How to implement peer-based mental health services for foreign domestic workers in Singapore?

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**Abstract**

Foreign domestic workers (FDWs) in Singapore are at particular risk for developing mental health problems, whereby Filipino FDWs are deemed to be especially vulnerable towards developing them. Among the identified specific risk factors for developing mental health problems amongst FDWs are homesickness, a lack of social support, communication-related barriers and employer restrictions and abuse (HOME, 2015). Despite this vulnerability, FDWs face substantial barriers to seeking help when experiencing mental health problems. This is due to their marginalized status in Singapore, an inadequate legal protection with a resulting fear of deportation due to ill health (including mental illness) and the lack of available formal psychosocial support services for migrants (Huang & Yeoh, 2003; Ueno, 2009). In addressing FDWs’ susceptibility to mental health problems and the lack of respective support services for migrants in Singapore, the Humanitarian Organization for Migration Economics, a migrants’ rights non-governmental organization in Singapore, aims to develop tailored mental health services for FDWs. In doing so, FDWs’ desired methods of receiving help are taken into account - empirical evidence suggests that FDWs’ preference for seeking mental health support from informal sources (e.g. friends and family) rather than formal ones (e.g. a mental health professional) and receiving face-to-face mental health support from a trained fellow FDW (HOME, 2015).

We present and discuss the results of a concurrent mixed-method evaluation of a pilot four-week peer-based mental health paraprofessional training program focused on Cognitive-Behavioural Therapy (CBT) for Filipina FDWs (Wong, 2016; Wong et al., 2017) that was delivered face-to-face in English. A self-report assessment measure was developed to evaluate participants’ perspectives of the training. Questions covered the participants’ assessment of the training program and preferred modes of the implementation of a permanent peer counseling service by HOME. Results from 37 participants of the training program indicated a high satisfaction with the program. Reported challenges included difficulties in understanding the training material and a perception of cognitive overload. Moreover, eight out of ten participants were willing to attend further training and more than seven out of ten agreed to be supervised by a qualified mental health professional. As to the mode of a future service, 73% of participants preferred providing peer counseling in a mixture of Tagalog and English. 75% favored delivering the service face-to-face as opposed to using ICT.

The presented data overall suggests that there is strong interest in peer-based mental health support services by the target group and further corroborates the documented preference for trained peer support. Results further underline the feasibility of implementing this training program as part of a peer-based mental health service within a proposed broader stepped-care mental health service model for FDWs to be delivered by HOME in response to a service gap. We conclude that peer-based mental health programs may form a useful first-line mode of treatment and a means to improve accessibility to mental health care for FDWs. Peer-support approaches not only may provide an opportunity to mitigate mental health problems but also represent a means of empowerment for this marginalized group by giving them the capacity to access support within their community. Nonetheless, further challenges to capacity-building in service provision for FDWs exist - for instance, in relation to further streamlining the training curriculum to the target group’s needs and characteristics and manpower needs.

# 1. Introduction

## 1.1 The Humanitarian Organization for Migration Economics (HOME)

The Humanitarian Organization for Migration Economics (HOME), founded in 2004, is a non-governmental organization and registered charity with Institution of a Public Character (IPC) status in Singapore. Dedicated to serving the needs and protecting the rights of the almost one and a half million migrant workers in Singapore, the mission objectives of HOME are to provide welfare services and education (empowerment) for migrants in Singapore and to develop applied research on the socioeconomics of migration in Singapore and the countries of origin to inform advocacy (see for more details, HOME, 2017).

Each year, approximately 3,000 migrant workers receive assistance from HOME. Approximately 60% of those assisted by HOME are FDWs. Through its day-to-day interactions with the FDW community, HOME has clear insights into the challenges faced by FDWs, as well as the support and services that they require.

## 1.2 Foreign domestic work in Singapore

Singapore has with about 36% of its population, one of the largest proportions of foreign-born workers in the world (Rubdy & McKay, 2013). 17% of the total foreign working manpower in Singapore comprises foreign domestic workers (FDWs) and their numbers are projected to increase (Ministry of Manpower, 2016). The hiring of live-in FDWs is deemed necessary for many households in order to manage domestic demands (Wong, 1996) with about one in three households employing them in Singapore (HOME, 2017). The documented 237,100 FDWs in Singapore are predominantly female and primarily come from the neighbouring developing countries of Philippines, Indonesia, Myanmar, India and Sri Lanka, with the majority from the first two countries (HOME, 2015).

However, FDWs in Singapore face inadequate legal protection and unregulated labour conditions (for a comprehensive review see HOME, 2015; 2017) compared to other foreign workers and local employees. They are only allowed to work for a single employer (to whom their work permit is tied to). Employers therefore have the unilateral power to end an employment and to repatriate the FDW without reason or to reject (or approve) a worker’s request to transfer employers. Employers are also at liberty to determine the number of hours of rest, work hours a day and wages. Given that most FDWs have come to Singapore to work for financial reasons (e.g. debts back home), reporting legal violations to authorities is often not in the workers’ interests as they could lose their jobs. Overall, the above policies foster power imbalance, and structural dependency on employers.

## 1.3 Vulnerability for ill mental health

The lack of sufficient laws and policies governing the living and work conditions of FDWs leave them open to exploitative practices, and ultimately a “structurally hostile work environment” (Ueno, 2009, p. 500). FDWs also face inadequate medical insurance coverage especially for serious medical conditions that require major medical procedures and extended hospital stays (HOME, 2017). Furthermore, the domestic nature of FDWs’ jobs is often ambiguous as working hours are undefined and household tasks can be varied and at the discretion of their employer. FDWs may therefore have to take up a wide range of responsibilities from basic housekeeping to caring for individuals with specific needs (e.g. children or the elderly). Furthermore, the mandatory live-in nature of the job poses difficulties for FDWs to have sufficient opportunities to socialize with others outside to develop a social support network. These could leave FDWs open to being overworked, with inadequate rest and time to develop social support systems or to engage in recreational pursuits. Taken together, the combination of migration stress (due to financial and familial stress in their countries of origin), and the structural constraints they face in the destination country from the inadequate legal protection and possible less than ideal working and living conditions can put FDWs in a stressful position.

Most FDWs further face other personal circumstances that leave them open to experiencing psychological distress. Many FDWs are also mothers (54%; HOME, 2015) who have had to leave their families behind and who have taken on most of the responsibility in financially providing for their families back in their countries of origin. Hence the pressure of keeping their jobs as well as facing homesickness can concomitantly increase FDWs’ experiencing isolation, stress and overall poor psychological adjustment (Bagley, Madrid, & Bolitho, 1997; Nakonz & Shik, 2009).

Overall, socio-cultural-legal vulnerabilities (i.e. systemic conditions) evidently can themselves predispose FDWs to experience psychological distress during their time in Singapore. They can also contribute to perceived (and actual) high barriers for help seeking and perpetuate a sense of helplessness when faced with mental distress.

## 1.4 Empirical evidence on mental health of FDWs in Singapore

HOME conducted the first large-scale mixed-method research (*N* = 670) on employed FDWs’ mental health and related factors (HOME, 2015), using a self-administered questionnaire. This study aimed to (a) assess working and living conditions of FDWs in Singapore, (b) establish the prevalence of mental health problems among FDWs in Singapore, and (c) identify relationships between mental well-being and employment conditions of FDWs in Singapore. A detailed overview on the study’s methodology and findings can be found at HOME (2015).

Overall, there was a **high level of mental distress** foundin the FDW population in Singapore, with more than one out of five participants (or 24%) classified as having poor mental health (HOME, 2015). In comparison to worldwide and local statistics, this number indicated that FDWs were more than twice at risk of developing mental health problems. The most severe psychological symptoms highlighted were “psychoticism”, followed by “depression”, and “interpersonal sensitivity”. The level of mental distress related to “psychotic” symptoms suggests that professional treatment is required. In summary, the protective and risk factors for all FDWs’ mental health (specific factors relevant sub-sample: i.e. Filipino, Indonesian, Burmese can be accessed from HOME, 2015) is provided in Table 1.

|  |  |  |
| --- | --- | --- |
|  | **Protective factors:** | **Risk factors:** |
| *FDWs’ individual attributes and behaviours* | * Perceived privacy in the employer’s house
* **A perceived integration into the employer’s family**
* A perceived treatment with dignity by the employer or employer’s family
* Satisfaction with the employer or employer’s family and with working in Singapore
 | * Debt
* Physical health problems
* Family concerns
* Homesickness
 |
| *Social circumstances* | * Sufficient daily sleeping hours
* An own room as sleeping accommodation
* Nutritional attention and provision of sufficient daily proper meals by the employer
* Adequate medical and dental attention by the employer
* Frequent contact to friends/family outside Singapore or in home country
 | * **Language-related communication barriers with the employer or employer’s family**
* Invasions of privacy by the employer or employer’s family
* Restrictions on communication by the employer or employer’s family
* **Verbal, physical,** moral and sexual abuse by the employer or employer’s family
 |

Note. Effect sizes: small, **medium** (based on bivariate correlation analysis)

Table 1: Protective and risk factors for all FDWs’ (regardless of nationality) mental health (HOME, 2015)

Based on the HOME (2015) study, 43% of the surveyed FDWs highlighted that they preferred to seek help from their peers rather than from professionals such as doctors (1.6%) when facing emotional problems. An additional qualitative analysis of participants’ coping mechanisms, captured via responses to the question of “What do you think is the best way to help the emotional well-being of domestic workers in Singapore?” revealed various internal and external factors (HOME, 2015). At the internal level, they believed that open communication with their employers, having strong social support and adapting to Singapore’s culture and knowing its laws were helpful. At the external level (environment), participants highlighted that having employers who trusted them, a government that played a larger role in regulating and enforcing decent working and living conditions and the availability of civil society organizations that provided formal support would be helpful for them (HOME, 2015).

Overall, the empirical evidence indicates that FDWs are particularly vulnerable as a population to experience ill mental health and that migration stressors (e.g. leaving families back home, debt) and the conditions they find themselves working in (post-migration) can precipitate and perpetuate poor psychological health.

## 1.5 Filling the mental health service gap for migrants in Singapore: The potential of peer-based mental health services

Evidently, based on the data above, there are multiple levels of intervention and support that can be provided to FDWs to support their well-being:

Figure 1: Multi-systems approach towards improving FDWs’ well-being (diagram adapted from HOME, 2015)

Strategies on the environmental level often are at the country-level. They include the cultural and social norms operating within Singapore, the existence of policies and methods to reduce inequalities (including exploitative socio-economic practices), and access to support systems such as healthcare. Changes at this level however, usually take a considerable amount of time and coordinated efforts from multiple agencies.

The mental health needs of FDWs are potentially highly specific, owing to the unique psychosocial circumstances they operate in, and are separable to a certain extent, from the larger host population. A comprehensive understanding of specific community mental health needs by healthcare professionals is therefore necessary to provide context specific and culturally sensitive services to the FDWs community.

In the context of addressing the mental health needs of FDWs in Singapore, health care professionals in Singapore would ideally have to be cognizant of these circumstances and utilize culturally-relevant clinical strategies so as to provide the most sensitive assessment and treatment to them. However, and critically, FDWs themselves face huge barriers to seeking help owing to fear and anxiety over possible deportation and/ or lack of knowledge on where or how to seek appropriate help for their needs (HOME, 2015).

In addressing both the lack of mental health professionals who are able to provide culturally sensitive interventions and the perceived barriers to seeking help, the use of peer-based services may particularly be a useful mode of reaching out and empowering the community.

### 1.5.1 Delivery of psychological therapies by paraprofessionals (peers)

In recent years, peer-based interventions have risen in popularity in a variety of institutional and community contexts across the world, and have been used across different age groups for a range of physical health outcomes (e.g. smoking cessation), chronic disease management (e.g. Caroll, Lankin & Cooper, 2007), and mental illness management (e.g. Fors & Jarvis, 1995; Lawn et al., 2007). Within this approach, non-professionals can be briefly trained and supervised and to also collaborate with mental health professionals to enhance preventive efforts and deliver treatment (Kakuma et al., 2011).

Paraprofessionals are often peers belonging to the community of concern who, upon receiving some basic level training from professionals, can provide interventions (Miller, 1999). Within mental health, the term paraprofessional generally refers to persons without formal training in the mental health care, non-experts or lay psychotherapists (Montgomery, Kunik, Wilson, Stanley & Weiss, 2010). While the delivery of psychological therapies has traditionally been through mental health professionals (Moffic, Patterson, Laval & Adams, 1984), the use of paraprofessionals has been relied on in the development of community-based interventions in places (e.g. developing nations) where people have minimal access to professional care (Boothby, 1994). They also often serve as links between professional agencies and the community (Grant, Ernst, Phipps, Streissguth & Gendler, 1996). Other than making the treatments of common psychological disorders (e.g. depressive and anxiety disorders) more accessible to the community (den Boer, Wiersma, Russo & Bosch, 2005), they are cost efficient and empower the target group considerably (Bedell, Cohen & Sullivan, 2000), and there has been some evidence that paraprofessionals can achieve outcomes that are equal to or significantly better than those of professionals (den Boer et al., 2005; Durlak, 1979; Hattie, Sharpley & Rogers, 1984).

Cognitive-Behavioural Therapy (CBT) is one of the most researched psychological treatments (Butler, Chapman, Forman & Beck, 2006). The evidence-base for its efficacy in treating a range of psychological disorders continues to increase, with its use being extended to wider forms of disorders and problems (Beck, 1997; Dobson, 2009; Salkovskis, 1996). CBT is based on the premise that psychological distress is due to negative cognitions, and the modification of unhelpful thinking styles (and consequently behaviours) will alleviate symptoms. In particular, there is substantive evidence for the efficacy of CBT for the treatment of depression (Parker, Roy & Eyers, 2003; Tolin, 2010). Depression specifically is one of the more common mental illnesses, and the leading cause for disability worldwide (World Health Organization, 2017). Particularly in the FDW community in Singapore, depressive symptoms are the second most prevalent (HOME, 2015). In alleviating depressive and anxiety (both often co-occur) symptoms, there is substantial evidence to show that CBT provided by paraprofessionals is as effective as those delivered by professionals in reducing those symptoms (e.g. Bright, Baker & Neimeyer, 1999; Kraus-Schuman et al., 2015; Rahman, Malik, Sikander, Roberts & Creed, 2008).

Although no studies on the use of paraprofessionals in providing mental health services for FDWs have been conducted, given the aforementioned structural and socio-cultural barriers to mental health care for FDWs, and the literature on the use of paraprofessionals (peers) in the delivery of therapy for depression, it would appear feasible to consider the training of FDWs in delivering intervention to individuals in need within the community.

# 3. Pilot study: mental health paraprofessional training for Filipino FDWs

A four-week peer-based mental health paraprofessional training program, focused on the provision of CBT by Filipina FDWs was conducted. The results of a mixed-method evaluation of this pilot training project were used to inform the future implementation of a permanent peer counselling service by HOME.

The training exclusively involved female Filipino domestic workers due to their particular vulnerability in developing depressive and anxiety symptoms (see Section 1.4). Sampling this particular population was also methodologically advantageous and pragmatic as it achieved relative sampling homogeneity (as the FDW population in Singapore speak a variety of native languages) and most Filipino FDWs were sufficiently proficient in the English Language (Lim, 2010; McArthur, 2003).

## 3.1 Study objective and methodology

The overall **aim** of the study was to assess the effectiveness and acceptability of a tailored CBT-based paraprofessional training program for a selected group of Filipino FDWs (Wong, 2016; Wong et al., 2017).

The **training content** was adapted from a CBT paraprofessional training manual originally developed for Burmese refugees in North Carolina, United States of America (Buck, 2015). The adaptation involved (1) a replacement of refugee-specific issues with ones that were more relevant to the FDW community in Singapore, (2) community-relevant examples and homework exercises (Wong, 2016).

40 Filipino FDWs were **recruited** through social media and HOME. They additionally had to meet the following criteria (a) able to travel physically to the training site for four consecutive weeks, (c) literate in English, (d) have had at least nine years of formal education (Wong, 2016). They were randomized into either the intervention (or experimental) group (EG, *n* = 20) or a wait-list control group (WL, *n* = 20).

The program was **administered** in a group format on HOME premises in four weekly, three-hour sessions by two trainee clinical psychologists. The four sessions covered the following topics: (1) introduction, depression and migration stress, (2) depression and abuse, (3) depression and isolation, homesickness, loneliness, and (4) depression and suicide, review (Wong, 2016). Each session consisted of didactic teaching, discussions and role-plays to facilitate the learning of practical CBT delivery skills. Session handouts and homework exercises were also provided to consolidate topical knowledge and skills (Wong, 2016).

The following **measures** were completed by participants prior to the training (baseline T1), one week after completing the training program (T2, post intervention) and two months after the training (T3, follow-up) (see Figure 2 below and refer for further details to Wong, 2016; Wong et al., 2017):

To capturethe **effectiveness of the program**, the following outcome variables were measured:

1. The ***Depression Literacy Questionnaire*** (Griffiths et al., 2004) assesses general knowledge of depression on a 3-point scale (‘true’, ‘false’ or ‘i don't know’).
2. The ***Knowledge of Cognitive Behavioral Therapy Questionnaire*** (adapted from Buck, 2015) assesses the level of knowledge of CBT by responding to nine multiple-choice questions.
3. The ***General Self-Efficacy Scale*** (Schwarzer & Jerusalem, 1995)scale assesses a general sense of perceived self-efficacy on a four-point Likert scale ranging from 1 (‘not at all true’) to 4 (‘exactly true’).
4. The ***Self-confidence in Supporting Individuals with Depression*** (adapted from Wright & Jorm, 2009) assesses the level of confidence in supporting individuals with depression on a scale from 0 (‘no confidence at all’) to 10 (‘very confident’).
5. The ***Attitudes Towards Seeking Professional Psychological Help-Short Form*** (Fischer & Farina, 1995) measures attitudes towards seeking help for psychological problems from professionals on a four4-point Likert scale ranging from 0 (‘disagree’) to 3 (‘agree’).
6. The ***Depression Stigma Scale*** (Griffiths et al., 2006) assesses respondents’ own attitudes towards depression on a five-point Likert scale, ranging from 0 (‘strongly disagree’) to 4 (‘strongly agree’).
7. The ***Depression, Anxiety and Stress scale- 21***(Antony et al., 1998) is a short form of Depression, Anxiety, and Stress Scale-42 (Lovibond & Lovibond, 1995) that measures levels of depression, anxiety and stress on a four-point Likert scale from 0 (‘did not apply to me at all’) to 3 (‘applied to me very much, or most of the time’).

To capture **acceptability** **of the program** (at T2), the following variables were assessed:

1. ***Program attendance***, that is, number of sessions participants attended, and
2. ***Dropout rate.***
3. The ***Client Satisfaction Questionnaire–3*** (Nguyen et al., 1983), is a three-item survey that assesses participants’ level of satisfaction with the program.
4. The ***Participant evaluation of training*** (adapted from Buck, 2015) measured i) reasons for participating in the program, ii) participants’ satisfaction of the training, (iii) their level of understanding of signs and symptoms of depression, (iv) the clarity of the skills taught by the trainers, and (v) the extent to which participants found the training useful and valuable to community members. These were assessed through open-ended and Likert scale questions.
5. ***HOME evaluation survey***. HOME further designed a self-administered mixed-method evaluation questionnaire to capture participants’ perspectives on the future implementation of the training program (this measure is detailed in Section 2.4.3.1)

Randomization to Intervention or Wait-List (WL) group (*n* = 40)

***Randomization***

Allocated to WL group (*n* = 20)

Allocated to intervention group (*n* = 20)

***T1: Baseline***

Completed baseline questionnaire (*n* = 19)

Dropped out (*n* = 1) *(reason: work schedule problem)*

Completed baseline questionnaire (*n* = 20)

Completed same set of questionnaires before start of training and after Intervention Group completed training (*n* = 19)

Dropped out (*n* = 1) *(reason: work schedule problem)*

Training:

- Attended all sessions (*n* = 13)

- Attended 3 sessions (*n* = 6)

Training:

- Attended all sessions (*n* = 13)

- Attended 3 sessions (*n* = 5)

- Attended 2 sessions (*n* = 1)

***Intervention***

Completed post-intervention questionnaires and HOME Evaluation Survey (*n* = 19)

Completed post-intervention questionnaires (*n* = 18)

Did not complete post-intervention questionnaires (*n* = 1) *(reason: repatriated back to Philippines)*

***T2: Post-intervention***

***(1 week after training)***

Completed 2-month follow-up questionnaire (*n* = 15)

Did not complete 2-month follow-up questionnaire (*n* = 4) *(reason: lost to follow-up x1; repatriated back to Philippines x1; not in Singapore x2)*

Completed 2-month follow-up questionnaire (*n* = 17)

Did not complete 2-month follow-up questionnaire (*n* = 2) *(reason: lost to follow-up x1; repatriated back to Philippines x1)*

***T3: Follow-up (2 months after training)***

Figure 2: Research steps and measurement times (adapted from Wong, 2016; p. 44)

It was hypothesizedthat participants who underwent the paraprofessional training (EG) would report significantly

1. greater knowledge of depression,
2. greater knowledge of basic CBT skills,
3. lower stigma towards people with depression,
4. improved attitudes towards seeking professional psychological help,
5. greater self-confidence in supporting individuals with depression, and
6. greater self-efficacy

from (a) pre- (T1) to post-intervention (T2) and pre-intervention (T1) to two-month follow-up (T3), and (b) compared to the wait-list group (CG) participants before intervention.

Statistical analysesinvolved descriptive and inferential statistical procedures, such as chi-square tests, independent and paired-sample t-tests, hierarchical linear multiple regressions and Spearman’s rank-ordered correlations (on a 95% confidence level) to test the hypotheses (for more details, refer to Wong, 2016). Effect-sizes (Cohen’s *d*) were also reported to examine the clinical significance of observed changes over time and (b) within groups (Cohen, 1988), for which values of .02, .05 and .08 represent small, medium and large effects, respectively (Field, 2005).

## 3.2 Results

Statistical analyses revealed that there were no significant differences between the groups on any of the demographic variables or outcome measures (i.e. depression literacy, knowledge of CBT, general self-efficacy, self-confidence in supporting individuals with depression, attitudes towards seeking professional psychological help, levels of depression, stress and anxiety) at baseline (Wong, 2016). The demographic variables also did not predict changes on any of the outcome measures, suggesting there is no potential for co-variation. This therefore allowed for the combination of both the intervention and wait-list groups (i.e. combined sample) for the pre-post-follow-up analysis of the outcome variables (Wong, 2016).

The table below provides an overview of the **sample characteristics** based on demographic variables of the study participants:

Table 2: Sample description (adapted from Wong, 2016, p. 42)

|  |  |  |  |
| --- | --- | --- | --- |
| **Variable**  | **Value**  | **Intervention Group (*n* = 19)** | **WL Group (*n* = 19)** |
| **Age** | Mean (range) | 37.6 (27-50) | 39.6 (32-53) |
| **Marital status**  | Single, never married (%)Married (%)Separated, divorced, widowed (%) | 36.831.631.6 | 602020 |
| **Education** | Completed High School (Secondary) 4 years Completed University  | 78.921.1 | 6535 |
| **Religion** | Roman CatholicChristian | 73.726.3 | 7030 |
| **Time working in Singapore**  | Mean years (range) | 9.3 (3-24) | 9.6 (1-24) |
| **Number of rest days in current job**  | 1/ week and public holidays (%)1/ week (%)2/ month (%)3/ month (%) | 57.936.805.3 | 603055 |

### 3.2.1 Effectiveness of training program

Following training, both groups (i.e. IG and WL group) showed significantly greater depression literacy, CBT knowledge, improved attitudes towards seeking professional psychological help, and lower stigma towards depression (see Wong, 2016 for detailed descriptions of statistical procedures, results and discussion).

***Depression literacy and CBT knowledge***: From baseline (T1) to post-intervention (T2), both groups demonstrated significant **increases** in depression literacy (*t*(36) = 3.00, *p* <. 001, *d* = .09) and CBT knowledge (*t*(36) = 2.63, *p* < .05, *d* = .04).

A significant increase in depression literacy pre to post training (*t*(29) = 5.80, *p* < .001, *d* = .09) and CBT knowledge (*t*(31) = 2.34, *p* < .05, *d* = .04) was also measured long-term at two-month follow-up (T3).

***Attitudes towards seeking professional help for psychological problems and depression stigma***: Both groups further showed significantly **improved** attitudes towards seeking professional help for psychological problems (*t*(36) = 2.53, *p* < .05, *d* = .04).

At two-month follow-up (T3), the significant improvement of attitudes towards seeking professional health for psychological problems (*t*(31) = 2.83, *p* < .01, *d* = .05) compared to the baseline was sustained.

**Depression stigma**: Both groups showed significantly **lower stigma** towards depression (*t*(36) = 3.00, *p* < .01, *d* = .05) from pre-to post-intervention.

Levels of stigma towards depression remained stable from baseline to follow-up, i.e. there were no significant changes.

***General self-efficacy and self-confidence in supporting individuals with depression***: The combined sample indicated – contrary to the hypotheses – a **significantly lower** general self-efficacy (*t*(34) = 3.51, *p* = .001, *d* =.06) from pre-to post-intervention.

However, at two-month follow-up (T3), there were no significant changes in general self-efficacy compared to the baseline measurement. Additionally, a negative correlation between the number of sessions attended and and change in self-confidence (*r* = -.412, *p*<0.5) was identified, indicating that attending more sessions was associated with reduced self-confidence.

In summary, all participants (i.e. not in comparison between the intervention group and wait-list group), demonstrated greater knowledge of depression and basic CBT skills as well as improved attitudes towards seeking professional psychological help and lower stigma towards people with depression (trend observed). However, there was a short-term (T2) decrease in participants’ general self-efficacy, which later stabilized (T3).

### 3.2.2 Acceptability of training program

***Program attendance***: 92% of those allocated to the program completed at least 3 out of four sessions. No significant differences were found between the number of sessions attended and changes in assessed variables (for the program’s effectiveness) from pre to post-training (Wong, 2016). There was a **negative correlation** between number of sessions attended, level of **depression stigma** (*r* = .338, *p* = .058); and **stress levels** as reflected on DASS (*r* = .340, *p* = .057) from pre-training to two-month follow-up.

***Dropout rate***: Overall, 97% of participants attended 75% of the training (i.e. 3 out of 4 sessions), indicating a degree of feasibility. Three participants did not complete the intervention - one did not achieve the minimum 75% attendance stipulation, one had dropped out citing work schedule issues, and the other was repatriated to the Philippines (refer to Figure 2). Of the remaining 37 participants who completed the intervention, 26 attended all four sessions (70%), while 11 attended three sessions (30%). Therefore based on the original participant number of 40, the attrition rate is 7.5%.

***Participant satisfaction***: On the satisfaction with the program, 48.7% were very satisfied with it, while 51.4% were mostly satisfied. No one was unsatisfied. All participants also reported a perceived increase in knowledge and skills to be more valuable and helpful to the community (75.7% strongly agreed and 24.3% agreed). This could be indicative of a sense of enhanced empowerment amongst the participants.

Additionally, participants’ reasons for participating in the training program (through an open-ended question on the participant evaluation questionnaire) were descriptively captured and subsequently categorised (Wong, 2016). The main reasons participants highlighted were:

Table 3: Participant reasons for participation

|  |  |
| --- | --- |
| **Reason** | ***n*** |
| To help others including family and friends who need help  | 28 |
| To gain more knowledge about mental health, depression, CBT and coping skills  | 25 |
| To help oneself  | 25 |

### 3.2.3 HOME’s evaluation

Participants were also invited to complete an additional post-training assessment. This assessment measure was developed by HOME to further elicit participants’ views on implementing the paraprofessional training program as part of HOME’s welfare services. This measure was administered alongside the other measures described above to both groups one week after the training ended (T2). Both open-ended and multiple-choice questions were used and covered three areas: (a) assessment of CBT training, (b) satisfaction with CBT training, and (c) Implementation of peer counseling service as part of HOME’s mental health program. Descriptive statistics are presented below (*n* = 37).

***Assessment of CBT training***: The majority of participants (59.5%) indicated that the aspect they liked the most were the CBT-specific techniques (e.g. thought record) as well as counseling micro skills (e.g. reflective listening). On the aspects that they liked the least, 43% indicated that there was nothing they did not like and they enjoyed all aspects of the program, 40.5% highlighted specific CBT skills (e.g. thought monitoring, goal setting) and session topics (e.g. abuse and suicide), and the rest did not favour doing homework exercises between sessions.

***Satisfaction with CBT training*** (i.e. the trainers and training satisfaction): On trainer satisfaction: 86.5% were ‘very satisfied’, and the remaining 13.5% were ‘satisfied’. Qualitative data revealed that majority of the participants found the trainers to be “understanding”, “clear”, “informative” and “helpful”. On satisfaction with the training overall: 75.7% were ‘very satisfied’, 21.6% were ‘satisfied’ and 2.7% indicated ‘neutral’. The primary reason for their satisfaction was the perceived enhancement of their knowledge and skill set. Furthermore, although many had expressed gratitude at having the training opportunity, some challenges were reported. These largely related to difficulties understanding the training material and the perception that the four-week training bloc was too rushed.

***Implementation of peer counseling service***: Participants’ views on service delivery matters (e.g. language, communication platform) as well training and development issues (e.g. willingness to be supervised, further training sessions) were also sought:

Table 4: Preferences on service delivery and training/ development issues

|  |  |  |
| --- | --- | --- |
| **Question** | **Response (multiple choice)*****\*participants could select more than one option*** | **% (*n* = 37)** |
| **Communication preference** **(best way to help a FDW in distress)?**  | In personTelephoneEmail/ text messageSocial media (e.g. Facebook) | 75.716.210.821.6 |
| **Language preference?**  | EnglishTagalogMixture of English & Tagalog  | 21.65.473 |
| **Availability to be a peer counsellor for HOME?** | YesMaybe/ Not sureNo | 70.329.70 |
| **Willingness to attend more training sessions?** | YesMaybe/ Not sureNo | 81.118.90 |
| **Willingness to be supervised by a mental health professional regularly?** | YesMaybe/ Not sureNo | 7321.65.4 |

***Communication preference***: Consistent with research on migrants’ culturally-informed perceptions of help-seeking and previous empirical evidence (HOME, 2015; Selkirk, Quayle & Rothwell, 2014), majority of the sample preferred providing assistance to their fellow FDWs through face-to-face contact. A follow-up qualitative analysis revealed that the majority felt that physical presence would enable better understanding of one’s difficulties and to express concern – i.e. a perceived greater relational intimacy with the support seeker.

***Language preference***: Similarly, the majority preferred providing the service in a mixture of Tagalog (the Philippines’ national language) and English. Apart from participants’ personal comfort levels with language choice, linguistic (and cultural) similarity with the service consumer (peer) is advantageous given that it facilitates communication of culturally bound mental health beliefs and symptom expression. This can further elicit the perception of being understood. Research has indicated that ineffective intercultural communication (e.g. being misunderstood by a health professional of host country due to accent issues or language proficiency) is a barrier to seeking healthcare services amongst migrants (Gluszek & Dovidio, 2010; Maneze, DiGiacomo, Salamonson, Descallar & Davidson, 2015). The participants’ choice of both English and Tagalog also indicates their recognition of flexibility and fitting with the service consumer’s language preference.

***Availability to be peer counsellors***: Although the majority indicated that they were available to be peer counsellors for HOME and preferred face-to-face service provision, the frequency for in-person availability was expectedly limited. Most were only available on Sundays (i.e. the usual rest day for domestic workers in Singapore), with a minority available on weekday evenings. The greatest availability was found to be via social media or text messaging. This suggests that flexibility in service provision will be necessary, with due consideration given to setting and time in order to accommodate the realities of the working lifestyle of most FDWs in Singapore.

***Willingness for further training and supervision***: Research has indicated the importance of continued education and skill development of paraprofessionals (Durlak, 1979). This is especially important as despite the empirical evidence supporting the value of paraprofessionals, there have been reports of inadequate training and supervision, unethical behaviour and professionals’ misgivings of paraprofessionals’ clinical performance (Durlak, 1979). Continuing education and training and clinical supervision are considered to be the primary methods of improving paraprofessionals’ service delivery (Sotelo, 2015). These are expected to assist paraprofessionals in developing technical knowledge and skills as well as to consequently increase their perceived efficacy in service delivery (Durlak, 1973; Sotelo, 2015).

The majority of the participants indicated a willingness to attend further training and to be supervised by a mental health professional. This finding is especially vital in further highlighting the acceptability of the peer/ paraprofessional approach amongst the participants. Despite, short-term lowered self-efficacy of the participants, it is encouraging that the participants recognised that they needed more support and were open to investing their time and efforts in additional training and supervision.

## 3.3 Significance of results

As to the substantive or clinical significance of the results, the short and long-term increase (T2 and T3) in **depression literacy** is of a large magnitude with a confidence level of over 99.99%. This outcome strongly underlines the learning impact of the training, especially given the small sample size. Additionally, enhanced literacy is hypothesised to facilitate one’s own help-seeking behaviour and for identifying and assisting others in need (Rickwood & Braithwaite, 1994). Although there was a significant **increase in CBT knowledge**, the post-training effect was of a small effect size. This suggests that there is a need to address any pedagogical issues in content delivery so as to maximise participants’ learning of CBT’s principles and methods. It is likely that the program was too intensive (i.e. too much information and too little time). Participants’ comprehension levels could also be affected by language issues or preferences (this will be discussed in section 2.5.3.1 when considering overall training evaluation data). The **increase in attitude towards seeking professional help** (with a medium effect size at T3) suggests a benefit of in this population as to the known hesitation to seek help when facing mental health problems (e.g. the fear of deportation if having health issues, as mentioned in the introduction). Equally, the short term decrease in stigma levels towards people with depression (which remained stable over time) suggests that the training is helpful in confronting mental health related stigma. This is especially a crucial finding as stigma itself discourages mental health service utilisation. Filipinos in particular have been found to be generally reluctant in seeking professional help for psychological problems (Hechanova, Tuliao, Teh, Alianan, & Acosta, 2013), with Filipino migrant workers facing added barriers such as fears of deportation and cultural mistrust (David, 2010). Research has also documented that this hesitance could be due to Filipino cultural norms such as internalised shame (‘e.g. *hiya*’) or culturally bound lay conceptualisations of mental illness that is incompatible with the medical model (Abdullah & Brown, 2011; Lauber & Rössler, 2007; Tuliao, 2014). Indeed it has been found that such lay mental health beliefs in the Philippines exist. These create the impression that mental health professionals are not helpful or that mental illnesses are due to supernatural causes or due to an individual’s weakness in his or her willpower or character fraility which altogether emphasise personal blame and responsibility (Santa Rita, 1993; Thompson, Manderson, Woelz-Stirling, Cahill & Kelaher, 2002; Tuliao, 2014).

With regards to medium effect size of the **decrease in participants’ general self-efficacy** following training, it is likely that participants could have been overwhelmed by the new knowledge and skills they had learnt within a short period of time. It is likely that ‘unlearning’ or assimilating a new way of handling emotional difficulties is a substantial endeavour and could have left participants feeling inadequate in applying the new information and skills learnt (as opposed to mere receipt of new knowledge – e.g. symptoms of depression). This is plausible given the aforementioned culturally bound norms of handling psychological difficulties in Filipina society (e.g. Tuliao, 2014). Additionally, observations by the facilitators of the program (the first and third authors of this paper), indicated that majority of participants had particular difficulties during the role-play component of the program, which required participants to demonstrate skills. Participant’s struggles included using counseling microkills (e.g. reflective listening) and applying the CBT ‘hot-cross bun model’- both of which are necessary for the effective delivery of CBT. Participants had difficulties utilising a collaborative approach and were observed to be relying on directive, advice-giving methods as one would so with a friend. This also appears to be consistent with literature – for instance, within the Filipino community, the etiology of depression is seen as relationship-related and resolvable through talking with friends, family or community members (Hechanova, Tuliao & Ang, 2011; Tuliao, 2014), and as such, within cultural norms, seen as the ‘best’ way to handle such emotional distress. While this does signify that peer-support is beneficial and favourable generally, cultural considerations will have to be accounted for in the context of efficaciously delivering specific psychological therapies as peer paraprofessionals (or professionals; Hwang, Myers, Abe-Kim & Ting, 2008; Yamada & Brekke, 2008). Yet another explanation could have been that participants, while filling out the general self-efficacy scale – which is a global measure of personal agency in dealing with a range of demanding or novel situations and that which is influence by one’s mastery (Bandura, 1994; Schwarzer, 1994) – could have rated their competence in handling challenging situations based on their perceived (lack of) ability in mastering the necessary skills in supporting individuals with depression following the training, thereby affecting self-efficacy ratings.

**4. Implementing peer-based mental health services for FDWs in Singapore**

## 4.1 Implications of the pilot study results for the implementation of paraprofessional training

As to the **recruitment** of peer counsellors, the transient nature of FDWs poses a structural service dilemma for HOME. This is because FDWs in Singapore enter Singapore generally on (renewable) 2-year work permits. This together with the fact that they can be repatriated at any time without reason, brings the sustainability of a relatively stable group of paraprofessionals (or peer support providers in general) into question. Pilot results further indicate the need for modifications to future paraprofessional training programs. As to the **training period**, given the intensity of the four weekly 3-hour training sessions, and the steep learning curve of the participants, the most evident modification recommended is to increase the training periodwith shorter sessions so as to maximize learning and the acquiring of skills through more opportunities for practice. The program would also likely benefit from further **cultural adaptations** that involve not only FDW specific issues (that has been done in the current program) but also adaptations that are unique to the Filipino community (and the other nationalities in the future – e.g. Burmese, Indonesian). Hence the consideration of the ‘multiple cultures’ (Rathod & Kingdon, 2009) that migrant workers live in is vital. This would ultimately produce more culturally sensitive paraprofessional training and care. This is also consistent with the general call to the mental health profession to incorporate cultural adaptations into their delivery of empirically founded psychological therapies (such as CBT) to minority clients (such as migrants; Bernal, Jimenez-Chafey & Rodriguez, 2009). There is recognition that without sensitivity to cultural norms, there would be a barrier during the cognitive and behaviour change process, which affects a treatment’s efficacy (Rathod & Kingdon, 2009). A useful conceptual framework for incorporating cultural adaptations into mental health services is provided by Healey and colleagues (2017). In general the adaptations can occur across three levels – (a) community outreach and involvement (e.g. involving FDWs in the adaptation process), (b) changes in structure and process of service delivery (e.g. matching language and/ or nationality of FDW with that of trainer’s; translation of material to native language as a supplement), and (c) adaptation of content (e.g. cultural allusions, references to values, culturally appropriate examples). Finally, it will be necessary to develop a base of mental health professionals willing to provide continual training and supervision to these paraprofessionals. However, a key challenge of this would be to have professionals who are familiar with the FDW community and the key issues they face, as well as to provide their expertise as **supervisor** on a voluntary basis. Apart from issues of manpower, a system of assessing paraprofessional training outcomes (e.g. **assessment** and evaluation measures) will need to be developed.

**4.2 Envisioning community-level care with a stepped-care approach**

The paraprofessional training described above has focused on the delivery of CBT to alleviate depressive and anxiety symptoms. However, the scope of peer-based mental health services can be expanded to include preventive services. With the recognition that there is “no health without mental health” (Prince et al., 2007, p. 859) and the importance of mental health for living a socio-economically productive life, preventive programs would be particularly useful for the FDW community to enhance the community’s mental health literacy and to also subsequently facilitate help-seeking behaviour without a fear of repercussions.

Given the vast heterogeneity of peer-based mental health interventions in the literature (Brown et al., 2007; Simoni, Franks, Lehavot & Yard, 2011), appropriate frameworks would also guide HOME’s program development.

Figure 3 below presents Brown and colleagues’ (2007) framework for identifying the scope of **peer-based interventions in mental health**. It was developed to support current and forthcoming peer-support initiatives (Brown et al., 2007).



Figure 3: A framework for positioning peer-based approaches in mental health promotion (Brown et al., 2007)

The framework above highlights a range of possible peer-based approaches that mental health service delivery can take. In the case of the paraprofessional initiative, it would likely best fit within “formal support” group of interventions. There are other possible areas of preventive intervention that can occur to further empower FDWs in Singapore. In particular, mental health professionals could be involved in developing and conducting thematic mental health literacy workshops that serve to enhance knowledge and to impart skills and/ or healthy coping methods (much like a ‘self-help’ book). Members of the FDW community could also then be involved in translating the material or to also collaboratively conduct the workshops to the community (i.e. culturally sensitive psychoeducation). Given the strong social networks within the FDW community in Singapore, such knowledge may also be informally passed down (i.e. a ‘trickle down’ effect) to members of the community. Similarly, information technology methods can also be capitalized on to deliver content knowledge, given that the use of social media amongst FDWs in Singapore is rife (HOME unpublished research). It is envisaged that such efforts in spreading mental health awareness can somewhat attenuate the stigma of mental health issues (that is prevalent amongst many Asian cultures; Ng, 1997) within the FDW community through enhanced knowledge and to consequently facilitate greater help-seeking behaviour.

It is recognised that while peer-based services may be empowering for the migrant community, such services alone may not be sufficient to provide comprehensive mental health care to the FDW community. It is therefore necessary that some thought be given to incorporating the formal health care system into providing services for the community (i.e. a community-level care model). In particular, peer-based programs would be well positioned to fit at the lowest level within a **stepped-care** (SC) **approach** to mental health service delivery for the community. The SC approach is used as means of improving the public’s access to psychological therapies (Richards et al., 2012). Under this approach, the majority of individuals are first provided with the least intense, least expensive and least restrictive (i.e. the most effective yet least resource intensive) intervention in the first instance (level 1). Individuals who do not respond well to this first level of treatment will be then “stepped up” (to level 2) to more intense interventions. At this level, treatment is provided by professionals in an outpatient setting and for presenting concerns that are more severe. At level 3 (highest), treatment would be provided in an in-patient setting.

The stepped-care approach also recognizes that a partnership between the professional community and the FDW community is vital for providing mental health interventions that will best resonate with the FDW community’s needs and interests. At the most basic level, peer-based approaches would facilitate within the FDW community (1) knowledge and (2) access to a safe social space to address any mental health concerns. Given that HOME is highly familiar to the FDW community, and has played a significant role in advocating for them in Singapore, it is arguably best positioned to build the peer-based service and to facilitate the building of professional networks higher up the rungs of the stepped-care model. Mental health professionals who eventually form a part of this network of mental health care providers would also ideally be culturally sensitive to the needs and difficulties of the FDW community.

# 4. Conclusion

The FDW community in Singapore is generally susceptible to developing mental health difficulties. Having left their families behind, they often come to work in Singapore with a perceived loss of social support and increased stress and anxiety from dealing with acculturation issues, and possible distressing work and living conditions. However, the community is in general reluctant to seek professional help for psychological difficulties. This can be due to a persistent anxiety and fear of possible repatriation if found ill, or specific cultural barriers. Given the importance of mental health for living a meaningful and productive life, it is crucial that the mental health needs of FDWs be addressed on multi-systemic levels.

Overall, given that the paraprofessional training study is the first of its kind to be conducted with the FDW community, its results are promising. The paraprofessional program was well-received by the participants, as evidenced by both the low drop out rates, willingness (motivation) to engage in further training and supervision as well as their interest in becoming a peer counsellor for HOME. Notwithstanding these encouraging signs, there are further considerations to be accounted for if this paraprofessional training program and a subsequent peer counseling service is to be developed and sustained in the long-run by HOME.

The peer-based approaches discussed in this paper could potentially help and empower the community to address their own psychological needs in a culturally congruent manner, alongside the current socio-legal constraints FDWs face. While peer-based mental health services may be feasible in forming a preventive and first-line approach towards managing psychological distress, it is equally necessary that affordable, accessible and sensitive systems of formal mental healthcare be developed to serve the FDW population in Singapore.

HOME’s lead on this role is also a small step towards advocating for FDWs’ rights to access mental health care, through not only empowering FDWs but also through forging collaborative partnerships with mental health agencies and professionals who are keen to know more and to develop contextually appropriate mental health interventions for the community. It is hoped that these partnerships will eventually form a stable referral system through which FDWs can access affordable, yet culturally sensitive mental health care.

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