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The institutionalisation of peer support in France: development of a social role and roll out of public policies

L'institutionnalisation de l'accompagnement par les pairs en France : entre développement d'un rôle social et déploiement de politiques publiques

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Key words: *Peer, support, counselling, peer counselling, peer support, peer health mediator, disability, mental health, knowledge, experience, experiential knowledge, institutionalisation.*

Mots-clefs : *Pair, accompagnement, soutien, pairémulation, pair-aidance, médiateur santé pair, handicap, santé mentale, savoir, expérience, savoir expérientiel, institutionnalisation.*

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Synopsis: In France, the practice of peer support is currently developing and becoming institutionalised in health (particularly mental health), social and medico-social sectors. Despite significant shared values, a common background and a universal acceptance of experiential knowledge as the basis of their expertise, there is a diversification in practices. In a context where public health and social policies encourage the development of the social role of peer supporter and where funding is available for a number of salaried posts, some practitioners opt for a voluntary or informal system. This article aims to explore the varied ways in which the role has developed through an analysis of its institutionalisation process.

To do this, data from two surveys will be analysed: one based on peer counsellors who set up an association under the law of 1901 and the other on peer-support workers from "Housing First", an experimental public policy intervention programme.

Two different processes of institutionalisation of the peer-support role emerge from the analysis: one which prioritises the development of a social role and the other the roll-out of public policy. Neither is yet sufficiently successful to guarantee the sustainability of the practices, owing to a lack of legitimisation process or shortcomings in reciprocal typification. This situation has delayed the professionalisation of the peer-support role. It also raises two questions: that of the links between experiential knowledge and professional knowledge and that of the effects of a meeting of peer supporters who were hitherto isolated in their respective fields (health, mental health, disability, exclusion, addiction, etc.) and within their causes.

Key words: *Peer, support, counselling, peer counselling, peer support, peer health mediator, disability, mental health, knowledge, experience, experiential knowledge, institutionalisation.*

Résumé : Aujourd'hui en France, les pratiques d'accompagnement par les pairs se développent et s'institutionnalisent dans les secteurs d'activité de la santé (et notamment de la santé mentale), du social et du médico-social. Malgré une unité de valeurs prégnante, une origine historique commune, la revendication unanime de savoirs expérientiels fondant leur expertise, une diversification des pratiques s'observe. Dans un contexte où les politiques publiques sanitaires et sociales impulsent et favorisent le développement de ce rôle social de pair-accompagnant, où des financements sont ouverts pour quelques postes salariés, d'autres optent pour une pratique bénévole ou même informelle. Cet article vise à comprendre les développements différenciés d'un même rôle social à travers une analyse de son processus d'institutionnalisation.

Pour ce faire, le matériau de deux enquêtes sera analysé : l'une portant sur les pairémulateurs constitués en association loi 1901 et l'autre sur les pairs-aidants du programme expérimental d'intervention des politiques publiques « Un Chez soi d'abord ».

Se dégagent de l'analyse deux processus d'institutionnalisation du rôle de pair-accompagnant : l'un priorisant le développement d'un rôle social, l'autre le déploiement de politiques publiques. Tous deux sont insuffisamment aboutis aujourd'hui pour assurer la pérennité des pratiques, en raison d'un processus de légitimation lacunaire ou de la faiblesse des typifications réciproques. Cet état de fait a pour conséquence de freiner une possible professionnalisation du rôle de pair-accompagnant. Se pose également deux questions : celle de l'articulations des savoirs expérientiels et des savoirs professionnels, celle des effets d'une rencontre entre pairs-accompagnants jusqu'alors cloisonnés dans leurs champs respectifs (santé, santé mentale, handicap, exclusion, addictions, etc.) et à

l'intérieur de leurs causes.

Mots-clefs : *Pair, accompagnement, soutien, pairémulation, pair-aidance, médiateur santé pair, handicap, santé mentale, savoir, expérience, savoir expérientiel, institutionnalisation.*

Introduction

The image of someone, supporting their peer, on the strength of their experience of similar situations is not new. Having previously made little headway, in the fields of disability and health in France, there is now renewed interest based on a political agenda: legislation on Mutual Assistance Groups (GEM, in its French acronym), the deployment of the Accompanied Response for All policy (RAPT), the establishment of a national network by the “Housing First” programme, the government’s call for national pilot projects targeting health autonomy and the five year strategy for the development of medico-social services for people with disabilities. All these schemes rely, at least in part, on counsel, help and support from peers.

The current success of peer support can be explained by its association with new aspirations and principles of action, such as social innovation, empowerment, self-determination, users taking control of their lives, participation in institutions, health democracy, recognition of the knowledge and skills of the people directly involved, etc. This interest in peer intervention can also be explained by the fact that it enables us to envisage a solution to various political crises, such as homelessness, psychiatry or disabled people who have no means of exercising their rights.

In real terms, a wide variety of methods and practices are currently emerging: face to face, in groups, by telephone or on the Internet. Employment status varies: to a great extent practitioners are informal or voluntary; some peers are employed or work freelance. Some examples of peer support have been devised and supported by public policy, such as educational therapy or health promotion; others, such as self-help, peer support or harm reduction, have been set up outside the establishment and public services (harm reduction has now become part of public policy). There are many different names: peer-helper, peer-counsellor, peer-health mediator, peer-worker, peer-advisor, etc. We suggest bringing together these various titles under the generic term of peer-supporter.

In France, these days, the legitimacy of peer support is frequently questioned by professionals and institutions from health, social and medico-social fields. More broadly: peer-support is not well recognised. Many still question the effectiveness of peers, even though the question has already been answered in many professional and institutional contexts and with a wide variety of audiences. Most Anglo-Saxon scientific literature (Salzer and coll., 2010; Brodaty Thibaut, 2010; Moran and coll., 2012; Chinman and coll., 2014; Cherrington and coll., 2015; etc.) concerned with peer intervention provides specific evidence of its effectiveness, efficiency and the added value of legitimate professional contributions.

Peer supporters claim specificity to their experiential knowledge. But recognition remains low notably because this knowledge is largely informal or as yet unknown (Gardien, 2017), even, on occasion, by practitioners. Moreover, the usual process of role creation by segmentation (Abbott, 1988) is not happening. Neither is the drive for the development of health professions and their recognition, based on formal knowledge and related skills, as described by Freidson (1986), in evidence. What is occurring is the institutionalisation (Berger, Luckmann, 1996) of a social role, which is likely to become more professional and is built on largely informal and/or unrecognised experiential knowledge.

The key question of experiential knowledge, its content and procedures, the reasons for the lack of awareness and social recognition etc., will not be dealt with here, this work having been recently published (Gardien, 2017). Neither will the analysis of specific features of the functioning of peer relationships be addressed since various writers including Léon Lévy (1976) and Thomasina Borkmann (1978, 1999) have already carried out this exercise. This article will focus on clarifying

the institutionalisation process (Berger, Luckmann, 1996) of this social role¹, at a time when public policies are investing in it and when practices are developing, buoyed up by these new expectations, support and funding.

According to Berger and Luckmann, institutionalisation is a process of reciprocal typification by social actors (Berger, Luckmann, 1996 [2002]: 78). The institution is the result of this process, of both knowledge and typification. It relates both to actions, actors and behaviours and objects and the world of everyday life more generally. The process of reciprocal typification unfolds in the course of a shared history with other individuals (Berger, Luckmann, 2002: 79). The resulting institution shapes and attaches significance to the behaviours of social actors by the social role which it embodies, the approaches which it supports and the reduction in options which it involves. Thus, the meanings conveyed construct an emerging, yet objective, reality of a history shared by those who took part in it, outward looking and influencing those who were not involved. It is, therefore, possible to speak of an institutional order: social roles correspond, in their implementation, to previously constructed reciprocal typification, and conversely, institutions define roles taken on at the present time, give them meaning and legitimacy. Any actor who has not participated directly in the reciprocal shaping of an institution, therefore is receiving it as an external imposition, is likely to show some resistance. This is why the process of legitimation is an inherent part of the transmission of typification, and creates new meanings.

Promoting this theoretical perspective is relevant to our work. Indeed, analysis of the practice of peer-support enables us to identify a social role which cuts across health, social and medico-social fields, without the actors having met. (Gardien, 2017). Helping one's peer to cope, to struggle and survive, supporting their self-determination, defining the problem by drawing upon one's own experience and similar experiences of peers and within this framework, finding a suitable, relevant solution together; these are the main principles upon which these practices are based. This way of working is mentioned in reference to the *self-help* movement of the 1960-70s in the USA by both peer support groups studied. Yet today we see a diversification in practices. How can this be explained? What factors are influencing these disparities? Have reciprocal typification and the legitimation criteria been changed, and how? What does this give to the understanding of the development of peer-support in France?

The analysis presented below is based on data collected during the course of two separate studies.

The first² clarifies the role of the peer-counsellor. This study, which was conducted with the French

Organisation of Disabled People (GFPH in its French acronym),³ took place over two years between 2011 and 2013. It included the observation of support practices, interviewing peer-counsellors, those in receipt of peer-counselling and the organisation of a focus group. The second

study⁴ documented the development of the experimental "Housing First" programme and evaluated its practices and effects both from a quantitative (randomised study) and a qualitative perspective. The "Housing First" programme was deployed over four sites initially, driven by cross-disciplinary teams which always included two peer-support workers. Participant observation, interviews, focus group and a questionnaire were used. Therefore, the analysis presented here includes the retrospective editing and evaluation of material which was initially collected for other

¹ Social role is to be understood in the context of the theory of Berger and Luckmann, as an expected pattern of behaviour.

² This research programme and in particular the long term field survey entitled "Peer-counselling: an emerging social function?" was financed by FIRA and la Fondation de France.

³ Le GFPH has filed the trademark « pairémulation » with the National Institute of Industrial Property (INPI)

⁴ Evaluative research on the experimental « Housing First » programme was supported by the Ministry of Health.

purposes.

Any review of an institutionalisation process is preceded by a study of its history. The remainder of this article will first of all study the context of the emergence of these two forms of peer-support (peer-counsellors in the GFPH, peer-support workers in the Housing First programme) then their implementation on French soil. Finally, the main factors clarifying this differentiated social construction will be discussed.

I. Background to the emergence of the peer support role in France

Historically, in France, the first two forms of peer support to explicitly demand peer support action were peer-counselling for people with disabilities and peer-support in the field of mental health.

I.1. Background to the emergence of peer-support: the recovery paradigm

Peer-support is closely linked to the concept of recovery⁵ in the field of mental health and is spread across France through a series of parallel and more or less convergent initiatives.⁶ These concepts

were first used in a European programme geared towards return to work (Emilia) launched in 2005 (Greacen, Jouet, 2013), as well as in the national programme of health peer-mediators from the World Health Organisation Collaborating Centre (CCOMS in its French acronym) Lille, from the Public Mental Health Establishment (EPSM in its French acronym) Lille Métropole and the

National Federation of Psychiatric Patients (Fnapsy in its French acronym, 2010)⁷, or in more local

initiatives, such as the Club House in Paris (2010)⁸. It is now spreading more rapidly but still in a limited way, through professionals and user associations via publications (Greacen, Jouet 2012), public presentations, or conferences on the subject which are becoming more frequent within the

National Union of Families and individuals with mental illness (Unafam)^{9,10}.

One of the main distribution channels for these concepts was the “Housing First” programme which has been trialled in France since 2011. In response to an official report (report by Girard, Estecahandy, Chauvin, 2010), this programme, supported by the Ministry of Health, was presented

as a possible response to two crises: that of public psychiatric services¹¹ and that of social

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The users’ movement places at the heart of recovery, mutual aid which only people who have lived a similar experience of mental health issues can offer. Cf.: Apprendre le rétablissement, *revue Rhizome*, n°65

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EMILIA: *Empowerment of Mental Illness Service Users through Lifelong Learning Integration and Action*- European programme of action research (2005-2010) oriented to occupational reintegration of people suffering from severe mental disorder.

7

The national programme of peer health mediators (2010-2013), CCOMS-Lille, EPSM Lille Métropole, Fnapsy: <http://www.mnasm.com/files/uploads/TRIPTIK.pdf>

8

The Club House France organisation was created in April 2010.

9

UNAFAM: National Union of friends and families of people with mental illness.

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See : MOREAU, Delphine, LAVAL, Christian (2015). Care et recovery : jusqu’où ne pas décider pour autrui ? L’exemple du programme « Un chez-soi d’abord ». *ALTER – European Journal of Disability Research / Revue Européenne de Recherche sur le Handicap*. Available on line: <http://dx.doi.org/10.1016/j.alter.2014.05.003>

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During the first decade of the 2000s, the focus of discussions between professionals on their own knowledge and institution (so called specialist psychiatry) left them somewhat unmindful of the demand for recognition of knowledge based on the experience of being or having been a psychiatric patient, having experienced mental illness

emergency¹². Its reference model comes from Anglo-Saxon culture. In 1992, a new model of intervention which claimed to be part of an evidence based intervention approach (“evidence based policies”), is tested in New York (Tsemberis et al., 2004). “Housing first” targets homeless people who have mental health problems. Two key strands characterise “Housing First”: the allocation of personal and permanent housing without obligatory care and accompaniment which gives priority to personal choice and an ability to define their own priorities. The only requirement for tenants is a weekly meeting at their home or at a place of their choice in town, with an ‘intensive’ medico-social team (comprising a psychiatrist, psychologist, social workers and peer-support workers). This multi-agency support is based on a recovery model. A focus on recording the experience of the people concerned, with the aim of empowering them, legitimises the presence of peer-support workers in the support teams.

In France’s case, recruitment of peer-support workers and their participation in the professional intervention team remains a defining principle of the “Housing First” programme. This programme has opened up eight paid posts in its professional teams with no requirement for any specific prior training. Thus for five years, peer-support workers have had paid employment as “peers” for the reason they are “peers”, in the field of mental health.

I.2. Background to the emergence of peer-counselling: the independent living movement

In the 1990’s, the institutional sector, caring for disabled people in France was not in crisis. Politically, the biomedical model of disability (the individual model) was not challenged before the early 2000s with the law of 11 February 2005. The protest movement with an alternative vision of disability (social model), remains limited, apart from on issues of accessibility.

The inspiration for a new means of support *by and for* peers would come to a young French activist from the GIHP¹³, with the meeting of the principles of the philosophy of “Independent Living”¹⁴ and that of one of the American founders of this international social movement: Edward V. Roberts. The young activist decided to get involved with the international department of the GIHP. Thus in 1992, he attended the 1st World Congress of the OMPH (Disabled People’s International) in Vancouver (Canada) and at this event, discovered an international social movement driven *by and for* people with disabilities, focusing on recognition of their rights. His journey continued to the USA, as far as Berkeley in California (Simon, 1999a: 10). It was here that a handful of activists had founded the Independent Living movement and in 1972 the first Centre for Independent Living (CVA). By providing disabled people with peer support, personal assistants, advice on benefits and rights, a workshop dedicated to repairing wheelchairs, etc., it became easier for them to take control of their daily life from a wheelchair. Buoyed up by this experience, convinced of the opportunities

and the effects of medication, etc.

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Since the mid-2000s, the existing social emergency schemes have had their limitations regarding integration publicly exposed. The inefficiency of the “incremental steps route”, denounced by the Damon report (2002), contributed to keeping homeless people in a form of desocialisation and permanently degraded states of health. For all that, the homeless person remains ineligible for treatment in hospital or out-patient psychiatric facilities, sent back by the psychiatric teams to their stigmatised status.

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Le GIHP is an association under the law of 1901, created in 1964, on the initiative of students with motor and visual disabilities. They campaigned for the opportunity to study, notwithstanding their state of health, convinced that obtaining high level qualifications would help with their social and professional integration. The acronym GIHP first and foremost means “Organisation of Intellectuals with Physical disabilities”.

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Independent living: the key concept of the social movement known as *Independent Living* (IL), “... [which] considers that all human beings are interdependent and that the notion of independent living does not contradict this. The term “independent living” does not mean total independence vis-à-vis other people, but the freedom of an individual to choose and control their life and their way of living.” (*French Definitions*, ENIL, 2012).

opened up by appropriate support and more confident in his own abilities, the young activist returned to France with his head full of plans.

The first national days for Independent Living, took place at the Cité Internationale of Paris in November 1994. Fourteen disabled activists from all over France and also from the Netherlands, England and Germany came together to discuss the opportunity of setting up Independent Living in France.

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An important turning point was reached during a working group on peer support¹⁵. From this group, a new term would emerge to translate the expressions “peer support” and “peer counselling”, namely: “pairémulation”, also a definition in French of this new term was also established: “*the sharing of experience by independent disabled people, for disabled people seeking more independence, with the aim of increasing awareness by disabled people of their opportunities, rights and responsibilities*”. It was confirmed that this project would be established in France. All that remained was to try and find a way to organise it.

In the end this project was driven by a new organisation: the GFPH, created in 1992. At present, despite attempts to give structure to its activities “pairémulation”, remains largely undeveloped and has barely been institutionalised in France. The emergence of “pairémulation” in France remains a process which is primarily driven by a handful of disabled people who have a shared philosophy.

I.3 Putting it into context: a common American origin but with different political contexts and different methods of transfer

The transfer of the concepts of peer-support and peer counselling from the USA to France were carried out in different societal contexts and by different social actors. In the field of mental health, two crises (psychiatry and homelessness) were at the heart of the public debate and both highlighted the limitations of current public policies. Thus peer-support was presented by innovative social actors as a practice which forms part of a new paradigm – recovery with peer-support workers - as a solution capable of resolving the two crises mentioned above. As regards the field of disability, no real counter argument has been formulated or publicised. The peer-counsellor activists did not support the concept of peer support as a solution to public problems. (Blumer, 2004). They did not include it in a new theoretical paradigm yet at the outset, the prospect of Independent Living was passed over (Gardien, 2010). This practice was essentially presented as a complementary and effective method of intervention, which opened up the opportunity for specific benefits linked to the sharing of experience between peers.

French practitioners responsible for transferring the concept of “peer-support” have been facilitating a group of international experts who, for several years have already been producing (broadly positive) evaluations on programmes rooted in the recovery paradigm, in particular that of “Housing First”. Conversely, the transfer of the concept of peer counselling is still largely in the hands of a poorly organised group, with little by way of public recognition or a network.

It was as an experimental project that the “Housing First” programme obtained funding for operations and evaluation carried out by professionals and researchers. In the face of public concern

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Support by peers: the literal translation of the expression peer support. This statement has had multiple definitions including the one adopted by the European Network for Independent Living during its congress in October 1992 in Berlin: “ a) to use peer support as the foremost educational tool for sharing information, experiences and insights in order to make people with disabilities conscious of the audio, visual and cultural, psychological, social, economic and political oppression and discrimination that they are exposed to, b) to make persons with disabilities aware of their possibilities to reach full equality and participation, c) to empower persons with disabilities by assisting them to acquire the skills to manage their social and physical environment with the goal of full equality and participation in their families and society.”

and media coverage of the presence of homeless people on the streets of our towns, some of whom presented with serious – so called psychiatric – disorders, and possibly dangerous behaviour, a top down public policy was introduced to strengthen and legitimise the bottom-up public action of those promoting the concepts. As for peer-counselling, it was not identified as the answer to a public issue or a crisis situation by the politicians in its early days. As a result, it was not included in the political agenda and did not obtain large scale support for any national development before 2015.

Tableau 1

II. The development of support by peers

II.1. The implementation of peer-support in the «Housing First» programme

The "Housing First" programme operates in Marseille, Lille, Paris and Toulouse. Initially intended to run for a three-year period (2011-2014), and extended to 2016, it is organised at national level by an interministerial delegation: the DIHAL (Regnier et al. 2011). The study group of homeless people benefit from the usual services. Half of them are housed under a sub tenancy agreement and are supported by a multi disciplinary mobile team of ten professionals per site including two peer-support workers (two peer-support workers per team and per site).

A lack of clarity regarding their role

If, for the sake of convenience, we have until now used the term peer-support worker, it should be noted that there was always an issue with naming the activity. The plurality of names reflects the difficulty faced by those involved in reaching a consensus on the definition of the content of their mission, of their identity as a peer-support worker. The notion of «peer worker» sometimes used by programme sponsors, suggests the objective is to create a new profession. The term “peer-support worker” points to a professional role. It is commonly used in team meetings. The term derived from “peer support” in English, introduces a dimension of reciprocity and lack of hierarchy between peers and thus points towards a non-professional role. It is only used in inter-site training situations but very little by stakeholder teams. The term “peer health mediators” (PHM), so called because of the support of the Ministry of Health, is ultimately the term used in the official programme reports. Whilst other terms have been in regular and varied spoken use, this PHM denomination, imposed from “on high”, is historically from outside the field of mental health, the development of the Housing First programme and the philosophy of recovery.

Professionalisation without a safety net

The initial criteria for the recruitment of peer-support workers, namely: previous experience of psychiatric treatment, drug addiction and living in precarious conditions (homelessness), were difficult to define from the start, giving rise to lengthy discussions at each site. With the exception of the Marseille site, recruitment of peer-support workers was delayed compared to that of other members of the dedicated team of professionals. This delay was due to uncertainty regarding the type of experience sought: experience of the street and its codes and/or experience of mental illness and its effects? These questions sometimes gave rise to disputes and less frequently to clashes between programme associates regarding the profile of one or other candidate. These questions were fuelled, in particular, by differences between peer-support workers already in post, qualified professionals and actors from outside the intervention teams (stakeholders and institutional bodies). Beyond the consensus on the need for their life experience, the debates did not lead to the establishment of a clear professional identity, although the question of recruitment criteria has emerged every time a peer-support worker vacancy has arisen and this has continued throughout the entire duration of the programme.

The speed with which the programme was set up did not allow for the definition of the content of the role, the skills required, any more than their professional status. Most peer-support workers were recruited on the basis of take home pay very close to the minimum wage, with no prospect of advancement in a professional career. Moreover, depending on the sites, they used either hospital public service rates or on collective agreements specific to social work professions. In other words, although their status as an employee was legitimised by the “programme”, their entry level in the professional sector varied from one site to another.

Granting status, in this way, however precarious it may be, to peer-support workers, has, in turn, caused a national controversy, led by the nursing and psychiatrist unions. Taking on former patients to support clients in the mental health teams caused an outcry from the nursing unions. They saw the prospect of creating peer-support worker positions as a major threat both to the validity of their qualifications and to their professional status. Many psychiatrists and their representatives have denounced the recovery paradigm which, in their view is certainly not based on the added value of peer-support workers. According to them, the introduction of peer-support workers indicates an intention to squeeze out healthcare professionals and ultimately challenge the clinical foundations upon which psychiatry is based. There were significantly fewer who considered that “the *intrusion of peer-support workers in psychiatric services marks the end of the mental asylum and proves that*

mental illness can be cured in the community”¹⁶.

Moreover, the question of handling the disparity in skills of lay people and professional skills has routinely arisen since the beginning of the “Housing First” experiment. Should they be given *ad hoc* training which would set them on a learning trajectory or should we consider their previous life experience to have been sufficient for them to fulfil their role? The question remains unanswered, leading to another dilemma: wouldn’t training them be to risk formatting “their experience” according to professional precepts?

The emergence of a specific identity for peer-support workers through practice

Gradually over the period of the programme’s implementation, attempts to define a clear role for peer-support workers have given rise to discussion. External training on the principles of recovery and the concept of empowerment, which was provided to teams in 2012, played a particularly revealing role. During this training, the perceived special relationship between peer-support workers and «users», their ability to “say it like it is”, the role they played in leading to professionals adopting less stigmatising language with regard to clients, were revisited and debated. This specific identity, which was certainly debated but was ultimately validated by most of the licensed professionals, positioned peer-support workers at the heart of intervention teams as colleagues with an equally legitimate right to intervene.

The process of legitimising their role has been underway on all four of the programme’s sites. The role of the peer-support worker has been taken up by the teams as a serious issue which cannot be dismissed. Little by little, in practice, and on a case by case basis, peer-support workers have been recognised for their ability to maintain links with people who are the most resistant when faced with other professionals and for making a specific contribution in situations considered to be “borderline”.

II.2. “Bottom up” implementation of peer-counselling

The term “pairémulation” (which only exists as a French word) when typed into Google gives no fewer than 4890 references. This shows the level of interest in this word and probably in the practice which is thus named. In order to remain in control of developments related to the usage of

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Pr. Christophe Lançon, head of psychiatry department at Sainte-Marguerite Hospital in Marseille, one of the 12 partner establishments involved with the CC-WHO project.

this term and this practice, the GFPH filed “pairémulation” as a trademark with the National Institute of Industrial Property (INPI in its French acronym). The submission was registered on 21 October 2010 and published in BOPI (French Official Bulletin of Industrial Property) on 12 November 2010. Since then, the GFPH advises users of the term of its submission to copyright usage and of the necessary authorisation from the GFPH. Nowadays, once duly informed, most organisations have chosen to change their terminology, and words such as “peer-companion”, “peer-support worker”, “peer worker” and “mutual aid” are growing in popularity. Other actors, whether aware or not of the registration of the trademark, continue to use the “pairémulation” terminology without being part of or having any connection to the GFPH.

Peer-counselling: between an informal and a formal practice

The practice of peer-counselling under the aegis of the GFPH currently takes several different forms. These are the result of poor awareness of this practice both in health and medico-social sectors and amongst disabled people living in a mainstream environment (few requests for peer-support-worker), and also the paucity of resources and funding obtained for its implementation, and finally by the small number of practitioners.

The informal practice, where the peer benefits from the commitment of a peer-counsellor providing personal and practical support without this ever being a formal arrangement, is certainly the most common. Moreover the peer being counselled may not know they are being supported. In fact, this practice may take place in addition to and as part of other activities which are a regular feature of a disabled person’s life (e.g.: physiotherapist, charity president or volunteer), or may be initiated completely spontaneously during an everyday encounter, or during exchanges on Internet forums. There are also formal arrangements within the framework of agreements between a local association of peer-counsellors and physiotherapy and rehabilitation centres or a nursing home. In this situation the peer-counsellor is identified as such. Arrangements of this type, which are running or have run, these past five years can be counted on one hand.

Positions actually taken on by peer-counsellors are most commonly voluntary. Occasionally, it does happen that a practitioner may obtain a salaried post in the voluntary sector or may choose to work on a freelance basis. That said, the professionalisation of peer-counsellors is an objective which has

been supported by the local charity Handi’Cap Citoyen¹⁷ and the GFPH since the early 2000s. In this context, the first conventions on peer-counselling took place in the city of Caen. This event brought together the majority of peer-counsellors from all over the country and enabled the laying of foundations for the constitution of a national agency, a prerequisite for the recognition of any such profession as there may be in the future. A notable outcome of this meeting was the drafting of a framework of activities and skills to clarify, communicate and legitimise this practice in readiness for institutions and potential financial backers. A further element of cohesion of this emerging network: a charter for “pairémulation”¹⁸, establishing a moral framework for this practice, was devised and adopted collectively in 2003, then revised in 2009.

Great emphasis has been placed on training peer-counsellors by the GFPH since its inception, another necessary step towards professionalisation. A number of training activities have already taken place between 1998 and 2014. Furthermore, this network of peer-counsellors took the initiative of preparing a framework of activities and competencies. To this end, this stakeholder

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The dissolution of this charity was registered with the prefecture of Calvados on 20 December 2014, following the death of its leader.

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© Charter for Pairémulation : http://gfph.dpieurope.org/PublicationECLAS_Def/EthiqueDeontologie/ChartePairs2009Def.pdf

group took technical advice from a research consultancy and from the AFPA¹⁹ (2006). After several interim drafts, the framework of activities and competencies is now fixed. The threshold of validation by the peer-counsellors network and the institutions is yet to be achieved. Through applied research, a training manual and certification standard (Dufour, 2015) have been developed. A further stage to be implemented is for example a demand for the recognition of a peer-counsellor certificate or diploma by the National Register of Professional Certifications (RNCP in its French acronym) (First National Meeting of Pairémulation, 2011).

The late opening of a political window of opportunity

The promotion of peer-counselling is also carried out by a network of peer-counsellors amongst politicians, network heads in medical and medico-social fields, and especially aimed at health professionals in functional re-education and rehabilitation centres and in institutions such as the National Solidarity Fund for Autonomy (CNSA in its French acronym) or social security, and private foundations. In fact, publicising and legitimising peer-counselling is necessary for its deployment and recognition with the institutions. Following a report by Piveteau (2014) entitled “Zero without solution”, a mission for “major change to the professional practices of those who are involved with the advice and support of disabled people” was entrusted to Marie-Sophie Desaulle by the Ministry of Social Affairs and Health. One of the stated objectives of this roadmap is the organisation of a system of peer-support which is deployed as part of the “supportive response for all” ministerial project (RAPT), a new scheme which has been piloted by the General Secretariat of the Interministerial Committee for Disability (CIH) since 2016.

II.3. Putting it into context: inconsistent implementation

The process of institutionalisation of peer support in France faces obstacles, whether in the field of mental health or disability. The first impediment to remove is the relative uncertainty between partners over its very definition.

Under the experimental “Housing First” programme establishing peer-support raises no doubts, however the fact remains that repeated attempts to define the role do not really reach consensus. Moreover, the practice of peer-support, because of its non-hierarchical organisational teamwork structure, is not considered for itself but becomes part of a broader perspective which is the theory of recovery and the “Housing First” programme. As regards recruitment criteria, the status and level of training required have not been the subject of thorough reflection. Peer-support workers are routinely taken on as paid employees, as advocated by the North American model. Charity workers, volunteers, and the self employed are not asked about their potential suitability. There is no required

level of training,²⁰ with experience being the relevant criterion.

Meanwhile, peer-counselling is defined by peer-counsellors themselves, outside regulatory frameworks, in words which aim to be close to the administrative standards of a professional diploma, with a framework of activities and competences (Référentiel, 2006). If this formalisation does exist, it is more like putting on paper the hypothetical optimal shape of the role, rather than an

¹⁹ AFPA: National Agency for Professional Training for Adults

²⁰ However, since the latest decree of 28 December 2016, expectations in terms of level of training have moved on: “A peer health mediator whose experience of mental healthcare services as a user, is supplemented by either a minimum level II certification registered with the national directory provided for in article L. 335-6 of the education code, or by validation of personal achievements according to conditions laid out in articles D. 613-38 and following of the same code with a view to obtaining such certification, subject to a commitment to obtain this within five years from the date of recruitment, or subject to the favourable opinion of the team psychiatrist, or by any other mental health training”. It remains to be seen which options will actually be implemented from now on in the context of recruitment.

established practice. In reality, it is to a great extent informal, and at odds with its definition regarding information, raising awareness and training target audiences. The conditions required for peer-counselling have also been formalised, albeit within the same documents (Framework, 2006), but no appointment of paid employees has ever been made on this basis and volunteer practice does not always meet the outlined criteria. In fact, the level of training required for volunteers is nil. The status is almost always that of volunteer, which does not represent any real opportunity for choice or deliberate intention.

Tableau 2

III. General Discussion

Sustainable institutionalisation of a social role presupposes both its reciprocal typification by actors in shared situations, and also its legitimation at the time of transmission to actors outside the reciprocal typification premium (Berger, Luckmann, 1996). The general discussion will, therefore, focus on these two points in turn.

III.1. Reciprocal typification of the peer-supporter role

Inspired by and drawing upon the American self-help movement, the role of peer-supporter has gradually come to be characterised differently by actors involved with peer-counselling from those from the “Housing First” programme.

Peer-counsellors, who usually work alone, have only rare opportunities to observe the way others operate. On the other hand, the interpersonal relationships woven between them and those with whom they have formal meetings organised by the network are also opportunities for mutual exchange and for reciprocal typification. In addition, since 1994, they have jointly established a definition of their activities: “Sharing experience by independent disabled people with disabled people who are seeking greater independence, with the aim of increasing disabled people’s

awareness of their opportunities, their rights and their responsibilities”²¹. This definition remains unchallenged by peer-counsellors. They continue to recognise themselves in and identify with this statement. Furthermore, whilst working on the production of guidelines for activities and competencies, debates between peer-counsellors lasting several years have led to the fine tuning and clearer definition of reciprocal typification. It should be noted that owing to the broadly informal nature of the practice, neither the views of peers-counselled, nor those of professionals or other actors in the field were actively engaged in this endeavour of reciprocal typification. In fact, in reality, peer-counselling is a social construct of peer-counsellors alone.

As for the social role of the peer-support worker, there has been little typification by actors from the “Housing First” programme. Initially, given the urgent need for intervention with homeless people, the presence of peer-support workers was clear evidence of support for the North American model. They obtained *de facto* employee status. Because of the strong team culture, where specialisation is not appropriate and where everyone takes part in all activities neither the content nor definition of peer-support worker has been produced. Recruited individuals have learned about peer-support on the job. Along the way, typification of the role of peer-support worker has gradually emerged through the recognition of their specific skills in reputedly difficult situations. However, this reciprocal typification has been hindered by significant observable differences between peer-support workers with experience of life on the streets and those with experience linked to mental health issues. Born of a social construct, shared by all actors of the programme, the typification of the role of peer-support worker continues alongside outside initiatives, for example the peer health

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Definition adopted at the first National Days for Independent, Paris, 18-20 November 1994

mediator diploma supported by the WHO-CC of Lille or more recently through modules offered by the Recovery Training Centre (CoFoR in its French acronym)²². The dynamic for typification of the role of peer-support worker goes beyond merely the “Housing First” programme.

III.2. Process of legitimation of the role of peer-supporter

Let us remember that the process of legitimation of a social role is driven by the transmission of typification devised by their predecessors to new workers.

As regards peer-counsellors, a wide variety of routes and support mechanisms are employed to enable transmission. Firstly, according to the proximity principle, some peer-counsellors train new candidates. Thus a generation of trained workers succeeds another, who have become trainers. This handing over the reins between peer-counsellors is accompanied by a more formal search for legitimacy amongst politicians, managers of organisations, actors in the field of training and professionals, in short all parties likely to be involved in better integration of peer-counsellors in the sectors concerned. A variety of measures is used for a more widespread dissemination of the concept of peer-counselling: participation in conferences, writing articles in specialist publications, creating pages on organisation websites. Other devices for legitimation were deployed such as the ethical charter for peer-counselling and, going one step further, a framework for activities, competencies, training and certification. Bringing the narrative which legitimises the practice of peer-counselling into the public domain presupposes that a coherent common perspective both now and moving forward will be reached. But this structuring of the network, which has been fraught with tension and rivalry between people aspiring to leadership, has not actually been possible. The network has not genuinely sought alliances with researchers, nor to establish scientifically the professed social value of their practice. Nonetheless, a window of political opportunity has just opened with the RAPT. Time will tell whether they have or have not succeeded in seizing the opportunity to convince other actors of the legitimacy of “pairémulation”.

This lack of institutionalisation is linked to ambivalence between resistance and interest in many stakeholders (e.g. professionals, directors and management and institutions) from the field of disability who have not been involved with the process of reciprocal typification of the pioneer generation. Yet whilst they are, in some cases, applicants for peer-counselling interventions in their institutions, they would also like to have a handle on the ins and outs, so that they can assess the quality and be involved with improving practices taking place on their site.

As regards peer-support, there is a paradox: the process of legitimation exists despite unclear typification of the identity and content of the actual role of peer-support worker. There are two reasons for this. Firstly, the legitimation of peer-support workers follows a power grab linked to a window of political opportunity which employed peer-support workers in the wake of the experimental “Housing First” programme. Thus it was through loyalty to the New York “Housing First” programme that peer-support was recognised as legitimate, and not through the charisma or proven capabilities of the pioneer peer-support workers in the French context.

Secondly, the process of legitimation was also deployed in the promotion and dissemination of the recovery paradigm by psychiatry professionals (some of whom some were trained in the USA). In fact, these professionals were the main agents of transmission and legitimation of this model of intervention combining recovery and peer-support. They were able to join in the intervention research of “Housing First” and build bridges and alliances with the world of quantitative and

²²

Cf. : revue rhizome n°65-66, “apprendre le rétablissement ”, article by Julien Gard and coll.

qualitative research²³, discovering new arguments to support their perspective.

However, particularly at the start of the programme, this top-down imposition of peer-support workers also met with resistance from those who were not familiar with the model or who were critical of the philosophy. This resistance was particularly strong at the beginning of the programme, from public psychiatric services and, to a lesser extent, within the field of homelessness which is largely made up of charitable organisations.

Conclusion

We are currently at a crossroads: The process of institutionalisation of the role of peer-supporter, be that peer-support worker or peer-counsellor, is well underway. However, typification and legitimation are still lacking and the role of peer-supporter is uncertain. Peer-counsellors' self institutionalise, disregarding the outside world. As a result, their work on legitimation meets with resistance from a wide range of actors: financiers, politicians, professionals, institutions, etc. Conversely, the introduction of peer-support workers was a result of legitimation work by many people who were directly involved: researchers and experts, professionals and institutions, politicians, etc. although their presence has concealed gaps in the typification of the role.

There are implications for both forms of institutionalisation, particularly with respect to professionalisation. Despite the undeniable efforts of a number of actors - professionals, peer-supporters and institutions - the momentum for recognition of this role as a profession is still marginal. Indeed, actions currently under way to this end are primarily intended to gain recognition for a very small number of peer-supporters, namely: peer health mediators (Demailly, 2014b), several peer-support workers who are appointed locally (RAPT and Housing First programmes) or a handful of peer-counsellors (Gardien, 2010). Other peer-supporters are not so far affected. In addition, no monopoly of skills or body of knowledge is truly recognised.

Therefore, today the question arises of an institutionalisation which would exceed the framework of the "Housing First" intervention programme or internal peer-counsellors from the GFPH. If the true aspiration of actors involved is the institutionalisation of a role, is it necessary for abilities and competencies to be typified and recognised as cross-cutting, whatever the field of application: mental health, psychiatry, social, medico-social, but also homelessness, addiction, prostitution, etc? Who could bring about this change? Can sector leaders open up to communities that they don't come from, where they don't necessarily share, or only partly share, experiences? And do they want to? Can these various activists share a common cause? If so based on what common identity? Will peer to peer relationships remain possible? Or will this joining together produce different identities and different roles?

Similarly, what happened to the strong values of the original self-help model upon which these two processes of institutionalisation were initially based? What of this common matrix in the present situation? The emphasis placed on self determination and empowerment by peer-counsellors has made control of the development of the practice crucial, and has prevented them from forming strong external alliances. Conversely, peer-support workers entered an intervention programme which was already rooted in the principles of self-determination and empowerment, supported by the institutions and researchers. Although more aggressive, this strategy risks depriving them of self-determined collective action with the process taking precedence over the importance of the role

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For example, see: Bread and Shoulders: Reversing the Downward Spiral, a Qualitative Analysis of the Effects of a Housing First-Type Programme in France, Pauline Rhenter, Delphine Moreau, Christian Laval, Jean Mantovani, Amandine Albisson, Guillaume Suderie, French Housing First Study Group, †, Mohamed Boucekine, Aurelie Tinland, Sandrine Loubière, Tim Greacen, Pascal Auquier, Vincent Girard, *International Journal of Environmental Research and Public Health*, 15, 2018

of peer-supporter. The same point of tension is implicit in these distinct institutionalizations: the clash of the experiential knowledge of peer-supporters with so-called professional knowledge, with as yet no clear reconciliation between the two.

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Tableau 1

The development of peer support practices		
	Peer-support worker <i>Housing First</i> Intervention programme	Peer-counsellor Various organisations and the GFPH
Time frame	2010s	1980s
Practitioners	Researchers and international experts, professionals (particularly psychiatrists), elected officials, users	A disabled champion and people directly affected who form the GFPH organisation
Presented as a solution to a public problem	Yes Crises in psychiatry and homelessness	Not in the 1980s
Put on the political agenda	Yes	No
Implementation	Top down	Bottom up
Funding for peer support	Significant public funding	Poor, intermittent funding
Relationship with professionals in the field	Coalition with professionals from Housing First programme	No coalition
<i>Evidence based policies</i>	Yes	No

Tableau 2

Implementation of peer support		
	Peer-support worker <i>Housing First</i> Intervention Programme	Peer-counsellor Various organisations and the GFPH
Job description	Relatively indeterminate/undefined both for professionals and peer-support workers	Skills and activity framework devised amongst peer-counsellors, without soliciting the views of professionals or the peer-counselled.
Designation of the role	Variety of designations depending on context	Unified under the one term “pairémulation”
Expected competencies including experience and expertise	Experiential knowledge expected without strict definition of content. Concrete expectations covering a variety of life experiences (Homelessness, experience of mental disorders)	Experiential knowledge claimed without definition of content. Concrete expectation of experience of disability
Status	Paid post in a multi-professional intervention team	Mainly volunteers or informal actors
Training for the role	No specific training, but diploma project underway in addition to the Housing First programme (Cf.: circular December 2015)	Specific training but rarely completed Training and certification framework (without official approval at national or local level)
Constitution of a specific collective to represent the positions and interests of peer supporters	Only in-house within the Housing First programme	Yes supported by the GFPH
Principles and norms of intervention	Those of the multi-professional team	Ethical Charter of “pairémulation”