

Florida Peer Network, Inc.

An independent organization of and for people who are recovering from a psychiatric disability

Statewide Teleconference May 15th, 2006

***Certified Peer Specialists
Hiring Consumers in Provider Agencies
Peer-Run Services
Transportation***

Summary Report

Submitted to
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Executive Summary

Speakers on the teleconference were satisfied that the Florida Certification Board will work with the Florida Peer Network (FPN) and other consumers on the delineation study and curriculum for *Certification of Peer Specialists*. Although this yearlong process might be a problem for persons already working as Peer Specialists, hands-on training, internships, and trainings by other peer groups and Peer Specialists might serve during the interim. Another concern was the need to stay true to the philosophy and values of self-help while creating a consistent standard throughout the state so that Peer Specialists would be billable under Medicaid. It was recommended that the language of self-help and recovery be incorporated both in the Certification Board curriculum and in Medicaid and licensing documents.

In the discussion on *Hiring Consumers in Provider Agencies*, successful employment activities were reported from Northeast Florida Hospital Community Behavioral Health Care Services and Florida Health Partners. Recommendations included incentives for providers to hire consumers at all levels of their organization, and creating internship programs leading to permanent part-time or fulltime employment. Speakers said that there is a culture of exclusion that might be addressed by encouraging employees to self-identify and by including Peer Specialists and other consumer employees in all team meetings and social activities. Consumer workers should receive full benefits as well as reasonable accommodation in meeting job requirements.

Peer-run Services were defined as those meeting the SAMHSA definition in the national COSP multisite study. An independent consumer-operated program must have a consumer majority on its board of directors, with consumer control over hiring staff and managing finances. It is important to recognize the difference between a peer-run organization and one that is not fully independent, such as a clubhouse. The Florida Peer Network (FPN) recommends greater support for peer-run programs in Florida and the creation of a variety of peer-run programs such as businesses, housing programs, employment programs, moving programs, warm lines, etc. It was suggested 5% of block grants be allocated to peer programs, and a percentage of district budgets set aside for consumer-run services.

Transportation was acknowledged to be a universal problem for both urban and rural peer programs. All agreed that existing services such as Medicaid-provided transportation and public transportation are inadequate. Some programs are able to provide transportation through the use of state vehicles or bus passes, but peer leaders are not reimbursed for travel to required meetings. It was emphasized that this topic requires much further study.

One topic that came up several times in different contexts was the need to include peer support systems within all consumer/survivor endeavors. Peer support was emphasized as essential to the success of Peer Specialists, peer-run programs, and peer leaders throughout the state.

These recommendations are further detailed in a matrix on page 11 of this report. Projects recommended for the Florida Peer Network (FPN) included website links and teleconferences with other Peer Specialist models, technical support for local and regional programs, a workgroup on peer support, and intensive involvement in creating local and regional support systems as well as online groups for peer leaders. FPN should be funded to organize regional and local face-to-face meetings and an annual statewide conference at the earliest date possible.

Introduction

Board President Tom Lane facilitated this first statewide teleconference call sponsored by the Florida Department of Children and Families (DCF) for members of the Florida Peer Network (FPN). The call took place from 3:00 pm to 5:00 pm on May 15, 2006. Approximately 16 speakers participated:

Jan Anastasato, Consumer Support Project Director, 9 Muses Art Center
Tanya Branch - Northeast Florida Hospital Community Behavioral Health Care Services
Sally Clay - Editor, On Our Own, Together, Lake Placid
Dianne Côté - Executive Director, Silver Center
Cathy Falls - Neosho, Florida
Lucy Gatsby - Northeast Florida Hospital Community Behavioral Health Care Services
Patrick Hendry - Vice President, Florida Peer Network
Richard Mills - Peer Specialist, Hillsborough County
Sharon Hamilton - Value Options Florida Health Partners
Thomas Lane - President, Florida Peer Network
Mark Moening - Manager of Peer Support Services, PEER Center, Fort Lauderdale
Clint Rayner - Chief, Florida Office of Consumer and Family Affairs
Dawn Rix - Executive Secretary for the Florida Peer Network
Bill Schneider - Treasurer, Florida Peer Network, & Office of Consumer Affairs,
Fort Lauderdale
Sherri Trahin - Recovery Coach, Ruth Cooper Center, District 8

As the call began, Tom announced that former Board of Directors (BOD) member Clint Rayner has now assumed his position as Chief of the new Florida Office of Consumer and Family Affairs in Tallahassee.

Certified Peer Specialists

A 40-hour training was conducted in Pensacola for the first five Peer Specialists in the state. Patrick Hendry said that Clint Rayner and the DCF state program office have agreed to a process to determine specifications for a certified Peer Specialist. The state Certification Board will use a delineation study, working directly with the Florida Peer Network (FPN) and consumers from around the state to develop the best curriculum for a certified position.

There are several different models for Peer Specialists. One is being used in Broward County, and the Georgia model is being used by the Depression and Bipolar Support Alliance (DBSA). Once the position is certified, the language in the Medicaid handbook will be changed so that these services are billable under Medicaid. This will be about a yearlong process—six months for the role delineation study and six months for the curriculum.

The delineation study will allow input from consumer/survivors who are already acting as Peer Specialists. However, it is necessary to come up with a standard curriculum that would allow statewide certification. Mark Moening said that his agency was not interested in Medicaid billing because Medicaid describes mental health services in medical terms, whereas peer support

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services, if done properly, do not follow the medical model. The Florida Peer Network BOD members responded that any program can choose its own curriculum for its particular area.

It was noted that since certification is a different topic from Medicaid billing, discussion should concentrate on the mechanism of certification. Consumer input must be well protected, and the curriculum for certification should represent all parts of the state. The issue of staying true to the philosophy and values of self-help and consumer driven services came up in earlier calls around transformation. The issue is how to balance this with the realities of Medicaid requirements, to find ways to fund expansion of consumer-driven services, while at the same time addressing managed care environments in the Medicaid waiver that is being rolled out in Broward and elsewhere. How will consumer choice be impacted, for example, if peer-provided services such as Peer Specialist jobs are not available to Medicaid recipients in a provider setting?

Tanya Branch described how her agency was working with Peer Specialists based on the Georgia model. They have hired some Peer Specialists to work in their drop-in center, and they have been running poetry groups, art and crafts groups, outings, fund raisers, etc. They need a training program for these Peer Specialists. She said that a year is a long time to wait for certification, because the Peer Specialists are already working. Right now her agency cannot bill the state contract or Medicaid, but they did create a staff position in order to pay the Peer Specialists. "We decided to pay them because we know it works," she said. "I would love to be able to send them to some kind of training somewhere in the state for what they are doing."

Richard Mills commented that he was one of the consumers who took the course in Pensacola, which was based on the Georgia model. The idea was to learn to train others statewide. They wanted to come down to the local districts to do this. Presently Richard has been invited to run a weekly group in his local community mental health center to help others and show them Peer Specialist skills.

Tom observed that it might be useful to provide links on the Florida Peer Network website to other curriculum trainings. Several other states have certified Peer Specialist trainings. National DBSA has their Peer-to-Peer resource center, and other national consumer and technical assistance centers are sponsored by the Center For Mental Health Services. Some research universities like Dartmouth and the University of Illinois in Chicago also post information on the Internet. On the Florida Peer Network website, people can download and read about models that are working successfully elsewhere. The FPN website can be used to educate everybody. Having teleconferences is another method to educate and collect data in the interim before certification, and the Florida Peer Network might host future teleconferences with other experts in the field, both consumer leaders and other stakeholders who could help us to meet some needs.

At the same time some people may want to access services that are not Medicaid reimbursable. It was noted that the Peer Center has always been actively involved in training from the self-help model and can offer an internship and some hands-on training during the interim period before certification. There currently are five people working as Peer Support Specialists at the PEER Center. The ultimate goal is to develop a standard that is consistent throughout the state, using the consumer definition of peer support.

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In response to a question about consumer input to the delineation study, Patrick said that in discussions with the Certification Board, it was agreed that the FPN will do the study itself, guided by the Certification Board, which will grandfather in Peer Specialists who have already worked through some of the programs that have been around for awhile in Florida. Sherri Trahin said that she understood that the role delineation study would include persons from the FPN steering committee and provide materials to demonstrate what the study shows. That process would determine the questions that would be used in the certification exam.

Hiring Consumers in Provider Agencies

Bill Schneider commented that a Peer Specialist will not be a token but an equal partner in the treatment team process, and no treatment team meeting will occur unless the Peer Specialist is also in the meeting, along with the case managers, psychiatrist nurse, and psychiatrist. At the Ruth Cooper Center, the original intent was to hire people as Peer Specialists and then move them into other roles within the provider agency. That has been done successfully in a couple of cases where people decided to move from the Peer Specialist program into specific roles in agency. That has added a great deal of acceptance for the Peer Specialists, because they are not APART FROM the agency, but are PART OF the agency.

When Tom asked to hear from people who wear a couple of hats, Tanya from Northeast Community Behavior Healthcare Services stated that when her agency hires peers, they integrate them as part of the team. For example, they come to all staff meetings and are invited to social luncheons and staff retreats. They still receive services through the clinic—they still see the psychiatrist and the therapist sometimes, and they attend groups at the drop-in center. Nevertheless they are very much part of the team. Culturally, this takes some adjustment, and it is a learning process. Bringing the consumers into the social activities of the team makes them feel more part of the team. “We are really trying to break that culture of exclusion,” Tanya said, “and to bring those walls down by saying, *whatever we do, they do with us.*”

Sharon Hamilton from Florida Health Partners said that her agency hires consumers as consumer advocates, such as John Massolio in Tampa area, and she herself is a consumer. She goes out and meets with the provider agencies, trying to find out what they need, so that her agency can assist them in servicing the Medicaid clients who are vastly underserved. The advocates get consumers involved in recovery events and alternative programs, and they try to get consumers more active in their community and in their own treatment. “You know,” she said, “Its nice to be able to come in to a position out of the ‘crazy cause,’ as I call it. It’s nice to be given the flexibility I need to stay healthy, and to do my job at the same time.” She said that as they get contracts in other areas, they will be able hire more consumers, people who actually know what the recovery process involves and what is helpful or what is not.

Tanya added that when they hire a Peer Specialist there are times that they still bill on them, for example, when working on a vocational aspect of their job. When they are able to do their job proficiently with little or no feedback, the agency looks at hiring them fulltime or part time so that they will have benefits and will not have to rely on their disability income or Medicaid. The agency is looking for Peer Specialists to replace part-time, fulltime staff completely, and evolving this position to a point where the agency no longer has treatment plans for them.

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Tom observed that New Horizons has pioneered a career development internship program that hires people as temporary part-time employees who become employees after a period between six months and eight months. In this way, individuals are able to reenter the workforce after not working for a long time or perhaps to work for the first time. With a combination of a supportive employment program and case management, they can still maintain benefits or at least understand what the impact is going to be when they start earning income. People are able to work in a variety of areas within the organization, including support staff, medical records, or in the front office. Four of the people who have worked on recovery teams have gone on to be hired as permanent part-time employees, and one was hired as a fulltime employee. Other people have moved on to competitive employment in the community. Some people are less successful in this process, so they are graduated out of the Career Development Internship Program and receive additional support. This is all part of a changing culture, not so much from the direct service provider's perspective, but from the perspective of some of the employees who usually work with no direct contact with traditional clinical services. In the business office, for example, when career development interns began to receive paychecks, some of the older employees worried that other people would see their addresses! It was stunning to discover this stigma within the agency, and amazing to see the misconceptions of employees who did not have any concept of what recovery is. Therefore, there is a lot of value in hiring people in roles you may not traditionally think would have an impact on culture.

It was pointed out that when anyone becomes an employee they receive a W2 form or a 1099 form, and there are laws that protect them as an employee, whether they are a mental health consumer or not. As an employee, an individual is expected to live up to the standards that are set by the employer, although occasionally they may need a reasonable accommodation such as a schedule change under the American Disability Act. People are allowed a reasonable accommodation if they set it up ahead of time and use it on a regular basis. The accommodation may be that instead of coming in as 8:00 or 9:00, someone comes in at 10:00 and works later.

Dianne observed that she had worked in the consumer movement for twenty-four years, and in most of her jobs, she did not have health insurance. For that reason she was obliged to work for a lower salary in order to keep the health care she needed. She pointed out that most mental health consumers need medications and a therapist if they are going to succeed, and this reality is constantly overlooked. She added, "You should not be forced to live a life of poverty while you are working sixty hours a week. Under Disability or Medicaid, you can only earn \$700 a month." Another speaker agreed, saying, "Look at what we did on the state level in setting up the director position for the Office of Consumer and Family Affairs." It was noted that one of the issues that the Florida Peer Network addresses is equal pay for equal work.

Also noted was the lack of a support system for leaders of peer run programs or Peer Specialists. Some other states have created support systems for peer advocates and Peer Specialists. In New York State Dianne and Sally would hold weekly peer support groups using the American Indian council method. Each member got a couple of minutes to talk about personal issues, and because there was no cross talk, it was not dominated by anyone. After that the group went out to a diner, where free conversation and socialization took place. Dianne said, "Those two pieces of peer support—listening and socializing—are vital. We all know of persons working as peer advocates or specialists that who have a rough time and need support. But we keep forgetting that we can succeed when we are there for each other."

Other speakers agreed that the common need for support often goes unmet. One speaker observed that in Broward County, the first part of two-hour Peer Specialist meetings was supposed to consist of networking and peer support, and the second hour was supposed to be business. In the workplace, regular jobs within the clinical setting often provide supervision, and Peer Specialists need the same thing. This works well because employees need a good relationship with the people they work with, and Peer Specialists in particular need someone just to listen to the issues they are dealing with. “Otherwise,” Mark said, “this work can burn you out in a heartbeat.”

Tom observed that people in leadership need peer support for the same reason that they want to provide peer support to others—because peer support helps maintain wellness and recovery. The topic of peer support and recovery for Peer Specialists needs to be addressed in another conference call, he said, and perhaps FPN can even make it happen as an online support group. Eventually there will be statewide face-to-face meetings and an annual statewide conference, and certainly in the local community level there is a need. Perhaps in future telephone calls and some kind of a workgroup can be formed in the context of not only certified Peer Specialists, but also in the larger area of peer support, especially for leaders.

Peer-Run Services

The topic of peer-run services refers to programs such as drop-in centers and DBSA affiliates that are not affiliated with a provider setting and that face unique challenges as independent consumer centers. There are also programs that are consumer-driven but not independent, and these include NAMI consumer support groups as well as programs operated through Mental Health Association affiliates.

The discussion opened with ways of dealing with burnout among leaders and people with responsibilities in the self-help movement in Florida. Richard said that at his agency one facilitator for a peer support group has other people take the leadership role when she is not able to run the group. He felt that a peer leader should not work in the same place where he or she receives treatment. Tanya, however, pointed out that because she works in a rural community, and her agency is the only community mental health provider, she cannot go elsewhere to receive services. She suggested that consumers who work alongside regular employees help to breakdown barriers, and bring new things to the table.

Tanya asked Sally to speak about the SAMHSA multisite research, called “Consumer Operated Service Programs” (COSP), which studied peer-run programs at a national level. Sally responded that the first requirement of a consumer-run program is that the program be operated and controlled by a majority of consumers. In other words, most members of the board of directors are consumers, and consumers have independent control over the programs’ finances. The way a lot of programs, such as clubhouses, diverge from the consumer-run model is that their finances are controlled by another agency, such as a community mental health center, NAMI, or the MHA. A peer-run program is independent, incorporated with its own 501C3. Consumers hire and fire their own staff, and there is no pass-through agent for their budget. A peer-run drop-in center does not have restricting criteria for participation—whether participants receive Medicare, Medicaid, or no benefits at all.

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Although the finances are controlled by the consumer-run organization, the organization does contract with DCF and other funders. A peer organization contracts with DCF the same way other agencies do; in other words, they must follow the requirements of the contract, including documenting services and writing grant reports. Still, as long as the organization maintains its own bank account and 501C3, it remains consumer operated.

Mark noted that in Broward County, for example, the PEER Center and Silver Center are consumer operated. The budget of the Rebel center, on the other hand, comes through the South Broward Hospital District, and members have no control over how their money is spent. Their director is a consumer, and their employees are all consumers, but the director does not get to hire and fire employees, because that is done through Human Resources at the hospital. Nine Muses, too, is a program that is run through another agency's board of directors, which oversees their budget. Jan commented that Nine Muses is sponsored by the Mental Health Association, but everybody who works there is a consumer, and their volunteers are "stakeholders." "You know," Jan said, "I don't care whether you have a 501C3. I mean, who wants to do annual reports, and payroll and all that if you can find somebody else to do it for you? So we can just devote ourselves to art, music, and creative writing and stuff like that..."

Sally added that it is easy to get caught in semantics, which are the bane of the whole consumer movement. However, it is important to make the distinction between a consumer-operated program as it was described in the COSP study, and a program that is not fully independent. In her view, "consumer run," "consumer operated," and "peer run" all refer to programs that have a majority consumer board, a 501C3, and financial control, as well as all management responsibilities. The Florida Peer Network, for example, is a peer-run program. Other programs such as clubhouses and some drop-in centers may have intensive consumer input and participation, but they do not meet SAMHSA's definition of "consumer-operated." Such programs might be described as "consumer-driven" rather than consumer-run. Both kinds of programs can be successful and beneficial to consumers, but it is important to understand the difference between them. Sally also commented that for a consumer-operated venture to succeed, it is necessary to begin and end with peer support. Fancy programs and plans and intentions will not amount to much unless consumer/survivors start with peer support.

Patrick remarked that there are people who hold the position that consumer-run services should not contract with the state. Sally agreed that contracting with the state can impose some restrictions, but you can say "no" to some parts of what they want to do or ask them to do it differently. A peer-run program must negotiate over these issues. In some cases, funding agencies might impose rules and regulations that require practices that are common in clinical agencies but that threaten the core values of peer support. For example, a peer counselor is often expected to follow the same strict procedures and complex paperwork as a counselor at a provider agency. The danger is that peer workers will not be peers anymore if they are expected to adhere to many of these bureaucratic requirements. Their service could lose the whole quality of "peerness." In other words, a peer-run program will work alongside provider agencies and professionals, but it should not become just other provider agency. A consumer-operated program looks much different from a community mental health center.

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The issue of peer programs providing both mental health and substance abuse services arose. Patrick noted that in the formation of the Florida Peer Network, the steering committee focused mainly on mental health, not to the exclusion of substance abuse, but as a way to begin. He added that the FPN steering committee has talked about doing some quality assurance in order to help to develop and implement consumer satisfaction tools. He asked the group to talk about other types of consumer-run services besides drop-in centers, such as supported employment programs, housing programs, and consumer businesses.

Dianne said that many of these kinds of services can be provided through existing peer programs such as drop-in centers. In a sense a drop-in center is an employment program because consumers are hired. Some programs that might be developed include a moving service operated by consumers or a meals program. The only problem is that the state will only fund certain programs, such as community support services, which include drop-in centers, and supported or sheltered employment. For some activities, an agency has to look elsewhere for funding, such as the county. A peer-run program can generate some money through businesses such as a computer repair service or a print shop, and the money generated by peer-run businesses can be spent for any activity. It is important to have a good director to carry that momentum, and to have good business professionals on the board of directors. Agencies that have their own 501C3 often do not get enough of the professional support that they need to keep themselves out of trouble.

“The sky’s the limit in terms of what we can do,” Dianne said, “but it is extremely important to have a board of directors who are supportive and knowledgeable. A big danger that peers face is that we continuously chop each other off at the knees in public, so that we lose our respect from the community.” Florida needs many other peer-run programs in addition to drop-in centers, she added, and an easy way to discover what those might be is to read the book *On Our Own, Together: Peer Programs for People with Mental Illness*. This book describes three categories of consumer run programs from eight different sites. It includes a wide array of peer-run programs that were researched by SAMHSA and acknowledged as true consumer-run programs.

Tom gave an example of a peer-run program from his experience in New Mexico. In that program, a warm line provided peer support for a very diverse community including Native Americans and Latinos. The warm line was consumer operated by both English- and Spanish-speaking peer staff. It was very cost effective because it was run by a drop-in center that received funding from a variety of sources. Other speakers mentioned that AA, which is the largest and most successful self-help group in the world stays self-sustaining because individual members put a “buck in the basket” at meetings.

Richard remarked that when some self-disclosed consumers were first hired at New Horizons, they worked only at menial jobs that could not be billed for. His concern was this could create a parallel workforce rather than ensuring that there are meaningful roles for self-disclosed people in provider agencies. This brings up the value of encouraging employees to self-identify. When people at administrative or supervisory levels self-identify, it impacts the culture of the organization, making it less centered on the medical model and more on the recovery model.

Mark said that the first office of consumer affairs in the country was in Alabama, and there they offered incentives to professionals to self-identify. Similarly, in the substance abuse field, the

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experience of recovery is a plus in the work environment. He suggested that Florida could put together an incentive for professionals to self-disclose. Already in Broward County, contracts for provider agencies include a requirement to hire consumers. Patrick agreed, saying that everyone is aware that people who work in this field often they have a personal connection to either mental health or substance abuse problems. For years in the mental health field it has been taboo to self-identify, and for years agencies required an employee to maintain a type of impersonal relationship with their clients. That is the way the licensing language is written.

Transportation

Tom said that issues around transportation always come up in discussions such as the transformation teleconference hosted by FPN. Transportation is always a big issue because people cannot get to where they need to go. Medicaid-provided transportation is difficult to access and does not provide a lot of choice. Often people have no choice in when they are picked up or when they get to their destination.

Tanya said that transportation was a huge issue in her county. Her agency hired a Peer Specialist to drive two routes a day. These routes were designed with a pickup site and some other centrally located sites around the county. The bus went out once in the morning to bring people to the drop-in center, and in the late afternoon the driver dropped them off at those main stops. Because Medicaid-provided transportation is difficult to access and does not provide a lot of choice, their service is helpful for people who have no Medicaid or find the Medicaid bus hours inconvenient. Jan said that members of Nine Muses also have transportation problems. Her agency purchases bus tickets for each person who needs them, and anyone who comes in and participates in some way can have two bus tickets, one to go home and one to come back.

Richard remarked that there is a difference in transportation needs between rural areas and urban areas. Dianne said that the Silver Center in Fort Lauderdale had to buy a bus because Medicaid will not bring elderly consumers to the center. The members live in a horrible area, in ALF's. They cannot afford to take private transit, and they have memory problems as well as mental illness and physical challenges. Therefore, even an area that provides public transportation, there are a lot of people who cannot maneuver it. Dianne said that the Silver Center was able to buy a bus because one of their board members gave them an interest-free loan for that purpose. There is a federal Department of Transportation grant that can be applied for to make the purchase. DOT will pay 65%, the county and state pay 25%, and the peer program pays only 10%. Patrick said that an agency can get used vehicles from the state DOT, although usually they are in poor condition. He added that another transportation need is funds to pay peer leaders for travel to and from the frequent meetings on a district level or state level. The difficulty in traveling to such meetings is an obstacle that has prevented consumers from having more input.

Mark said that in Broward County mental health services have traditionally been carved out, with a certain section of the district budget set aside for consumer-run services, and agency contracts include a requirement to hire consumers. It was suggested that the state mental health planning council set aside up to 5% of the state level block grant for consumer travel. This might be doable under the federal law that controls the state mental health planning councils. It would also be consistent with the block grant money, because now it is required for consumers to have a voice in how to spend block grant dollars.

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Patrick stated that there have been preliminary discussions about some funds becoming available from the state to fund transportation to some FPN meetings, and he asked for suggestions on who would administer that and how the funds would be distributed to people. It was suggested that such funds should not always support the same peer leaders, but be available a wider number of people. The Florida Peer Network was put together to help network consumers all over the state. In the future it is hoped that the Network can devise a good process to distribute funds. One way is for someone who receives travel funds to bring somebody else to ride with them or share their hotel room.

Conclusion

Tom announced that the FPN has scheduled two more teleconferences, and more might be scheduled on other topics. The FPN Board of Directors hope to have regular statewide toll-free teleconferences on a variety of subjects, and the FPN website offers a place for people to provide input. Another goal of FPN is to find ways to provide some additional technical assistance for consumers in local communities. The network can help out with local teleconferencing up to a certain number of participants. For additional information, people can contact Dawn Rix.

Speakers were heartened to know that the FPN will be working with the Florida Certification Board. There are different perspectives on certifying and paying for Peer Specialists. The sense of the discussion was that people strongly want a certification program to come to Florida, and this might include an interim training that would be offered until the formal process is developed. Existing programs want ways to meet the immediate needs of those who are already acting in these roles. Most speakers felt that grandfathering Peer Specialists is a wonderful idea.

Another issue still up for discussion is how to maintain consumer values in self-help programs, and how to stay true to the philosophy that has grown in the consumer movement over the past 30 or 40 years. An issue that has emerged around the discussion of Peer Specialists is the phenomenon of self-disclosed consumers changing cultures within the provider workplace, and in rural settings where there are not a lot of resources. Dianne said that she would like to see people in rural areas such as Highlands County receive better services.

There is still much to discuss regarding successful partnerships with providers, as well as developing consumer-operated programs. A resource on these issues is the book that Sally edited, *On Our Own, Together: Peer Programs for People with Mental Illness*. Finally, the topic of transportation is always raised whenever you try to get folks together who are consumer advocates, and this is a topic that requires some intensive study and action.

Sally repeated that she hoped people would bear in mind that peer support is the fundamental basis for what consumer/survivors do, and this is something to remember when writing grants. "Peer leaders should do not forget who we are, and where our values come in. We need to consider not just the technicalities but the values." Patrick said that the Florida Peer Network in particular needs to stay true to peer values. "Our network is still in a formative stage, and we are trying to bring in as many different players as possible. One of our difficulties is the lack of knowledge throughout the state of what other people are doing, and who are the leaders in each individual area of the states."