Discover Mental Health

Research

The exploration of attitudes and perspectives of mental health workers on peer support in Singapore

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Abstract

Background Using the lived experience as their expertise, peer support specialists (PSS) focus on the empowerment of individuals with mental health conditions. Despite its value, peer support services in Singapore are relatively uncommon. Perspectives from mental health workers may provide insights on targeted strategies to address the organisational changes needed for the continued growth of the lived experience workforce.

Aims The study aims to explore the attitudes and perceptions of mental health workers regarding the benefits, challenges, and potential strategies in the implementation of peer support services across mental health settings in Singapore.

Methods A total of 59 responses were gathered for an online survey via convenience sampling. Descriptive statistics were generated for quantitative data, while an inductive thematic analytic method was utilised for qualitative inputs. The coding and refinement of themes were discussed between both authors.

Results The majority of the respondents were willing to accept PSS as a healthcare profession (72.9%), willing to work with PSS (89.8%) and perceived there should be PSS where they worked (64.4%). Key themes identified highlighted a supportive and inclusive workplace environment, the power of the lived experience, and recovery-oriented contribution as the underlying benefits and potential challenges in implementing PSS in Singapore.

Implications Policymakers could consider funding initiatives and regulatory standards to support the implementation of PSS across mental health settings in Singapore, while organisations could implement training programmes and supervision targeted at enhancing the practice of recovery-oriented care amongst its staff.

Keywords Peer support specialists (PSS) · Mental health · Singapore

1 Introduction

The role of peer support specialists (PSS) in the mental healthcare system has garnered increased recognition in recent years [1]. Using the lived experience as their expertise, PSS focus on the empowerment of individuals with mental health conditions [1, 2]. Worldwide, it has been suggested that PSS remain as an underutilised resource that could address treatment gaps by promoting more equitable access to mental health services, while contributing to the mental healthcare workforce [2]. As PSS disclose their lived experience, they normalise difficulties and instil hope in clients, promoting

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self-determination, interpersonal learning, and social connections to the community through the establishment of an empathic relationship [2–4]. Furthermore, peer support has been identified as a protective factor of mental health in times of crisis [5].

With most of the peer support literature originating from Western countries, research in Asian countries remains in a stage of infancy [6, 7]. The extant literature indicates that clients in Asia have provided positive feedback in favour of an expansion of peer support services, in relation to a perceived improvement in psychosocial outcomes [7]. Similarly, the value of PSS in Singapore has been commended when PSS provided social support for clients during the COVID-19 pandemic when resources were scarce [8]. Despite its value, peer support services in Singapore are uncommon, with the majority being provided in Singapore's sole psychiatric institution [9]. Although PSS in Singapore have been employed on a paid basis as early as 2009, it was only in 2017 when a standardised certification course for PSS was developed [10, 11]. PSS in Singapore are likely to have completed the local certification programme to work in the capacity of a paid professional role and could be involved in a range of work from individual case management to emotional support groups [11]. Supervision within the workplace depends on the availability of resources. Where there are fewer PSS in the workplace, the supervisor is more likely to be from another profession. Numerous studies in Singapore have sought to understand the experience of PSS. PSS in Singapore have highlighted positive influences on their mental health through the work they perform [12]. Besides the identification of personal meaning in their role, organisational factors such as a supportive work environment, the maintenance of clear role boundaries, and ongoing training and supervision have been commonly identified by PSS to be important facilitators of role performance [9, 13, 14]. However, the existing studies have focused on the perspectives of PSS within the setting of a psychiatric hospital [9, 13, 14].

Given the prevalence of organisational influences, the success of peer support services would require an active collaboration amongst all stakeholders instead of the sole perspectives of PSS [11]. Perspectives from mental health workers overall (including PSS, non-peer staff and managers) may provide insights on targeted strategies to address the organisational changes needed for the continued growth of the lived experience workforce [6, 10, 15, 16]. In addition to gathering the views of relevant stakeholders, it has been identified that further research on the factors influencing the work of PSS across different settings would be beneficial [9]. Such research could facilitate the widespread implementation of peer support services, promoting an increased uptake of services as clients may be more likely to access services based outside of the psychiatric hospital to avoid stigma [17].

Hence, to support the growth of peer support services in Singapore, the present study aims to gather the perspectives of mental health workers across settings using an online survey. Specifically, the study aims to explore the attitudes towards peer support (i.e. acceptance of PSS as a healthcare professional and willingness to work with PSS), as well as perceptions regarding the benefits, challenges and potential strategies, so as to inform the relevant organisational considerations in the implementation of peer support services across mental health settings in Singapore.

2 Methods

2.1 Participants

In accordance with the definition of a healthcare worker by the World Health Organisation (2006) [18], the current study defines a mental healthcare worker as someone who acts with the primary intent to enhance health in clients with a primary diagnosis of a mental health condition. Peer support is defined as support from a person with lived experience of a mental health condition [19]. Participants were included if they were a mental healthcare worker in Singapore who worked directly with these clients, and who were willing and able to provide informed consent. Recruitment was performed mainly through convenience sampling via emailing relevant contacts in the authors' networks. The invitation to participate in the study was further shared on social media platforms including Facebook, Telegram, Whatsapp and LinkedIn, alongside formal contacts made with local mental health organisations. The survey responses were collected from 1 August to 22 September 2023. There was no reimbursement for participation.

2.2 Instruments

The survey was conducted via Google Forms. The content of the questions were crafted based on a review of the literature relating to considerations of peer support implementation. Given the range of definitions in contemporary practice, a definition of peer support was provided to ensure that survey participants have an understanding consistent with the

study's definition [20]. The use of a survey was preferred to the use of interviews to acquire a generic overview of the needs for peer support service development in Singapore across various settings, so that future studies may utilise interviews to delve deeper into relevant areas.

The development of the questions was based on the INSPIRE measure [21] to elicit insights from participants that could inform the development of peer support services that are recovery-oriented. Compared to other measures, the INSPIRE measure has been regarded as having the best fit with the theoretical underpinnings of recovery, whilst demonstrating increased reliability and sensitivity to change [22]. There was a total of 20 items which consisted of both multiple-choice and open-ended questions. Where the questions were multiple-choice, participants had the option to enter free text responses in the "other" option. There were 8 questions on demographics and work experience, 4 questions on the participant's experience in working with PSS (i.e. presence and number of PSS at current workplace, duration spent working with PSS, any existing strategies used in their organisation), 7 questions to elicit the participant's knowledge and attitudes regarding peer support implementation (i.e. acceptability of PSS as a mental healthcare profession, willingness to work with a PSS, perceptions of the suitability of having PSS where they work, role of a PSS, benefits of peer support services, provision of supervision to PSS, potential challenges and strategies). To gather more insights, multiple-choice questions relating to perspectives on the role of PSS, benefits, potential challenges and strategies relating to peer support implementation were supplemented with an open-ended prompt for elaboration on the choices made. The full questionnaire is attached in the Appendix.

2.3 Data analysis

The preliminary cleaning of data was performed on Microsoft Excel, followed by the generation of descriptive statistics for responses to multiple choice questions. SPSS was utilised to perform one-way ANOVA to detect the impact of age and duration of work experience on inputs relating to the participants' attitudes towards peer support.Open-ended responses were analysed with the use of NVivo 12, with the use of an inductive thematic analytic method [23]. The first author read through all the responses to have a holistic understanding of the general themes. Subsequently, line-by-line coding of each response was performed to ensure that the meaning was captured in full. With an inductive approach, codes and themes were added accordingly as they emerged. To summarise the data, the themes were refined prior to the organisation of similar codes in the newly defined themes that answered the research questions. Themes that appeared irrelevant to the research questions were removed. Where there was ambiguity in responses and the participant consented to be contacted, the first author emailed the participant to request for elaboration of details. Emails were sent to 3 participants to clarify the involvement of peer support specialists in the strategies highlighted (e.g. if peer support specialists were the one providing supervision), however there were no replies received.

It was recognised that confirmation bias could have been present given the interest of the first author in promoting the cause of peer support. This was addressed with repeated cycles of coding, with themes cross-checked by the second author as a neutral party. that were reviewed by the second author as a neutral party to reach a consensus on the final themes.

We conducted a One-Way ANOVA and independent samples t-test to analyze differences in several variables across groups.

2.4 Reflexivity

The first author is an occupational therapist who works in a public healthcare institution in Singapore. The second author is a licensed clinical psychologist and an academic member who does not teach and have a practice in Singapore. Both authors do not have direct experience working with PSS and believe that PSS is a useful resource to improve treatment outcome in various healthcare settings. As there was neither funding nor managerial roles held by the authors, there were no vested interests that required the study to yield positive findings.

2.5 Ethics

The study received approval by the Human Research Ethics Committees at the University of Queensland prior to study commencement (2023/HE000995). As the study was conducted as part of a research project from an Australian

university, ethics approval was obtained from the university. The study was performed in accordance with ethical standards informed by The National Statement on Ethical Conduct in Human Research (2023) of Australia [24]. All participants provided informed written consent and were given the opportunity to contact the researcher via email if they had any concerns.

3 Results

There was a total of 62 responses, 3 of which were excluded due to a repeated submission from one respondent, a response from a retired healthcare professional, and finally another who had no experience working with clients with mental health conditions. The remaining 59 responses were included for analysis, including 5(8.5%) from PSS. Reflecting the current state in Singapore, the majority of PSS who responded were working in the psychiatric institutional setting.

A summary of the themes identified is presented in Fig. 1. In terms of attitudes, participants highlighted the importance of a supportive and inclusive workplace environment for peer support implementation. Benefits of peer support implementation identified include leveraging on the power of the lived experience and promoting recovery-oriented contributions. To facilitate the implementation of peer support, participants highlighted challenges and related strategies in promoting the acceptance of PSS, their professional identity and growth, and the need for targeted support.

3.1 Demographics

The demographics of the respondents are summarised in Table 1. The demographics of the individual participants are located in the Appendix. The most common professional background of the respondents were psychologists (25.4%) and occupational therapists (OT) (23.7%) and counsellors (11.9%). Most respondents worked full-time (86.4%) and had an average of 6.81 years of work experience with clients with mental health condition(s). More than half of the respondents reported to be in a managerial role (junior level—32.2%, mid-level—16.9%, top level—5.1%). Almost half of the respondents worked in the community setting (general organisation—8.5%, mental health-based organisation—16.9%, private practice—20.3%). There was a greater proportion of respondents who did not have PSS at their workplace (55.9%) compared to those who had (44.1%). For respondents with PSS at their workplace, the average duration of experience of working with PSS was 3.63 years and close to half of those respondents had less than 4 PSS at their workplace.

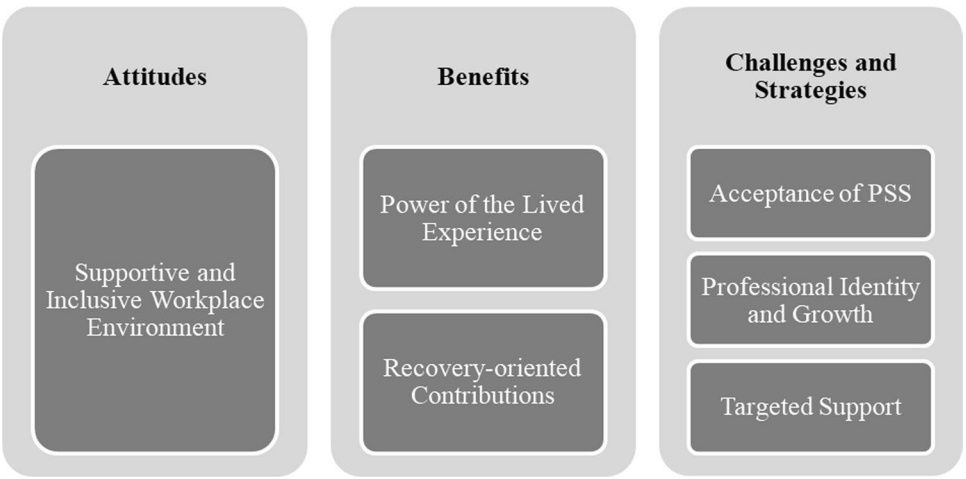

Fig. 1 Summary of themes: considerations in peer support implementation

Table 1 Demographics of study sample

Characteristics	n = 59	%	Range (minimum to maximum)	*M*	*SD*
Age, in years			38 (20–58)	34.83	8.13
Sex					
Female	47	79.7			
Male	12	20.3			
Ethnic groups					
Chinese	52	88.1			
Indian	4	6.8			
Malay	3	5.1			
Profession					
Case worker	3	5.1			
Counsellor	7	11.9			
Nurse	2	3.4			
Occupational therapist	14	23.7			
Peer support specialist	5	8.5			
Programme executive	4	6.8			
Psychiatrist	2	3.4			
Psychologist	15	25.4			
Social worker	4	6.8			
Others	3	5.1			
Work arrangement					
Full-time	51	86.4			
Part-time	6	10.2			
Others	2	3.4			
Managerial role					
Not applicable—not in a managerial role	27	45.8			
Junior level (e.g. oversees decision making for the team and day-to-day operations)	19	32.2			
Mid level (e.g. oversees decision making for the department)	10	16.9			
Top level (e.g. oversees decision making for the organisation / multiple departments)	3	5.1			
Work setting					
Community organisation, General	5	8.5			
Community organisation, Mental health-based	10	16.9			
Hospital, general	17	28.8			
Hospital, psychiatric	14	23.7			
Private practice	12	20.3			
Others	1	1.7			
Presence of PSS at current workplace					
Yes	26	44.1			
No	33	55.9			
1–3 PSS	15	25.4			
4–6 PSS	2	3.39			
7–9 PSS	0	0			
10–12 PSS	2	3.39			
13–15 PSS	3	5.08			
Unsure of exact number	4	6.78			
Duration of work experience, in years					
With PSS			22.5 (0.5–23)	3.63	3.61
Without PSS			22.5 (0.5–23)	6.81	6.08

Table 1 (continued)

PSS peer support specialists

3.2 Attitudes towards peer support

3.2.1 Quantitative analysis

Table 2 summarises the responses relating to the attitudes of respondents towards PSS. In general, respondents appeared to adopt a positive attitude towards PSS in their workplace. Relating to the acceptance of PSS as a mental healthcare professional, most respondents responded yes (72.9%), approximately one-fifth of respondents responded maybe (22.0%), and a small number responded no (5.1%). As for the willingness to work with a PSS, an even larger proportion of respondents answered yes (89.8%), with a smaller proportion answering maybe (8.47%) or no (1.69%). Participants who are currently working with PSS are significantly having higher acceptance, $t(57) = 2.066$; $p = 0.043$, and higher willingness, $t(57) = 2.228$; $p = 0.030$, to work with a PSS as their colleagues. A One-Way ANOVA was conducted to determine whether participants' willingness to work with PSS and to accept PSS (categorized as 'yes', 'maybe', or 'no') differed significantly based on age and duration of work experience. Neither age (acceptance: $F(2) = 0.689$, $p = 0.506$; willingness: $F(2) = 0.738$, $p = 0.483$) nor duration of work experience (acceptance: $F(2) = 1.314$, $p = 0.277$; willingness: $F(2) = 0.968$, $p = 0.386$) was a meaningful variable in determining the acceptance of PSS as a mental healthcare professional or willingness to work with PSS. Further breakdown in terms of the respondents' exposure to peer support services at the workplace and duration of work experience are summarised in Tables 3 and 4. In terms of qualitative responses, there was no variation in the themes identified amongst respondents who responded differently to both questions.

3.2.2 Qualitative analysis

Supportive and inclusive workplace environment Respondents with PSS at their workplace generally reported a supportive workplace environment which seems to imply a positive attitude taken towards peer support by both the management and colleagues alike. In terms of organisational support, respondents from community mental health-based organisations shared about the presence of workplace guidelines and staff education that promote clarity and confidence in the role of the PSS, alongside the provision of supervision, training opportunities and workplace accommodations.

Table 2 Attitudes towards PSS

	Yes		Maybe		No	
	n	%	*n*	%	*n*	%
Would you accept PSS as a mental healthcare profession?	43	72.9	13	22	3	5.1
Would you be willing to work with a PSS as your colleague?	53	89.8	5	8.47	1	1.69

Table 3 Acceptance towards PSS compared with work experience

Would you accept PSS as a mental healthcare profession?	Are there peer support services at your workplace?							
	Yes				No			
	n	Duration of work experience, in years			*n*	Duration of work experience, in years		
		Range (minimum to maximum)	M	SD		Range (minimum to maximum)	*M*	*SD*
Yes	23	22.5 (0.5–23)	3.8	3.7	20	17.5 (0.5–18)	6.36	5.86
Maybe	2	2 (5–7)	3.5	2.1	11	22.5 (0.5–23)	8.53	7.32
No	1	0 (7–7)	0	0	2	2 (4–6)	5.67	1.53

Table 4 Willingness to work with PSS compared with work experience

Would you be willing to work with a PSS as your colleague?	Are there peer support services at your workplace?							
	Yes				No			
	n	Duration of work experience, in years			*n*	Duration of work experience, in years		
		Range (minimum to maximum)	M	SD		Range (minimum to maximum)	M	SD
Yes	26	22.5 (0.5–23)	4.02	3.94	27	22.5 (0.5–23)	6.69	5.83
Maybe	0	NA	–	–	5	22.5 (0.5–23)	9.3	8.7
No	0	NA	–	–	1	0 (0.5–0.5)	0.5	0

"Conduct presentations and sharings on the importance of PSS. Additionally, sharing examples of past implementation along with its results, to support the efficacy of PSS. "—R54
"they get to take additional time off if they need to cope with some symptoms returning"—R3

Furthermore, respondents reported the presence of opportunities for interprofessional collaborations with PSS, including workgroups and multi-disciplinary team meetings.

"To ensure that PSS have a role to play in MDT and allow them to integrate to the team"—R26
"work group of PSS … encourage discussion and ideas exchange, and promote the understand[-ing] of PSS roles among other colleagues/clients"—R7

In addition to professional interactions, respondents perceived informal interactions with PSS as being helpful to promote the integration of PSS in the workplace, such as having *"social activity, peer bonding"* (R42) and *"leisure interaction after work"*(R27).

3.3 Perceived benefits of peer support

3.3.1 Quantitative analysis

The perceptions of the benefits of peer support, corresponding role of PSS and whether respondents perceived there should be PSS in their workplace are summarised in Tables 3, 4 and 5 respectively.

In general, respondents perceived peer support to be beneficial in various aspects (Table 5). More than half of the respondents identified the benefits of peer support services to include providing hope (94.9%), reaching out to clients (88.1%), empowerment of clients (86.4%) and providing employment opportunities for clients as PSS (64.4%). Some respondents perceived peer support to be beneficial through the reduction of workload for the healthcare team (45.8%) and the improvement of clients' symptoms (33.9%). Relating to the role of a PSS (Table 6), the top five most common responses were the sharing of personal experiences with clients (91.5%), engagement in advocacy for mental health (88.1%), provision of emotional support for clients (86.4%), facilitating community re-integration (86.4%) and engagement in outreach efforts (78.0%).

Table 5 Perceptions relating to the benefits of having peer support services

What do you think are the benefits of having peer support services?	*n*	%
Provide clients with hope	56	94.9
Reach out to clients, especially those with limited social support	52	88.1
Empower clients	51	86.4
Provide employment opportunity for clients as PSS	38	64.4
Reduce workload for the healthcare team	27	45.8
Improve clients' symptoms	20	33.9
Others	3	5.1

Table 6 Perceptions relating to the role of a PSS

What do you think the role of a PSS should entail?	*n*	%
Share personal experiences with clients	54	91.5
Engage in advocacy for mental health	52	88.1
Provide emotional support to clients	51	86.4
Help clients reintegrate in the community	51	86.4
Engage in outreach efforts	46	78.0
Help clients deal with day-to-day challenges	41	69.5
Help clients to widen their social network	36	61.0
Develop recovery plans for clients	31	52.5
Monitor medication compliance of clients	23	39.0
Provide company for clients	18	30.5
Others	6	10.2

Most respondents perceived that there should be PSS where they worked (64.4%), with some ambivalent (30.5%) and a minority who did not (5.08%). Respondents who answered yes were more likely to have PSS at their workplace, and vice versa for respondents who answered no or maybe (Table 7). Age is not a meaningful variable in determining whether they perceived the need for a PSS at their workplace ($F(2) = 0.169$, $p = 0.845$), likewise for the duration of work experience with clients with mental health condition ($F(2) = 0.049$, $p = 0.952$).

3.3.2 Qualitative analysis

For the perceived benefits of peer support, the two main themes extracted were the power of the lived experience and recovery-oriented contributions. Respondents recognised the widespread benefits and the unique recovery-oriented nature of the work that PSS performs in the utilisation of their lived experience.

Power of the lived experience In general, respondents emphasised on how the lived experience was a key focus of the role of PSS, and how it provided PSS with a leverage in the support provided to clients. PSS were perceived to be more sensitive to the needs of clients and could therefore advocate for clients in the healthcare team, while providing the client with practical, emotional and social support. Furthermore, respondents highlighted that clients were likely to be more receptive to the support provided by PSS given their lived experience.

" I believe in sharing lived-experience.... can generally help improve the relationship between the team and client as well as being able to find out what are the holistic needs of a client... Let's say someone shares about her condition and does not feel comfortable talking to the other healthcare professionals. That's when a PSS can help to be that bridge or gap in between - to link the team with the client. "—R32

"Clients may be more receptive when PSS uses their own lived experiences to help clients integrate back to community and develop plans and it helps with rapport building . there are many roles that PSS can fulfil that we (have) yet to explore,..."—R21

"Clients will likely be more trusting and be more accepting of professional recommendations when PSS share about their lived experiences and benefits of various interventions."—R22

Table 7 Perceptions relating to the potential of having PSS at current workplace

Do you think there should be PSS where you work?	PSS presence at work		Duration of work experience, in years			
			With PSS		Without PSS	
	Yes	No	*M*	*SD*	*M*	*SD*
Yes	24	14	4.31	3.63	6.87	6.25
Maybe	2	16	0	0	6.53	6.30
No	0	3	–	–	7.67	2.89

Other respondents highlighted how the lived experience could be a powerful tool in the empowerment of clients and in instilling hope that change is possible. PSS could serve as role models in the use of practical strategies to navigate daily life with a mental health condition.

"PSS can help to instill hope in persons with mental health conditions that recovery and a fruitful life is very possible... also help to increase their social circle and improve social skills/life (skills) that many persons with mental health conditions struggle with."—R28
"Their experience gives clients hope and practical steps for recovery."—R8

Overall, the role of a PSS was considered to have benefits on the wider systemic level, for instance through involvement in mental health advocacy, and through compensating for weaknesses of a medical-oriented system.

"With PSS in outreach efforts, it also serves to educate the public on mental health and also reduce the stigma especially in Singapore's culture."—R28
"PSS can help augment areas deficient in the current hospital centric system."—R39

Recovery-oriented contributions In general, respondents valued the role of PSS in promoting a recovery-oriented focus using their lived experience and perceived PSS to be a valuable addition to the healthcare team.

"PSS can support persons with mental health conditions in their recovery journey, and having lived and living experience, they can provide a voice to advocate for mental health services to be relevant to the needs of service users."—R59
"As experts of the condition, PSS can support in many different aspects of the recovery plans of clients, e.g. social support, emotional support, etc"—R4

Some respondents expressed strongly about the differentiation of the role of PSS from the roles of other healthcare professionals, which were perceived to be more oriented with a medical model.

"The most valuable contributions from peer supporters would come from their lived experiences, managing the conditions and day-to-day struggles. As for the treatment plan and medication compliance that should still be managed by professionals with training and experience in these aspects."—R11

3.4 Perceived challenges and potential strategies

3.4.1 Quantitative analysis

The perceptions of the challenges of peer support, potential strategies and specifically, who to provide supervision for PSS are summarised in Tables 8, 9, 10 respectively.

Relating to challenges in the implementation of peer support services (Table 8), the top 5 most common responses were poor understanding of the role of PSS by colleagues (93.2%), followed by a lack of supervision for PSS (78.0%), limited professional development (72.9%), poor understanding of the role of PSS by clients (69.5%) and then a lack of

Table 8 Perceptions relating to the challenges of implementation of peer support services

What are some challenges that you think could arise with the implementation of peer support services?	*n*	%
Poor understanding of PSS role by colleagues	55	93.2
Lack of supervision for PSS	46	78.0
Limited professional development for PSS	43	72.9
Poor understanding of PSS role by clients	41	69.5
Lack of emotional support for PSS	36	61.0
Lack of trust in PSS to perform duties	30	50.8
Reduced receptivity by colleagues	26	44.1
Poor relationship with colleagues	18	30.5
Reduced receptivity by clients	14	23.7
Poor relationship with clients	7	11.9
Others	2	3.4

Table 9 Perceptions relating to the potential strategies to address challenges in peer support implementation

What are some strategies that you believe could help with addressing the above challenges and /or improve the likelihood of success of peer support services?	*n*	*%*
Supervision	53	89.8
Training	52	88.1
Job description for PSS role	46	78.0
Match PSS to specific departments that might suit their experience	45	76.3
Standardised protocol for implementation of peer support services	43	72.9
Opportunities for PSS to work with other team members	42	71.2
Match PSS to specific clients that might suit their interpersonal characteristics	37	62.7
Others	5	8.5

Table 10 Perceptions relating to the provision of supervision for PSS

Who do you think should provide supervision to PSS?	*n*	*%*
Healthcare professionals	52	88.1
Fellow PSS	34	57.6
Others	4	6.8
Caregivers	3	5.1

emotional support for PSS (61.0%). The top five most common responses relating to potential strategies (Table 9) included supervision (89.8%), training (88.1%), a job description for the role of PSS (78.0%), matching of PSS to specific departments in accordance with their experience (76.3%) and then a standardised protocol for the implementation of peer support services (72.9%). Pertaining to the provision of supervision (Table 10), respondents most indicated healthcare professionals (88.1%), followed by PSS (57.6%) and caregivers (5.1%).

3.4.2 Qualitative analysis

Respondents recognised factors that contributed to a culture which compromises the *Acceptance of PSS,* organisational barriers that hinder the *Professional Identity and Growth* of PSS,as well as the role-specific challenges of PSS that require *Targeted Support*. Each theme is further discussed in relation to its associated challenges, then the role which the organisation could play in addressing those challenges.

Acceptance of PSS The lack of understanding of the role of PSS, along with the lack of training, were identified as major challenges that influenced the acceptance of the role of PSS by both clients and colleagues. Respondents cited possible reasons such as the lack of trust from clients and colleagues in the capabilities of PSS, reduced understanding in the value that PSS could bring with the work they do, as well as PSS' reduced confidence in performing their role.

"The lack of understanding / awareness of the role of PSS as well as training/ development can cause doubts about PSS' ability to perform duties. However, if PSS are adequately and properly trained, it should help in both colleagues and clients being more open and receptive to working with them."—R5
"PSS may lack confidence in their role as they do not have adequate training to do their work well"—R59

Stigma and unfavourable attitudes associated with the lack of acceptance of PSS may influence the support provided to PSS for professional development and performance of job tasks, for instance the lack of supervision and workplace accommodations.

"Stigma attached to this concept extends to both clients and professionals, which in turn would also limit PSS opportunities for supervision and professional development"—R54
"Depends again on setting and willingness of PSS and staff to accommodate"—R40

To promote a shift in attitudes, initiatives to raise awareness of the role of PSS, such as staff education and the development of structured guidelines, were considered crucial. In addition, opportunities for professional collaboration with other healthcare professionals could allow a better understanding of the role of PSS within the multidisciplinary team. It was perceived that the organisation could role-model the acceptance of PSS by training and providing

opportunities for PSS to contribute at various levels. Furthermore, a cultural shift towards recovery-oriented practice was thought to be helpful in facilitating the acceptance of PSS.

"The organisation needs to move beyond token acceptance of peer support work to integrating it at various levels and to value its contribution as an essential part of mental health services."—R59
"…my department introduced PSS in steps by slowly including a few users in some teams…as well as adopting complementary practices such as recovery language and other recovery-oriented practices. "—R38

Professional identity and growth Limited workplace resources and guidelines to guide the implementation of peer support was highlighted to compromise the professional development of PSS, which further perpetuates a lack of understanding of role definition and boundaries for both PSS and colleagues. This could compromise PSS' development of professional identity as they remain unclear about their role, while not receiving the relevant support or training they require.

"I feel that there is a lack of structure for PSS and it seems like they have to define their role although they may not be trained to."—R25

The lack of adherence to role boundaries was identified by PSS as a common experience, where PSS could be assigned to work according to the needs of the organisation rather than within their intended scope of practice. One PSS highlighted an experience in having to attend to clients in relation to manpower constraints.

"...the team is too busy with their job roles & client's needs/daily routine as there is a shortage of manpower. I was once told to help to take care of a client because she was causing too much noise/trouble in the ward and I have heard from a colleague of mine, that he was once told to "pacify" a client."—R32

Targeted support A common challenge highlighted by the respondents was the perceived need for intensive support, in particular in relation to PSS' mental health needs. Training and supervision were highlighted to be crucial in ensuring the safety of PSS and the clients, especially in consideration of PSS having to negotiate personal needs and professional duties. Furthermore, PSS might have to learn to negotiate relationship boundaries with their colleagues and clients.

"PSS may also themselves go through relapses, and balancing personal needs and a professional identity can be challenging."—R39
"Also, due to their relatable experiences they may have transference or countertransference issues and may be more inclined to cross boundaries in a bid to help more."—R6

Some respondents highlighted the need for having a PSS, or a healthcare professional, with the relevant training and experience, to provide supervision in meeting the specific learning needs of PSS. In addition, training could be targeted according to the PSS' present abilities and interests to provide a just-right challenge. To further tailor the training, PSS could be facilitated to apply their lived experience to the particular clientele group they are working with.

"Would be great if PSS could have their own supervision by their fellow senior PSS. Because I'm sure they can understand the challenges better"—R3
"I think the experience of a PSS may not be applicable to all clients and they may benefit from training to generalise their experience or be assigned to clients who are more likely to benefit"—R25

Collaboration with PSS was identified to be a key factor in ensuring the provision of appropriate, targeted support.

"Through working together in a collaborative effort, organisations will have a deeper understanding of PSS and how to provide a more holistic support for PSS to better serve the targeted client."—R58

4 Discussion

This study is the first to explore the attitudes and perceptions of mental health workers in Singapore relating to the benefits and challenges of peer support implementation. Overall, the findings point towards the importance of the role of the organisation in providing a supportive workplace environment to support the implementation of peer support services. In particular, an organisational shift towards a recovery orientation has been highlighted to be an essential foundation for the integration of PSS in the workplace [15, 25].

The findings in the present study showed that mental health workers were generally willing to accept PSS as a healthcare profession (72.9%) and to work with PSS (89.8%). Amongst respondents who did not express willingness to accept PSS as a healthcare profession or to work with PSS as their colleague, they were more likely to not have PSS at their present workplace. Previous studies have suggested that healthcare workers with prior experiences in working with people with mental health conditions and PSS were less likely to hold stigmatising attitudes [17, 26]. It has been proposed that exposure to interactions with people with mental health conditions may provide experiences that challenge any existing misconceptions or concerns, which could promote greater acceptance amongst mental health workers towards PSS [27]. For example, staff educational sessions performed by PSS relating to recovery-oriented care principles and the use of lived experience in their work could promote opportunities for interaction and an understanding of the value of peer work, thereby building trust in the professional capacity of PSS [9, 10].

Consistent with previous findings, respondents highlighted challenges relating to the lack of adherence to clear role boundaries and a lack of understanding of the role of PSS [6, 9, 10]. Accordingly, the findings of the present study seemed to suggest a lack of understanding of the role of PSS with a split in opinions relating to the tasks that PSS could perform. In general, respondents recognised the centrality of the use of the lived experience in the work of PSS and its benefits in facilitating both clinical and recovery-oriented outcomes, which are congruent with the literature [2, 28]. However, some respondents were firm on PSS not having job tasks that overlap with that of other healthcare professionals, expressing concerns relating to a lack of expertise or compromising the role authenticity of PSS. Others expressed that PSS could contribute to clinical work such as suicide risk assessments and the development of recovery plans, so long they were appropriately trained. Indeed, there exists the risk of compromising the role authenticity of PSS in involvement in tasks that do not tap onto their expertise, which could ultimately lead to dissatisfaction and failure of integration of the new role of PSS in the organisation [2]. At the same time, it is notable that recent studies have supported the expansion of the role of PSS to further tap into the potential of the work of PSS in utilising their lived experience, which is also believed to help with improving attitudes of co-workers and an understanding of their role [9, 29].

Specific to the challenge in the maintenance of role boundaries, some respondents highlighted the impact of organisational priorities (e.g. ongoing operational demands in an acute setting), which is consistent with literature findings of how organisational structure and demands often overrode the implementation of recovery-oriented care in different mental health settings [30]. This might be particularly true in the context of Singapore where the biomedical system remains entrenched in its mental healthcare systems, which would likely pose resistance towards the implementation of peer support work in the face of increasing workload and lack of incentive for change [9, 10].

Recognising the importance of organisational influence, respondents highlighted the importance of organisational commitment towards the cultivation of a recovery-oriented workplace culture. Non-work interactions with PSS (e.g. "leisure interactions after work") were perceived as a helpful strategy in contributing to the sustainability of existing peer support services. A workplace environment which emphasises on the health and well-being of staff exemplifies the values of a recovery-oriented organisational culture [31]. The organisational role in promoting PSS' accessibility to various forms of social support have been crucial in upholding the values of recovery-oriented practice for the implementation of peer support services [15, 32]. Furthermore, as the nature of peer support work is aligned with recovery principles, respondents recognised how the implementation of peer support work could facilitate a shift in towards recovery-oriented care, potentially reducing the power imbalance inherent in a medically-oriented system [15, 33]. This could further enhance the success of peer support services, through promoting collaboration with PSS to ensure that strategies and workplace accommodations are tailored to PSS' needs [11].

In agreement with recommendations from the literature, the current findings espoused the benefits of having structured guidelines for the implementation of peer support services and related training [6, 7]. Not only could the guidelines signify an organisational commitment to upholding recovery-oriented principles by protecting the role boundaries of PSS, but it could also help with improving an understanding of the role and confidence in the professional capacity of PSS [6, 7, 15]. In addition, the development of policies and mission statements that highlight the value of recovery-oriented practices and the contributions of PSS could demonstrate the organisation's commitment [15].

Finally, an organisational commitment to recovery-oriented care cannot preclude the commitment towards the professional development of PSS, which respondents across all settings have commonly identified to be lacking and to contribute towards the attrition of PSS. Specifically, supervision was the most common strategy highlighted to promote the success in peer support implementation (89.8%), with the consensus that supervision could be provided by healthcare professionals (88.1%) and PSS (57.6%). Although previous studies have supported the provision of supervision from PSS, respondents in the current study expressed the relative importance of having the supervisor appropriately equipped to support PSS in role-specific challenges [13, 15, 25]. Respondents highlighted the need for the supervisor to be trained

in recovery-oriented practices and be well-versed with the role of PSS so that guidance could be provided relating to the navigation of their mental health needs, dual relationships, and transferences during interactions with clients. For instance, supervisors could provide guidance on setting boundaries in terms of what aspects of their lived experience to share, which is an important form of self-care for PSS in performing their role [34].

4.1 Limitations

The limitations of the present study included response bias. It is likely respondents, especially those who elaborated more to open-ended questions, may have a stronger view than non-respondents. Furthermore, there might be response bias relating to social desirability, especially for respondents who included their contact details for potential clarification. We acknowledge the potential bias in including the PSS in the study. However, given that there were only 5 respondents (8.5%) who were PSS, the impact on the results were likely limited. The themes highlighted were also backed up by responses from a range of healthcare professionals beyond PSS.

The use of a survey limited the clarification of details and capture of nuances that could have been mitigated with a face-to-face interview. Although the researcher attempted to clarify details by contacting some respondents, most respondents who were contacted did not reply. Finally, the sample may not sufficiently reflect the mental health workers population in Singapore with its greater proportion of OT and psychologists. Nonetheless, the sample included mental health workers from varying professional backgrounds and settings.

5 Implications

Policymakers could consider funding initiatives to provide the resources required for supporting the professional development of PSS across mental healthcare settings in Singapore. For organisations new to peer support services, such funding could further act as an incentive for a trial of the implementation of peer support services, which provides organisations and mental health workers the exposure to witness its benefits. Setting up regulatory standards for PSS may enhance clarity of the role definition of PSS and help to divert appropriate resources towards professional development, which would contribute to the sustainability of peer support services. On the organisational level, measures to inculcate recovery-oriented values in healthcare professionals and to enhance understanding of the role of PSS may include training programmes that are delivered by PSS, as well as supervision targeted at enhancing the practice of recovery-oriented care.

6 Future research

Further studies could utilise an interview methodology to investigate how organisational considerations for peer support implementation may differ in the respective mental health settings, such as the differences between larger institutional settings and smaller community organisations or private practices. Studies in other countries could clarify the cultural considerations relevant to the implementation of peer support services in the respective countries.

7 Conclusion

The findings of the current study contribute to an enhanced understanding of the perspectives of mental health workers relating to the factors influencing peer support implementation in Singapore. The cultivation of a recovery-oriented culture in mental healthcare services is crucial towards the provision of a workplace environment which is conducive for the work of PSS. Although there is a general trend of acceptance amongst mental health workers towards the role of PSS, policymakers and organisations need to step up their efforts to expand on this trend for the sustained growth of the profession of PSS.

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Declarations

Competing interests The authors declare no competing interests.

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