



Making connections. Informing solutions.

University of New Haven

September 2nd, 2026

2:00 PM – 4:00 PM

Hybrid, LOB 2C and Zoom

Viewing options: [YouTube](#) or [CTN](#)

TCB September Monthly Meeting Minutes

Attendees

Sarah Eagan

Christina Ghio

Lorna Thomas-
Farquharson

Tammy Venenga

Javeed Sukhera

Susan Hamilton

Lisa Morrissey

Shari L. Shapiro

Yann Poncin

Sean King

Howard Sovronsky

Tammy Exum

Kai Belton

Cristin McCarthy

Catherine Osten

Jody Bishop Pullan

Gerard O' Sullivan

Carolyn Grandell

Kimberly Karanda

Edith Boyle

Tammy Freeberg

Claudio Gualtieri

Toni walker

Carrie Bourdon

Mickey Kramer

Melissa Santos

Jeanne Milstein

Manisha Juthani

Michael Powers

Alice Forrester

TYJI Staff

Erika
Nowakowski

Emily
Bohmbach

Ryan Connick

Stacey Olea

Welcome and Introductions:

The Meeting was opened with a welcome to all attendees.

University of New Haven University of New Haven

Acceptance of TCB July Meeting Minutes:

A motion was introduced to accept the July meeting minutes. The motion carried and was approved.

Meeting Summary

The meeting opened with welcome remarks to members. The meeting was described as an opportunity for a robust discussion of several important issues affecting Connecticut's children's behavioral health system. The beginning of the school year was highlighted as an important time to increase awareness among children, youth, parents, and families regarding the behavioral health services and support available throughout the state.

The committee also acknowledged the behavioral health press conference that was held earlier in the day, which highlighted the range of services and resources available to children, youth, and families. The discussion emphasized the importance of ensuring that families are aware of these resources and understand where to seek assistance when behavioral health concerns arise. Although Connecticut has a range of behavioral health services, the tri-chair noted that the availability of services is limited in its impact when families are unaware of the resources or do not know how to access them. The tri-chair recognized the collaborative efforts of state agencies, community-based providers, and other partners in expanding awareness of and access to behavioral health services. The committee was made aware that September is Suicide Awareness Month and highlighted the importance of addressing the behavioral health needs of children and families, including concerns related to anxiety and the growing impact of social media and technology on young people.

TCB Senior Project Manager followed with administrative announcements before introducing the meeting agenda. An update was provided on the workgroups, ongoing studies, and upcoming deliverables. The School-Based workgroup continues to advance three areas of work, including the school Medicaid billing project, the special education study, and the development of a school-based health center subgroup. The Medicaid

billing subgroup is scheduled to present its draft report, with a meeting with DSS and the CT DOE planned to review the work. The special education subgroup continues its work toward the report, which is due January 1st, 2027, while the school-based health center subgroup is being established in partnership with the National School-Based Health Alliance.

The prevention and services workgroups will continue reviewing the findings of the behavioral health services array report and the work completed during the August 4th workshop. The systems infrastructure workgroup will follow up on its July discussion and review the statutory charges of Children's Health Oversight Boards. The related statutory document was released on August 25th, following the Committee's request at its July meeting. The committee reviewed the status and anticipated timelines for its ongoing studies and projects, with several deliverables scheduled between October 2026 and January 2027. An interim update on the UCC private insurance report and the school Medicaid behavioral health billing study is scheduled for October 1st, 2027; the committee is scheduled to receive an interim update on the school-based health center study, the behavioral health concerns and special education study, and the crisis continuum report.

The Senior Project Manager noted that the current meeting's presentations consist of updates on the behavioral health crisis continuum and UCC marketing as well as a continued conversation on Solnit. This continued focus allows the committee to connect prior work with current initiatives and advance ongoing efforts toward implementation and future recommendations.

UCC & Crisis Continuum Marketing – United Way of CT and Daydream Communications

The speakers presented two behavioral health marketing initiatives developed over approximately six months in collaboration with Daydream Communications, United Way of Connecticut, the three community-based Urgent Crisis Centers (UCCs), mobile crisis agencies, DCF, the State Department of Education, and other partners. The campaigns are intended to increase awareness of available behavioral health and crisis



University of New Haven

services and help children, youth, parents, and families understand where and how to access appropriate support. Materials are available in English and Spanish.

The statewide Youth Behavioral Health Crisis Continuum campaign follows the SAMHSA Crisis Response Framework of someone to contact, someone to respond, and somewhere safe to go. The campaign was developed with input from youth, 211 contact center staff, the working group, and the Community Voices group. Focus groups and approximately one month of A/B testing were used to refine the messaging and ensure that materials would resonate with children, youth, parents, and families.

A comprehensive marketing toolkit was developed to support consistent statewide messaging. The toolkit includes English and Spanish flyers, website content, email templates, and social media materials with alternative text for accessibility. A campaign landing page provides information about the behavioral health crisis continuum, UCCs, and other available resources.

The statewide outreach strategy includes partnerships with schools and the Connecticut Interscholastic Athletic Conference, with campaign materials planned for athletic championship events, school bathrooms, video boards, and public service announcements. Outreach will also extend to community settings such as barber shops, nail salons, and malls, as well as digital platforms including social media, gaming sites, Discord, and other online communities. Promotional items will also be used to increase visibility among youth and parents.

The separate UCC marketing campaign is designed to build awareness and trust in the three community-based UCCs and increase traffic to ucchelp.com. The target audience is parents of children ages 5 through 18 living within approximately one hour of the three UCC locations. Research found that approximately 63 percent of parents surveyed had never heard of the UCCs, although many expressed interest in using the centers after learning about them.

The UCC campaign uses a digital-first strategy that includes social media, search engine advertising, online communities, and outdoor advertising. The creative approach presents the UCCs as warm, welcoming, and accessible settings. Campaign materials

University of New Haven

use storytelling, carousel advertisements, animated advertisements addressing concerns such as depression, anxiety, and thoughts of suicide, and a 30-second parent-perspective video available in English and Spanish. The campaign launched on August 24, 2026, with early results showing positive engagement, particularly through Google Search and carousel advertisements. The campaign will increase activity during September and October, with outdoor advertising beginning during September and the campaign continuing through January.

Q&A

Members discussed how the campaign will reach schools, parents, and families. Approximately 1,100 toolkits are being distributed initially through the State Department of Education and school communication systems such as ParentSquare and PowerSchool. DCF-contracted care coordination agencies are also assisting with distribution to schools statewide. Members suggested expanding outreach to colleges and community colleges to reach young people during significant transitions.

Members asked about sustaining the campaign beyond its initial launch. TCB administrative funding has been allocated to support continued marketing, subject to available appropriations, and the organization responsible for the UCC help line, landing page, and related marketing activities is expected to assume a greater role beginning in January. Members also emphasized using campaign analytics to measure effectiveness, identify populations that are not being reached, and guide future outreach and language-access efforts.

Members discussed how parents who are already familiar with UCCs learned about the services. School nurses, trusted professionals and community partners, and families with previous UCC experience were identified as potential referral sources. Members also discussed expanding language access beyond English and Spanish based on community needs and analytics.

Members emphasized the importance of consistent messaging across websites and referral systems. The toolkit, landing page, and related materials are intended to help participating organizations provide consistent information, and 211 staff are being

trained on the campaign's core messaging and service options, so families receive consistent information and appropriate referrals.

The discussion also focused on strengthening school-based outreach. Members emphasized reaching superintendents, administrators, counselors, coaches, school nurses, and other individuals who regularly interact with students, including students who may be less connected to school or less likely to seek traditional behavioral health services. School communications, parent meetings, and athletic events were identified as opportunities to provide families with practical information about recognizing behavioral health concerns and accessing assistance.

Members asked how the UCC campaign could be incorporated more directly into school-based outreach, particularly for middle and high school students and their families. Speakers explained that the current partnership with the Connecticut Interscholastic Athletic Conference represents the first phase of the initiative. A potential second phase could expand outreach through hospitals, physicians' offices, school counselors, and other school-based partners.

Members emphasized the importance of incorporating the perspectives of children, youth, and families into the campaigns and recognized UCCs as an accessible option for families seeking behavioral health assistance. Additional resources, including Impact Centers at Stamford Hospital and Yale, were also noted.

Speakers recognized the collaborative effort involving state agencies, community providers, United Way of Connecticut, Daydream Communications, UCCs, mobile crisis agencies, DCF, youth, families, and other stakeholders. The campaigns will continue statewide through January, with ongoing monitoring of performance and continued efforts to engage schools, health care providers, counselors, and community partners.

Solnit Updates – DCF and UConn Health

The discussion opened with an acknowledgment of the longstanding partnership among the TCB, DCF, and the provider community, as well as the significant progress made in Connecticut's children's behavioral health system over the past 25 years. Over time, the behavioral health continuum has expanded through sustained investment in



University of New Haven

community-based services and crisis services, including mobile crisis response, Urgent Crisis Centers, subacute services, psychiatric residential treatment facilities, residential programs, and hospital-level care. The collective goal remains to ensure that children receive services in the least restrictive setting appropriate to their needs, while recognizing that some youth require an extended period of hospital-level treatment.

Building on this broader context, the group reviewed the ongoing partnership between DCF and UConn Health/John Dempsey Hospital as a follow-up to the July presentation. The partnership began on April 15th, 2026. The transition status and related progress are expected to remain a standing topic for continued updates and input from TCB members.

As part of the transition, UConn Health reported that its priorities for Solnit Hospital remain focused on patient and staff safety, workforce stabilization, program enhancement, facility enhancement, and regulatory compliance. To address these priorities, initial efforts included developing a staffing plan based on the 2023 staffing statute and conducting a staffing analysis to determine appropriate staffing ratios at different census levels. As a result, 14 new registered nurse positions and 23 new child service worker positions were approved, with recruitment, onboarding, and training underway. Existing vacancies are also being actively filled, and an automatic refill process was approved for direct-care positions to expedite recruitment.

In the interim, additional measures were implemented to address immediate staffing needs while permanent positions are filled. Nine travel registered nurses were engaged with OPM approval, and increased overtime opportunities were authorized for frontline and interdisciplinary staff. In addition, weekly meetings are being held to monitor recruitment, operations, personnel, finances, and policy. These efforts reflect continued coordination among UConn Health, OPM, and DCF to strengthen staffing and operational capacity.

Alongside the staffing initiatives, the regulatory transition was also discussed. As part of the change in licensure, a DPH consent order established criteria that must be assessed on an ongoing basis. An independent monitoring team was engaged to provide approximately 40 hours of onsite oversight each week and to report regularly to DPH

University of New Haven

regarding progress. The consent order also included provisions for contracted security staff to support patient and staff safety and respond to emergency situations, including circumstances involving restraint. Two security staff are assigned to each shift and have completed required training. It was subsequently clarified that the contracted security staff began on August 22nd, 2026, rather than September 22nd as initially stated during the presentation.

Early operational indicators suggested measurable improvements in key areas of performance. In particular, mandatory overtime has decreased substantially, especially on weekends, and workers' compensation injuries were reported to be approximately 30 percent lower. A decrease in emergency safety interventions, restraint, and seclusion was also reported. Together, these developments were described as part of a broader effort to strengthen programming, facility conditions, and workforce stability.

Turning to census and admissions, Solnit Hospital continues to serve as a distinct hospital level of care within Connecticut's Medicaid system. Youth are generally referred to from other hospitals, emergency departments, inpatient units, PRTFs, and, in some circumstances, the juvenile court system. The level-of-care criteria remain focused on youth who require inpatient psychiatric treatment and cannot safely receive the necessary care in another setting or who require an extended period of hospital-based treatment before transitioning to a lower level of care.

The hospital operates four units and primarily admits adolescents age 13 and older, although younger children may be admitted on a case-by-case basis. There are generally no diagnostic exclusions, and youth present with a wide range of behavioral health needs and functional capacities. However, youth with significant medical complications requiring substantial medical intervention may not be appropriate for admission. At the time of the presentation, the hospital was operating with an approximate census threshold of 24, reflecting both staffing considerations and the need to provide intensive, youth-specific care. Although the licensed capacity is higher, the intention is to enhance staffing, programming, and the facility sufficiently to support a return to higher census levels.

University of New Haven

The discussion then addressed DCF involvement among youth admitted to Solnit. The presenter elaborated that approximately one-third of youth are committed to DCF at the time of admission, while another group has active involvement with DCF Child Protective Services while remaining in their homes. Taken together, approximately half of the youth have active DCF involvement at admission. In addition, many youth who are not actively involved with DCF at admission have had prior involvement with the department. Referrals generally originate from inpatient units, emergency departments, PRTFs, and, in some cases, juvenile court for evaluation or restoration-to-competency services.

Because Solnit serves youth with a broad range of needs and does not rely on narrow diagnostic admission categories, treatment must be individualized rather than based on a one-size-fits-all model. Accordingly, each youth receives a comprehensive multidisciplinary assessment involving psychiatry, psychology, social work, nursing, rehabilitation, medicine, and other disciplines. The initial assessment generally occurs over several weeks and provides an opportunity to engage the youth, family, and other stakeholders in developing an individualized treatment plan.

In addition, all youth admitted to Solnit are enrolled in Unified School District 2 and receive public education on campus. Educational services are provided through the school district, with individual educational plans and special education services implemented as appropriate. Treatment includes individual, family, and group services, with continued efforts to enhance group programming. Families are encouraged to participate in treatment, generally at least weekly when possible, and staff work to address barriers such as transportation and financial limitations through support including transportation assistance and gas reimbursement. At the same time, staff work to understand families' experiences with the system and build trust and engagement in the treatment process.

The treatment program also includes extensive rehabilitation services, including therapeutic recreation, music therapy, art therapy, dance and movement therapy, and occupational therapy. Youth participate in these activities as part of their individualized treatment plans. Additional programming includes specialized groups and partnerships

University of New Haven

with outside organizations, including training related to dialectical behavior therapy, youth at risk of domestic minor sex trafficking, yoga, and substance use disorder recovery.

Further, Solnit is re-engaging with the developers of the Attachment, Regulation and Competency (ARC) framework. ARC emphasizes creating a safe and predictable environment rooted in attachment and connection so that youth can engage in treatment and develop skills at an appropriate pace. The approach places significant emphasis on how staff and the treatment environment respond to youth, including creating consistency, safety, and predictability. Formal training and technical assistance from the ARC developers are planned as part of the renewed implementation.

With respect to outcomes, Solnit uses the Ohio Scales at admission, during treatment, and at discharge. These measures incorporate both parent and youth reports regarding problem severity and functioning. The hospital also tracks length of stay and discharge destination, with successful transition to a less restrictive and preferably community-based setting considered an important outcome.

Approximately 40 percent of youth are discharged directly to a home setting, including their own or a foster home. Another approximately 40 percent transition to PRTF, with many subsequently returning home. Other youth may return to the juvenile court system or transition to a group home or residential setting. Overall, these discharge pathways reflect an effort to transition youth directly or through intermediate levels of care toward reintegration into their communities.

The average length of stay at Solnit is approximately four to six months, although some youth remain substantially longer. Five youths were reported to have been at the hospital for more than one year. Extended stays may result from the time required to develop sufficient functional skills or from difficulty identifying an appropriate next setting with the necessary resources and supports. Therefore, discharge planning begins at admission and continues throughout treatment to align the youth's functional abilities, family and community support, and available resources.

University of New Haven

The discussion then turned to facility and infrastructure improvements. Initial work has included replacing or repairing furniture, addressing damaged finishes, repairing security doors, improving nurse stations, and maintaining exterior recreational areas. These measures were described as initial steps toward improving safety while larger projects are developed.

In addition, approximately 80 facility-related task items have been identified by DPH, the Fire Marshal, and the Office of the Child Advocate, with 41 completed at the time of the presentation. Fifty-two of the identified items were associated with the DPH change-of-ownership process and included life-safety assessments, ADA compliance, and utility and functional assessments. Completion of these assessments will provide a longer-term plan for prioritizing and funding infrastructure improvements.

Major infrastructure projects include replacement of the facility's boilers and chillers. One of the two primary boilers has been replaced, while funding for the second remains necessary. A chiller replacement project has been approved and is being managed through DAS to complete the work before the next cooling cycle.

At the same time, additional safety improvements include the replacement of 23 security doors, upgrades to four nurse stations, replacement of patient-room and hallway lighting with abuse-resistant materials, installation of anti-ligature and anti-barricade patient-room doors, improvements to security cameras, and mitigation of potential ligature risks associated with windows and other fixtures. Tamper-resistant hardware and attachment mechanisms are also being incorporated into the facility improvements.

Environmental and aesthetic improvements are also being considered, including improvements to bathrooms, flooring, high-impact paint, patient courtyards, and other areas of the facility. Additional attention is being given to patient-room fixtures, housekeeping, landscaping, and other routine environmental improvements intended to support a safer and more functional treatment environment.

In addition to the physical improvements, regulatory oversight remains an important component of the transition. As part of the acquisition and licensure process, DPH

University of New Haven

established a consent order requiring independent oversight. UConn Health has engaged a five-member independent consulting team providing approximately 40 hours of on-site review each week for one year, including coverage across shifts and weekends. The team completed an initial assessment and provided recommendations addressing multiple aspects of operations at Solnit South. An environmental consulting firm is also reviewing life-safety and environmental conditions throughout the facility.

The independent clinical consultants are reviewing staffing, security, environmental and ligature risks, serious safety-event reporting, staff education, and hospital policies. The consultants report every other week during the initial three months and monthly thereafter for the remainder of the year. Meanwhile, UConn Health is working to consolidate and align the hospital's policies so that staff are operating under consistent expectations and procedures.

The use of restraint and seclusion was also addressed as part of the regulatory and clinical discussion. These interventions may be necessary in an inpatient psychiatric setting when there is an immediate risk of harm. Restraint involves physical intervention to prevent a patient from harming themselves or others, while seclusion limits access to other individuals or environmental hazards that could be used to cause harm. Because youth receiving psychiatric care are particularly vulnerable, restraint and seclusion were described as significant patient-rights concerns, and their use is subject to careful monitoring, documentation, and ongoing efforts toward reduction.

Importantly, reducing restraint and seclusion was described as dependent primarily on the broader treatment environment rather than the interventions themselves. Key strategies include leadership, data review, staff training and supervision, prevention, debriefing, family involvement, engagement, and connection with youth. Restraint and seclusion are not intended to modify behavior or serve as incentives; rather, they are emergency safety interventions to be used only when necessary. Accordingly, Solnit is renewing its focus on these strategies and reviewing crisis-intervention practices in consultation with other inpatient programs and UConn Health/John Dempsey Hospital to align with current practices and protocols.

University of New Haven

Community engagement was subsequently discussed as another area of ongoing development. Solnit has historically engaged volunteers, community organizations, churches, businesses, a community advisory group, parent representatives, and a youth advisory board. The community advisory group had previously met quarterly and included representatives from community providers and academic institutions; however, its meetings were interrupted around the time of the transition. As a result, re-engagement with parents, current and former youth, and other individuals directly affected by Solnit services was identified as an opportunity for improvement.

Meaningful involvement of youth and families in programming, planning, and decision-making was identified as an important component of creating a trauma-responsive environment and reducing restraint and seclusion. Solnit is also looking to UConn Health and John Dempsey Hospital for opportunities to incorporate established consumer-engagement processes and strengthen mechanisms for receiving input from individuals who have experience with the system.

Looking ahead, the transition was described as an opportunity to strengthen Solnit's role within the broader behavioral health system while leveraging the expertise and resources available through UConn Health. Future planning will continue to consider what children and families across the state need from a hospital-level behavioral health facility and how Solnit can adapt its programs and services to meet those needs.

Solnit Hospital represents one component of a broader continuum and that hospital outcomes are influenced not only by the services available during hospitalization, but also by the availability of appropriate services before admission and after discharge. Therefore, future planning should consider both investments that can prevent the need for hospitalization and the availability of lower levels of care when youth are ready to transition.

The discussion concluded with an emphasis on continued improvement, data monitoring, and collaboration across the behavioral health continuum. It was recognized that there is no point at which the system should be considered complete and that ongoing evaluation and refinement will be necessary to improve outcomes for children and families. Finally, the importance of supporting youth receiving care in

emergency departments throughout the state and strengthening access across the broader continuum was identified as an ongoing priority

Q&A

The discussion began with questions from the tri-chairs regarding the use of restraint and seclusion, including the typical duration of each intervention and the strategies being used to prevent or reduce their use. It was noted that the two interventions serve different purposes and should be evaluated separately. In response, it was explained that the hospital tracks both the number and duration of restraint episodes and that all restraints require physician authorization and nursing oversight. Youth are continuously assessed throughout an intervention, including consideration of their physical and emotional status and whether the intervention can safely be discontinued. Duration may vary considerably depending on circumstances, ranging from about five minutes to, in some cases, 45 minutes.

The tri-chair followed up with a question on what incentives or positive interventions we know are effective in engaging children, even when they are experiencing these challenging situations. In response, the presenter explained that incentives can be complicated, particularly because approaches such as token economies, where a young person receives something in exchange for a particular behavior, have become less common. While recognizing that everyone is motivated by different things, the presenter emphasized that the focus should be less on rewards and more on engagement, motivation, relationship-building, coaching, and skill development that can generalize beyond the current setting. The presenter also noted that this is especially important for youth with complex trauma histories. Staff cannot assume that young people will immediately trust them or feel safe in relationships with caregivers or treatment providers. As a result, staff need to be well trained and supervised to recognize each young person's cues, needs, and level of comfort, rather than allowing interactions primarily on privileges, consequences, or what a youth can or cannot do.

Questions were also raised regarding the current census at Solnit, the length of stay for youth, and discharge planning. It was reported that 22 youth were currently receiving care and that each youth has an identified discharge goal. Developing and

University of New Haven

implementing the corresponding discharge plan requires coordination with families, DCF, probation, education systems, and other community resources. The average length of stay is approximately four to six months, although some youth remain for shorter periods and a smaller number remain for a year or longer. Discharge planning is incorporated into treatment reviews throughout the hospitalization, with the goal of establishing the support and community connections necessary for a successful transition.

Another question raised by one of tri-chairs regarding education, what a typical school day looks like for these students. In response, the presenter explained that youth admitted to DCF-Operated facilities are enrolled in Unified School District Two, which operates public schools on the PRTF North and South Campuses and within the hospital. The schools are staffed by certified teachers, special education teachers, pupil services specialists, and a principal. Each student has an educational plan, including implementation of an IEP when applicable, and participates in PPT meetings. The presenter described the school day as similar to a typical school day, with classes being held from approximately 8:30 a.m. to 3:00 PM, including a lunch period. Classes are small, generally consisting of four to 6 students, and provide instruction in core academic subjects. USD2 also assesses each student's educational level and provides individualized instruction, recognizing that many youth have experienced educational delays or disruptions due to prior placements. A significant focus is helping students recover missed credits and make academic progress toward their educational potential. As students prepare for discharge, USD2 coordinates with their home school districts to support a smooth transition and transfer of educational responsibility.

The discussion further addressed opportunities for young people to spend time outside the hospital environment. It was explained that the facility is a controlled setting, but youth mobility is determined through individualized assessment of functioning, safety, and the youth's demonstrated ability to manage different environments. Depending on the youth's status and physician authorization, activities may occur within the unit, elsewhere in the building, on the hospital grounds, or off campus. Youth may participate in supervised outdoor activities, community activities, shopping trips, home visits, and family passes as clinically appropriate. As discharge approaches, overnight

visits and other community-based experiences may be incorporated into the treatment plan. These activities provide opportunities to assess how youth manage transitions, identify challenges, and strengthen the skills and support needed for a successful return home or to the community.

Members of the TCB then raised questions regarding staffing levels, staff classifications, workers' compensation cases, coverage for staff absences, and the demographic and length-of-stay characteristics of youth across the Solnit North Campus PRTF, South Campus PRTF, and hospital. It was clarified that the requested information included staffing and demographic data for each of the three settings.

The discussion also focused on changes in the acuity and characteristics of the youth served at Solnit Hospital. Questions were raised regarding whether the hospital's staffing and clinical resources remain appropriate given these changes and how the system can support youth with increasingly complex needs. It was acknowledged that the acuity of the Solnit population has increased over time. However, it was clarified that this change should not be attributed solely to juvenile justice involvement. Rather, improvements in the broader behavioral health continuum have resulted in many youth who previously would have required hospitalization being served in less restrictive settings. As a result, the youth who continue to require hospital-level care often have more complex and acute needs because existing community-based and intermediate services have not been sufficient to meet their needs.

Staff training was identified as an important component of responding to the changing acuity of the population. Concerns were raised regarding whether staff have received sufficient training to manage higher-acuity youth and whether there is a timeline for implementing additional training related to the ARC model and other therapeutic approaches. It was reported that the ARC model is being re-engaged at Solnit, with an initial onsite program evaluation and readiness assessment planned to inform implementation. A two-year implementation, supervision, coaching, and reinforcement plan is being developed to help embed the model into the program. In addition, UConn Health is considering implementation of its existing crisis-prevention program at Solnit to further prepare staff to safely respond to behavioral crises.

University of New Haven

Staffing ratios were also discussed in relation to the increased acuity of the youth population. It was noted that a staffing analysis had been conducted with frontline nursing staff to identify appropriate staffing levels and ensure that registered nurses are able to work at the top of their scope of practice. Recruitment and hiring processes have therefore been prioritized to improve staffing levels and support both patient care and staff safety. The continued implementation of the ARC program and additional crisis-prevention training were identified as important components of this effort.

Members of the TCB further discussed delays in discharge from PRTFs and the broader behavioral health continuum. Concerns were raised that limited foster care, group home, and other residential placement options may result in youth remaining in PRTFs after they are ready for a lower level of care, potentially contributing to delays elsewhere in the system. It was explained that discharge delays can occur for a variety of reasons, including waiting for a foster placement, return home, or another congregate care setting. Efforts are therefore focused on expanding placement capacity and, where reunification is the permanency goal, strengthening connections between youth and their families during treatment. Coordination with the courts, attorneys representing youth, families, and other community partners was identified as an important part of expediting successful transitions to home and community settings.

Readmissions were also identified as an important measure of transition success. The hospital tracks readmissions within 90 days, and it was reported that two youth had been readmitted to the hospital during the previous six months. Readmissions to other community hospitals are not captured directly by Solnit, although broader hospital readmission data are tracked through the appropriate systems. When a readmission occurs, the treatment team reviews what support or services may have been insufficient and uses that information to inform renewed treatment and improve future transitions.

The discussion also emphasized the importance of learning from other programs that have successfully reduced the use of restraint. Examples of approaches used in other systems, including positive behavioral interventions and supports, were referenced as potential areas for collaboration and learning. The broader discussion stressed the

University of New Haven

value of sharing effective practices across agencies and adapting approaches to the medical and therapeutic environment at Solnit.

TCB members requested clarification on the scope of UConn Health's involvement with Solnit. It was confirmed that UConn Health's current partnership applies specifically to Solnit South Hospital and does not include Solnit South PRTF or Solnit North PRTF. The clarification was considered important because all three programs operate under the Solnit name and on the same campus, which can create confusion regarding the scope of the transition.

Finally, members of the TCB discussed transparency and public access to information related to the Department of Public Health consent order, consultant assessments, monitoring reports, findings, recommendations, and corrective actions. It was explained that the consent order is a standard mechanism used by DPH when one hospital acquires or assumes responsibility for another institution and is intended to ensure continued compliance with regulatory and quality-of-care requirements. The consent order has been shared with stakeholders, although the consultant reports were not being routinely posted publicly at the time of the meeting. Further discussion with DPH was anticipated regarding the most appropriate way to share these materials and provide ongoing updates. Members of the TCB emphasized the importance of transparency and accountability, particularly given the history and complexity of services provided at Solnit, and expressed support for making appropriate public information and progress updates readily accessible.

The next TCB meeting will be on October 7th, at the LOB from 2:00 PM to 4:00 PM with a hybrid option.