DEVELOPING ACCOMMODATION TO SUPPORT SOCIAL INTERACTIONS AN ONGOING INNOVATION IN FRANCE

Desenvolvendo facilitações para apoiar intervenções sociais
inovações contínuas na França

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ABSTRACT: Historically, accommodations for people with physical disabilities have appeared much earlier than for those with mental illness. For the latter, a variety of community support services, recovery-oriented or not, have subsequently been created. These supports are generally person-centered. But what would result from working on environmental factors, and especially on social interactions in order to reduce disabling situations? This article presents the results of research carried out in a French peer-run organization. Four modalities of accommodations of social interactions have been analyzed: 1) accommodation of social interactions with partners and psychiatric professionals, 2) accommodation of social interactions between "peers", 3) organization of power sharing in the peer-led organization, 4) accommodation for the individual's development in the peer group. These accommodations are particularly important to enable social interactions to take place in a supportive environment, and to support the social participation and citizenship of people living with mental illness. These arrangements for social interaction need to be improved. The discussion will highlight three obstacles that still need to be overcome: adhering to these accommodations by new peer group participants; peer distinctions and hierarchization through power sharing that undermine the horizontality of peer relationships; and an improvement in partnership relationships over the long term.

Keywords: Peer. Accommodation. Peer-run Organization. Social Interaction Innovation.

RESUMO: Historicamente, as acomodações para pessoas com deficiência física surgiram muito antes do que para aquelas com transtornos mentais. Para este último, uma variedade de serviços de apoio à comunidade, orientados ou não por recovery, foram posteriormente criados. Esses apoios são geralmente centrados na pessoa. Mas quais seriam os resultados ao trabalhar os fatores ambientais e, principalmente, as interações sociais para reduzir as situações

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incapacitantes? Este artigo apresenta os resultados de uma pesquisa realizada em uma organização coordenada por pares na França. Quatro modalidades de facilitação e interações sociais foram analisadas: 1) facilitação de interações sociais com profissionais da psiquiatria, 2) facilitação de interações sociais entre "pares", 3) organização de compartilhamento de poder na organização liderada por pares, 4) facilitação para o desenvolvimento do indivíduo no grupo de pares. Essas facilitações são particularmente importantes para permitir que as interações sociais ocorram em um ambiente de suporte, apoio, participação social, e cidadania para as pessoas que vivem com transtornos mentais. Esses acordos para interação social precisam ser melhorados. A discussão irá destacar três obstáculos que ainda precisam ser superados: adesão às facilitações por novos participantes do grupo de pares; distinções e hierarquização entre pares por meio do compartilhamento de poder que rompem com a horizontalidade das relações entre eles e uma melhoria nas relações de parceria a longo prazo.

Palavras-Chave: Pares. Facilitação. Organização Coordenada por Pares. Interação Social. Inovação.

1 INTRODUCTION

The Independent Living Movement (DE JONG, 1979) promoted a new understanding of disability, inspired by the concomitant civil rights movements, the consumer movement, the self-help movement, the demedicalization movement and the deinstitutionalization movement. The individual is no longer a patient who trusts doctors, who has the responsibility to be compliant and to invest in their treatment. Neither are they a disabled person who is subjected to stigmatization and discrimination without saying a word, and who loses hope of finding their place in society. On the contrary, the Independent Living Movement has proposed the model of a self-determined person with a disability, capable of leading their own life, pursuing their aspirations and achieving self-fulfillment in the community, provided that environmental accommodations reduce or eliminate the obstacles that generate dependency on professionals, institutions, and families. At the academic level, this concept of disability as resulting from barriers in the environment has been examined within Disabilities Studies. It has been heavily criticized for its denial of functional disabilities, among other things. Two scientific models of disability have emerged from this debate at the international level: The Disability Creation Process Model (FOUGEYROLLAS and al., 1996) and the International Classification of Functioning (WHO, 2001).

Historically, acting to reduce or eliminate the environmental factors involved in producing situations of disability (FOUGEYROLLAS, 2010) has initially been applied to people with physical disabilities. In the US, Larry Davidson (2016) suggests that while the ADA[2] legislated in favor of accessibility to society for people with physical disabilities, it then took 26 years to conceive of its equivalent in terms of opportunities and resources for people with mental illness wishing to access and live in the community. He states that two main types of accommodations corresponding to reliable and competent social support in the community have thus been instituted: Assertive Community Treatment (ACT) and Recovery-oriented support. He explains that while recovery-oriented interventions have been inspired by ACT, the two modalities are very different in the way they propose accommodations. Assertive Community Treatment focuses on resolving crises, reducing symptoms and community life skills training. Recovery-oriented support responds to and supports the person's willingness to live in the community and develop a variety of relationships and activities. Recovery-oriented support is therefore not prescribed and is not a step-by-step program at the end of which the person is finally recognized as independent. The person is put directly in the life situation of his or her choice and supported for the time necessary.

In France today, the goal of an inclusive society is an important political objective. Support for living in the community is widely promoted. ACT-type interventions already exist. Recovery-oriented support is struggling to develop. The philosophy of Recovery is still very poorly understood. However, the idea that it is necessary to work on environmental factors to reduce disabling situations is very widespread. The 2005 law for equal rights and opportunities, participation, and citizenship for people with disabilities is a clear example. Since then, accommodations are primarily implemented following two themes: 1) development of public spaces, public transport, Internet, but also companies, schools, leisure spaces, etc., 2) an individual accommodation funded by the PCH[3] benefits which allows the adaptation of the environment to the sometimes

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[2] ADA: Americans with Disabilities Act

[3] PCH: benefits for the accommodation of the environment and the taking into account of specific needs, instituted by a 2005 law.

quite singular needs of the individual, since accommodations for the majority are not always sufficient or appropriate for everyone.

Environmental accommodation practices for people with mental illness have been increasing for about ten years in France (CHARZAT, 2002; LE ROY-HATALA, 2007). These include: raising public awareness to reduce stigmatization, better access to care, reform of legal protection measures, development of alternatives to hospitalization, the possibility of tasks being performed by several individuals in order to take turns in the event of a temporary interruption, part-time work to reduce the psychological burden, scheduling arrangements, etc. However, not all these measures focus on social interactions, which are recognized as contributing to amplifying or reducing disabling situations and social participation (FOUGEYROLLAS and al., 1996; WHO, 2001).

In this article, we will therefore focus on exploring the issue of accommodating social interactions for people living with mental illness. More precisely, it is not a question of interpersonal relationships and their contents, but rather that of the organization of the social framework in which they take place. To do so, we will present the analysis of data collected during a survey taking place in a peer support service that is under development. We will first discuss the regulation of social interactions between peers and with partners, then the formal organization of power within the peer group, and finally the accommodations that favor the development of the individual within the group.

Setting up a peer support service is a completely innovative initiative in France, where there are virtually no peer-managed services. Psychiatric institutions and services solicit peers for public testimony and advocacy, but not, or rarely, for peer support. From the point of view of professionals, support is the heart of their mission, the meaning of their actions. The sharing of this activity with a new kind of vocation was not obvious, without consensus, and not even truly meaningful in 2016. Today, this experimentation raises many questions for individuals and politicians alike, particularly about what would or would not allow it to develop and endure. Therefore, this article will also present some recommendations in its conclusion for improving its implementation and its partnership with professionals.

2 METHOD

In 2016, the founder and peers asked the researcher to lend support to an innovation under development: their project found a peer support service. They also wished to participate in the EXPEERTs research program. An ongoing qualitative survey has consequently been carried out on this subject since 2016.

EXPEERTs research aims to better understand the social processes underlying peer support and the production of experiential knowledge (BORKMANN, 1976). It is being conducted concurrently in twelve field sites.

Given the nature of the social phenomena studied, their dynamics, their evolution and their complexity, it is impossible to base the collection of data on a single method of investigation. The chosen option was a strategy of data triangulation (DENZIN, 1978), methods triangulation (COHEN; MANION; MORRISON, 2007) and open-ended triangulation (BECKER, 1970). The method triangulation approach targets a variety of data to document the complexity of phenomena and reduce biases inherent in each method. The survey uses both ethnographic observation (PENEFF, 2009; CEFAI, 2013) and several types of interviews: semi-directive interviews, explanatory interviews (VERMESCH, 1994, VERMESCH, 2012) and focus groups (MORGAN, 1997; MARKOVA, 2003). The ethical nature of the research was approved by the CNIL[4] (Lgd2323091#).

Only one field site is the subject of this article: a peer support service project. This field site included 10 people: the founder and nine peers living with mental illness. The data analyzed here correspond to the collection of data dealing exclusively with peer support and conditions surrounding its practice, based on ethnographic observation and semi-directive interviews. Observation began in July 2016 and ended in December 2019, at the rate of one day per month, i.e. 42 days of observation. One semi-directive interview was conducted with each peer and the founder, i.e. 10 interviews. The duration of the interviews ranged from 2 to 3 hours. All participants signed a consent form, agreed to participate in the research and to be recorded during the interviews. A thematic analysis of the data was carried out, focusing on accommodations developed in the framework of social interaction (PAILLÉ; MUCCHIELLI, 2008).

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[4] CNIL: National Commission for Information Technology and Freedom.

4 RESULTS

The qualitative analysis of the data revealed four domains in which accommodation of the social framework can take place: the regulation of social interaction between peers, the regulation of social interaction with partners, the formal organization of power sharing within the peer group, and arrangements that promote individual development within the peer group. Each of these modalities of accommodation of the social framework targets a particular level in processes of interaction: partners / peer group / and individuals directly concerned. Some of these modalities of accommodation have been modified and formally implemented by the peer group to improve social interaction. These include the regulation of social interaction with partners and the formal organization of power sharing within the peer association. Other modalities of accommodation result from various practical objectives of the group (for example: recovery). These also produce accommodation effects important for the group's sustainability and were therefore examined in the study: the regulation of social interaction between peers, and accommodations promoting the individual's development within the group.

Table 1 – Main results

Theme	Practicalities
Accommodation of social interaction with partners	Tolerance of falling asleep or leaving the premises Speaking with the support of a facilitator Speaking as a pair of peers Regular break times Use of accessible language, agreeing to explain vocabulary or acronyms
Accommodation of peer-to-peer interactions	Continuation of debate as long as there are reasonable objections Co-production of responses for each reasonable objection No more reasonable objection = consent by everyone Drafting of the content consented to for the group's memory
Organization of power sharing	Committee 1 decision-maker on functioning and directions:

	peers with the legal possibility to take responsibility for the association (no guardianship measure) Committee 2 participates in decisions regarding the philosophy/directions of the association, contributes to reasonable objections Committee 3 consulted on peer coaching, raises reasonable objections Committee 4 of partners consulted for technical support and reasonable objections Committee 5 of Advisory Facilitators. Provides support for tasks such as: accounting, etc.
Accommodation for the individual crises	Making the shared social space feel secure Tool to take control of one's well-being Tools to anticipate the management of possible Organization of a diversity of sharing time

4.1 Accommodating social interactions with partners and other psychiatric and mental health professionals

To publicize their peer support service project, the members of the collective have carried out activities of advocacy and self-representation with various bodies and organizations, for example, the Local Mental Health Council (CLSM) or the Departmental Council for Citizenship and Autonomy (CDCA). Two of them have been elected members of the Board of Directors (CA) of a Regional Mental Health Resources Center. Several have participated in the Territorial Mental Health Plan. Etc.

These numerous contacts and partnerships with psychiatric and mental health professionals have led to many questions: How can members have a comprehensive role and not be considered as minor participants? How can they be truly welcome, to be recognized and accepted with their specific needs? What framework should be set up for the exchanges to ensure that everyone can speak out? Feedback from various meetings was regularly debriefed by several individuals. The aim was to manage the intense emotional reactions triggered, to better understand each other in situations of social interaction, but also to better apprehend the behavior and positions of the professionals.

> "Peer I: You know, we really felt like we weren't being considered. When we spoke, nobody picked up on it, as if we were speaking in a vacuum! " (Survey Journal, debriefing following participation in a Board of Directors of a Regional Mental Health Resources Center, 10/09/2019)

Overall, the analysis of data from observations and interviews allows us to list situations where peers feel the need for specific support or tolerance: when there are occasional inhibitions of attention and concentration, very significant tiredness (possibly due to taking medication), difficulty in thinking clearly (in case of intense emotional reaction), various inhibitions in speaking, making inflammatory comments (due to very strong emotions), or when their interlocutors use an unexplained technical language.

> "Peer N: It's not easy to speak up. I don't feel interesting enough.
>
> Peer H: You have to dare! If we don't go, they [professionals, especially psychiatrists] won't come looking for us.
>
> Peer N: And then, I didn't necessarily have much to say... I felt empty inside..." (Survey Journal, debriefing following participation on the Board of Directors of a Regional Mental Health Resources Center, 02/13/2017).

The group has thought long and hard about the difficulties encountered in their partnership relations with psychiatric and mental health professionals. They decided to draft a charter setting out the communication and relationship modalities they would like to be able to implement with their partners. This document clearly expresses their desire to establish a quality of relationships and exchanges that avoid giving all the power to their illness. They also ask for tolerance when falling asleep or leaving the meeting place, which should not be considered as a lack of interest in the ongoing exchanges; the possibility of being helped by a facilitator to express their opinions publicly; regular breaks to reduce emotional overload; the use of accessible language and the freedom to ask for explanations without being judged in return. At each meeting with their partners, they wish to read this charter at the beginning of the session. This public statement of the charter is in itself one of the modalities for accommodating the social aspects of environmental factors.

> "Read this charter at the beginning of the meeting to give us confidence (setting the conditions)" (Extract of document, collected on site on 11/19/2020).

4.2 Accommodations of social interactions within the peer group

The functioning of the peer group has not always been easy. From the beginning, it has had to deal with disagreements, conflicts, mood swings, inhibitions and strong emotions, divergent interests and other difficulties inherent in group life. The founder's mediations were often necessary to take into account everyone's perspectives and arguments. Gradually, in an informal fashion, ways of regulating were established that specifically allowed this attention to each person's point of view while building common ground and a cohesive group.

Concretely, exchanges on initiatives from some, projects from others or subjects of tension are put on the agenda of regular meetings between peers. Each project, action or point of view is presented, without interrupting the speaker. This is followed by a time for exchange and debate, which continues as long as one or more participants present reasonable objections to some issue. This procedure allows collective reflection to mature and a wide variety of perspectives and arguments to be taken into account. Each reasonable objection is considered by all and a solution to each problem raised is gradually and collectively found. The exchanges last as long as the reasonable objections made by some have not been answered. They may therefore last several weeks and require several meetings. Once this has been done and all reasonable objections have been addressed, the decision is deemed to have been made with the free consent of each member of the group.

> "The Founder: Any objection, as long as it is reasonable, as long as it does not win the support of the rest of the group, it must continue to be discussed. "(Survey journal, informal exchange over coffee in the kitchen, 03/21/2017).
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> "It's easier to be together since we began spending long moments in discussion" (Interview Peer B, 12/15/2017)

For example, the Peer Support Service project was the subject of a text written by the founder, with contributions by various individuals from his network. This document is intended to serve as a reference for the actions and organization of the peer support service. Once the document had been sufficiently completed, it was submitted to those directly concerned for reading and amendment. Each individual personally read the document and discussed his or her understanding with the author. Then the group met several times over several weeks and discussed the precise meaning of the text with the author and the design of the peer support service. Many points were clarified, debated, modified and improved, until there were no more reasonable objections. It was at this point in the exchanges that the written form of the peer support service project in its present formulation was considered to have been freely consented to by all. This consent is therefore not the product of a weak consensus, but rather a co-production founded on common understandings. This is why this written document is considered as a reference for the peer group, and also as a regulation tool in case of tensions between participants.

> "H., if it's not clear, will come back to it. And he will be right to come back to it! If it's well laid out and set in stone, he won't be able to question it anymore. And there will be a paper that will justify the fact that he was in a position where he no longer had any reasonable objection. And that there, he has, he has accepted the consent, because he had no reasonable objection". (Founder’s interview, 04/17/2019)

This democratic procedure does not involve a vote. It is not based on the principle of a majority being right or having the legitimacy to decide. The decision taken is generally not unanimous and does not imply that everyone agrees on everything. The option chosen is the result of a collective process of elaboration and reflection leading to consent, or the fact that all reasonable objections have been answered. This approach engages the creativity of the group to build common solutions that are tailor-made, taking broadly into account personal perspectives, while not yielding to individual interests or the effects of the disease.

4.3 Formal organization of power sharing within the peer-led organization

The question of power sharing was an important issue for the continuation of the peer-led group over the long-term. The insatiable appetite of some for recognition, the need to control everything for others, social phobias and inhibitions largely moderating the contributions of others, etc., all these very diverse individual emotions and tendencies added together could have turned the group into a space for interpersonal tensions and violence. However, the group of peers decided not to give full power to the effects of their illnesses, and to make sure that everyone was welcomed and found their place within the group, on condition they accepted the rules of functioning and the aims of the group. It was therefore necessary to reflect on a model of governance[5] that would place the organization in the hands of the peers, allowing each person to express themselves and be consulted, taking into account the different statuses within the organization (salaried employee, volunteer member, member supported by peers, partner, facilitator) and therefore the diversity of their interests, the variability of individual skills and the desire to get involved, etc. In addition, it was also necessary to consider that a large number of individuals directly concerned (salaried, volunteers and members supported by peers) do not have the opportunity to take on responsibilities or make decisions on behalf of an organization but wish to participate in the decision-making process.

> "Functioning: harmonization rules for the members of the collective
> Building collective intelligence
> Make all requests heard
> Bringing a culture of participation
> Providing a flexible organizational framework [...]".
> (Survey journal, jumbled ideas proposed by peers at a meeting on the governance project, 10/17/2016)

As the organization's design work progresses, its implementation distributes the floor and power among five colleges. The college of the organization's board (made up of people who are members of the organization and elected as board members at the General Assembly (GA), then elected to the board), the college of members invested as volunteers in the organization, the college of peers supported by peers, the college of partners and the college of facilitators.

Committee 1 is the governing body of the association. This board is composed of a president, a treasurer and a secretary, to which may be added a

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[5] The founder was inspired by principles of governance promoted by the Hummingbird movement (Cf.: Pierre Rabhi). Although he remained independent, he was trained via their MOOC dedicated to the notion of Shared Governance. From his point of view, this learning and his investment greatly helped him clarify and develop his thinking. The organizational model proposed by the Hummingbird movement is based on humanist values of sharing and ecology to which the founder adheres. In this type of organization, everyone contributes to the system, and has the responsibility to do so, according to his or her skills.

vice-president and persons with specific tasks. All members are directly concerned by mental health problems. This college is the decision-maker concerning the functioning of the organization, in order to facilitate action. This committee shares decisions concerning the values and philosophy of the organization with the committee of volunteer peers. The members of committee 1 also represent the organization to its partners and also, on occasion, to the public during training sessions, conferences and other events.

Committee 2 is made up of active peers, chosen a priori in view of their ability to contribute to the development of the framework of collective values, to adhere to and carry out the principles of recovery, free consent, etc. They thus participate in decisions concerning the philosophy of the association, in conjunction with Committee 1. This committee of volunteer peers makes it possible to give a decision-making role to persons under legal protection (in particular those deprived of their right to sign on behalf of an organization), without them being a member of the board and legally responsible for the organization.

> "...] individuals who brought real power, but who were subject to legal constraints." (Founder's Interview 04/17/2019)

Committee 3 is composed of supported peers. It is currently staffed by two people who are peer-supported and do not wish to become volunteers. The vocation of committee 3 is to give opinions on behalf of the persons directly concerned by the support, and especially to make reasonable objections. In this way, committee 3 contributes to decision making, without having direct responsibility for it. No decision concerning the philosophy of the association can be taken as long as this committee makes reasonable objections.

Committee 4 brings together the partners of the association: representatives of professional organizations and institutions. The function of this committee is to provide technical support, also to make reasonable objections concerning the organization's projects. It is not a decision-making body but an advisory body.

The three facilitators are the members of the last and fifth committee. This committee is also consultative. These members bring expertise to the tasks that the organization must assume for its operation, such as accounting, secretarial work, etc. They transmit their know-how to peers interested in increasing their skills. The founder appoints himself as a facilitator and is assigned to committee 5.

The organizational architecture developed aims to put power in the hands of individuals living with mental health disorders. They are thus offered three ways to participate in decisions: direct input into all decisions concerning the organization, in the context of committee 1; direct input into decision-making on issues of principles and values that should guide the organization's directions; the opportunity to propose reasonable objections on all matters relating to the organization to committee 2; a contribution to the debates by raising reasonable objections relating to peer support to college 3. These three types of position allow each person to participate to the extent of the responsibilities he or she can assume, subject to being under legal protection or not, according to his or her desire to become involved. Not everyone wishes to take responsibility and invest directly in collective decision-making.

The distribution of positions for each person within the various committees was based on three main criteria: individual aspirations, the possibilities left to each person according to legal protection measures, and collectively constructed consent. And if, in spite of everything, power was not truly shared, there is a last principle adopted by free consent:

> "In the event of a significant deviation linked to psychological disorders: committees 4, 5 and members of other committees may request an Extraordinary General Assembly from college 1, with the appointment of a mediator. "(Organization project, revision of January 2018)

4.4 Accommodations that promote the development of the individual within the group of peers

In addition to a collective dynamic of informal and spontaneous support, the organization of the framework of social interaction has been designed to promote the development of each individual, and this on several levels: a secure shared social space, tools to initiate reflection on their well-being and to anticipate possible crises, moments of sharing allowing the individual to express their individuality and singularity in a warm and friendly group. Taking the individual into account produces effects on the quality of social interactions that are maintained, even when the aim of recovery guides these practices.

Trying to articulate what each person expresses while guaranteeing respect for all, leads to making shared social space progressively safer, in the face of behaviors experienced as insulting, discrediting, aggressive, etc. Indeed, being able to recover presupposes respect for the dignity of each individual (DAVIDSON, 2010). At the same time, the recovery of everyone is important, not just of some. Therefore, it was necessary to establish common benchmarks on the limits for tolerating negative behaviors attributed to the mental illness. What is acceptable? What is not?

> “No because there is B. who wants to support peers. But hey... Do you know him? Well... I mean... He likes power too much... It's not good for his peers.” (Interview Peer N., 12/08/2017)

The group of peers thus reflected on and amended a set of principles according to the rules for reasonable objections, excluding no one from these common deliberations. This text takes the form of a charter to which everyone is free to adhere or not. However, in order to become a member of the group – and not an occasional guest – it is necessary to commit oneself to respecting the principles presented in this charter. The document must be the object of a personal reflection and then be signed. Its subtitle is explicit: "Taking care of oneself and others". Today, this text consists of a set of principles that apply to every member of the association. Among them are mutual respect, respect for privacy, quality of relationships, avoiding giving any power to the illness, moderation in comments, the right to express oneself or not. This includes refusal to engage in vexatious or insulting remarks, polemics, attitudes of rejection or authoritarianism towards others. In addition, each member also undertakes to trust at least three members designated by him or her, who in return undertake to report any serious behavioral problems and to support him or her in the search for a solution to avoid jeopardizing the harmony of the group. The social space of the association is thus made safe by this common framework and consented to by each one.

> "If a member (Committee 1, 2 and 3) finds himself in these cases [non-compliance with one of the principles of the charter] because of his psychological problems, he commits himself beforehand by this charter to trust at least three of his peers to

> indicate the problem to him to avoid jeopardizing the harmony of the association." (Extract of the charter, version 2, p.2)

From the perspective of recovery, the organization also offers to work on each member's wellness plan and their crisis management plan. The concept of well-being proposed is based on the responsibility of each individual towards themself: "from self to self". It's a matter of reflecting on one's motivations or aspirations, on what helps one get up in the morning, on what would drive an active engagement in life. The action is therefore conceived of as at the core of well-being and recovery. In addition, the plan is an opportunity to raise awareness or to tell oneself more formally what simple things one good do, soothe one and give back a taste for life. It is then suggested to establish habits or rituals on these bases. Finally, the wellness plan suggests thinking about and writing down one's short-, medium- and long-term projects, to work on them gradually but also to hold fast to them in case of a major setback. The "by and for you" crisis management plan consists in developing the self-acceptable conditions to manage the crisis once it has been triggered. The announced objective is the return to a stable state, described as: " being your best ". Returning to this state of well-being presupposes being able to recognize it, so the plan recommends first of all making this state explicit. It will serve as a reference point for the individual and the trusted people who will support him/her during the crisis. The plan also includes identifying the occurrence of the crisis. Therefore, a description of the first time the illness was noticed by oneself and others is required. The choice of three trusted persons enables them to commit themselves to being attentive to these alarm signals. If one of them detects these alarm signals, he or she must inform the person directly concerned, who can then ask the other two for verification before taking the steps decided upon. Depending on the person, the plan also very clearly describes the list of medications needed in the event of a crisis and the reasons for choosing them, the list of treatments that help reduce symptoms, the list of treatments strictly refused by the patient in the event of hospitalization, the list of preferred places for hospitalization or respite, and the list of actions that can be taken concerning oneself and by whom. It is suggested this document be signed and stamped by the attending physician or psychiatrist to ensure it is taken into consideration by an emergency department. This reassurance of the individual in the face of a possible occurrence of a crisis and in the face of the consequences of hospitalization, as well as the establishment of routines supporting their daily well-being, bring their reassuring effects even in social interactions with their peers.

> "The discussion I've had with Q. about my crisis plan, the fact that I've discussed it with my psychiatrist, knowing that he agrees... All of this makes me feel much more confident in life." (Interview Pair N., 12/02/2020)

Finally, a set of opportunities has developed to meet, to exchange, to share moments and to act together, always with the aim of recovery. Several communication rituals have been established throughout this shared story. Two of them are particularly important and are regularly updated: "the weather report" and the "well-being charter". The "weather report" always takes place at the beginning of a meeting, whether it is work meeting or a time for sharing. It allows everyone who wishes to do so to make known their present situation, their state of mind and to be able to discuss them without formally requesting or receiving help. Sometimes the group, sensing the importance of what the other is saying, may take more time and converse in greater detail, even though no proposals or requests for help were made. Formally, the “weather report” is defined as a "round table discussion where everyone has the opportunity to say how they feel, how they are, in two minutes. » This moment when everyone can give news is particularly popular. It proves to be useful so that each person can take into account others’ experiences of the moment, and therefore useful for the maintenance of a certain harmony in the group.

> "The other day, N. said something heavy... I understood that he was relapsing. We have to help him not to fall into depression. He brings so much to the group! "(Interview Pair T., 03/10/2020)

Another ritualization of discussions was the institution of speaking rules regarding sharing times between peers. Several problems had been identified by the members. These sharing times – aimed at giving support to everyone in their ordinary lives – generated a good deal of frustration, little satisfaction and showed little effectiveness in terms of support. As this finding was widely shared, it was decided to make it a point of discussion in a peer-to-peer meeting. During discussions, various problems emerged and became clearer. Some individuals were sensitive to the length of the exchanges and needed regular breaks to be able to follow the discussions. Others expressed their difficulty in speaking in a group and wished to be asked to do so, made to feel safe, and supported. Still others spoke of their fear of being cut off or not really being listened to. Others responded to their difficulty in memorizing their questions or possible feedback, hence their tendency to interrupt before the end of the talk. Some stressed the importance of respecting everyone's word a priori, regardless of the opinion or feelings expressed, so that they can speak with confidence. Many other points were also made and discussed. An answer was suggested for each point in terms of improving the collective functioning to better suit those concerned. So much so that a collectively consented-upon text was created establishing the rules to be respected on sharing times that has made it possible to regulate many of the various problems raised. In particular, the text highlighted the need for two roles to improve these sharing times: the role of orchestrating the discussion and ensuring that everyone can speak; the role of monitoring participant fatigue and proposing break times. Various principles have also been firmed up and included in this text. Here are some of them: welcome the opinion or feeling expressed by the other even if it differs from one's own; express oneself with moderate words without aggression; memorize or note one's contribution to the exchanges so as not to cut off the speaker; if the need arises to leave the group for a moment, do so discreetly; signify the end of one's comments clearly so that others can speak without fear of cutting short ideas in progress, etc.

> "The facilitator invites some who wants to speak:
>
> The content and the form of his or her communication belong to him or her.
>
> The facilitator can verbally support the person and limit his/her overflows. In order for everyone to express themselves, the "time master" will pay attention to the length of time the person speaks.
>
> During his or her speaking time, the person can ask for support from a member of the group to back up his or her speech.
>
> The person signifies that he or she has finished, thus leaving room for the exchange. »
>
> (Extract from the document entitled: "Rules of exchange to be respected", collected on the field site on 08/25/2018).

5 DISCUSSION

Scientific models of disability (FOUGEYROLLAS et al., 1996; WHO, 2001) allow us to think about how interactions between personal and environmental factors produce disabling situations or not. The model suggested by Fougeyrollas and al. (1996) is known to have demonstrated the manner in which unfavorable personal factors are not necessarily indicative of an individual's social participation, because of interactions with environmental factors whose outcomes can significantly alter the production of disabling situations. In spite of these important scientific advances concerning all disabling situations, actions of accommodation are unevenly available today with regard to the diversity of personal factors. In France, public policies have developed more community-based services, but few recovery-oriented services, which are still largely the initiative of pioneering professionals. But what is the situation as regards accommodations needed for people living with mental illness in everyday social interactions?

The analysis of the data from this field site of a peer-support service being set up sheds light on different dimensions of a continuous process of accommodation of social interactions, deliberate and thoughtful for some approaches but not for others. The design of the framework for social interaction, its meaning and its relevance are now relatively well integrated by peers who have contributed to the debates, or who have invested in a recovery process. For the latter, even if they do not always respect the framework consented to, it is easy for them to recognize its appropriateness for themselves and the interest of the group, and consequently to agree to adjust their behavior. However, this adjustment is much more difficult to implement for newcomers who have neither participated in the debates nor contributed to the construction of the rules governing this group. Berger and Luckmann (1996) have shown that the institutionalization of parts of daily life implies the transmission of socially constructed reality to others who have not participated. However, this transmission, which is no longer a co-construction, makes this reality external, partly opaque, normative and constraining for newcomers. In order for this transmission to be possible, and for the co-constructed reality to be perpetuated, Berger and Luckmann (1996) stress the importance of a process of legitimization among the new generations. It remains to be constructed for this peer-organization; without it, these innovations in the accommodation of social interactions for people living with mental illness could be lost and forgotten.

The distribution of roles among peers within the organization has installed some as president, vice-president, secretary, coordinator, representative, etc. Others are peer-supporters. This organization has therefore created a hierarchy between peers, those with valued roles publicly representing innovation on one side, and the others. Some peers thus gain more recognition than others, in a social space where the struggle for recognition (HONNETH, 2000) due to the stigma (GOFFMAN, 1963) of mental illness is important. Furthermore, a debate among peers about who is or is not competent and legitimate to support their peers adds to these distinctions and the establishment of a hierarchy among peers. These unexpected consequences of the recent development of the peer-organization highlight two difficulties to be overcome. First, it will be necessary to accommodate the welcoming of newcomers in a more inclusive way or decide to limit the number of members. This implies long discussions to position all new members, regardless of their mental illness or skills, in Committees 1, 2 or 3 so as not to exclude anyone from reflection and decision-making. Second, it will also be necessary to consider the effects of a hierarchy and of the unequal distribution of positive recognition among peers. The risk is that this progressive hierarchization may trigger peer rivalry and the loss of *peerness* (GARDIEN; DAVIDSON, 2021).

Finally, despite significant work to manage relationships with partners and other professionals in the fields of psychiatry and mental health, it must be noted that Committee 4 is not very involved. Moreover, partnerships with professionals become a reality essentially when the latter take the initiative, as for example, in contributing to the Territorial Mental Health Plan (PTSM), whose legal framework requires the participation of peers. To explain this social process, it is hypothesized that there is a strong divergence of concepts of mental illness and recovery between peers and professionals, as well as stigma that continues to exist at low levels. That said, the framework for social interaction set out in the peer charter is generally respected by professionals. And building a lasting partnership between peers and professionals would require peers to accept minimal accountability for the support they provide. The relationship with potential partners is therefore an aspect that essentially remains to be (co-)built.

All these difficulties should not lead to an underestimation of the importance of accommodations developed in work on social interactions. Rather, they illustrate more the youthfulness and possible limitations of the organization and the importance of training peers in leadership. The future therefore remains open.

6 CONCLUSION

Setting up a peer support service in France is a major challenge, as this type of peer-led organization is rare or even non-existent. Adding a reflection on the distribution of power within the organization and on the relationships with partners is even more unexpected. This accommodation of the framework of social interactions has gradually been designed partly for its own sake, partly to meet another objective: creation of a social space conducive to individual's recovery.

Today it responds to many challenges. These include the attribution of power to those directly concerned; the possibility for everyone, whatever the legal protection measures, to participate in discussions and decision-making; the establishment of a charter explaining expectations in terms of accommodation of social interactions with partners and professionals in the sector; co-constructed tools allowing them to conceive and gradually build the conditions of their well-being or to anticipate their guidelines concerning a possible episode of loss of control linked to the disorders; and collectively-consented communication rules that allow the specific needs of each to be respected as much as possible.

Despite concrete proposals for accommodations in the framework of social interaction, the partnership with professionals in psychiatry and mental health remains difficult for many reasons. Nevertheless, working in conjunction with professionals remains a major issue for peers, in order to reduce the tendency to stigmatize patients, for the recognition of the possible contributions of peers, and to strengthen the democratization of the health system underway in France. These practices having emerged in France only a few years ago, their reception is still fragile. However, we can already state a certain number of pitfalls to be avoided: peers reduced to their illness and perceived as a priori incompetent, peers acculturating to professional practices and imitating them (DEMAILLY; GARNOUSSI, 2015), peers centered on their person and using this new social role to promote themselves individually, or even peers and professionals in rivalry. It is essential to sensitize and train professionals and institutions in the specificity of the contributions made by the experience of a life with mental illness in the relationship with peers, including *peerness* (GARDIEN; DAVIDSON, 2021) and experiential knowledge (GARDIEN, 2017). Recognizing the specificity of peers and their contributions will give a real chance to meaningful peer-professional partnerships.

REFERENCES

BECKER H.S. Sociological work: Method and Substance. Transaction Books.1970

BERGER P.; LUCKMANN T. La construction sociale de la réalité, Armand Colin.1966

BORKMANN T. Experiential Knowledge - New Concept for Analysis of Self-Help Groups, Social Service Review, 50, 3, 445-456.1976

CEFAI D. L’engagement ethnographique, EHESS.2010

CHARZAT M. Pour mieux identifier les difficultés des personnes en situation de handicap du fait de troubles psychiques et les moyens d’améliorer leur vie et celle de leurs proches. Rapport à Madame Ségolène Royale, Ministre déléguée à la Famille, à l’Enfance et aux Personnes Handicapées.2002

COHEN L., MANION L., MORRISON K. Research methods in Education, Routledge.2007

DENZIN N.K. The Research Act: A theoretical Introduction to Sociological Methods. McGraw Hill ed.1978

DAVIDSON L. Recovery from Psychosis: What’s love got to do with it?, Psychosis, 3, 2, 105-114.2011

DAVIDSON L. The Recovery Movement: Implications for Mental Health Care and Enabling People to Participate Fully in Life, Health Affairs, 35 (6), 1091-1097.2016

DE JONG G. Independent Living: From Social Movement to Analytic Paradigm, Arch Phys Med Rehabil, 60, 435-446.1979

DEMAILLY L. ; GARNOUSSI N. Le savoir-faire des médiateurs santé pairs en santé mentale, entre expérience, technique et style, Sciences et Actions Sociales, 1, en ligne.2015

GARDIEN E. L’accompagnement et le soutien par les pairs. Presses Universitaires de Grenoble.2017

GARDIEN E.; DAVIDSON L. The Roles of Lived Experience and Peerness in Effective Peer Support, The Journal of Mental Health, (submitted) 2021

FOUGEYROLLAS et al. Révision de la proposition québécoise de classification : processus de production du handicap. RIPPH.1996

FOUGEYROLLAS P. La funambule, le fil et la toile. Presses Universitaires de Laval.2010

GOFFMAN E. Stigma, Prentice-Hall. 1963

HONNETH A. La lutte pour la reconnaissance, édition du Cerf.2002

LE ROY-HATALA C. Lorsque les troubles psychiques deviennent un handicap : le salarié et l’entreprise à l’épreuve du maintien dans l’emploi. Thèse de doctorat en sociologie. CNAM.2007

LOI n° 2005-102 du 11 février 2005 pour l’égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées.2005

MARKOVA I. Les focus groups, in Moscovivi, Buschini, Les méthodes des sciences humaines, 221-242.2003

MORGAN D. L. Focus Groups as Qualitative Research, Sage Publications.1997

PAILLÉ P. ; MUCCHIELLI A. L’analyse qualitative en sciences humaines et sociales, Armand Colin. 2008

PENEFF J. Le goût de l’observation, La Découverte.2009

VERMERSCH P. L’entretien d’explicitation, ESF.1994

WORLD HEALTH ORGANIZATION. *International Classification of Functioning, Disability and Health.* 2001