Commentary

Peer Support in Mental Health: A Growing Movement in Singapore

Ying Ying Lee,[1] *PhD*, Suying Ang,[2] *BSocSc, GDip*, Hong Choon Chua,[3] *MBBS, MMed (Psych)*, Mythily Subramaniam,[1] *PhD*

Peer Support in Healthcare Services

Peer support is a growing global phenomenon in healthcare services. Peers for Progress, an international peer support association based in the University of North Carolina, currently oversees 320 peer support programmes in 6 continents. It defined peer support as "(linking) people living with a chronic condition such as diabetes. People with a common illness are able to share knowledge and experiences—including some that many health workers do not have".[1] Service users engaged in peer support work include breast cancer survivors[2] to young persons with diabetes[3] to people who have experienced a mental health crisis.[4] A reason for the growth of peer support in healthcare services is embedded in the definition of peer support—it enhances existing services by encouraging peers to share their knowledge and experiences with other healthcare staff and providers. Recovery from mental illness is a complex process[5,6] that often includes wellness in physical and mental health, social functioning and personal identity.[7]

Even as mental health professionals attend to the health and functioning of their patients, they could use more support in terms of rebuilding their patients' personal identities in the aftermath of a mental illness. Peer support therefore helps to enhance mental healthcare services when peer support specialists (PSS) are engaged to assist their peers to rebuild their identities after a mental health crisis. It can introduce a systemic shift in the delivery of mental healthcare services with a greater focus on all aspects of recovery. Much effort has therefore been made to establish peer support as a vocation in mental healthcare. Unlike peer support in other fields that relies mostly on volunteers, peer support in mental healthcare is gaining recognition as a profession in Singapore and overseas.[8]

Peer Support in Mental Health

Peer support is a relatively new field in modern mental health services. It traces its roots to 18th century Paris when Philippe Pinel and Jean Baptiste Pussin pioneered a new form of treatment to help mental patients in the Bicentre Hospital.[9] Their humanised approach included hiring workers who were recovering patients of the hospital. Harry Sullivan employed a similar strategy when he hired patients who had recovered from psychotic episodes in his inpatient unit in the 1920s. In 1935, Bill Wilson and his psychiatrist, Bob Smith, founded Alcoholics Anonymous in Akron, Ohio as a peer support group to help recovering alcoholics stay sober.[10,11]

Modern peer support originated from the psychiatric survivors movement in 1970s America after former patients organised themselves into a group to lobby collectively for reforms in mental healthcare and to advocate for fair treatment towards individuals with mental illness.[12] Over time, it evolved into a recovery movement, and peer support has become a part of the mental health system in the United States since the 1990s. It has also spread to other parts of the world like Australia, Hong Kong and the United Kingdom.

Peer Support Services in Singapore

In Singapore, peer movement formed organically after several individuals who had survived a mental health crisis published memoirs of their experiences with mental illness.[13-16] In 2009, the Early Psychosis Intervention Programme (EPIP)—which was established in 2001[17]—began to pay PSS for the support rendered.[18] In 2011, the Singapore Association for Mental Health (SAMH) and Singapore Anglican Community Services partnered the Agency for Integrated Care and invited trainers from the United States to introduce recovery-oriented services and peer support as a vocation to the country. In 2012, SAMH became the first organisation to conduct the peer specialist certification course. In 2013, the first full-time PSS was hired by SAMH.[19]

In 2014, the first PSS was hired by IMH for its Occupational Therapy Department and this was followed by similar hires for its Case Management Unit. The work of the PSS in IMH differed from one department to the next. Since the Case Management Unit serves only the outpatients of the hospital, the job of the PSS primarily involves the provision of one-to-one support sessions for these patients. As EPIP serves both inpatients and outpatients in the hospital, PSS

[1]Research Division, Institute of Mental Health, Singapore
[2]Department of Psychosis, Institute of Mental Health, Singapore
[3]CEO Office, Institute of Mental Health, Singapore
Address for Correspondence: Ms Lee Ying Ying, Research Division, Institute of Mental Health, Buangkok Green Medical Park, 10 Buangkok View, Singapore 539747.
Email: ying_ying_LEE@imh.com.sg

are also expected to engage inpatients on an individual basis or through group work. They also empower their peers to contribute in services by providing them training and engagement. While the details of their job scope may vary in IMH, peer support still constitutes the core of the work of PSS. When PSS intentionally share their lived experience of their own illness, they instill hope in their peers.

In an effort to introduce peer support to the local social service sector, the National Council of Social Services (NCSS) and IMH launched the inaugural Certified Peer Specialist (CPS) course at the Social Service Institute in February 2017. A total of 23 peers graduated from the first intake and the third run of the programme was completed in September 2018. NCSS also worked with Workforce Singapore to offer a Work Trial Apprenticeship Scheme that matches CPS graduates to participating social service organisations to work as apprentices.[20] In July 2018, NCSS supported the establishment of a peer-managed social service organisation called Resilience Collective. It is tasked to pilot recovery colleges[21] in Singapore to empower persons in recovery through education, peer support and stigma reduction. It is viewed as a symbolic move because it is the first organisation in Singapore that is run by peers to serve their peers in the mental health community.

Challenges in Local Peer Support Services

Within a few years, Singapore has established peer support training with help from its Western counterparts and has trained a pool of individuals in recovery to provide peer support in mental health. Although the local peer movement has grown greatly, it still faces challenges and obstacles.

From the beginning, the implementation of peer support services was met with resistance from the public as there were concerns over the readiness of peers to handle the demands and pressures of the workplace and even the possibility of an illness relapsing due to work stress. Although the public meant well, such concerns nevertheless expose the underlying prejudices they have against individuals with mental illness in the workplace.[22]

Philosophical differences over the career longevity of PSS have also since surfaced. Some have advocated the development of a career path for PSS since it may be maladaptive for such individuals to continue to work in the peer role indefinitely. Others argued that the vocation can be a stepping stone into a different profession in the mental health sector. They believed that the constant use of a lived experience of an illness can limit one's growth and impede their progression up the career ladder. The authors propose that lived experiences can still evolve as PSS continue their journey in recovery. Nevertheless, career progression can also help to hone the leadership skills of PSS and efforts can be made to help them have a career.

Peer support is a nascent field in Singapore. There is a pressing need to adapt and develop the sector to ensure the longevity of the movement in the country. Although the principles of peer support have remained unchanged throughout the world, they should be adapted to meet the needs of a local culture and its system in order to be effective. IMH has therefore set up a PSS unit under its Allied Health Department to train and develop PSS. Efforts are underway to define a clear reporting structure, job scope, continuous learning and development, and mapping competencies to create a career path for PSS.

There is a myriad of opinions on the job design of PSS in mental healthcare. Some believe that PSS who have full-time roles in a medical setting will bring about best recovery in patients. Others have argued their preference to integrate the peer function into existing healthcare positions to create peer healthcare attendant roles. There is worry that the efficacy of peer support in recovery may be diluted when peers are subsumed into conventional healthcare roles. This is because peer support is built upon the premise of hope and recovery with an intentional use of lived experiences and is therefore different from other mental healthcare roles. The authors envision that when PSS become more entrenched and accepted in the mental health sector, it will provide more clarity on how peer support vocations can fit into the job categories in the healthcare sector.

A common question on peer support is the perceived lack of its effectiveness in Singapore. While the overseas success of peer support is acknowledged, there is doubt that it has been replicated in this country. This poses a dilemma for the planning and delivery of local peer support services. Before any data or evidence can be furnished to demonstrate its usefulness, peer support must be implemented first (perhaps with a leap of faith) and then evaluated for its efficacy in the local context. Since the theoretical framework of recovery and peer support is fundamentally different from other medical interventions such as pharmacotherapy and psychotherapy, one must think out of the box to effectively evaluate the efficacy of local peer support services.

Finally, peer movement in Singapore is largely driven by mental health professionals. A more probing mind may wonder if it is truly a peer movement since most of the initiatives were undertaken by this group of healthcare professionals. This observation has implications on the significance of the movement. For a long time, people with mental illness were deprived of a voice. To help them regain their voice, the local peer movement must tread carefully between authentic peer involvement and tokenistic peer involvement. The concept of coproduction is a trendy one and it is easy to invoke it in proposals and presentations. However, the practice of coproduction in real life will require peer leaders to rise to the occasion and

for professionals to relinquish some of their power. This translates into a need for more dialogue between PSS and mental health professionals and they must move from a "us versus them" mentality to a collaborative paradigm working from a common set of shared beliefs and values. It is only when this power differential is levelled out that the peer movement could perhaps scale new and greater heights.

Conclusion

There are many hurdles to overcome in the journey to recovery from mental illness. Peer support provides a helpful means for patients to scale these obstacles. As we move in tandem with the mental health community worldwide, the stage is set for peer support and recovery to grow further in Singapore.

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