide and

operates within a strategic framework focused on equitable access, safe and supportive learning environments, high-quality instruction, and pathways to postsecondary success. Within this framework, the Bureau of Special Education is responsible for ensuring compliance with federal and state requirements while advancing efforts to improve outcomes for students receiving special education services.

i. CSDE does not provide direct services to students; rather, services are delivered at the local level through school districts. Planning and Placement Teams are responsible for determining eligibility and developing individualized education programs based on student needs. The Bureau of Special Education provides guidance, oversight, and technical assistance to support consistent and effective implementation across districts. Its responsibilities include administering general supervision systems, overseeing dispute resolution processes such as mediation and due process, and managing federal IDEA Part B funding to ensure appropriate use and impact at the local level.
ii. The general supervision system encompasses several federally required components, including monitoring, data collection, fiscal oversight, and dispute resolution, all of which are designed to strengthen accountability and improve student outcomes. As part of this work, the Bureau supports local teams in making accurate eligibility determinations. Eligibility for special education is based on the impact of a disability on a student's access to education and the need for specialized instruction, rather than the presence of a medical diagnosis.
iii. Data shared during the overview highlighted ongoing trends in special education across the state. There has been a steady increase in both the number and proportion of students identified as eligible for services, even as overall student enrollment has declined. This pattern reflects broader national trends. Notably, there have been significant increases in students identified with autism and intellectual disability over time, underscoring the need for continued system coordination and resource alignment to effectively support this population.
iv. Recent legislative updates were also discussed, including an expansion of the developmental delay eligibility category.

Previously limited to children ages three through five, this category has been extended through age eight, allowing students to remain eligible under this classification until their ninth birthday. This change provides greater flexibility for teams and supports developmentally appropriate identification during early childhood.

v. Coordination across state agencies remains a critical component of the system, particularly during key transition points. Ongoing collaboration with the Office of Early Childhood supports children transitioning from Birth to Three services into preschool special education, with systems in place to ensure timely evaluations and the development of individualized education programs by age three. As students' progress through the system, transition planning begins as early as age 14, supporting connections to postsecondary education, employment, and independent living through coordination with partner agencies.

vi. Broader interagency collaboration also supports student mental and behavioral health through shared initiatives, training opportunities, and coordinated planning across systems. These efforts reflect a comprehensive approach to supporting students and families, with a continued focus on strengthening access, improving coordination, and advancing long-term outcomes for students with disabilities.

7. The Autism Waiver's Role in Providing Services to Individuals with Autism – Department of Social Services

a. For the next presentation, the Department of Social Services, provided an overview of their Autism Waiver Program, including its purpose, eligibility criteria, and service structure. DSS administers a Home and Community-Based Services (HCBS) waiver designed to support individuals with autism spectrum disorders who do not have an intellectual disability. As a waiver program, services are not entitlement and are subject to available funding and capacity. Eligibility requires a primary diagnosis of autism spectrum disorder, Connecticut residency, diagnosis prior to age 22 with an expectation that the condition will

continue indefinitely, and cognitive and adaptive functioning above the level of intellectual disability. Individuals must also demonstrate substantial limitations in at least two major life areas, such as self-care, communication, learning, mobility, self-direction, or independent living.

i. Individuals enrolled in the waiver receive ongoing support through case management, including annual assessments and the development of individualized plans of care tailored to their specific needs. Services are capped at $50,000 annually and may include behavioral support, job coaching, community mentoring, life skills development, social skills groups, and respite services provided in-home or out-of-home. Additional support may include assistive technology, interpreter services, specialized driving assessments, personal emergency response systems, individual goods and services, non-medical transportation, and nutrition-related supports.
ii. Coordination with other state agencies is a key component of the program. Eligibility determinations for the waiver are conducted in partnership with the Department of Developmental Services (DDS). In some cases, individuals initially eligible for the Autism Waiver may later be identified as having an intellectual disability, requiring coordination between DSS and DDS to transition individuals to more appropriate services within the DDS system. DSS also collaborates with the Department of Children and Families (DCF) through a limited number of reserved capacity slots each year, supporting individuals involved with DCF who meet eligibility criteria and may benefit from waiver services.
iii. Several system challenges were identified, including a steadily increasing waitlist driven by rising rates of autism diagnoses. Capacity constraints, including limited administrative staffing, case management resources, and provider availability, continue to impact access to services. In some cases, individuals enrolled in the waiver experience delays in accessing services due to provider shortages, highlighting ongoing workforce challenges across the system. Despite these barriers, the program remains a critical resource for individuals and families, providing targeted support to promote independence and community integration.

8. Connecticut Department of Children and Families

a. The next set of speakers provided an overview of the Department of Children and Families' role across child protection, behavioral health, and prevention services, including its statutory responsibilities and system partnerships. DCF serves as the state's child protection agency, with a mandate to respond to reports of child abuse and neglect, while also overseeing children's mental health, substance use services, and prevention and early intervention efforts. These responsibilities are carried out through both protective services and a broader behavioral health system designed to support children and families across the state.
    i. Within its child protection role, DCF operates a centralized intake system that receives reports of suspected maltreatment statewide. This system processes a high volume of calls annually and determines whether reports meet statutory criteria for investigation or service involvement. Based on assessment outcomes, families may receive in-home or out-of-home services, or cases may be closed when concerns do not meet statutory thresholds. DCF may also provide continued support for youth beyond age 18, up to age 24, for those who were previously under its care, to support successful transitions into adulthood.
    ii. Coordination with other state agencies was highlighted as a critical component of DCF's work, particularly for children and youth receiving ongoing services. Collaboration occurs with the Department of Developmental Services for individuals with co-occurring needs, including through transition planning and interagency navigation supports. Coordination also occurs with the Department of Social Services for individuals connected to waiver programs, as well as with the Department of Mental Health and Addiction Services for transition-age youth. Partnerships with the Office of Early Childhood support referrals to early intervention services when appropriate. Additional collaboration occurs with the Judicial Branch and correctional systems to ensure continuity of care across settings.

iii. In addition to its child protection responsibilities, DCF plays a leading role in overseeing the children's behavioral health system. While DCF does not directly provide most clinical services, it administers and funds a statewide network of community-based providers that deliver a range of behavioral health supports. Direct services are limited to specialized settings, including psychiatric residential treatment facilities. Most services are accessed through referrals from schools, pediatricians, community providers, or through crisis response systems, including mobile crisis services.
iv. The behavioral health continuum includes outpatient services, intensive in-home supports such as Multisystemic Therapy and Functional Family Therapy, crisis services, urgent care centers, care coordination, extended day treatment, and therapeutic group homes. These services are designed to be flexible and responsive, with providers working closely with families to assess needs and determine appropriate levels of care. Access pathways include both provider referrals and, in some cases, self-referral by families seeking support.
v. A centralized online resource was also highlighted as a tool to improve access to services. This platform provides families and providers with information on available supports, including a guided matching tool to help identify appropriate services based on individual needs, as well as directories of providers and care coordination resources. This approach is intended to simplify navigation and improve access to care within the broader system.
vi. Additional programs were noted that support families outside of the child protection system, including voluntary behavioral health and community-based pathways administered through contracted partners. These programs allow families to access services without formal child welfare involvement, further expanding access to care.
vii. Overall, the system emphasizes strong collaboration across state agencies and community partners to ensure coordinated, responsive services. These efforts support a comprehensive continuum of care aimed at meeting the diverse behavioral health and safety needs of children and families across Connecticut.

9. Connecticut Department of Mental Health and Addiction Services

a. Following, the next set of speakers provided an overview of the Department of Mental Health and Addiction Services' Young Adult Services program, including its purpose, eligibility criteria, and service continuum. Young Adult Services is designed to support individuals ages 18 to 25 with complex behavioral health needs as they transition from the child-serving system into the adult behavioral health system. The program was established to address service gaps for young adults aging out of care and to provide developmentally appropriate supports that promote stability, independence, and long-term success in adulthood.
    i. The program serves young adults with significant mental health conditions, often accompanied by trauma histories, substance use disorders, legal involvement, and other complex needs. Strong coordination with partner agencies is central to this work, including collaboration with the Department of Children and Families, Carelon, and the Court Support Services Division to support early identification, referral, and transition planning. Engagement may begin as early as age 16 to ensure a coordinated and timely transition into services at age 18. For individuals with co-occurring intellectual or developmental disabilities, coordination with the Department of Developmental Services supports planning for appropriate long-term services.
    ii. Eligibility for Young Adult Services requires individuals to be age 18 or older, have a diagnosed serious mental health condition, and voluntarily agree to participate in services. Individuals with intellectual disability are referred to the Department of Developmental Services to determine eligibility for those supports, while individuals with autism spectrum disorder may be eligible if they also have a co-occurring mental health diagnosis.
    iii. Services are delivered through a statewide network of local mental health authorities, including both state-operated and private nonprofit providers. Young adults may access services through referrals from partner agencies or by contacting their local provider directly. The program offers a comprehensive range of supports, including outpatient clinical services, case management, psychiatric care, and specialized residential options. A dedicated

inpatient unit is also available to support individuals requiring a higher level of care.

iv. The service model emphasizes trauma-informed, developmentally responsive care, with a strong focus on skill-building and recovery. Supports include individual and group therapy, nursing services, crisis intervention, peer mentoring, and behavioral consultation. Additional services focus on building independent living skills, including employment and vocational support, educational planning, financial management, and assistance with transportation and daily living needs. Residential support is available across levels of care, including both supervised settings and independent living environments with supportive services.

v. Specialized supports are also available for young adults with unique needs, including programs for individuals with co-occurring autism and mental health conditions, as well as perinatal supports for young parents. These services provide targeted assistance during pregnancy and early parenting, including care coordination, health support, and connections to community resources. Substance use services are also integrated into the program, with staff trained to provide age-appropriate interventions for individuals with co-occurring substance use disorders.

vi. Overall, Young Adult Services reflects a coordinated, cross-system approach to supporting young adults during a critical transition period. Through early engagement, comprehensive service delivery, and strong interagency collaboration, the program aims to equip young adults with the skills and support needed to successfully navigate adulthood.

10. Department of Public Health

a. The final presenters of the day provided a brief overview of their agency's role in supporting maternal and child health and its regulatory responsibilities within the behavioral health system. Unlike several other agencies, they not primarily provide direct services but instead focuses on

funding, system support, and regulatory oversight to strengthen service delivery across the state.

i. Through the Title V Maternal and Child Health Block Grant, the agency supports key priority areas, including child and adolescent health, children and youth with special healthcare needs, and cross-cutting systems infrastructure. Within child and adolescent health, funding supports school-based health centers across multiple regions, providing access to medical, dental, and behavioral health services, as well as prevention programming. These services may include health screenings, immunizations, and therapeutic support delivered within school settings. Additional efforts include developmental screening and monitoring for children from birth to age five through partnerships with statewide systems, supporting early identification and connection to appropriate services.
ii. For children and youth with special healthcare needs, they support care coordination services through contracted providers to assist families in navigating medical, developmental, and social supports. These efforts are complemented by investments in statewide service navigation infrastructure, including centralized systems that connect families to health and social services and serve as key access points for priority populations. It was noted that while the Title V Block Grant provides critical support, it functions as supplemental funding and does not fully fund the programs it supports.
iii. The agency also plays an important regulatory role within the behavioral health system. The agency serves as the state survey authority for Psychiatric Residential Treatment Facilities (PRTFs) through an agreement with the Department of Social Services, applying federal standards and conducting oversight activities. This includes licensing responsibilities, reviewing serious incidents, and conducting audits to ensure compliance. In addition, the agency licenses conducts surveys of intensive outpatient programs and related services, including psychiatric outpatient clinics and hospital-based programs, to ensure adherence to regulatory standards.

iv. Overall, their role centers on strengthening system quality, access, and coordination through targeted funding and regulatory oversight, contributing to a broader, statewide approach to supporting the health and well-being of children and families.

Q&A:

11. The discussion opened with reflections on the information presented and the value of understanding how multiple agencies contribute to Connecticut's system of care. Participants noted that while the presentations helped clarify agency roles, they also underscored the complexity of the system, and the challenges families face when attempting to navigate services across multiple agencies with differing eligibility requirements and mandates.
    a. A central theme of the discussion focused on identifying gaps within the current system. It was noted that while each agency outlined the populations they serve and the services they provide, it remains difficult to determine where responsibility lies for individuals with co-occurring needs, particularly those with intellectual and developmental disabilities alongside behavioral health conditions. Concerns were raised regarding access to key services, including Applied Behavior Analysis (ABA), where waitlists may extend up to a year, limiting timely intervention. Additional challenges were highlighted for individuals requiring residential placements, as options are limited across systems. For example, residential services are not available through developmental services for certain populations, may not be accessible through autism waiver programs, and are not available through child welfare systems unless specific statutory criteria are met.
    b. Further discussion emphasized the difficulty families experience when service eligibility is determined by a "primary diagnosis," which can create barriers for individuals with multiple, intersecting needs. In these cases, families may be referred between agencies without a clear point of access, resulting in delays or gaps in care. Participants noted that this dynamic can also impact access to in-home services, where eligibility may depend on how a child's needs are categorized, rather than the full scope of those needs. As a result, families may encounter situations where no single agency assumes responsibility, leaving them with limited options for support.

c. Participants emphasized the importance of developing a more integrated and accessible system, including the concept of a "no wrong door" approach, where families can enter the system through a single point and be connected to appropriate services without needing to navigate multiple pathways independently. There was also discussion on the need to strengthen the continuum of care, ensuring that services are available across levels of need and that transitions between systems are coordinated and responsive.
d. Additional comments reinforced the importance of using the information shared during the meeting to inform future planning efforts. Participants expressed interest in moving beyond system mapping toward identifying actionable strategies, including short-term, intermediate, and long-term solutions to address service gaps and improve coordination. There was also recognition that while agencies operate within specific statutory and funding constraints, greater alignment and collaboration across systems will be critical to improving outcomes for children and families.
e. A question raised during the discussion focused on expectations for case management as youth transition out of school-based services. It was clarified that, in general, case management assignment may occur several months prior to graduation; however, access can vary based on system capacity, including workforce limitations. Differences in planning timelines were also noted depending on whether individuals are transitioning directly from school or from other service systems, with more extensive coordination required for those with complex needs.
f. Additional comments highlighted ongoing efforts to elevate family voice and strengthen community engagement, including opportunities for families to participate in community conversations and advisory groups. Resources and learning opportunities were also shared to support continued collaboration, including cross-agency initiatives and training efforts focused on improving service delivery for individuals with co-occurring needs.

The Next TCB Meeting will be held at the **Legislative Office Building on May 13th, in room 2D from 2:00 PM-4:00 PM** with a hybrid option on **Zoom.**

University *of* New Haven

University *of* New Haven