REPORT ON PEER-RUN RESPITE CENTERS

SUBMITTED PURSUANT TO § 17A-484H

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CONNECTICUT
Mental Health and Addiction Services

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Executive Summary

This report, submitted pursuant to §17a-484h of the Connecticut General Statutes, provides a comprehensive overview of the implementation, utilization, and outcomes of Connecticut's first peer-run respite center, The Gloria House, operated by New Life II in New Britain. Peer-run respite centers offer voluntary, short-term, non-clinical support for individuals experiencing emotional or behavioral distress, emphasizing trauma-informed care and mutual peer support in a home-like setting.

The Gloria House opened in July 2024 and served 117 guests during its first year of operation. Key findings include:

- *Utilization and Access*: The center operated at a 51% utilization rate, with most guests self-referring or being referred by behavioral health providers. Outreach efforts are ongoing to increase awareness statewide.
- *Demographics*: Guests ranged in age from 18 to 75, with the majority between 26 and 45 years old. The population was diverse in gender identity and race/ethnicity, with strong representation from Region 4.
- *Outcomes*: 92.4% of guests reported crisis resolution by discharge. Only 3.4% required higher levels of care. Discharge destinations varied, with many returning to stable housing or staying with friends/family.
- *Resources and Linkages*: Guests accessed a range of supports including rest, peer support, housing resources, and wellness activities. Community linkages to clinical and non-clinical services were facilitated.
- *Guest Satisfaction*: Survey responses indicated high levels of satisfaction, with guests valuing privacy, dignity, peer connection, and the ability to meet basic needs.

Throughout its first year of operation, The Gloria House has offered meaningful perspective on launching peer-run respite care in Connecticut, including the importance of sustained outreach to build statewide awareness, the need for flexible transportation options to support access, the impact of housing instability on guest transitions, and insights into how peer roles and responsibilities are embedded within the day-to-day operations of the model.

Early outcomes and guest experiences at The Gloria House offer a foundation for continued learning. As the model evolves, continued evaluation will be important to understand how the model can be strengthened and sustained within Connecticut's behavioral health system. While no peer-run technical assistance centers currently exist in other states, ongoing engagement with national peers may still offer useful perspectives as Connecticut considers future directions.

Statutory Mandate

Section 36 of Public Act No. 24-19 authorizes the establishment of a peer-run respite center by the Department of Mental Health and Addiction Services, within available appropriations. Originally introduced as a stand-alone bill that did not advance due to the significant fiscal impact of requiring at least eight peer-run respite centers and one peer-run technical assistance center, the enacted provision authorizes DMHAS to establish a single center, contingent upon the availability of existing fiscal resources. Codified in section 17a-484h of the Connecticut General Statutes, DMHAS is required to produce a report by October 1, 2025 regarding the operationalization of any peer-run respite center under this new authority. Any such report must include:

- Identification of barriers to implementing the peer-run respite center, including recommendations for addressing such barriers;
- Data regarding the outcomes and effectiveness of the peer-run respite center;
- Recommendations based on the outcome data about establishing additional peer-run respite centers in the state, including those managed, operated, and controlled by members of certain communities; and
- A review of other states' practices regarding the establishment of peer-run technical assistance centers.

This report fulfills the statutory requirement under section 17a-484h(c). See Appendix A for language.

Peer Respite Programs: Overview of Concept

Peer respite programs are voluntary, short-term, overnight programs that provide community-based, non-clinical support to assist individuals who are experiencing emotional and/or behavioral distress. These programs are often located in houses in residential neighborhoods and are staffed by people with lived experience who are trained peer support specialists. The environment is designed to be a safe, trauma-informed, home-like setting, with peer support availability 24 hours a day. This model offers individuals the opportunity to receive support from others with lived experience in ways that may be different from traditional, clinical interventions. Trained peer support specialists use mutuality and the sharing of their own personal experiences to offer hope and recovery-oriented support to individuals staying at the program. These unique programs are intended to provide alternative pathways to recovery and

potentially divert individuals with behavioral health disorders from accessing higher levels of care including emergency rooms and inpatient, psychiatric settings. The relationship between the individual and the peer support specialist is especially important as it focuses on the development of personal connection and the mutual exchange of personal stories. In this way, both parties play a role in the interpretation of the person's distress, seeing it as a valid and meaningful experience, where personal growth and recovery can occur.

Connecticut Peer-Run Respite Center: Gloria House

DMHAS contracted with New Life II, a Black-led, faith-based, peer-recovery, community organization, to open Connecticut's first peer-run respite center. Called "The Gloria House", the center is centrally located in New Britain and is open to all Connecticut residents who are 18 years of age and older. The Gloria House is a two-family style home, with the ability to have up to four guests at a time. Each guest has their own bedroom and there is a shared kitchen, dining area, and living area on each floor. The home also includes an area for individual or group activities including meditation, yoga, reading, or other desired interests. The Gloria House admitted its first guest on July 3, 2024.

According to the data collected between July 1, 2024 – June 30, 2025, the utilization rate for The Gloria House is 51%. As a new program in Connecticut, it is anticipated that the growth will occur gradually over time. New Life II Leadership continues to promote The Gloria House through different means including but not limited to, brochures, resource through 211, advertisement in the mental health and holistic factions of Facebook, Instagram, and other social media accounts, in-person or virtual presentations to local New Britain business/agencies, community hospitals including Hartford Healthcare New Britain General, Hartford Healthcare Hospital of Central CT, Bristol Hospital, as well as Yale New Haven Hospital, mental health and substance use programs, and libraries. New Life II team members have also reached out to area police departments.

Data and Outcomes

Methodology

New Life II Leadership provides monthly data to the DMHAS Evaluation, Quality Management and Improvement Division (EQMI) regarding The Gloria House. In turn, DMHAS EQMI provides quarterly reports (Dashboard Data) specifically related to

utilization rates and whether guests were readmitted to the same level of care or higher within 30 days. Another indicator on the dashboard is whether Gloria House participants accessed any DMHAS operated or funded program after they were discharged as a follow-up.

In addition to the data collected by EQMI, a comprehensive evaluation of the program is being conducted by DMHAS' Research Division. The Research Division was created over 30 years ago through a unique arrangement with the University of Connecticut (UCONN), in which Research Division personnel are hired through UCONN as research faculty and professional staff in the School of Social Work, and collectively serve as a DMHAS unit under a Memorandum of Agreement. The Research Division is a nationally recognized leader among state mental health and substance use agencies in services and applied research and serves DMHAS through the evaluation of DMHAS programs, among other responsibilities.

In order to complete the evaluation, the Research Division provided The Gloria House program staff with a tracker on REDCap, a HIPAA compliant data platform, to record demographic and program data for any individual who calls and requests to stay at The Gloria House. The tracker collects non-identifiable, individual-level data, including demographics, referral sources, admission decisions (accepted or not accepted), reasons for non-acceptance, placement on the waiting list (if applicable), type of crisis prompting self-referral, services and supports accessed while admitted, participation in program activities, and length of stay. It also captures outcomes such as crisis resolution status and living situation at discharge.

The Gloria House program staff also ask clients to participate in a brief, anonymous satisfaction survey prior to their discharge. There is an electronic version on REDCap and responses go directly to staff at the Research Division. A paper version of the survey is also provided to program staff for guests that prefer it over the electronic format, and a lock box was provided by the Research Division to securely store completed paper surveys. The survey collection begins with informed consent and generally takes less than 10 minutes to complete. The survey asks questions about the clients' demographics, satisfaction with the services and support they received while at The Gloria House, what they found to be most helpful about their time at The Gloria House, and what they would have done had The Gloria House not been available.

For the purposes of this report, data was collected over state fiscal year 2025 (July 1, 2024 to June 30, 2025). Data collected by the Research Division includes information gathered at the time guests entered the peer respite program (Tables 1 through 6)

and exited the program (Tables 7 through 10), as well as through the completion of a voluntary, anonymous questionnaire just prior to program exit.

Program Initiation

Through FY 2025, there have been 117 guests at The Gloria House, 15 of whom have returned to the program for support more than once. As Table 1 illustrates, the two largest numbers of referrals to The Gloria House came from a behavioral health or primary care provider (33.3%), or individuals self-referring to the program (29.1%). The next largest referral source was hospital and emergency departments (18.8%). Other referral sources include family or friend (11.1%), crisis teams (1.7%), and other sources, which include court, college, and other community providers (6.0%).

Table 1. Referral Sources

Referral Source/How did you hear about The Gloria House[1]?	**Frequency (#)**	**Percent (%)**
Behavioral Health or PCP	39	33.3
Self-Referral	34	29.1
Hospital/Emergency Dept	22	18.8
Family or Friend	13	11.1
Crisis Team	2	1.7
211	0	0.0
988	0	0.0
Police/Law enforcement	0	0.0
Other*	7	6.0
Total	**117**	**100.0**

**Responses included: DMHAS, New Life II, Community Renewal Team, Access to Health, Hearing Voices support group, college, and court.*

The Gloria House serves individuals throughout the adult life span. There was representation of individuals from age 18 through age 75 with the average age of guests being age 38. Table 2 indicates that most guests were between the ages of 26 to 35 (28.4%), closely followed by individuals between the ages of 36 to 45 (23.5%). Young adults ages 18 to 25 made up 16.7% of guests who utilized support from The Gloria House and individuals between the ages of 46 to 55 made up 15.7%. There were

[1] Mid-way through data collection – on January 28, 2025 - RD implemented a change in the question structure of the survey in order to better reflect the voluntary aspect of the services provided at The Gloria House. Instead of "referral source", the question was updated to ask "How did you hear about The Gloria House?"

12 guests (approximately 11%) who were between the ages of 56-75. Of note, four individuals did not include their age.

Table 2. Age of Guests

Age	Frequency (#)	Percent* (%)
18-25	17	16.7
26-35	29	28.4
36-45	24	23.5
46-55	16	15.7
56-65	10	9.8
66-75	2	2.0
Missing	4	4.0
Total	**102**	**100.1**

**Percentages may not total 100% due to rounding.*

Table 3 shows there were 53 guests (52%) who identified as female, while 41 guests (approximately 40%) identified as male. A total of 8 individuals (approximately 8%) identified as "other" which included transgender, non-binary, gender queer, two spirit, and gender plural.

Table 3. Gender Identity

Gender	Frequency (#)	Percent (%)
Female	53	52.0
Male	41	40.2
Other	8	7.8
Total	**102**	**100.0**

Table 4 suggests that slightly less than half of guests (49%) who entered The Gloria House identified as Caucasian. The remaining guests identified as Black/African American (25.5%) and Hispanic/Latine (18.6%). Other guests (5%) identified as American Indian/Alaska Native, Asian, and Middle Eastern/North African.

Table 4. Race/Ethnicity

Race	Frequency (#)	Percent (%)
White	52	49.5
Black or African American	29	27.6
Hispanic or Latine	19	18.1
Other*	5	4.8
Total†	**105**	**100.0**

**Responses included: American Indian/Alaska Native, Asian, Middle Eastern/North African*

†More than one race can be selected for each person

The Gloria House was designed to serve individuals throughout the state of Connecticut. As Table 5 indicates, guests have represented each of DMHAS' five regions. Not surprisingly, the highest representation of guests (64.7%) was from Region 4, which includes the town in which The Gloria House is located. Region 2, which includes the greater New Haven and Greater Middletown areas, was the second largest representation of guests making up 20.6% of the total. Region 5, which includes the greater Waterbury and Torrington areas, had 7.6%. There were three people who came to The Gloria House from Region 1 (specifically Monroe and Norwalk) and two people came to The Gloria House from the Region 3 area (specifically Putnam and Groton). Of note, there was one self-referred person who came to The Gloria House who was not from Connecticut but was staying in the state and was experiencing a crisis.

Table 5. DMHAS Region of Resident as Reported by Guests

DMHAS Region	Frequency (#)	Percent (%)
Region 1 *(Monroe, Norwalk)*	3	2.9
Region 2 *(Deep River, Guilford, Meriden, Middletown, New Haven, West Haven, Woodbridge)*	21	20.6
Region 3 *(Groton, Putnam)*	2	2.0

DMHAS Region	Frequency (#)	Percent (%)
Region 4 *(Berlin, Bristol, East Hartford, East Windsor, Ellington, Glastonbury, Hartford, Manchester, Marlborough, New Britain, Plainville, Plymouth, Somers, Southington, West Hartford, Windsor)*	65	63.7
Region 5 *(Bethel, Cheshire, Naugatuck, Prospect, Torrington, Waterbury)*	8	7.8
Not a CT resident	1	1.0
Missing	2	2.0
Total	**102**	**100.0**

Note: Towns reported in parentheses only include the towns guests reported to reside in within the identified region. For the full listing, see the Complete List of Towns by DMHAS Region.

Table 6 provides information regarding the type of crisis guests identified which led to their admission to The Gloria House. Mental health crises comprised 73.5% of admissions while the remaining experienced a co-occurring crisis (25.6%). Only one guest reportedly experienced a crisis related only to substance use.

Table 6. Type of Crisis Identified by Guest as Leading to Admission

Crisis Type	Frequency (#)	Percent (%)
Mental Health Only	86	73.5
Substance Use Only	1	0.9
Both	30	25.6
Total	**117**	**100.0**

Program Exit

Of the 117 guests who stayed at The Gloria House during FY 2025, only four guests (3.4%) required a higher level of care at the time of discharge. Staff filling out the tracker indicated that eighty-five guests (72.6%) had "reached the time limit" while 19 guests (16.2%) were categorized as "no longer in crisis." The Research Division suggested a change in the choices related to reason for discharge, since "reached time limit" could also include individuals that were "no longer in crisis." As a result, the guest log was modified on December 12, 2024, as a means of gathering more specific information about discharge status. Table 8 represents information gathered following the

modification. Since the tracker modification, there were 66 guests who stayed at The Gloria House. Out of the 66 guests, staff indicated that 61 guests' (92.4%) crises were resolved by the end of their stay at The Gloria House.

Table 7a. Reason for Leaving at Discharge – Total Guests

Reason for Leaving	Frequency (#)	Percent (%)
Reached Time Limit *	85	72.6
No longer in Crisis	19	16.2
Needed Higher Level of Care	4	3.4
Other †	9	7.7
Total	**117**	**99.9** ‡

**"Reached Time Limit" can include people who are no longer in crisis, which is why we added an additional question specifically asking if crisis was resolved by end of stay.*

†Other responses included asked to leave due to violation of rules, left to due circumstances at home or with family, secured bed or room elsewhere, guest elected to leave early.

‡ Percentages may not total 100% due to rounding

Table 7b. Reason for Leaving at Discharge, "Crisis Resolved" Post Survey Modification

Crisis Resolved	Frequency (#)	Percent (%)
Yes	61	92.4
No	5	7.6
Total	**66**	**100.0**

Guests identified their destination at the end of staying at The Gloria House. Most individuals (34.2%) identified that they would be staying with a friend or family member when they left The Gloria House. Others were returning home or going to other stable (not temporary) housing (26.5%). There were 15 guests (12.8%) who were unhoused/unsheltered at the time they left The Gloria House. Other discharge destinations included shelter/domestic violence shelter, residential treatment program, hotel or short-term rental, sober home, or "other" program including recovery home. One guest transitioned to a clinical respite program while awaiting housing. Of note, as indicated in Table 7a, only four individuals required a higher level of care which included going to the emergency room (3 guests) and inpatient (1 guest). Please refer to Table 8 for more information.

Table 8. Destination at Discharge

Destination at End of Stay	Frequency (#)	Percent (%)
Staying with friend or family (temporarily)	40	34.2
Home or other stable housing	31	26.5
Left TGH but is unsheltered	15	12.8
Shelter/Warming Center/Domestic Violence Shelter	7	6.0
Residential Treatment	6	5.1
Staying in a Hotel or Short-Term Rental	5	4.3
Living doubled up	4	3.4
Emergency Department	3	2.6
Sober House	1	0.9
Inpatient	1	0.9
Other*	4	3.4
Total	**117**	**100.1†**

**Responses included: went to clinical respite, moved into recovery home, unknown*

†Percentages may not total 100% due to rounding.

Staff indicated one or more resources each guest utilized during their stay at The Gloria House. Of note, multiple resources could be selected for each. Resources that were identified by a high percentage of guests include rest and recovery (79.5%), one-on-one peer support (73.5%), and housing resources (45.3%). Other resources and supports that were identified by guests included a sense of community (19.7%), access to computers (13.7%), creative activities (9.4%), mindfulness activities (9.4%), and employment resources (6.0%). Please refer to Table 9 for all identified resources. During the third quarter of FY 2025, the UCONN/DMHAS Researchers added questions pertaining to community linkages. The additional information identifies specific services guests were connected to independently or with assistance from peer staff, at the time of discharge. Data suggests that guests obtained community linkages including peer counseling activities, wellness activities, case management services, clinical services for mental health and/or substance use services, and recreation/community activities. For data on these linkages, refer to Table 10.

Table 9. Resources Utilized During Guest Stay

Resources and Supports Utilized	Frequency (#)	Percent (%)
Rest and Recovery	93	79.5
One-on-One Peer Support	86	73.5
Housing Resources	53	45.3
Sense of Community	23	19.7
Peer Counseling	20	17.1
Access to Computers	16	13.7
Wellness Activities	14	12.0
Case Management	12	10.3
Creative Activities	11	9.4
Mindfulness Activities	11	9.4
Recreation/Community Activities	9	7.7
Employment Resources	7	6.0
Health or Wellbeing Activities	5	4.3
Advocacy	4	3.4
Fun and Recreational Activities	4	3.4
In-house Support Groups or Meetings	1	0.9
Referrals	1	0.9

The linkage items were added to the log in April 2024 in order to get a better sense of the types of community connections TGH staff were facilitating for the guests.

Table 10. Community Linkages Accessed by Guests During Stay

Community Linkages	Frequency (#)	Percent (%)
Linkage to Clinical Services for Mental Health or Substance Use *	2	1.7
Linkage to Social Supports (Recovery Support, Peer Support, or Other Non-Clinical Services) *	3	2.6
Linkage to Medical Services (Primary Care, etc.)*	1	0.9
Other (existing clinical supports)	5	4.3
Other (Substance Use treatment resources)	3	2.6

**Specific Linkage categories were added at the request of DMHAS following the Quarter 3 report*

Voluntary Guest Survey

Beginning on September 24, 2024, the Research Division initiated an anonymous survey for guests to complete either by paper (of note, a lock box was placed at The Gloria House for guests to place the paper survey upon completion) or on-line, to collect additional data related to the quality of their stay at the peer respite. The on-line survey can be completed on an iPad provided by the research team (TGH staff give it to the guests to use) or on guest's own device. TGH staff invite the guests to fill out the survey prior to their exit from the house. (When the survey first started, some of the early guests were sent the survey to fill out by the TGH program manager after their exit.)

The total number of individuals staying at the house since the implementation of the survey through June 30, 2025 was 99 guests. Of the 99 guests, 36 guests (36%) completed the survey in its entirety. As a means to increase participation, discussion and encouragement around completion of the survey was initiated early on during a guest's stay at The Gloria House, although they aren't asked to fill out the survey until they're close to leaving. In addition, flyers about the survey which include the QR code and link to the on-line survey are placed in each of the apartments to encourage completion. Almost half of the survey respondents thus far identified as female, while the remainder evenly split with almost a quarter identifying as male, and a quarter identifying as transgender, gender fluid, genderqueer, gender plural, or non-binary. Respondents ranged in age from 18 to 75, with over 60% of reporting being completed by guests between the age of 26 to 55. Of the guests who completed surveys, 10 guests (27.8%) indicated that if The Gloria House had not been available, they would have contacted 211/988 or another crisis hotline. Nine guests indicated they would have sought admission to a psychiatric hospital (25%) and another 9 guests (25%) indicated they would have gone to the emergency room. Of note, guests who completed the survey were asked to identify all responses that applied.

Thirty-four guests (approximately 95%) expressed that peer staff were available 24 hours a day/7 days a week, that they were met warmly by peer staff, received orientation to The Gloria House, were able to discuss reasons for admission, were treated with dignity and respect, did not feel judged, and felt peer staff were sensitive to cultural/ethnic background. Two guests did not respond to these questions. When guests were asked to identify all the factors that made the stay at The Gloria House helpful, guests identified factors including catching up on basic needs (sleep, eating, self-care), privacy, not feeling judged, feeling understood, feeling heard, being around others, and connection with someone who worked at The Gloria House (guests were

able to respond to one or more choices). Please refer to Table 11 for frequency of responses.

Table 11. Factors that Made the Stay Helpful

Overall, what was most helpful during your stay at TGH?	**Frequency (#)**	**Percent (%)**
Able to catch up on sleep/eating/self-care	28	77.8
Had privacy	27	75.0
Didn't feel judged	25	69.4
Felt understood	25	69.4
Felt heard	24	66.7
Being around others	23	63.9
Connection with someone else working at TGH	22	61.1
Freedom to stay connected to work/school/friends, etc.	21	58.3
Able to accomplish specific goals	19	52.8
Connection with someone else staying at TGH	11	30.6
Learned new tools and/or coping strategies	8	22.2
Other	2	5.6
Unsure	1	2.8

Lessons Learned and Recommendations

Since the opening of The Gloria House, New Life II Leadership has met regularly with DMHAS to review the program's progress, identify strengths and areas for improvement, and address any emerging barriers to implementation. These discussions have focused on ensuring that the peer-run model remains aligned with its principles of mutuality, trauma-informed care, and recovery orientation, while also identifying practical challenges that can affect access, utilization, and sustainability.

The following summarizes the primary barriers identified during the program's first year of operation and the corresponding recommendations to address them.

Dissemination of Information and Awareness

As a new program model within Connecticut, one of the most significant challenges has been increasing awareness of The Gloria House among potential guests, referring providers, and community partners. Although utilization has grown steadily, current

use remains below the 90 percent target rate. Data show that most guests have come from DMHAS Region 4, where the center is located, suggesting that awareness and referrals from other parts of the state are still developing.

To address this, New Life II leadership has engaged in extensive outreach, including the development of brochures, listing The Gloria House as a resource on 211, and advertising through social media platforms such as Facebook and Instagram. Presentations have been delivered to local businesses, hospitals, mental health and substance use providers, libraries, and community agencies. New Life II has also made direct contact with area police departments to encourage diversion from arrest or incarceration where appropriate. DMHAS has supported these efforts by providing contact information and other resources to assist with outreach.

Recommendation: Continue and expand these dissemination efforts, particularly by strengthening referral pathways with hospitals, crisis lines (211 and 988), and behavioral health and primary care providers statewide. As awareness grows, utilization is expected to increase, supporting both the stability and long-term evaluation of the program.

Transportation

Transportation remains a consistent barrier for individuals across Connecticut who may benefit from The Gloria House but face challenges traveling to New Britain. Public transportation from certain areas - particularly the northeast and northwest corners of the state - is limited, and train use presents additional logistical and financial barriers.

To mitigate these challenges, DMHAS facilitated connections between New Life II and local providers who may assist with transportation needs. Community Mental Health Affiliates (CMHA), a DMHAS-funded nonprofit agency serving the greater New Britain area, has offered to collaborate with The Gloria House to assist with local transportation. Additionally, New Life II has been connected with the DMHAS Access Line, which coordinates transportation through partner agencies such as InterCommunity, Inc. and Columbus House, primarily for individuals with substance use needs. DMHAS has also provided contact information for TRED Services, which offers transportation across northwestern and central Connecticut. Most recently, New Life II has been exploring options for leasing a vehicle within its existing budget to expand in-house transportation capacity.

Recommendation: Continue developing partnerships with transportation providers and explore funding mechanisms to support a dedicated vehicle lease or rideshare partnership. Reliable transportation will be essential to ensuring equitable access to The Gloria House across all DMHAS regions.

Housing Instability

A number of guests have identified housing instability or homelessness as a key factor contributing to their crisis. Nearly 13 percent of guests discharged from The Gloria House were unsheltered at the time of discharge, and many others reported ongoing housing insecurity. Affordable housing remains a major challenge in Connecticut and directly affects individuals' ability to stabilize following a crisis.

Peer staff continue to provide emotional support and practical guidance during guests' stays, including assistance in contacting 211 and accessing housing resources. However, limited statewide housing availability often constrains what can be accomplished during a short-term respite stay.

Recommendation: Given the clear link between housing stability and recovery, it will be important for The Gloria House to maintain an active role in connecting guests to available housing supports and sharing data that highlights the scope of housing needs among individuals in crisis. Continued collaboration with the state's Coordinated Access Networks (CANs), local housing providers, and other system partners can help strengthen pathways to stable housing within existing resources. Where feasible, enhancing staff training in housing navigation and maintaining strong partnerships with housing agencies can further improve discharge planning and long-term outcomes.

Peer Staffing and Program Infrastructure

As with any new peer-run program, the initial year of implementation has provided valuable lessons about maintaining the right balance of staffing, supervision, and support to sustain a healthy, recovery-oriented environment. The Gloria House has benefited from a dedicated peer workforce, and continued investment in staff development, supervision, and human resources practices will further strengthen the program's consistency and operational stability.

Recommendation: Continue to enhance staffing capacity and training opportunities to ensure appropriate coverage and support across all shifts. DMHAS and New Life II will also review internal human resources policies and supervision structures to ensure alignment with best practices in peer-run settings. These efforts will help reinforce professional boundaries, promote wellness among staff, and sustain the recovery-focused culture that is central to the peer respite model.

Outcome Data Observations & Applicability to Implementation of Additional Peer Respite Programs

Early data from The Gloria House indicate strong potential for the peer-run respite model in Connecticut, particularly in its ability to provide person-centered, trauma-informed alternatives to hospitalization. Guests report high levels of satisfaction and resolution of crisis by discharge, and the program has demonstrated growing utilization as awareness increases statewide.

At the same time, the data also reflect that The Gloria House remains in an early stage of development. Utilization rates continue to build gradually, and ongoing refinement of outreach, transportation access, and data systems will be important to achieving the program's full capacity and impact.

Before additional peer-run respite centers are considered, continued operation of The Gloria House will allow DMHAS, New Life II, and the Research Division to:

- Monitor outcomes over a longer time horizon to assess sustained crisis diversion and community linkage effectiveness;
- Strengthen statewide referral pathways (including integration with 211, 988, and local providers);
- Continue to refine peer staffing, supervision, and data collection processes; and
- Identify the level of resources and technical assistance needed to ensure fidelity and quality if additional sites were to be developed.

These efforts will provide a stronger foundation to determine the most effective structure and supports for any potential future expansion of peer-run respite services in Connecticut.

Insight from Other States

Prior to the opening of The Gloria House and since its inception in July 2024, DMHAS made efforts to contact peer respite programs across the country as a means of learning from their experience. For this report, DMHAS conducted a landscape analysis utilizing the directory of peer respite programs located on the website of the National Empowerment Center (NEC), a nonprofit organization operated by those with lived experience. The directory indicated that there are currently 47 peer respite programs nationwide, including The Gloria House, located within fifteen states. DMHAS was able to connect with eighteen peer respite programs throughout the country, all of which worked with adults. These programs were from ten states: Vermont, Massachusetts, New York, New Jersey, Pennsylvania, North Carolina, Ohio, Iowa, Wisconsin, and California. Information from these established centers helped contribute to responses to some of the requirements of the legislation, including recommendations on the establishment of individual peer-run respite centers managed, operated and controlled by members of specific communities, including BIPOC, TQI+ and Spanish-speaking communities who have psychiatric histories or related lived experience; and the review of other states' practices regarding the establishment of a peer-run technical assistance center.

Outcome data specific to The Gloria House did not yet yield any significant insight into the need for population-specific peer respite homes. In addition, none of the programs contacted reported solely serving specialized populations as indicated for review in the legislation. The peer respite programs consistently indicated that they welcomed anyone who required their services and were open to providing support to all populations. Limited exceptions applied, such as cases where programs did not accept someone whose primary reason for entering the peer respite was homelessness. Of note, The Gloria House does accept individuals who are without a home as this allows the opportunity to connect with community resources and receive support from peer staff during the person's stay.

The legislation also required DMHAS to review other states' practices regarding the establishment of a peer-run technical assistance center. None of the peer respite centers contacted by DMHAS reported having a peer-run technical assistance center in their state.

Other findings include:

- *Staff Training*. All programs offered peer staff training which generally included Intentional Peer Support, Mental Health First Aid, cultural competency, and SAMHSA's 8 Dimensions of Wellness. Additionally, some offered education on

Motivational Interviewing/Conversations with Compassion, and Hearing Voices Training for staff working in the peer respite programs.

- *Transportation*. A few peer respite programs provide transportation upon admission and discharge and to grocery stores. However, the majority of programs indicated that there was no transportation services as part of their program. One program encourages LYFT services while another had an Uber account to assist with transportation. One program indicated that some guests' insurance covers transportation.
- *Data Collection*. All 47 programs collect data from guests, typically at the onset of service and at the time of discharge. Programs that have been in existence for ten or more years indicate that the data is utilized as a means of helping to continuously shape the program based on the needs/feedback from guests.

Conclusion

The establishment of The Gloria House marks Connecticut's first peer-run respite center, providing a voluntary, non-clinical, and trauma-informed environment for adults experiencing behavioral health crises. Data collected during FY 2025 indicate that The Gloria House has served a diverse population across age, gender, race/ethnicity, and geographic regions, with the majority of guests reporting positive outcomes, including crisis resolution and access to supportive resources.

Although utilization rates are currently below the program's target, early trends show growth, reflecting increased awareness and engagement over time. The program has also highlighted opportunities for improvement, including enhancing outreach, addressing transportation barriers, continuing to optimize access to housing resources, and determining best practices for peer staffing and program infrastructure.

The ongoing collection and evaluation of guest data, along with targeted outreach and program refinements, will continue to guide the operational success of The Gloria House and inform the potential development of additional peer-run respite centers in Connecticut.

References

DMHAS Evaluation, Quality Management, and Improvement Division: *Utilization Report FY 2025, Q4 for New Life II Teaching You Another Way Ministry, The Gloria House Peer Respite Program.*

The Peer Respite Program Directory located on the Empowerment Center website (https://power2u.org)

UCONN/DMHAS Research Division: *Peer Respite Evaluation Quarterly Report April 1, 2025 – June 30, 2025* (July 2025).

Appendix A

Sec. 17a-484h. Establishment of peer-run respite center. Report. (a) As used in this section:

(1) "BIPOC" means a person who is black, indigenous or a person of color;

(2) "Peer-run organization" means a nonprofit organization that (A) is controlled and operated by persons who have psychiatric histories or have experienced other life-interrupting challenges, and (B) provides a place for support and advocacy for persons who experience similar challenges, including, but not limited to, peer respite services and peer support services;

(3) "Peer-run respite center" means a facility that is operated by a peer-run organization in a safe, physical space that employs peer support specialists to provide peer respite services and peer support services for persons age eighteen and older who are experiencing emotional or mental distress, either as an immediate precursor to or as part of a mental health crisis;

(4) "Peer respite services" means voluntary, trauma-informed, short-term services provided to adults in a home-like environment that are the least restrictive of individual freedom, culturally competent and focus on recovery, resiliency and wellness;

(5) "Peer support services" means assistance that promotes engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports and identification of personal strengths;

(6) "Peer support specialist" means a person who has a psychiatric history or has experienced similarly life-interrupting challenges, who has experience in the provision of peer respite services and peer support services and has completed training specified by the Commissioner of Mental Health and Addiction Services; and

(7) "TQI+" means persons who identify as transgender, queer or questioning, intersex or other gender identities.

(b) The Commissioner of Mental Health and Addiction Services shall establish, within available appropriations, a peer-run respite center. The commissioner shall contract with a peer-run organization to operate such peer-run respite center.

(c) Not later than October 1, 2025, the commissioner shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the peer-run respite center and post such report on the Department of Mental Health and

Addiction Services' Internet web site. Such report shall (1) identify any barriers to implementing the peer-run respite center established pursuant to this section and include recommendations for addressing such barriers; (2) share data regarding the outcomes and effectiveness of the peer-run respite center and, based on such data, make recommendations regarding the establishment of additional peer-run respite centers in the state, including, but not limited to, the establishment of peer-run respite centers managed, operated and controlled by members of the BIPOC, TQI+ and Spanish-speaking communities who have psychiatric histories or related lived experience; and (3) review other states' practices regarding the establishment of a peer-run technical assistance center that may (A) assist peer-run respite centers in hiring and recruiting peer support specialists and other staff, (B) promote community awareness of peer-run respite centers, (C) evaluate and identify the need for peer respite services in communities throughout the state, (D) evaluate the effectiveness and quality of peer respite services in the state, (E) convene peer respite services meetings throughout the state to facilitate networking, collaboration and shared learning, (F) consult peer-run respite centers regarding development of peer respite services, (G) develop resources to support the supervision of peer support specialists, and (H) in consultation with peer-run respite centers and stakeholders in the TQI+, BIPOC and Spanish-speaking communities, develop recommendations regarding (i) best practices for delivering peer respite services, (ii) training requirements for peer support specialists, including specialized training requirements depending on the population that such specialists serve, and (iii) the establishment of a program fidelity tool to measure the extent to which the delivery of peer respite services in the state adheres to the provisions of this section and best practices for the delivery of peer respite services.