



February Services Workgroup Meeting Agenda

February 25th, 2026

2:00 PM – 3:30 PM

Zoom

- 1. Welcome and Introductions**
- 2. TCB Administrative Updates**
 - a. TCB Updates
 - b. Legislative Updates
 - c. Workgroup Updates
- 3. Review of the 2026 Workplan**

DRAFT 2026 ANNUAL SERVICES WORKGROUP WORKPLAN

Workgroup Co-Chairs: Edith Boyle, LCSW & Yann Poncin, MD

**Annual Workplans are developed from the 2025-2028 Strategic Plans and other priority areas and strategies identified in the strategic plan will be added to the workplan annually*

Suggested Services Purpose Statement: Ensure statewide and local capacity and awareness to provide a comprehensive range of affordable, integrated, coordinated, and family-centered services to children from birth to age 22, individualized and within the context of their families, caregivers, and communities.

Priorities: The workgroup will monitor the TCB recommendations related to the crisis continuum (including Urgent Crisis Centers (UCC's) Private Insurance Review, the Crisis Continuum Review, and IICAPs development of models and Target Trial Emulation (TTE)). Determine service needs gaps identified by the CT Children's Behavioral Health Provider Survey and input from families, from birth to 22. Additionally, the workgroup will continue to consider other structural factors on service delivery in partnership with other workgroups.

Short-Term Workgroup Goals:

- Identify meeting schedule, frequency of meetings, and meeting presentations with the workgroup
- Identify and finalize workgroup priorities and purpose statement with feedback from the workgroup

Medium-Term Workgroup Goals (2026):

- Consistent monitoring of TCB 2026 passed legislation and updates on the status of the implementation progress will be given at each services workgroup meeting.
 - Collaborate with identified responsible state agencies and private organizations on progress of implementation, barriers, and needed adjustments.

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- Consistent updates from subgroups of the Services Workgroup, such as progress of reports, data collected, and any barriers to projects.
 - Once legislative reports are finalized, review with the workgroup to evaluate and/or develop potential legislative and/or policy recommendations.
 - Present draft recommendations to the TCB Committee in October of 2026.
- Consistently monitor the progress of the CT Children’s Behavioral Health Survey
 - Review services array survey results, **gaps and challenges in the continuum of care**)
 - Review the draft report accompanying the results, provide feedback for the subgroup to further look into.
 - Evaluate the final report and produce if applicable, legislative recommendations to be considered in the 2027 session.
 - Present draft recommendations to the TCB Committee in October of 2026.
- Operationalize how the workgroup integrate work with the Prevention and School-Based Workgroups (e.g., UConn Services Array Results, 2026 and 2027 recommendations)
- Develop a set of 2027 draft recommendations with the workgroup and present recommendations to the TCB committee in fall of 2026.
 - TCB leadership will review drafts and provide feedback
 - Draft Workgroup recommendations will be presented at the October TCB Meeting

** The development of 2027 recommendations is dependent on priorities, and progress within the group. If the group does come up with a set of recommendations, the decision to proceed with 2027 legislative recommendations package depends on committee and leadership feedback*

Long-Term Workgroup Goals (2027-2028):

- Utilize information from the workgroup to plan for 2027, 2028, and in subsequent years.

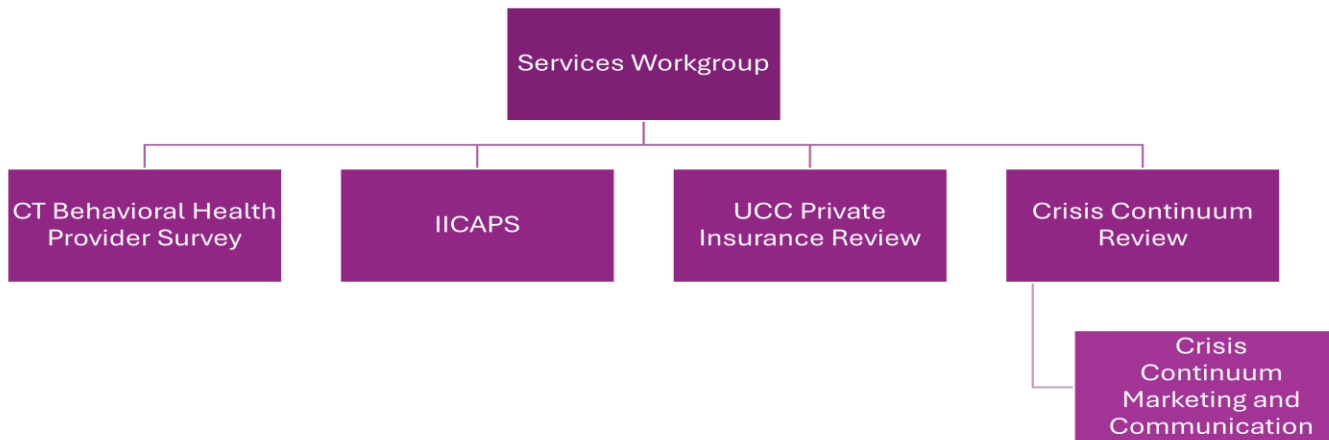
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DRAFT 2026 ANNUAL SERVICES WORKPLAN – SERVICES SUBGROUPS

The TCB is currently tasked with completing an array of studies and reports as identified in Legislation passed in 2025. In 2025, the Services Workgroup operationalized its mandate by forming dedicated subgroups to spearhead a range of comprehensive studies and reports focused on system improvements. Subgroups will report progress of the reports and studies to the larger workgroup. Subgroups will have their own project plan that may be adjusted throughout 2026.

The Services Workgroup is tasked with the following studies and reports:

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**The studies related to Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) do not have a subgroup, as the Yale Child Study Center will report to the workgroup when progress on the study has been made.*

2026 Services Subgroups

Report/Study:	Intent of the Subgroup:	Scope of the Project	Researcher/Agency Involved:	Interim Pulse Check with the TCB

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				Meeting Due Date:
<p>Urgent Crisis Center (UCC) Private Insurance Billing Review</p> <p>Due: October 1st, 2026</p>	<p>The TCB Urgent Crisis Center (UCC) Subgroup will lead the efforts of completing the UCC Billing Review Report. This subgroup will sunset upon completion of its goals.</p>	<p>This workgroup will lead the efforts of the Legislative charge that requires the Transforming Children’s Behavioral Health Policy and Planning Committee, in consultation with the Behavioral Health Advocate, Department of Children and Families and insurance commissioners, to convene a working group to</p> <p>(1) review private health insurance coverage for children’s treatment at urgent crisis centers,</p> <p>(2) identify potential barriers to commercial insurance coverage and reimbursement, and</p> <p>(3) make recommendations to address any barriers.</p> <p>The behavioral health committee must report, by October 1, 2026, on the working group’s findings and recommendations to the Appropriations, Children, and Human Services committees and the</p>	<p>DCF, DSS, DOI, led by the Behavioral Health Advocate</p>	<p><i>September 2026</i></p>

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		Office of Policy and Management secretary. An urgent crisis center is one that DCF certifies to treat children’s urgent mental or behavioral health needs.		
<p>Crisis Continuum Review</p> <ul style="list-style-type: none"> Crisis Continuum Marketing and Communications Plan <p>Due: January 1st, 2027</p>	<p>The TCB Crisis Continuum Review Subgroup will lead the efforts of completing the report identified in the legislation. Additionally, a subgroup was developed to create a communications and marketing statewide plan to increase the utilization of crisis services. These subgroups will sunset upon completion of its goals.</p>	<p>This workgroup will lead the efforts identified in the legislation, that required the TCB to review the Crisis Continuum. Such study shall include, but not be limited to, (1) the rates of utilization of the United Way of Connecticut 2-1-1 Infoline program, 9-8-8 National Suicide Prevention Lifeline, mobile crisis intervention services, urgent crisis centers, as defined in section 19a-179f of the general statutes, subacute crisis stabilization centers and hospital emergency departments for such services, outreach and marketing strategies utilized by the service providers, common sources of patient referrals to such service providers, the allocation of state and other financial resources to such service providers, and the anticipated demand for behavioral health services for children into the future.</p>	<p>DCF, Community Based UCCs, UnitedWay, CHDI, led by the Behavioral Health Advocate</p>	<p><i>September 2026</i></p>

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<p>Services Array Subgroup</p> <p>Due: May-June 2026</p>	<p>This subgroup will work closely with the Innovations Institute, at the UConn School of Social Work to assist in reviewing the progress of the CT Children’s Behavioral Health Survey.</p>	<p>The subgroup will obtain updates and help identify gaps in barriers in survey collection and data collected. The survey’s purpose is to survey to assess the availability, accessibility, and scope of behavioral health services for children, youth, and their families (ages 0–18) throughout Connecticut. This includes services focused on prevention, early intervention, and treatment related to mental health, substance use, and developmental disabilities.</p>	<p>Innovations Institute, UConn School of Social Work</p>	<p><i>Updates were provided at the February TCB Meeting.</i></p>
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Strengthening the system of care for all children in CT



**TRANSFORMING CHILDREN'S
BEHAVIORAL HEALTH
INFRASTRUCTURE COMMITTEE PRESENTATION TO
SERVICES WORKGROUP**

CONNECTICUT BEHAVIORAL HEALTH PLAN

In order to implement a system of care throughout Connecticut, system re-organization is needed that includes the integration of public funding, the creation of a Care Management Entity to streamline access and management of services, addressing areas of concern related to commercial (private) insurance; and creating an integrated data structure across the system of care.

Potential Vision for **CONNECTICUT'S SYSTEM OF CARE**

- **The CT full scope SYSTEM OF CARE will maintain and strengthen the ties between children, families and communities.**
- **The CT infrastructure redesign recommended by this committee will build on strengths of existing systems and services to develop a more effected integrated system of care.**
- **SOC will be payor agnostic, front door for all children and youth multiple issues for example IDD, JJ, Child Welfare, Emotional Disorders, Out of Home placement, Out of School Placement, etc.**

Where are SOC's utilized?

SOC frameworks have been **implemented and adapted nationwide** to reform children's mental health systems. Nearly **every state has received federal support or technical assistance** to develop or expand SOC approaches over time.

Because SAMHSA funding and technical assistance under SOC often involve *states and local communities* together, most states have *some* level of SOC-aligned services — though the **degree of implementation varies widely** (from planning phases to fully developed statewide systems).

Nearly every state in the U.S. (all 50) has engaged with the System of Care approach in some form — whether through federal grants, planning activities, or program implementation — largely supported through SAMHSA's Community Mental Health Initiative and other technical assistance.

Why look at NJ System of Care?

NJ CSOC is over 26 years old, is a **statewide, centrally-administered system** designed to route youth/families into a coordinated network of services (mental health, substance use, and intellectual/developmental disability supports). This is different than MA and AR models which are regional. Strong features worth of striving for in CT:

- **Single point of access (24/7)** through a contracted system administrator (**PerformCare**) for the whole state.
- **County-based Care Management Organizations (CMOs)** for intensive care coordination / wraparound-style planning, plus **Family Support Organizations (FSOs)** providing peer family support.
- **Mobile response / stabilization** as a core crisis component (often cited as a key operational feature of NJ's access model).
- **Family Support Organizations:** NJ explicitly frames its structure around System of Care core values (family/youth partnership, community-based, culturally responsive, coordinated network).

Outcomes expected

- **All Children will have improved emotional stability**
- **Children and youth more likely to remain in their communities**
- **Residential/hospitalization length of stays are reduced**
- **Re-admissions to ED and hospitals reduced**
- **Families and caregivers will have a stable environment to keep children home**
- **Children will improve in educational performance and overall social functioning**
- **Lower crimes are committed**
- **Many secondary outcomes seen in NJ: reduced incarceration, residential placements, adult mental health issues, etc.**

- **NJ system design and comparison to CT**

- **1) Governance and Operating Model (State sets the rails; locals deliver)**
- **CSOC sits inside NJ DCF** and runs a **statewide continuum** for youth under 21 with behavioral health, substance use, and I/DD needs. (NJ.gov). **County infrastructure is formalized**
- NJ uses **Children's Inter-Agency Coordinating Councils (CIACCs)** as a county-level mechanism to advise and coordinate a responsive, integrated SOC (with youth/family voice + agencies/providers). (NJ.gov)
- **IDEA: What we have or need to replicate in CT: a statutory/contractual state and county (or region) "SOC round table" with required membership, feedback loop to the state, and problem-solving authority (not just an advisory meeting).**

NJ DCF COMMISSIONER

Family Voice

Resilience

Staff Health and Wellness

Community and Connection

Chief Financial Officer

Contracting

Revenue

Accounting

Procurement

Budgeting

Deputy Commissioner of Operations (vacant)

Chief of Staff

Communications & Public Affairs

Community Outreach

Constituent Relations

Legislative Affairs

Task Force Coordinator

Deputy Commissioner Administration

Human Resources

Information Technology

Training & Professional Development

Strategic Development

Facilities

Emergency Management Services

Security Operations

Child Protection & Permanency

9 Area Offices and 46 Local Offices

Adoption Operations, Resource Families

State Central Registry

Adolescent Services

Children's System of Care

Clinical Services

Integrated Health and Wellness

Constituent Affairs

Community Services

Residential Services

Engagement and Service Excellence

Division on Women

Displaced Homemaker Services

Domestic Violence Services

Empowerment Initiatives

Sexual Violence Direct Services

Sexual Violence Prevention Services

Deputy Commissioner Policy, Legal Affairs and Compliance

Policy, Oversight & Regulatory Affairs

Policy and Regulatory Development

Grants and Proposals Management and Reporting

Child Care Licensing

Employee Relations

EEO/AA

Litigation Liaison/Records

Office of Education

14 Regional Schools

Monitoring

Legal Affairs

Ethics

OPRA

HIPPA

Institutional Oversight and Special Investigations

Conflict Unit

Institutional Abuse Investigation Unit

Youth Residential Licensing

CARI

AHU

Family & Community Partnerships

Early Childhood Services

Family Preservation & Reunification

Family Support Services

Housing

Analytics and Systems Improvement

Applied Research & Evaluation

Data Management & Reporting

Quality

Fatality & Critical Incident Review



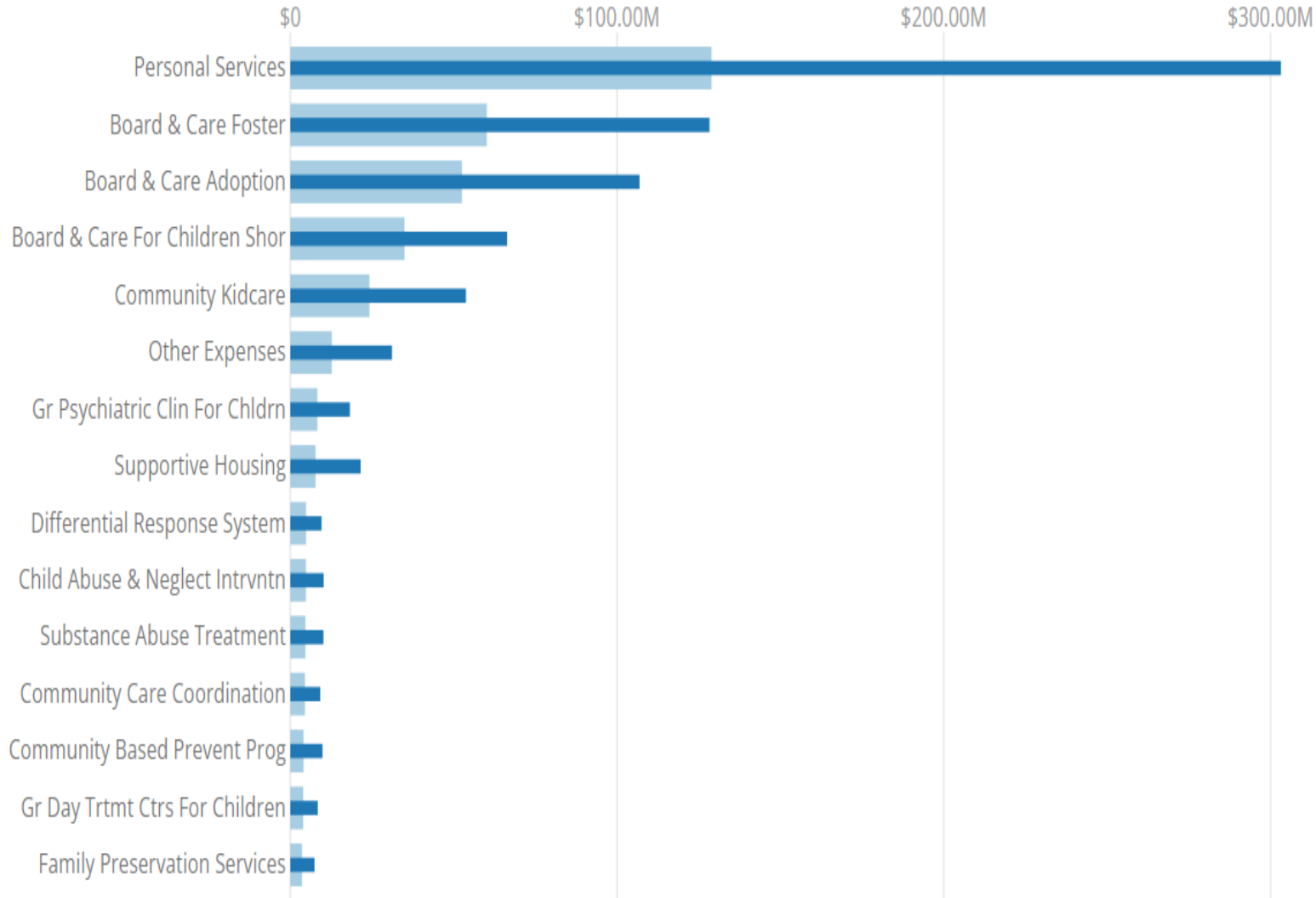
NJ Budgeted to help strengthen families; funds braided and blended on state level

- State and federal funds blended:
 - Medicaid
 - Block Grants, ...
 - Federal Title 19
 - Federal Title 4E
 - Private Insurance on board
- Integrated Funding Pool of grants, Medicaid, insurances and philanthropy

SOC IN NJ COSTS \$280 million annually

State	Under 18 (measured)	Estimated 0–21 (approx)
Connecticut	~723,000	~850,000–900,000 (approx)
New Jersey	~2.0–2.3M (estimated)	~2.4–2.7M (approx)

2026 CT DCF budget **\$821,689,469**



**STATE OF CT
SPEND ON
HUMAN
SERVICES
6.6.BILLION
DOLLARS**

- **2) Single Point of Entry (the “front door”)**

- NJ uses **PerformCare** as the **Contracted System Administrator (CSA)** and *single point of access* to the service array statewide. (NJ.gov). **Why this matters operationally** :One number/entry point reduces churn, duplication, and “wrong door” referrals.
- The CSA can standardize **eligibility, triage, prior authorization, provider network management, and data reporting** across the state.
- **Entry sources:**
 - Families / caregivers (self-referral), Schools, Pediatricians / hospitals, Emergency departments
 - Child welfare, Juvenile justice, Courts, Community providers. **All entries funnel to the same access entity**
- **IDEA: What we have or need to replicate in CT:** a statewide ASO/CSA (or equivalent) with clear scope: intake/triage, authorizations, network adequacy, utilization management, and performance dashboards.

- **3)The Core Service “Spine”:** Mobile Crisis + Wraparound Care Management + Family Peer Support
- NJ’s public-facing CSOC materials describe a **continuum** that includes (at minimum) mobile response, care management, and family support orgs, plus in-home/community services and residential when needed. (NJ.gov)

1. Mobile Response & Stabilization (MRSS)

- Operationally, MRSS is structured as:
- **Immediate response period** (often described as an initial 72-hour intervention window) with clinical intervention, followed by **Stabilization management** (up to ~8 weeks) coordinating supports to keep youth safe at home when possible. (ubhc.rutgers.edu)
NJ materials also describe response that can be **very rapid (potentially within an hour)** depending on circumstances. (njcpac.org)
- **IDEA: What we have or need to replicate in CT: We have 24/7 Mobile Crisis. We need defined crisis SOW (response time expectations), stabilization duration/episodes, and explicit ties to step-down services (IIC, BA, outpatient) so mobile crisis isn’t a “one-and-done.”**

- **2) Care Management Organizations (CMOs) = local wraparound hubs**
- NJ's CMOs are **county-based nonprofits** providing face-to-face care management for youth with complex needs, using **wraparound and the Child/Family Team process**. ([PerformCare](#)). Access typically requires **prior authorization through PerformCare**. ([PerformCare](#))
- **IDEA: What we have or need to replicate in CT:** regional nonprofit care management entities (or contracted teams) with (1) wraparound fidelity expectations, (2) required Child/Family Team cadence, and (3) clear handoffs from mobile crisis/hospitals/schools.
- **3) Family Support Organizations (FSOs) = peer-led family navigation**
- FSOs are **family-run, county-based** and provide **peer support, education, and advocacy**; families can call them directly or enter via the CSA. ([NJ.gov](#))
- **IDEA: What we have or need to replicate in CT:** peer-led family orgs with **stable funding, defined deliverables (peer-to-peer support, system navigation, training), and a tight interface with care management.**

- **4) Mid-level and “Step-Down” Case Management (important for right-sizing)**
- NJ also runs **Youth Case Management (YCM)** as a **moderate level** of community case management for multi-system youth with moderate need. ([NJ.gov](https://www.nj.gov))
- **IDEA: What we have or need to replicate in CT:** don't make wraparound the only case management tier. Build a lower-intensity option so the high-intensity team is reserved for truly complex youth.

- **5) High-volume home/community services that make the model work**
- A big operational lesson from NJ is: mobile crisis + wraparound fail without **rapid-access in-home clinical capacity**.
- Example: **Intensive In-Community (IIC)** is defined as short-term, goal-oriented clinical intervention delivered in-home or in community settings by licensed clinicians, intended to stabilize and deter higher levels of care. ([PerformCare](#)).
- **IDEA: What we have or need to replicate in CT:** contract for enough IIC-like capacity and measure “time-to-first-appointment” after crisis referral. IICAPS?

- 6) “Only as a last resort” residential is explicit—and operationalized
- NJ’s CSOC framing explicitly states a preference for **home/community-based care** with residential/hospitalization as last resort. ([NJ.gov](https://www.nj.gov))
Residential placement is described as reserved for highest-need youth who can’t be maintained at home. ([NJ.gov](https://www.nj.gov))
- **IDEA: What we have or need to replicate in CT:** embed “least restrictive” expectations into authorization criteria, with required step-down planning and family contact expectations during placement.

What's next?

Present to all TCB committees

Have UCONN present on SOC to TCB in July

Have workgroups on specific topics before July presentation

Policy recommendations for Next Legislative Session

Thoughts and Questions