Philippine National Survey on Mental Health and Well-being (NSMHW)

National Survey for Mental Health and Well-being (NSMHW)

and

Child and Adolescent National Survey

for Mental Health

(CANSMH)

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I.   Introduction

Mental health is the state of well-being which influences in which the individual realizes one's own abilities and potentials, copes adequately with the normal stresses of life, displays resilience in the face of extreme life events, works productively and fruitfully, and is able to make a positive contribution to the community. (Mental Health Act of 2018). For Filipinos, this concept should include a psychosocial framework of *ginhawa* or the Filipino concept *of* emotional, social and spiritual *well-being* that should complement mental health. This framework also takes into account the following domains: biological and physical; material; emotional; social; cultural; and, spiritual needs; which are all inter-related and inter-dependent. (Ignacio, 2011). Thus, the promotion of mental health and *well-being* can be described as the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment, in ways that promote subjective well-being and optimize opportunities for development and use of mental abilities (Australian Health Ministers, 2003).

Given the above definition, the measurement of mental health is not simply the absence of mental illness, but involves more complex and multi-layered dimensions. Mental illness is a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional, occupational and social abilities for both acute and chronic conditions. Depending on the type of disorder and its degree of severity, people with mental illness may require specialist management, treatment with medication and psychosocial rehabilitation services. Therefore, it is important to recognize that mental illness is not only a growing public health concern but also a major psychosocial and economic issue affecting individuals, families and communities throughout the world.

Effective mental health policy implementation and service delivery planning requires knowledge of the number of people affected by mental disorders. Ever since, the Department of Health (DOH) has depended on expert opinions or secondary sources to estimate the prevalence, disability and treatment rates. Estimates derived from other studies derive from one country may not serve the needs of the other because there is a wide variation in the rates reported for both lifetime and 12-month prevalence of mental disorders across studies. Variability in rates is expected to be even more marked when socio-demographic are cultural differences are significant, as these factors can have an impact on the development of mental disorders.

"A mental health policy and plan is essential to coordinate all services and activities related to mental health. Without adequate policies and plans, mental disorders are likely to be treated in an inefficient and fragmented manner."

The Philippines had just recently passed into legislation two landmark bills that has longed been overdue. The first law was the *Mental Health Act (MHAct) of 2018 R.A. 11036* provides for a rights-based mental health bill and a comprehensive framework for the implementation of optimal mental health care in the Philippines. The second law was the *Universal Health Care of 2019 (R.A. 11223) or the UHC Law* which proposes that all Filipinos are guaranteed equitable access to quality and affordable health care goods, and services, and protected against financial risks through a whole-of-system, whole-of-government, whole-of-society, people centered approach. These policies place most of the public mental health care within the integrated primary health care system. To achieve the goals of these two acts, the Department of Health requires a population-based data that identifies the prevalence of mental disorders, the reasons for these disorders, the patterns of treatment, the barriers to treatment, and the possible approaches to providing care.

In the *Implementing Rules and Regulations of MHAct of 2018 R.A. 11036*, the law provided funding for a comprehensive epidemiological survey among adults, children and adolescents, and psychiatric services being utilized by people with Mental, Neurological and Substance Use disorders (NMS) to be able to assess the state of mental health of the Filipino population. To be able to deliver mental health services to an entire population and at all levels of care (tertiary, secondary and primary), it needs to be backed-up by scientifically and clinically relevant research. The Department of Health developed the *Advancing Health through Evidence-Assisted Decisions with Health Policy and Systems Research (AHEAD-HPSR) of 2018* Program as a strategy to implement its medium-term health policy and systems research agenda. With the inclusion of mental health as among the health issues in the Philippine Health Agenda for 2016 -2022, the **2021 Philippine National Survey of Mental Health and Wellbeing** was carried out as the first ever baseline, epidemiological survey on mental health. It has two components**: National Survey for Mental Health and Well-being (NSMHW)** for the adult population of 18 < years and the **Child and Adolescent National Survey for Mental Health (CANSMH).**

The NSMHW was designed to provide lifetime prevalence estimates for Mental, Neurological and Substance Use Disorders MNS) for the Filipino adult population. The NSMHW survey aims to obtain valid information about the prevalence and correlates of mental disorders in the general population, unmet needs for treatment of mental disorders, treatment adequacy among patients in treatment for mental disorders, and the societal burden of mental illness. Respondents were asked about experiences throughout their lifetime. In this survey, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. Assessment of mental disorders presented in this publication are based on the definitions and criteria of the Diagnostic and Statistical Manual for mental Disorders 5th Edition (DSM-V) and World Health Organization's (WHO) International Classification of Diseases, Eleventh Revision (ICD-11). Prevalence rates are presented with hierarchy rules applied (i.e. a person will not meet the criteria for particular disorders because the symptoms are believed to be accounted for by the presence of another disorder). The survey tool is in English, and has been adapted to the Philippine cultural context and experiences. It has been translated into 5 Philippine languages (Filipino, Ilocano, Hiligaynon, Cebuano/Bisaya, Bicolano and Waray).

The CANSMH made use of 2 questionnaires. The *Strengths and Difficulties Questionnaire (SDQ)* by Dr. Robert Goodman to determine the common behavioral problems in children and adolescent. And the Mini Neuropsychiatric Examination for Kids (MINI-Kid) by Dr. David Sheehan that servs as a screening and diagnostic instrument for mental disorders in children based on the DSM-IV classification. The instruments have been officially translated in Filipino, which was utilized for data collection.

Collaboration with the World Mental Health Survey Initiative for the NSMHW

Large-scale surveys are expensive to carry out and demand survey expertise and a lot of resources. The World Mental Health (WMH) Survey Initiative Consortium is a WHO initiative designed to help countries carry out and analyze epidemiological surveys of the prevalence and correlated of mental disorders. Over the past 30 years, the *Composite International Diagnostic Interview* (CIDI) was developed based on the Diagnostic and Statistical Manual for Mental Disorders – 5th Edition (DSM-V) and the International Classification of Mental Disorders – 11th ed. (ICD-11), which has made possible large scale and replicable epidemiological studies of mental disorders possible. The *World Mental Health Composite International Diagnostic Interview* (WMH CIDI) *version 5* has been the standard instrument used by several countries in conducting their own national prevalence surveys on mental illness. This survey will also train researchers, health administrators, specialists, general practitioners (GPs) and local health workers (LHW), and non-mental health professionals in the use of this instrument for data collection in this prevalence study and serve as a screening instrument for diagnosing individuals with mental illness as part of the health care delivery system.

The WHM CIDI version 5 is a fully structured diagnostic interview that can be administered by non-mental health professionals. The WMH-CIDI includes a screening module and 40 sections that focus on diagnoses (22 sections), functioning (four sections), treatment (two sections), risk factors (four sections), socio-demographic correlates (seven sections), and methodological factors (two sections).

The WMH-CIDI 5.0 was chosen because it:

- provides a fully structured diagnostic interview;
- can be administered by lay interviewers;
- is widely used in epidemiological surveys;
- is supported by the World Health Organization (WHO); and
- provides comparability with similar surveys conducted worldwide

The WHO WMH-CIDI allows the investigator to:

- Measure the prevalence of mental and neurological disorders
- Measure the severity of the disorders
- Determine the burden of the disorders
- Assess service use
- Assess the use of medications in treating these disorders
- Assess who is treated, who remains untreated, and what are the barriers to treatment.

Collaboration with Dr. Robert Goodman and Dr. David Sheehan for the CANSMH

In the same measure, the CANSMH made use of 2 questionnaire: *Strengths and Difficulties Questionnaire (SDQ) and the Mini Neuropsychiatric Examination for Kids (MINI-KID)* with permission from the authors for the data collection for children and adolescents.

The SDQ is a short behavioral screening questionnaire for children aged 4 to < 18 years. The questionnaire is used to assess children's mental health, and can be completed by children and young people themselves, by their parents or by their teachers. The SDQ was developed by the English child psychiatrist Robert N. Goodman, who granted the license to use the SDQ in the CANSMH. The questionnaire assesses emotional and behavioral problems in children and adolescents.

The MINI-KID a short structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders in children and adolescents. The MINI-KID is the most widely used psychiatric structured diagnostic interview instrument in the world, employed by mental health professionals and health organizations in more than 100 countries. The MINI has been translated and linguistically validated in over 70 languages, even in *Filipino*. The standard MINI *Kid* assesses the 30 most common and clinically relevant disorders or disorder subtypes in pediatric mental health. With this version the child and parent are interviewed together. The question is directed to the child. The parent is asked to remain silent and not to respond unless the parent believes it is clear that the child has provided inaccurate information. The interviewer then triangulates the discussion between child, parent and interviewer, to get the most accurate assessment, and records the responses accordingly. The license agreement for the MINI-KID was granted by Dr. David Sheehan under the MAPI Trust Organization.

II. Significance of the study

The DOH developed the *Advancing Health through Evidence-Assisted Decisions with Health Policy and Systems Research (AHEAD-HPSR)* Program of 2018 as a strategy to implement its medium-term health policy and systems research agenda. The main objective of the study is to establish the lifetime and

12-month prevalence of select mental disorders and neurological disorders in the Filipino adult, child and adolescent resident population at both the national and regional levels. The NSMHW for the adult population, the results from the WHO WMH-CIDI version 5 will also be able to do the following: measure the severity of the mental and neurological disorders; determine the burden of the disorders; assess service use; assess the use of medications in treating these disorders; and assess who is treated, who remains untreated, and what are the barriers to treatment. It will also describe the socio-demographic factors, as well as, psychosocial factors and environmental factors affecting mental disorders: e.g., utilization of mental health services, the level of unmet needs including identifying treatment gaps and facilitators/barriers to mental health treatment; and, to determine the extent of disability.

For the CANSMH study, the survey tools will be able to provide the prevalence of mental disorder sin children and adolescents, determine the impact of mental disorders as well as look into the overall health and the other possible risk factors (e.g. internet use, history of abuse, living arrangements, co-morbidity with medical illness) that may contribute to a child or adolescent developing a mental health problem. It will also map out the needs of those seeking help, the treatment referral patterns and the type of services needed.

In view of the need to provide for financial resources under the universal coverage of *All for Health towards Health for All Filipinos* through PHILHEALTH, the outcome of the survey will also help to estimate the societal costs of economic and social burden of Mental Disorders, Neurological Disorders and Substance abuse Disorders (MNS): treatment, hospitalization and provision for psychosocial services. The study will then be able to provide DOH the data necessary to track and trend the changes following the passing into law the *MHAct*, which will give rise to major changes in health policy implementation to provide equitable access to mental health care and psychosocial rehabilitation services at all care levels (e.g., tertiary, secondary and primary) in the community. It will also create appropriate mental health policies needed for the rational allocation of health resources and delivery of services, both at the national and regional levels. In this way, one of the sustainable development goals can be achieved of ensuring healthy lives and promoting well-being for ALL FILIPINOS at all ages.

At the international level, close collaboration can be achieved, using identical methodology, common with a common resolve on an international level with other participating countries to pool the existing expertise for consultation and consequent proper action.

III.   Methodology

A. Sample design

The projected Filipino resident population was 108,667,043 based on the 2015 Census of Population and Housing by the Philippine Statistics Authority. The 2022 NSMHW was designed to provide reliable estimates at the national and regional level. The survey was not designed to provide data at the provincial level data.

There were two levels of sampling units. The primary level of sampling were the **barangays**[1] that were included in the survey in each region. The barangays were selected at random using a stratified,

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[1] A **barangay** is the smallest political unit in the country. Generally, enumerator is assigned to enumerate one barangay. Foe enumeration purposes, a large barangay is usually divided into parts, and each part is called an enumeration area (EA). (PSA, 2022). It is the native Filipino term for a village, district, or ward. In metropolitan areas, the term often refers to an inner city neighborhood, a suburb, or a suburban neighborhood

multistage area sample based on the Philippine Statistics Authority (PSA) National Census of 2020. These samples included barangays from the geographic areas covered by the survey. Sample was allocated to regions and provinces roughly in proportion to their respective population size. The secondary level of sampling were the **households**[2] in each barangay. The households were selected through systematic random sampling [3] based on the list of the no. of households/ household heads in the barangay. If the list of the no. of household is not available, then the basis can be the spot map [4] of the barangay. If the spot map is still not available, then the serpentine method will be used. The eligibility of respondents is determined by household membership.[5]. A "*Take All Strategy*" was implemented to interview all the eligible members of the household (adults and children) to form part of the NSMHW survey.

B. Data Collection

The NSMHW survey was carried over a 12-month period from November 2020 to October 2021 with the assistance of the Philippine Statistics Authority in carrying out the sampling design on the barangays per region.

There were 510 barangays selected for the survey who were initially informed by their local government units through a letter with instructions to assist the lay interviewers (LIs) in the selection of the households. Systematic random sampling of the households was done in all the barangays for the identified households. A total of 4,650 full responding-households were visited. A total population of 13,090 respondents were interviewed both adults and children and adolescents. This sample was able to deliver the desired fully-responding sample, based on an expected response rate of 70 % and sample loss.

After getting the informed consent, information collected in the study includes:
- Household Information, which can be completed by any responsible adult in the household who is aged 18 years or over. The Household Information component of the study collects basic demographic information about all usual residents of the household, including those aged under 18 years, as well as information about the dwelling and household income.
- WHO WMH CIDI version 5 was administered to those 18 < years.
- Child Personal and Family Questionnaire (CPFQ), Health Service Utilization Questionnaire (HSUQ), Strengths and Difficulties Questionnaire (SDQ), Child and Adolescent Questionnaire for COVID-19 (CARC-19), and Mini-Neuropsychiatric Questionnaire for children (MINI-KID) were administered to 4 - <18 years old

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[2] A **household** is a social unit consisting of a person living alone or a group of persons who sleep in the same housing unit and have a common arrangement in the preparation and consumption of food.
[3] Systematic sampling is **a probability sampling method where researchers select members of the population at a regular interval** – for example, by selecting every 50th person on a list of the population. If the population is in a random order, this can imitate the benefits of simple random sampling
[4] Spot map is a map or diagram of the barangay showing the distribution of households.
[5] In determining household membership, a basic criterion is the usual place of residence or the place where the person usually resides. This may be the same or different from the place where he is found at the time of the census. As a rule, it is the place where he usually sleeps (PSA, 2022)

C. Data Analysis

Observations were weighted using the inverse of the probabilities of selection of the observations in the estimation of the parameters of interest. Since cluster sampling was employed, the design was considered in the calculation of the standard errors and 95% confidence intervals of the estimates.

For each mental illness studied, the prevalence of mental illness was estimated using a weighted approach using the inverse sampling probabilities as weights. Other methods of estimation such as unweighted analysis, a meta-analytic approach where each cluster is considered a separate study, and different approaches to variance estimation such as robust estimation and random effects (RE) was applied for comparison of approaches.

Comparisons of this prevalence based on the selected variables for domain was done. For the examination of the associations of mental illness with selected physical and health characteristics, odds ratios was computed to assess the strength of these associations of these proposed variables. Comparisons were assessed for statistical significance using standard Chi-square tests. Logistic regression will likewise be employed to assess the association of each of these variables with mental illness controlling for the effect of potential confounders.

The extent of missing data was assessed. The percent of missing data was determined across categories of the selected domains. Missing data imputation was carried out on the data using multiple imputations by chained equations (Royston 2005). In this approach, several data sets containing different versions of imputed values of missing data were created. The selected domain factors was included in the model for imputation. The statistical analysis was performed on each of these imputed data sets. The results were then combined to derive a single set.

Data analysis will be performed using Stata Version 15.1.

Base weights were computed using the 2015 Census accounting for the sample selection methods of the barangays and the households. Finals weights were adjusted to coincide with the projected population for the year of the survey (2020/2021) for specific segments (male/female, age-group, etc.).

III. Results of the Philippine NSMHW 2021

A. NSMHW 2021

The NSMHW 2021 is unique among large-scale population surveys in that it provides in-depth information which is not limited to symptoms, but also disability, health service utilization and self-perceived need for services. The survey will generate the necessary information that will prove valuable for service planning and delivery and advocacy at all levels of care.

Of the 9,857 Filipinos aged 18 – 65 < years, almost 28% (2,760 people) had a lifetime disorder, i.e., a mental disorder at some point in their life. And about 72% (7,097 people) had not have a life time mental disorder. Almost 1 out of every 5 Filipinos suffer from a mental disorder in their lifetime.

Of people who had a lifetime mental disorder, 20% (or 552 people) had a 12-month mental disorder and had symptoms in the 12 months prior to the survey interview, and 22% (2,208 people) had experienced a lifetime mental disorder but did not have symptoms in the 12 months prior to the survey interview.

Population characteristics

Mental health and mental illnesses are determined by multiple and interacting social, psychological, and biological factors, just as they generally are in health and illness (WHO, 2005). Mental health may be impacted by individual or societal factors, including age, sex, rural/urban place of residence, economic disadvantage, poor housing, lack of social support and the level of access to, and use of, health services (**Table 1**)

Table 1. Socio-demographic profile of the respondents (2021)

	Frequency	Percentage
Sex		
Male	3819	38.74%
Female	6040	61.26%
Total	9859	100.00%
Age Group		
18-35	4261	43.22%
36-49	2762	28.02%
50-64	2011	20.40%
65+	825	8.37%
Total	9859	100.00%
Marital status		
Married/ Common-law/ Live-in relationship	6810	69%
Separated/ Divorced/ Annulled/ Widowed	828	8%
Never Married	2221	22%
	9859	100.00%
Highest Educational Attainment		
None	125	1%
Elementary/ Primary school but not completed	1502	15%
Elementary/Primary school	1230	12%
Junior high school (K-12 program) or High School Graduate (non-K-12 program)	3764	38%
Senior high school (Grades 11-12)	1613	16%
Associate degree	533	5%
College Degree	1092	11%
Total	9859	100.00%
Employment Status		
Self-employed	2403	24.37%
Employed	1670	16.94%
On maternity or paternity leave	7	0.07%
On sick leave from a job	5	0.05%
Temporarily laid off	30	0.30%
Retired	135	1.37%
Full-time student	783	7.94%
Part-time student	51	0.52%

Unemployed and looking for work	711	7.21%
Unemployed and not looking for work	829	8.41%
Disabled and unable to work	85	0.87%
Homemaker	2529	25.65%
Something else	620	6.29%
Total	9859	100.00%

According to sex, of the 9,859 population, there were more female respondents at 6,040 (39%) than males at 3,819 (39%).

According to age-group, of the 9,859 respondents, the age group 18-35 years, younger adults, comprised the highest number of respondents at 4,261 (43%) followed by age group 36-49 years old (middle age group), followed by the age group 50-64 (older age group), and finally an elderly group age 65 and above at 825 (8%).

According to marital status, of the 9,859 respondents, there were more respondents from those who were married/common-law/live-in relationship, followed by those who are separated, and finally, those who were never married.

Marital status has also been shown to be related to a person's physical and mental health. People who had never been married experienced almost twice the prevalence of 12-month mental disorders compared with people who were married or living in a de facto relationship (28% and 15% respectively). However, this may be partly explained by the number of young people who have never been married, and their higher prevalence of 12-month Substance Use disorders. The prevalence of Substance Use disorders for people who had never been married was more than four times as high as the rate for people who were married or living in a de facto relationship (11.1% compared with 2.5% respectively).

According to the highest educational attainment, of the 9, 734 respondents, majority finished junior high school at 3,764 (38%), followed by senior high school at 1,613 (16%) , then elementary/ primary school not completed at 1,502 (15%), elementary/ primary school at 1,613 (16%), and those who have a college degree at 1,092 (11%).

According to the employment status, of the 9,238 respondents, 5,153 (56%) were unemployed, followed by 2,403 (26%), then about 1,682 (18%) were employed.

Selected mental disorders

The 2021 NSMHW collected information on selected mental disorders, which were considered to have the highest rates of prevalence in the population and that were able to be identified in an interviewer-based household survey. These mental disorders were:

A. Anxiety disorders
- Panic Disorder
- Generalized Anxiety Disorder (GAD)

B. Affective (mood) disorders
- Depressive Episode
- Bipolar Affective Disorder

C. Unusual Experiences (Psychosis)
D. Drug Use Disorders and Substance Use disorders: Harmful Use and Dependence
E. Epilepsy
F. Dementia
G. Self-harm and Suicide

Life-time and 12-month prevalence of Mental, Neurologic al and Substance Use Disorders

1. Lifetime Prevalence of MNS Disorders

Prevalence of mental disorders is the proportion of people in a given population who met the criteria for diagnosis of a mental disorder at a point in time. To estimate prevalence, a sample (smaller group) from the entire population to be describe is randomly selected. Using random selection methods increases the chances that the characteristics of the sample will be representative of (or similar to) the characteristics of the population. For the Philippine NSMHW, the domains of the study are the geographic regions. The study sites for the survey have been generated through computerized sampling which was based on the Philippine Statistics Authority Census of 2015. This means that sampling design is implemented on each region to come up with highly reliable estimates for each. As a result, a reliable estimate of national prevalence rates will be achieved. For each of the regions, the barangays are the primary sampling units and are randomly selected using probability proportional to size. The barangays, as the primary sampling units, have been identified. Then for each sampled barangay, households are randomly selected using systematic sampling (based on the household listing, spot map or serpentine method) and thus serve as the secondary/ultimate sampling unit. A TAKE-ALL-STRATEGY will be used, all members of the household that are eligible will be interviewed.

The tables below show the Lifetime and 12-month prevalence rates for each of the major disorder groups (Depression, Bipolar Disorder, Anxiety, Affective and Substance Use, Epilepsy and Dementia) and prevalence rates for each of the mental disorders within each group. To ensure a selected sample is representative of an entire population, statistical 'weights' may be applied. Weighting the sample mathematically adjusts the sample characteristics to match with the target population.

Lifetime prevalence is the proportion of a population who, at some point in life has ever had the characteristic. The total population of respondents is 9,758, among which 1,431 (15%) had developed a mental health problem during their life time, with anxiety disorders (panic attacks) (6%) and alcohol use (5%) were the most prevalent, followed by MDD (2%) and dementia (2%). (**Table 2).** About 1 out of every 5 Filipinos have had a mental health problem during their lifetime, which is comparable to other countries, e.g., Australia, Hongkong, and Japan (World Health Report 2017)

Table 2. Lifetime prevalence of MNS disorders

Lifetime prevalence of MNS Disorders N = 9758	N = 1,431	Mean	Std Error of Mean	99% CL for Mean	
Major Depressive Disorder	105	2%	0.002046	0.01116206	0.01918372
Major Depressive Episode	110	2%	0.002107	0.0118889	0.02014851
Bipolar I Disorder	14	0.23%	0.000828	0.00067259	0.00341911
Bipolar II Disorder	13	0.20%	0.000708	0.00064485	0.00341911
Generalized Anxiety Disorder	38	0.49%	0.001182	0.00260463	0.00723911
Panic Attack	496	5.94%	0.003787	0.05194546	0.06679104
Panic Disorder	85	0.85%	0.001217	0.00606842	0.01083767
Alcohol Use Disorder	304	5%	0.00464	0.03782261	0.05601185

Substance and Drug Use Disorder	46	1%	0.001406	0.0046701	0.01018372
Seizure	52	1%	0.00139	0.00438488	0.00983303
Dementia	168	2%	0.002085	0.01439531	0.02256865

12-month prevalence of MNS Disorders

Prevalence of mental disorders is the proportion of people in a given population who met the criteria for diagnosis of a mental disorder at a point in time. The tables and diagrams below show the 12-month prevalence rates for each of the MNS disorders (Depression, Bipolar Disorder, Anxiety, Affective and Substance Use, Epilepsy and Dementia) and prevalence rates for each of the mental disorders within each group.

For the 12-month prevalence, a total of 979 (10%) had developed a mental health problem during the past 12 -months, with panic attacks (6%) being the highest, followed by alcohol use (2%) , and MDD (1%). **(Table 3)**

Table 3. 12-month prevalence of MNS disorders

12-month prevalence of MNS Disorders N = 9758	N = 979	Mean	Std Error of Mean	99% CL for Mean	
12-month Major Depressive Disorder	96	1%	0.001801	0.00957951	0.01664089
12-month Major Depressive Episode	101	1%	0.00187	0.01028982	0.01762221
12-month Bipolar I Disorder	14	0.23%	0.000828	0.00067259	0.00391881
12-month Bipolar II Disorder	13	0.20%	0.000708	0.00064485	0.00341911
12-month Generalized Anxiety Disorder	34	0.39%	0.000874	0.00221439	0.00564253
12-month Panic Attack	496	5.94%	0.003787	0.05194546	0.06679104
12-month Panic Disorder	85	0.85%	0.001217	0.00606842	0.01083767
12-month Alcohol Use Disorder	129	2%	0.003262	0.01240914	0.02519678
12-month Substance and Drug Use Disorder	11	0.17%	0.000566	0.00054884	0.00276788

1.1. Lifetime prevalence of Affective Disorders

Affective disorders involve mood disturbance, or change in affect. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations. Affective disorders comprise: Depressive Episode and Bipolar Affective Disorder. Depressive Episode was the most prevalent Affective disorder are the Lifetime MDD at 105 (2%) and Lifetime MDE at 110 (2%.). Both lifetime prevalence for Bipolar I and Bipolar II Disorder are 14 (0.23%) and 13 (0.20 %)., respectively.

1.2 Lifetime prevalence of Anxiety Disorders

Anxiety disorders generally involve feelings of tension, distress or nervousness. A person may avoid, or endure with dread, situations which cause these types of feelings. Anxiety disorders comprise: Panic Attacks, Panic Disorder and GAD. Lifetime prevalence of anxiety disorders was highest on those with Panic Attacks at 496 (6%), followed by Panic Disorder at 85% (0.9%), followed by GAD at 38 (0.5%).

1.3 Lifetime prevalence of Alcohol and Substance Use Disorders

Substance Use disorders involve the harmful use and/or dependence on alcohol and/or drugs and comprise: Alcohol Harmful Use, Alcohol Dependence and Drug Use disorders. Harmful Use is the pattern of use of alcohol or drugs that is responsible for (or substantially contributes to) physical or psychological harm, including impaired judgement or dysfunctional behaviors. Dependence is a maladaptive pattern of use in which the use of alcohol or drugs takes on a much higher priority for a person than other behaviors that once had greater value. The central characteristic of Dependence is the strong, sometimes overpowering, desire to take the substance despite significant substance-related problems.

Drug Use includes the use of illicit substances and the misuse of prescribed medicines. Four drug categories were included in this survey:
- sedatives, , sleeping pills, valium
- stimulants, e.g., amphetamines, speed
- cannabinoids e.g., marijuana
- opioids, e.g., heroin, methadone, opium.

Alcohol consumption

Excessive alcohol consumption is a health risk factor that contributes to morbidity and mortality. Alcohol consumption may also interact with mental health in various ways, including:

a. people who are diagnosed as having an Alcohol Dependence are more likely to suffer from other mental health problems; and

b. people with mental health problems are at particular risk of experiencing problems relating to alcohol

Of the Substance Use Disorders, Alcohol use disorder was the most prevalent with a Lifetime prevalence of 304 (5%) and a 12-month prevalence of 129 (2%). Substance Use disorder had a Lifetime prevalence of 46 (1%) and a 12-month prevalence of 11 (0.2%).

1.4 Prevalence for Unusual Experiences (Psychosis)

Of the symptoms related to psychosis, among those with unusual experiences, the most prevalent symptoms are those with visual hallucinations at 223 (3%) followed by auditory (voices) hallucinations at 236 (2%).**(Table 4)**

Table 4. Prevalence of Unusual Experiences (Psychosis)

Statistics					
Unusual Experiences N = 9,758	**N = 700 (0.1%)**	**Mean**	**Std Error of Mean**	**95% CL for Mean**	
Visual hallucinations	223	3%	0.002417	0.02193531	0.03141066
Voices hallucinations	236	2%	0.002221	0.02054375	0.02925202
Thought insertion	58	1%	0.001789	0.00567656	0.01269206
Stolen Thoughts	58	1%	0.001194	0.00508033	0.00976207
Mind being controlled	36	1%	0.00148	0.00302574	0.00882613
Forces communicating	50	1%	0.001294	0.00389202	0.00896553
Paranoid thoughts	39	1%	0.002876	0.00164731	0.0129238

Suicide

Suicide is a major public health issue. In this survey, people were asked about suicidal behavior in their lifetime and in the 12-months prior to the   survey. About 960 (8%)   people

reported suicidal ideation (thoughts of killing oneself) in the 12 months prior to the survey interview (that is they had serious thoughts about committing suicide) . **(Table 5)** Suicidal ideations (SI), often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.   From this group, 421 (41%) had a suicide plan and 224 (21%) had a suicide attempt. **(Table 6).**

Table 5. Prevalence of Suicidal ideation

N = 9758	N	Mean	Std Error of Mean	99% CL for Mean	
Suicide ideation	960	8%	0.004264	0.07016465	0.08688283

Table 6. Prevalence of Suicide

Statistics					
Variable		**N = 960**	**Mean**	**Std Error of Mean**	**95% CL for Mean**
Suicide Plan	**Positive**	421	41%	0.024821	0.36550631	0.46292527
	Negative	539	59%	0.024821	0.53707473	0.63449369
Suicide attempt	**Positive**	224	21%	0.017729	0.17215293	0.24173595
	Negative	737	79%	0.017729	0.75826405	0.82784707

Lifetime Prevalence and 12 Month Prevalence by Regions

Part of the requirement of the WHO WMH Survey Initiative is the need to have collaboration with the Philippine Statistical Authority (PSA) for technical assistance to have an accurate sampling procedure. The NSMHW research proposal had been submitted to the Censuses and Technical Coordination Office of the PSA requesting for survey clearance.

Consistent with other household-based surveys of the PSA, the study participants will be selected using a two-stage sample selection method with barangays as the primary sampling units and households as the secondary sampling units (SSU). Households are defined by PSA as group of individuals living under the same roof and sharing food preparation. Each of the seventeen (17) regions will be considered as the survey domains, i.e., high precision of the estimates of prevalence proportion will be targeted for each of the regions. Hence, sample selection will be done independently in each region. Coding for the regions **(Table 7).**

Regional estimates of the prevalence of mental disorders is in **Table 8.** Among the 17 regions, NCR had the highest lifetime prevalence and 12-month prevalence in MDD and MDE, followed by Region 3 and Region 4A. As to Manic and Hypomanic episodes, the highest lifetime prevalence and 12-month prevalence is in NCR, followed by Region 4B and BARMM.

Among the 17 regions, for Anxiety Disorders, NCR had the highest lifetime prevalence and 12-month prevalence for GAD, Panic attacks and Panic Disorder, followed by NCR and Region 2

Among the 17 regions. for Alcohol use disorder, NCR had the highest lifetime prevalence and 12-month prevalence, followed by Region 3 and Region 8.

Among the 17 regions, for Dementia, Region 4B had the highest lifetime prevalence and 12-month prevalence, followed CAR and Region 11,

Among the 17 regions, for Epilepsy, Region 9 had the highest lifetime prevalence and 12-month prevalence of epilepsy followed by Region 8 and NCR.

Among the 17 regions, for those with Unusual experiences, as to visual hallucinations, Region 3 NCR had the highest lifetime prevalence and 12-month prevalence, followed by CAR and Region 11. As to voices (auditory) hallucinations, Region 11 had the highest lifetime prevalence and 12-month prevalence followed by Region 8 and CARAGA.

Among the 17 regions, for those with Thoughts of killing themselves, Region 8 had the highest prevalence, followed by CAR and Region 4B. Among those who have thoughts of killing themselves, CARAGA had the highest prevalence for suicide plan, followed by Region 7 and Region 12. For suicidal attempt, Region 1 had the highest prevalence, followed by Region 9 and region 12 and BARMM.

Table 7. Coding per region

1	R1	Ilocos
2	R2	Cagayan Valley
3	R3	Central Luzon
4	R4A	CALABARZON
5	R5	Bicol
6	R6	Western Visayas
7	R7	Central Visayas
8	R8	Eastern Visayas
9	R9	Zamboanga Peninsula
10	R10	Northern Mindanao
11	R11	Davao
12	R12	SOCCSKSARGEN
13	NCR	NCR
14	CAR	CAR
15	BARMM	BARMM
16	R13	CARAGA
17	R4B	MIMAROPA

Table 8. Regional estimates of the prevalence of MNS Disorders

Disorders	R1	R2	R3	R4A	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	BARM	CARAGA	R4B	National (%) (R3 included)
TOTAL NO. OF RESPONDENTS PER REGION	651	598	521	488	731	455	396	429	522	694	674	596	608	578	528	752	650	
Lifetime Major Depressive Episode	0.16	0.76	2.50	1.28	0.78	1.05	0.00	1.56	1.10	0.76	1.11	0.73	4.23	0.68	1.03	0.58	1.35	1.60
12 Month Major Depressive Episode	0.16	0.56	2.50	1.28	0.78	1.05	0.00	1.40	1.10	0.66	0.93	0.73	3.15	0.42	1.03	0.58	1.35	1.39
Lifetime Major Depressive Disorder	0.16	0.76	2.50	1.28	0.78	1.05	0.00	1.33	1.10	0.76	1.11	0.73	3.87	0.68	1.03	0.58	0.95	1.52
12 Month Major Depressive Disorder	0.16	0.56	2.50	1.28	0.78	1.05	0.00	1.17	1.10	0.66	0.93	0.73	2.78	0.42	1.03	0.58	0.95	1.31
Lifetime Manic Episode	0.14	0.00	0.15	0.00	0.22	0.00	0.00	0.00	0.00	0.00	0.14	0.20	1.00	0.00	0.28	0.00	0.37	0.23
12 Month Manic Episode	0.14	0.00	0.15	0.00	0.22	0.00	0.00	0.00	0.00	0.00	0.14	0.20	1.00	0.00	0.28	0.00	0.37	0.23
Lifetime Hypomanic Episode	0.00	0.00	0.70	0.24	0.28	0.00	0.00	0.23	0.00	0.00	0.11	0.00	0.26	0.00	0.00	0.00	0.58	0.20
12 Month Hypomanic Episode	0.00	0.00	0.70	0.24	0.28	0.00	0.00	0.23	0.00	0.00	0.11	0.00	0.26	0.00	0.00	0.00	0.58	0.20
Lifetime Bipolar I Disorder	0.14	0.00	0.22	0.00	0.22	0.00	0.00	0.00	0.00	0.00	0.14	0.20	1.00	0.00	0.28	0.00	0.37	0.23
12 Month Bipolar I Disorder	0.14	0.00	0.22	0.00	0.22	0.00	0.00	0.00	0.00	0.00	0.14	0.20	1.00	0.00	0.28	0.00	0.37	0.23
Lifetime Bipolar II Disorder	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.02
12 Month Bipolar II Disorder	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.02
Lifetime Generalized Anxiety Disorder	0.14	0.93	1.00	0.22	0.23	0.00	0.00	0.25	0.58	0.42	0.35	0.10	1.32	0.00	0.42	0.45	0.14	0.49
12 Month Generalized Anxiety Disorder	0.14	0.53	1.00	0.22	0.23	0.00	0.00	0.25	0.58	0.42	0.15	0.10	0.83	0.00	0.42	0.45	0.14	0.39
Lifetime Panic Attack	2.80	7.52	7.97	4.47	5.26	6.09	2.65	5.50	1.46	2.70	4.51	1.90	11.23	4.57	3.98	6.60	5.92	5.93
12 Month Panic Attack	1.16	3.78	4.23	1.80	2.58	3.47	1.15	2.60	0.81	1.01	1.64	1.02	5.57	2.05	1.69	3.03	3.14	2.88
Lifetime Panic Disorder	0.46	1.25	2.51	0.20	1.07	0.20	0.36	0.79	0.61	0.07	0.58	0.51	1.13	0.63	0.48	1.00	1.74	0.86
12 Month Panic Disorder	0.30	0.88	1.87	0.20	0.78	0.20	0.16	0.79	0.61	0.00	0.29	0.25	0.80	0.48	0.48	0.68	1.06	0.63
Lifetime Alcohol Use Disorder	2.39	1.68	7.57	1.14	3.80	1.98	3.67	4.16	1.26	2.85	3.66	1.14	11.95	2.64	1.19	3.92	2.85	4.69
12 Month Alcohol Use Disorder	0.87	0.93	2.97	0.48	2.36	0.55	0.73	2.74	0.64	1.12	2.29	0.64	4.58	0.43	0.53	1.39	1.18	1.88
Lifetime Substance Use Disorder	0.52	0.00	1.35	0.41	0.00	0.25	1.23	0.32	0.00	0.27	0.97	0.13	1.64	0.26	0.35	0.26	0.00	0.74
12 Month Substance Use Disorder	0.27	0.00	0.17	0.21	0.00	0.00	0.38	0.00	0.00	0.00	0.32	0.00	0.33	0.00	0.00	0.00	0.00	0.17
UE: Vision	2.58	0.80	5.63	2.28	3.21	1.41	0.76	1.49	0.00	1.27	3.74	1.14	4.14	4.12	0.42	3.24	2.68	2.67
UE: Voices	3.02	0.98	3.63	1.48	2.21	1.91	1.16	3.86	1.03	3.10	4.76	1.74	2.49	2.50	0.49	4.11	2.95	2.49
UE: Mysterious Force	0.77	0.00	0.95	0.40	0.77	0.61	0.18	0.75	0.00	0.36	0.26	0.00	2.93	2.95	0.00	0.72	1.02	0.92
UE: Stolen Thoughts	0.60	0.21	1.12	1.03	0.48	0.40	0.00	1.60	0.00	0.69	0.13	0.13	1.21	1.21	0.30	0.41	0.74	0.74

	R1	R2	R3	R4A	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	BARM	CARAGA	R4B	
UE: Mind Taken	0.48	0.21	0.92	0.43	0.32	0.00	0.00	1.07	0.00	0.62	0.11	0.13	1.67	1.68	0.14	0.35	0.00	0.59
UE: Force Communicating	0.82	0.21	0.98	0.20	0.91	0.61	0.00	1.14	0.00	0.51	0.11	0.20	1.42	1.42	0.00	0.57	0.20	0.64
UE: Plot to Harm	0.61	0.21	0.58	0.40	0.16	0.00	0.00	1.26	0.00	0.15	0.70	0.20	2.59	2.60	0.28	0.37	0.39	0.73
Thoughts of killing self	6.10	7.61	8.62	6.86	8.87	5.02	6.81	12.65	2.38	5.51	8.35	5.43	10.20	10.34	4.07	7.80	10.31	7.86
Suicide plan	43.04	41.00	33.44	48.19	43.71	42.77	58.40	41.95	41.07	38.16	46.19	57.87	31.40	31.22	38.44	60.89	42.58	41.38
Suicide attempt	34.60	22.72	20.98	27.33	30.05	12.37	19.54	20.98	33.62	16.81	16.25	31.36	16.06	15.98	31.36	25.56	18.66	20.67
Dementia	1.04	0.15	2.20	1.49	0.55	0.53	0.19	0.62	0.64	1.67	2.91	0.42	0.43	3.36	0.14	0.41	4.54	1.56
Epilepsy	0.56	0.49	0.62	0.45	1.97	0.00	0.17	4.43	4.80	0.59	0.37	0.72	3.13	1.09	1.00	0.80	0.83	1.00
Total # of respondents	651	598	521	488	731	455	396	429	522	693	670	596	601	578	528	752	650	9859

Legend: yellow – highest regional prevalence
turquoise – 2nd highest
gray – 3rd highest regional prevalence

B. CANSMH

Methodology

The National Survey of Mental Health and Well-being (NSMHW) conducted its first national survey in 17 regions including NCR, covering both the child and adolescent mental health surveys. A total of 4,500 children and adolescents were interviewed, from two (2) regions in Luzon, from two (2) regions in the Visayas, and 2 regions from Mindanao. For the child and adolescent data collection, a *Take all Strategy* was employed for all young people age 4- < 18 years old in the eligible households, about 30 -35 % of the total respondents may be young people (360-420 young people). The respondents were administered four tools – a self-administered questionnaire (Paper and Pencil) for **Strengths and Difficulties Questionnaire - Parent Version (SDQ for parents)** and an interview for the   **Child Personal and Family Questionnaire (CPFQ), Health Services Utilization Questionnaire (HSUQ),** and the **Mini Neuropsychiatric Interview for Children and Adolescent (MINI Kid) version 6.0.**

Algorithm

The choice of instruments to be administered is based on the age of the child or adolescent. Likewise, the participation of the parent/primary caregiver during the interview will also depend on the age of the young person. The administration of the instruments follows an order – CPFQ ➜ SDQ ➜ MINI Kid ➜ HSUQ. Below is an Algorithm for the collection of data in the child and adolescent mental health survey (Figure 1).

Figure 1. Algorithm for the administration of the survey tools for young people.

Algorithm for the Child and Adolescent Mental Health Survey
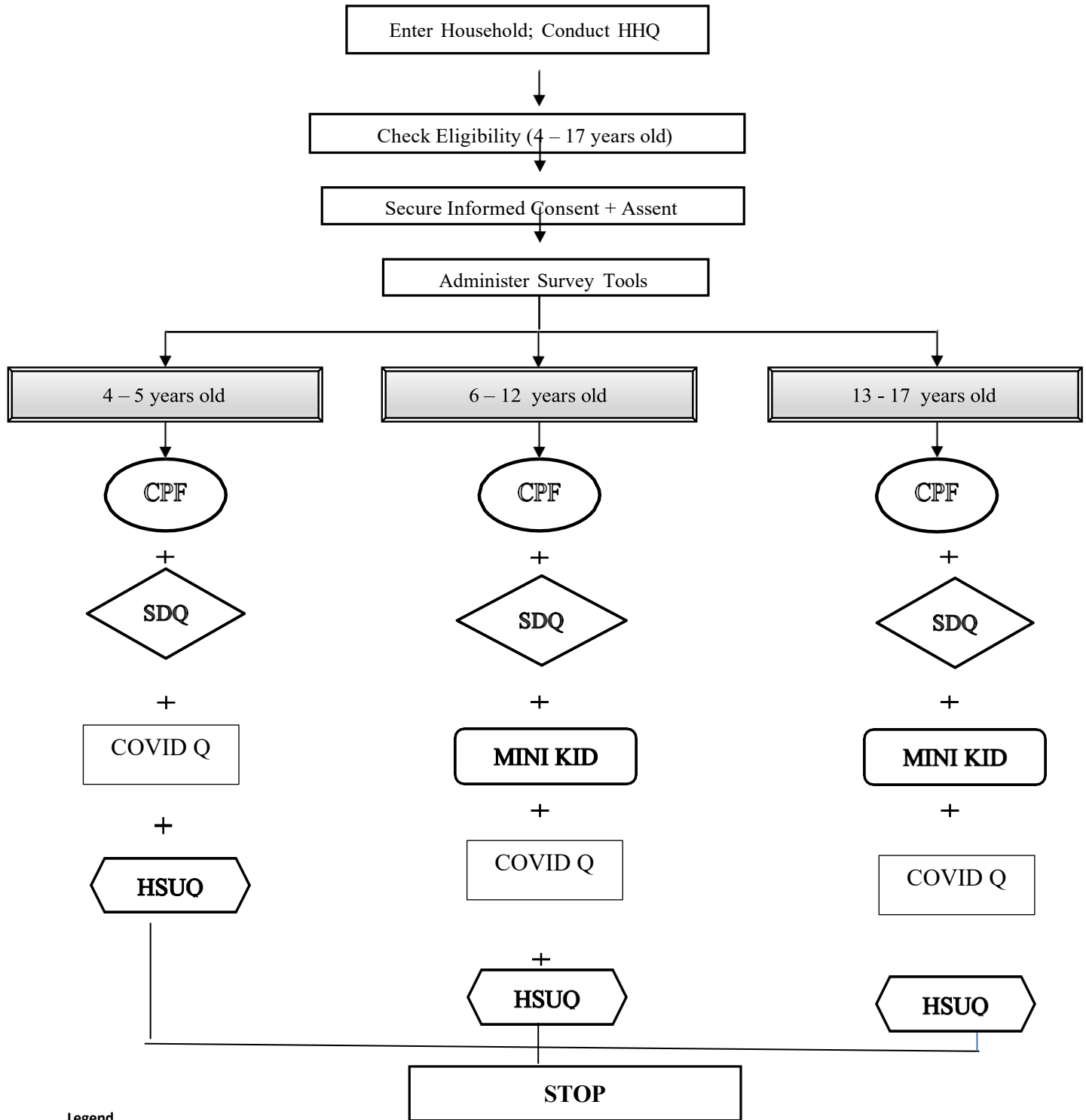
Legend

HHQ – Household Questionnaire
CPFQ – Child Personal & Family Questionnaire
MINI KID – Mini Neuropsychiatric Interview for Children and Adolescents
SDQ – Strengths and Difficulties Questionnaire   HSUQ – Health Services Utilization Questionnaire

Child and Adolescent Survey Tools

Child Personal and Family Questionnaire (CPFQ):

The Child Personal and Family Questionnaire (CPFQ) will collect information regarding the child or adolescent's age, gender, residence (urban/rural), educational attainment, living arrangements, migrant status in the place of residence and primary caregiver demographics. This questionnaire also includes medical comorbidity, presence and type of disability, level of physical activity, internet and mobile use. This questionnaire is administered at the start of the interview; data is elicited from the child's parent or primary caregiver.

Strength and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a short, 25-item questionnaire, developed by Dr. Goodman in 1997, that **screens** for emotional and behavioral difficulties among children and adolescents, which can be completed in 5 minutes. It has versions designed to elicit information from multiple informants: the informant-rated versions which can be completed by either the **parents** of children and adolescents aged 4- <18 years old, and the self-report version which is for **self-completion** by young people aged 11- <18 years old. The 25 items deal with five domains, namely "emotional symptoms", "conduct problems", "hyperactivity/ inattention", "peer relationship problems" and "prosocial behavior", with each domain consisting of five items each.

The main strength of the SDQ is its brevity. It can be completed in 15-20 min by the parent, teacher, or the child. It must be self-administered and the researcher or clinician who gave the tool should not interfere or further explain the instructions written on the tool. The limitation of SDQ is that it is only a screening tool which means it cannot be used to diagnose a child of a specific psychiatric disorder. Rather, it helps in identifying children with symptoms who can then be followed-up for a formal psychiatric assessment. The process of screening psychiatric problems in children is important because this can aid the diagnosis of disorders in children. The sooner they are diagnosed, the sooner they can receive therapy, and the sooner the parents can receive guidance and advice in taking care of their children.

Child and Adolescent Reactions to COVID- 19 Questionnaire (CARC)

The Child and Adolescent Reactions to COVID- 19 Questionnaire (CARC) was developed as a supplement to MINI Kid 6.0 (Sheehan DV, 2010) and Strengths and Difficulties Questionnaire (Goodman, 1999.) These two questionnaires are the principal tools used for the *National Prevalence Survey on Mental Health and Wellbeing* to detect mental health problems among children and adolescents in the Philippines. The CARC was added to help determine how the COVID- 19 pandemic affects the mental health of children and adolescents in the Philippines.

The CARC is an interviewer- administered tool. The interviewer directs questions to the child but if the child is unable to answer, the accompanying adult may reply. The questionnaire has two forms. The first form (CARC 6-17) is a supplement to the MINI Kid 6.0 and is to be administered to children and adolescents 6-17 years old. The second form (CARC 4-5) is to be administered with the Strengths and Difficulties Questionnaire for children 4-5 years old.

There are three sections to the questionnaire. Sections A and B ask about experiences/ exposures/ situations related to the COVID pandemic that affect the child. These factors are external to the child.

Section A asks about situations that affect the child in a bad way while section B asks about situations that affect the child in a good way. Depending on the age of the child, section C picks up from either the Mini Kid 6.0 or Strengths and Difficulties Questionnaire. If the child is detected to have symptoms based on these questionnaires, the interviewer asks the child/ adolescent how intense these symptoms are during the interview compared to pre- COVID period (before December 2019) using a 4- point Likert scale to scale.

Health Services Utilization Questionnaire (HSUQ):

The Health Services Utilization Questionnaire (HSUQ) is one of the last questionnaire to be administered (among the four questionnaires).

If the child is 4-5 years old, the HSUQ is administered after the Strengths and Difficulties Questionnaire (SDQ) has been completed by the parent/guardian.

If the child is 6-17 years old, the HSUQ is administered after the Mini International Neuropsychiatric Interview (MINI Kid) interview has been completed.

The HSUQ inquires about mental health services use in them last 12 months, types of services accessed, perceived need for services, barriers to accessing services and availability of school services and supports. Hence, it is best administered after determining presence or absence of psychological symptoms and psychiatric diagnosis through the SDQ and MINI Kid.

Given the sensitive topic of Abuse, the experience of abuse (emotional, physical and sexual) has been included in this questionnaire.

Mini International Neuropsychiatric Interview for Children and Adolescents (MINI Kid)

The **Mini International Neuropsychiatric Interview for Children and Adolescents (MINI Kid)** is a short, structured diagnostic interview developed by psychiatrists and clinicians in the United States and Europe for childhood psychiatric disorders. Training on the use of the MIN-Kid was carried out by Dr. David Sheehan, a Child and Adolescent Psychiatrists, of the University of Southern Florida and Dr. Evelyn Gapuz, a Child and Adolescent Psychiatrist, from the University of the Philippines- Manila.

The MINI KID has been validated for use among 6 to < 18 years old young people. Hence, only young people within this age group will be administered the MINI Kid in the NSMHW. For children who are 6-12 years old, the child and parent are interviewed together, although the question is directed to the child. For adolescents 13- < 18 years old, the young person is interviewed alone to allow for privacy and honest reporting.

The MINI KID is the primary diagnostic tool to achieve the objective of determining the prevalence rates of child and adolescent psychiatric conditions in this survey. As the main instrument, it is imperative that the MINI KID is administered correctly, completely and accurately. With an administration time of approximately 15-30 minutes, the official and authorized Filipino (Tagalog) translation of the MINI Kid version 6.0 (Child Version) which will be used in the NSMHW Survey is compatible with DSM IV-TR disorders. Although the MINI Kid assesses 30 of the most common psychiatric conditions among children and adolescents, the NSMHW will focus on 14 modules using a Paper-and-Pencil (PAPI) format. **(Table 9)**

Table 9. Modules on the MINI-KID

Module	Psychiatric Condition
A	Major Depressive Episode
B	Suicidality
D	Manic/Hypomanic Episode
G	Separation Anxiety Disorder
H	Society Phobia (Social Anxiety Disorder)
J	Obsessive-Compulsive Disorder
K	Post-traumatic Stress Disorder
L	Alcohol Dependence/ Alcohol Abuse
M	Substance Dependence/ Substance Abuse
O	Attention-Deficit/Hyperactivity Disorder
P	Conduct Disorder
U	Generalized Anxiety Disorder
W	Medical, Organic, Drug Cause Ruled Out
X	Pervasive Developmental Disorder

The MINI KID is divided into **Modules** identified by letters, each corresponding to a **diagnostic category.**

At the beginning of each diagnostic module (Except for the Suicidality module), **screening questions** corresponding to the main criteria of the disorder are presented in a **gray box.** Screening questions are answerable by Yes or No. Depending on the responses, the interviewer is guided on whether to end the interview and move to the next module because the condition has been ruled out, or proceed with the follow-up diagnostic interview questions for further exploration of symptoms.

Follow-up **diagnostic interview questions**, answerable by Yes or No are presented in the rest of the module. These interview questions correspond to the DSM IV-TR diagnostic criteria of each psychiatric disorder.

At the end of each module, a **diagnostic box** permits the interviewer to indicate whether the diagnostic criteria are met.

Psychiatric Disorders are diagnosed based on the types and number of presenting symptoms, duration and presence of functional impairment. For several of these disorders, symptoms that are better accounted for by a medical cause or use of alcohol and drugs are also ruled out. All these

dimensions are elicited in the MINI Kid. For purposes of brevity, MINI Kid employs an algorithm in which psychiatric conditions are ruled in or out depending on the presence of core/primary symptoms (elicited in the Screening Questions) and secondary symptoms, duration and functional impairment (in the follow-up diagnostic questions).

Results

A total of 4,275 children and adolescent were interviewed, from 6 regions, with two regions representative of Luzon, Visayas and Mindanao. The disorders that were most common and had the greatest impact on children and adolescents were assessed.

These were:

1. Attention-Deficit/Hyperactivity Disorder (ADHD)
2. Conduct disorder.
3. Major depressive disorder
4. Suicidality
5. Social Anxiety disorders - Generalized anxiety disorder

Results

Socio-demographic Profile of Children and Adolescents

A total number of 4,414 children and adolescents were administered through PAPI the child and adolescent survey tools.

As to age group, there is adequate representation among the different age levels, 8 – 12 years old 1,375 (32%), followed by 4 – 7 years old 1,293 (30%), then 12 – 15 years old at 1,167 (27%), then the 16 - < 18 years old at 440 (10%).

As to gender, there is a more or less equal distribution, with females at 2,173 (51%) and males at 2,105 (49%).

As to educational level, the no of school children was highest in primary education (elementary) at 2,135 (50%), followed by lower secondary (junior high school) at 1,098 (26%), followed by those who finished only up to early childhood education at 842 (20%), and finally those who finished up to upper secondary (senior high school) at 203 (5%).

As to the primary caregiver for the children and adolescent, the main primary caregiver is the mother at 2,886 (82%), followed by grandparents at 317 (9%), and the father at 211 (6%).

As to living arrangements, a greater majority of the children and adolescent live with their parents at 3,022 (83%), followed by relatives at 504 (14%).

As to the presence of medical illness, a greater majority of children and adolescent do not have a concomitant medical illness at 3,343 (95%) while those who have a medical illness are 184 (5%).

As to the rating in terms of overall health, the majority rate good as to overall health at 2,014 (57%), followed by those who rate very good in terms of overall health at 956 (27%), and fail at 527 (15%).

As to internet usage, about a greater majority use it for less than 2 hours a day at 2,938 (70%) since they do not have laptops nor cell phones for home-school classes. The children are usually given module to work on. This is followed by those who use it for 2 -4 hours daily at 854 (20%), followed by 5 – 8 hours at 311 (7%), and those who use it more than 8 hours at 124 (3%).

A greater majority of the children and adolescent manage to have physical activity at home, at 4,143 (97%).

As to history of abuse, majority of children and adolescent do not experience it at 4,144 (7%), while those who have had a history of abuse is at 130 (3%). As to the type of abuse of those who have a history of abuse: physical abuse at 73 (56%), verbal abuse at 48 (37%), emotional/ psychological abuse at 34 (26%) and sexual abuse at 13 (10%)

As to the need for health services, about 826 (24%) have requested for it, in the form of mental health consultations at 500 (60%), followed by courses on parenting, values education at 193 (24%), then counselling at 71 (8%) and medications at 62 (8%).

As to barriers that prevent the families from accessing health services, majority claim that they do not have money to pay and could not afford it at 1,761 (41%), and would prefer to handle the problems on their own or with the family at 894 (21%). Quite a number are not sure where to get help at 770 (18%) , and they are not sure if the child and/or adolescent needs help at 579 (14%). Many are also concerned about what other people might think at 521 (12%), while others think that services are not available at 436 (10%). The rest of the barriers as to not sure where to get help, could not get an appointment, and the child or family member refuses to go , all of which are less the 10%.

Table 10. Socio-demographic profile of the respondents (2021)

	Frequency	Percentage
Sex		
Male	2105	49%
Female	2173	51%
Age Group		
4 – 7 years	1293	30%
8 – 11 years	1375	32%
12 – 15 years	1167	27%
16 – < 18 years	440	10%
Educational level		
Early Childhood Education	842	20%
Primary Education (Elementary)	2135	50%
Lower Secondary (Junior High School)	1098	26%
Upper Secondary (Senior High School)	203	5%
Primary Caregiver		
Mother	2886	82%
Father	211	6%
Grandparents	317	9%
Sibling	22	1%

Relatives	75	2%
Yaya	2	0%
Others	14	0%
Living arrangements		
Parents and siblings	3022	83%
Relatives	504	14%
Non-relatives	22	1%
Others	73	2%
Medical illness		
No	3343	95%
Yes	184	5%
Overall health		
Very Good	956	27%
Good	2014	57%
Fair	527	15%
Poor	29	1%
Very Poor	1	0%
Internet use		
Less than 2 hours/day	2938	70%
2-4 hours/day	854	20%
5-8 hours/day	311	7%
More than 8 hours/day	124	3%
Physical activity		
No	134	3%
Yes	4143	97%
History of abuse		
No	4144	97%
Yes	130	3%
Type of Abuse		
Physical	73	56%
Emotional and Psychological	34	26%
Verbal	48	37%
Sexual	13	10%
Others (bullying, trauma)	8	6%
Need for health services		
No	3488	76%
Yes	826	24%
Type of health services		
Health Services – medical consultations	500	60%
Medications	62	8%
Counselling	71	8%
Courses: parenting, values education, catechism	193	24%
Barriers to accessibility of health services		

Prefers to handle problems by self or with family	894	21%
Concerned about what other people might think	521	12%
Not sure if the child and adolescent needs help	579	14%
Not sure where to get help	770	18%
The situation would improve and get better over time	265	6%
Services not available	436	10%
No money to pay and could not afford it	1761	41%
Could not get an appointment	328	8%
Child or family member refuses to go	231	5%
Others	221	4%

Strengths and Difficulties Questionnaire

The SDQ is a commonly used measure of child and adolescent psychological functioning (Goodman, 1997). It is a brief emotional and behavioral screening questionnaire for children and adolescent through Paper Administered Personal Interview (PAPI). The tool can capture the perspective of children and parents. It consists of 25 items across five domains: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior.

Emotional symptoms: 'mood or emotional responses dissonant with or inappropriate to the behavior and/or stimulus' (Medical.Webends.com)

Conduct problems: 'identifiable behaviors in the individual that fail to conform to societal norms and encroach on the rights of others' (Larmar & Gatfield, 2006)

Hyperactivity-inattention: level of attention deficit or hyperactivity disorder, which is characterized by persistent and impairing symptoms of inattention, hyperactivity and impulsivity (Galéra, Melchior, Chastang, Bouuvard & Frombonne, 2009)

Peer problems: evidence that children who experience difficulty making friends and getting along with their peers are at increased risk of a wide range of psychosocial outcomes (Woodward & Fergusson, 2000)

Prosocial behavior: 'voluntary behavior that benefits others or promotes harmonious relations with others' (Bergin, Talley & Hamer, 2002).

The 25 items can also be conceptualized as a three-factor model consisting of internalizing problems, externalizing problems, and positive behavior (Dickey & Blumberg 2004; Hill & Hughes, 2007).

In the CASMH, the SDQ scores are based on respondent reports, usually from parents for younger children ages 6 – 10 years old and self- report measure for adolescents aged 11- < 18 years old. Where the child or adolescent is aged 11 - < 18 years, the SDQ is undertaken with the adolescent, rather than their parent or carer.

The SDQ instrument asks respondent to base their ratings on the past six months. Each item is scored on a 3-point ordinal scale where 0=not true, 1= somewhat true and 2= certainly true. Scores for scales 1- 4 are summed to provide a total difficulties score. Children are categorized as being in one of three score

ranges; within the normal range (< 80th percentile), within the borderline range (90-90th percentile) and within the clinically significant range (>90th percentile).

It is important to remember that the SDQ is only a screening tool and should not replace other processes, assessments and/or knowledge of the child and adolescent and their behaviors. After completing the SDQ, the respondents proceeded to answering the MINI-Kid through PAPI by the LIs. Once the SDQ and MINI-Kid have been completed with the parent or carer the LIs must ensure that the SDQ scores and MINI-Kid results are recorded on the CSpro.

Recording the Questionnaire

The overall score (classified as 0-15, 16-19 and 20-40 – with the highest scores being of most concern) and the Pro Social score (classified as 6-10, 5 and 0-4 – with the lowest scores being of most concern) will be generated on the form once each field has been entered. The Pro Social Score is not included in the calculation of the child's emotional well-being. The terminology for the scores within the SDQ guidance is explained below, with the relative score. However, the terminology used in these procedures is Low, Medium or High.

Total SDQ score	Pro Social score
Normal 0-15 Low	Normal 6-10 High
Borderline 16-19 Medium	Borderline 5 Medium
Abnormal 20-40 High	Abnormal 0-4 Low

SDQ Outcomes and Analysis in the CASMH

Low scores

Where total SDQ score is Low, this should be recorded on the child or adolescents' record and no further action is required.

Medium or High scores

Where the total SDQ score is Medium or High and where the Pro Social Score is Low or Medium (the pro-social score is a concern but not in isolation), this is a concern as it may signify that the child or adolescent may have emotional needs and needs to be address.

Using the SDQ score

A number of bandings have been developed which can help predict children and adolescents who are likely to develop significant mental health problems, based on their SDQ scores. **(Table 11).** The bandings classify scores as:

- 'normal'

- 'borderline'

- 'abnormal' - cause for concern'

These bandings are identified by obtaining the total difficulties score and the scores in each of the scales. If the child's total difficulties score is outside the normal range (**Table 10)** and considered as giving cause for concern, as already presenting with signs of poor emotional well-being or mental health, then an appropriate referral should be made to the nearest access point.

Table 11. SDQ bandings for parent/carer questionnaire results – using the SDQ score

Main parent/ career completed SDQ	Normal	Borderline	High - Cause for Concern
Total Difficulties score	0 – 15 (Low)	16 – 19 (Medium)	20 – 40 (High)
Pro Social Score	6 – 10 (High)	Borderline 5 (Medium)	Abnormal 0 -4 (Low)

For example, ratings on the SDQ Emotion subscale significantly predicted the likelihood of having concurrent clinical anxiety and depression scores. Ratings on the Hyperactivity subscale predicted concurrent anxiety levels. These findings suggest the SDQ could be a valuable screening tool for identifying existing mental health difficulties in children recognized as struggling, as it can be in typically developing children and those with specific diagnoses.

The SDQ Total Difficulties Score is considered low or normal for the all children and adolescents at the national level, as well as for all areas of Luzon, Visayas and Mindanao (LuzVizMin). **(Table 12).**

The Pro Social score is considered high or normal for the all children and adolescents at the national level, as well as for all areas of Luzon, Visayas and Mindanao (LuzVizMin).

Table 12. SDQ results at the national level and in the 3 major islands of the Philippines (LuzVizMin)

SDQ Scale	Prevalence (%)			
	Luzon	**Visayas**	**Mindanao**	**National**
Emotional Symptoms Scale				
Abnormal	13.89	17.77	20.27	16.78
Borderline	10.69	14.2	13.04	12.39
Normal	75.42	68.03	66.69	70.83
Conduct Problems Scale				
Abnormal	12.73	15.18	16.65	14.53
Borderline	12.24	13.2	15.64	13.44
Normal	75.03	71.62	67.7	72.03
Hyperactivity Scale				
Abnormal	7.25	4.83	6.3	6.26
Borderline	9.12	5.73	8.48	7.92
Normal	83.63	89.44	85.22	85.82
Peer Problems Scale				
Abnormal	41.5	45.62	45.46	43.82
Borderline	27.33	22.67	20.31	24.03
Normal	31.17	31.71	34.23	32.15
Prosocial Scale				

Abnormal	10.03	12.22	13.79	11.7
Borderline	16.26	13.39	13.17	14.56
Normal	73.71	74.39	73.04	73.74
Total Difficulties Score				
Abnormal	14.79	12.5	15.38	14.25
Borderline	12.16	17.66	18.28	15.47
Normal	73.05	69.84	66.33	70.27
Impact Score				
Abnormal	7.64	7.62	5.18	6.97
Borderline	2.89	3.26	1.4	2.6
Normal	89.48	89.12	93.42	90.42

Mini- Neuropsychiatric Interview for Kids (MINI-Kid)

The standard MINI *Kid* assesses the 30 most common and clinically relevant disorders or disorder subtypes in pediatric mental health. It is PAPI administered by the LI.   In the CASMH, the child and parent are interviewed together. The question is directed to the child. The parent is asked to remain silent and not to respond unless the parent believes it is clear that the child has provided inaccurate information. In this event the LI then triangulates the discussion between child and parent, to get the most accurate assessment, and records the responses accordingly.

Based on the above results, hypomanic episodes, both current and past are considered the highest , with 94.22% and 93.11 % respectively. This can be considered normal in children and young people. This is followed by Conduct Disorder at 32.94% followed by ADHD with combined at 17.49% and inattentiveness at 18.33 %. This followed by Major Depressive Episode at 2.54% for current, 4.23 % for past and 2.74% for recurrent. This will need to correlate with Suicidality Risks, though low at 7.56% but high risks are 4.67%, followed by Moderate risk ate 1.18%. Lifetime Mood disorder is 11.82%. Social Anxiety Disorder, Generalized is at 1.14%. The rest, fall below 1 %: Pervasive Disorder; Psychotic Disorder; Alcohol and Substance Use Disorder. **(Table 13)**

Table 13. Prevalence of Mental Disorders in Children and Adolescents (2021)

Module	Prevalence (%)			
	Luzon	**Visayas**	**Mindanao**	**National**
Major Depressive Episode				
Current*	5.15	0.48	0.86	2.54
Past	8.69	0.92	1.01	4.23
Recurrent	5.51	0.63	0.82	2.74
Major Depressive Disorder				
Current*				
Past				
Recurrent				
*past 2 weeks				

	Luzon	Visayas	Mindanao	National
Suicidality*				
Low	10.07	4.13	<mark>7.41</mark>	7.56
Moderate	1.16	0.87	<mark>1.62</mark>	1.18
High	<mark>7.95</mark>	1.77	2.52	4.67
current (past month)				
	Luzon	**Visayas**	**Mindanao**	**National**
Manic Episode				
Current	0.80	0.19	0.16	0.44
Past	2.74	0.19	0.38	1.31
Hypomanic Episode				
Current	2.11	0.60	0.18	1.13
Past	2.90	0.52	0.09	1.42
Hypomanic Symptom				
Current	96.16	76.02	100.00	94.22
Past	94.33	78.91	100.00	93.11
	Luzon	**Visayas**	**Mindanao**	**National**
Separation Anxiety Disorder*	6.78	4.48	8.41	<mark>6.45</mark>
current (past month)				
Social Anxiety Disorder*	**Luzon**	**Visayas**	**Mindanao**	**National**
Generalized	1.11	1.55	0.66	1.14
Non-Generalized	0.61	0.00	0.24	0.33
current (past month)				
	Luzon	**Visayas**	**Mindanao**	**National**
Obsessive Compulsive Disorder*	0.54	0.00	0.21	0.28
current (past month)				
	Luzon	**Visayas**	**Mindanao**	**National**
Post-Traumatic Stress Disorder*	1.93	0.00	0.24	0.88
current (past month)				
Alcohol Dependence*	1.55	0.00	0.00	0.61
Alcohol Abuse*	0.76	0.23	0.49	0.52
Substance Dependence*	0.00	0.00	0.00	0.00
Substance Abuse*	0.00	0.00	0.17	0.04
past 12 months				
ADHD*	**Luzon**	**Visayas**	**Mindanao**	**National**
Combined	14.04	25.60	50.14	17.49
Inattentive	19.19	15.24	12.15	18.33
Hyperactive/Impulsive	1.10	31.62	8.70	4.83
past 6 months				
	Luzon	**Visayas**	**Mindanao**	**National**

Conduct Disorder*	39.87	25.13	26.27	32.94
past 12 months				
	Luzon	**Visayas**	**Mindanao**	**National**
Mood Disorders				
Lifetime	15.57	12.90	0.97	11.82
Current	0.00	0.00	0.00	0.00
Psychotic Disorders				
Current	0.51	0.00	0.00	0.47
Lifetime	0.36	0.00	0.00	0.33
	Luzon	**Visayas**	**Mindanao**	**National**
Generalized Anxiety Disorder	13.22	30.65	24.55	13.78
*current (past 6 months)**				
	Luzon	**Visayas**	**Mindanao**	**National**
Pervasive Disorder	0.15	0.00	0.00	0.14
Unsure	0.76			0.74

IV.   Discussion

The Philippine NSMHW was carried out in the hope of addressing the problem of the need for epidemiological data on the prevalence and correlates of mental disorders. The survey for the adult population was carried out in close collaboration with the WHO World Mental Health (WHM) Survey Initiative (Kessler et al, 2006). The NSMHW is a cross-sectional, face-to-face, household survey of a probability sample of the adult population of the Philippines. It is the first Philippine nationwide study to investigate the 12-month and lifetime prevalence rates and socio-demographic correlates of MNS disorders.   It also assessed the levels of disability, the quality of life, the use of services, and the consumption of psychotropic medications by people with mental disorders.

With the total adult population of   9,758, about 15% of the respondents reported lifetime presence of any mental disorder, with nearly 11.% experiencing a mental disorder in the past 12 months. Of the respondents, 6% reported a lifetime history of anxiety disorders (panic attacks) being the most prevalent followed   by 5% for alcohol use, and followed by 2% for both MDD and dementia. In general, about 1 out of every 6 Filipinos have had a mental health problem during their lifetime, which is lower compared to other countries, e.g., Australia, Hongkong, and Japan (World Health Report 2017).

Within the 12 months preceding the interview, 12% of the respondents met the criteria for any mental disorder. Among those with mental disorder anxiety disorders (panic attacks) was the most common followed by alcohol and MDD, both having similar prevalence rates at 2%.

As to regional estimates, for the lifetime prevalence of mood disorder, whether MDD or manic, NCR had the highest prevalence, followed by Region 3 and Region 4A. For the lifetime prevalence of anxiety disorders, e.g., GAD, panic attack and panic disorder, NCR had the highest prevalence followed by Region 4A and Region 3. For the lifetime prevalence of alcohol and substance use disorder, NCR had the highest prevalence followed by Region 4A and Region 8. For the lifetime prevalence of dementia, Region $B had the highest prevalence followed by CAR, and Region 11. For the lifetime prevalence of epilepsy, Region 9 had the highest prevalence followed by Region 8 and NCR.

As to suicide, with regard to thoughts of killing oneself, Region 8 had the highest prevalence followed by NCR and Region 4B. Of those who have thoughts of killing oneself, the suicide plan was highest in CARAGA followed by Region 7 and Region 12 and the suicide attempt was highest in Region1, followed closely by Region 9, and Region 12 and BARM at a tie for 3rd place.

On the other hand, the CASMH was carried using the SDQ and the MINI-Kid, to determine the prevalence of mental health problems in children and adolescents. Besides the socio-demographic variables, data is available regarding living arrangements, presence or absence of co-morbid medical illnesses, overall evaluation of the child's health, duration of internet use, presence or absence of physical activity, history and type of abuse, the need and type of health services, and finally, barriers to accessibility of health services.

Of the total number of 4,275 children and adolescents, the most common disorders were ADHD, Conduct disorder, MDD and Social Anxiety Disorders. Of great concern is the high prevalence of suicide in Luzon at 7.95 %.

V.   Recommendations for Mental Health Policies and Plans

Public Mental Health is not only limited to promoting and protecting the mental health and well-being of the population; as it also involves the prevention of mental health problems and mental illness; reducing the impact of mental health problems and mental illness including the effects of stigma and discrimination; improving the quality of life of those suffering from mental health problems and recovering from mental illness; and, assure the rights of people with mental health problems and mental illness, and enable them to participate and contribute to society in a meaningful way.

The enactment of the MH Act of 2018 serves as a monumental step towards providing the delivery of integrated mental health services, promoting and protecting the rights of persons utilizing psychiatric, neurologic and psychosocial health services for all Filipinos. With the creation of the **Philippine Mental Health Council (PCMH)** in 2018 as mandated by the MH Act of 2018, as the policy-making body, it has developed a national multi-sectoral strategic plan for mental health and will ensure its implementation through monitoring and evaluation of polices. The PMHC represents the commitment of all government agencies (DOH as Chair, DOLE, DILG, CHED, CHR, DepED, academe, NGO and professional organizations) coming together for the continual improvement of the mental health of the nation.

Policy Paper	Titles
Policy No. 1	Strengthening effective leadership and governance for mental health systems development and mental health service delivery at the central (DOH) and local (LGUs) level.
Policy No. 2	Innovating through Digital Mental Health as part of the DOH's eHealth Strategy
Policy No. 3	Integrating Mental Health into the Universal Health Care Coverage (UHC) and Primary Health Care (PHC)
Policy No. 4	Measuring Mental Health
Policy No. 5	Advocating for a recovery-oriented medical care for those suffering from serious mental illness
Policy No. 6	Providing a comprehensive, integrated and responsive mental health services in disasters and emergencies

Policy No. 1 Strengthening effective leadership and governance for mental health systems development and mental health service delivery at the central (DOH) and local (LGUs) level.

The Department of Health (DOH) sets national policy, develops technical standards, enforces regulation, monitors services, and provides tertiary and specialized care. Below are the following mental health policies that have been implemented.

Implementation of National Mental Health Program Strategic Plan 2019 – 2023 to be scaled down to the LGUs

1. The strengthening of the National Mental Health Program through DOH-AO 39 s.2016 expanded the implementation of mhGAP, Mental Health and Psychosocial Support (MHPSS) (disaster preparedness) and MAP-MH, which are core mental health programs at the community level. Due to the limited access to quality mental health care and support, the DOH supported the WHO's call of training on the **Mental Health Gap Action Programme (mhGAP)** for capacity building of health care providers at the primary care level to scale up care for identified MNS disorder and facilitate delivery of evidence-based psychological services s in non-specialized settings. As of 2019, 69% of LGUs have trained health providers in mhGAP and have implemented their local mental health ordinance of the creation of Access Sites for the delivery of essential mental health care. While 14% of the LGUs have trained staff on MHPSS disaster preparedness.

2. The **Medicine Access Program for Mental Health (MAP-MH**), started in 2012 by the DOH Pharmaceutical Division (PD) and operationalized by the National Center for Mental Health (NCMH), was designed to ensure availability of mental health drugs in the community. With the transfer of MAP-MH to the National Mental Health Program (NMHP) under the DOH Disease Prevention and Control Bureau (DPCB) and the goal of expanding coverage of beneficiaries and medicines being provided, there is a need to establish standards and guidelines to aid in the proper implementation of MAP-MH nationwide.

3. **National Suicide Prevention Strategy** was formulated by DOH in 2020   as part of its multi-sectoral approach to mental health with programs and interventions across a variety of settings (e.g., workplaces, schools, communities) aimed at high-risk groups. The comprehensive suicide prevention services should encompass crisis intervention and a response strategy on a nationwide scale. DOH has initiated the commemoration of the **World Suicide Prevention Day every September 10** to raise awareness on the plight of those who   are undergoing severe forms of depression. Another project included the creation of psychosocial services such as the NCMH's Crisis Hotline "Kamusta Ka? Tara Usap Tayo," launched on 2 May 2019 with the hotline available 24/7 for prompt psychological first aid.

The Philippines' health care system has evolved since the enactment of Republic Act No. 7160 or the Local Government Code (LGC) of 1991. The code institutes—through a system of decentralization—more power, and a transfer of authority, responsibilities and resource management capacities, to the local government units (LGUs). The LGUs include the province headed by the governor, the city/municipality headed by the mayor, and the barangay (village) headed by the captain.

With the devolution of health service delivery down to the LGUs, there has to be more coordination and collaboration of the LGUs local health board (LHB) with the Regional Centers for Health Development (CHDs) to ensure an aligned and concerted health system from the local level to the CHD and the national

level and vice versa. With the passage of RA 11223 and the move on integrating the local health systems to province-wide and city-wide health systems, it is also imperative that the skills and expertise of the DOH Representatives be upgraded so they can provide technical assistance to the LGUs efficiently and effectively.

The national DOH will provide support mechanisms to help the LGUs-LHB come up with policies, guidelines and tools to improve mental health services and delivery.

1. To continue conducting training-of-trainers through the regional mental health coordinators, and roll out the training programs on the mhGAP to the health workers in all the provinces and municipalities/cities. An evaluation of the impact of the mhGAP training on the delivery health services can be done.

2. To provide substantial resources for mental health services in the health budget to meet the goals of policy. The 2018 MHAct put mental health costs under the country's 2019 UHC coverage scheme which requires careful planning for prioritization and improvement of services. (ref. module on *Mental Health Financing).* The DOH can assist the LGUs to assess current financing mechanisms for mental health, maximize the resource base for mental health and make the best use of available funds to promote mental health reforms at the local level. The Local Government Units (LGUs) provincial and city/municipal governments are responsible for financing and operating local public health systems. Provincial governments provide primary and secondary hospital care.

Policy No. 2 Innovating through Digital Mental Health as part of the DOH's eHealth Strategy

'Into the Light' was a public-private partnership launched in 2013 to establish the Philippines' first integrated health information system for mental health conditions (PHIS-MH), particularly schizophrenia and bipolar disorders. During the first year of the Program, approximately 2,500 data entries were recorded in the system across 14 government and private hospitals and health care facilities and institutions nationwide, with 42% of patients diagnosed as living with schizophrenia, 15% with bipolar disorder and 6% with a history of substance abuse. For the first time, data showing that many patients were of working age and in their most productive years, but that only 22% were covered by PhilHealth (either as members or dependents), suggesting that many patients face a cycle of poverty resulting to poor access to treatment and care and lost employment.

1. With the integration of the PHIS-MH system into the DOH's e-Health strategy for all public and private hospitals with psychiatric facilities by capturing information during admission to inpatient mental health service. The data provided will provide them magnitude of the burden of the disease so that integrated solutions for accessibility of care and psychosocial interventions can be provided.
2. The need to maintain at all times the practice of ethical principles with regard to managing clinical records. Given the set-up, patient-doctor confidentiality and identify should be respected, with data collected with informed consent.

Policy No. 3. Integrating Mental Health into the Universal Health Care (UHC) and Primary Health Care (PHC)

A strong government policy commitment is needed to provide for health budget for the integration of services through the following: 1) financing and establishment of psychiatric facilities in all government hospital with the corresponding increase in the number of the mental health workforce; 2) promotion and integration of community-based care at the primary care level; 3) training on the mhGAP for all public health professionals and community workers; and 4) the implementation of the *Medication Access Program* in every region and province;

The MH Act of 2018 mandates the integration of mental health care in the basic health care services at the appropriate levels of care.

1.   Primary health care services must integrate mental health care as part of the basic health services, particularly at the city, municipal, and barangay or village levels that can lead to early intervention and limit the stigma of treatment. Community-based mental health care (CMHC) should be established which should not only be localized and accessible but should also be able to address the multiple needs of individuals. The staff are able to provide assessment and short-term treatment for less severe and time-limited disorders, and provide on-going care for people with severe mental illness, especially those who have complex needs and have significant risk factors.

2.   Implementation of the Mental Health Facilities Plan at the secondary levels of care with the setting of Mental Health Basic Comprehensive Centers in DOH hospitals that consists of Acute Psychiatric Facilities with in-patient services, as well as provide Crisis intervention and outpatient services.

3.   For the tertiary levels of care, the creation of Advanced Mental Health Centers must be able to provide outpatient services, crisis intervention, forensic psychiatry, geriatric psychiatry, child and adolescent psychiatry, custodial care, neuro-related management (e.g., Alzheimer's, Neurodevelopmental disorders, seizure), psychotherapy and tele psychiatry.

4.   The National Specialty Center (e.g., National Center for Mental Health) must be able to provide all services from basic comprehensive to advanced comprehensive centers. Eventually , the NCMH will need to develop a phased and budgeted plan for closing long-stay psychiatric patients and provide for their continuity of care in the community.

National Specialty (1)	Advanced Comprehensive Center (9)	Basic Comprehensive Center (14)	
NCR: National Center for Mental Health	**CAR:** Baguio General Hospital and Medical Center **R2:** Cagayan Valley Medical Center **R3:** Mariveles Mental Wellness and General Hospital **R5:** Bicol Medical Center **R6:** Western Visayas Medical Center **R7:** Vicente Sotto Memorial Medical Center **R8:** Eastern Visayas Regional Medical Center **R9:** Zamboanga City Medical Center **R11:** Southern Philippines Medical Center	**NCR:** Dr. Jose N. Rodriguez Memorial Hospital and Sanitarium East Avenue Medical Center Quirino Memorial Medical Center Rizal Medical Center **R1:** Mariano Marcos Memorial Hospital and Medical Center Ilocos Training and Regional Medical Center Region I Medical Center **R3:** Dr. Paulino J. Garcia Memorial Research and Medical Center Jose B. Lingad Memorial Regional Hospital **R4A:** Batangas Medical Center	**R5:** Bicol Regional Training and Teaching Hospital **R10:** Northern Mindanao Medical Center **R12:** Cotabato Regional and Medical Center **BARMM:** Amai Pakpak Medical Center

Policy No. 4. Measuring Mental Health

The vision of the National Survey for Mental Health and Well-being

The Philippine National Survey for Mental Health and Well-being (NSMHW) was a program with 2 targeted mental health epidemiological survey that based their classification of mental disorders on existing diagnostic criteria to estimate the lifetime prevalence and the 12 month prevalence of MNS. The 2 surveys inlcuded the National Survey for Mental Health and Well-Being (NSMHW) and the Child and Adolescent National Survey for Mental Health (CANSMH).

Information about a nation's mental health and ill health is valuable for the administration of health services, for advocacy and for research. The first mental health policy instituted by the Department of Health was DOH Administrative Order No. 8 series of 2001 entitle the "National Mental Health Policy". This policy set forth the guidelines for the establishment of a sustainable health program.   The program was followed by the issuance in of DOH Administrative Order No. 2016-0039 Revised Operational Framework for a Comprehensive National Mental Health Program , which provided for equitable access to the rational use of a wide range of pharmacologic interventions in the treatment and management of mental, neurologic, and substance use (MNS) disorders.

1. The NSMHW and CANSMH can be done on regular intervals of every 5 years   Given the implementation of the mental health policies and plans, the NSMHW and CASMH   is necessary to evaluate the gains of the the National Mental Health Program Strategic Plan 2019 – 2023 and to improve mental health service delivery under the UHC program .

2. A proposal to include a *National Survey of Psychotic Disorderes*, a community-based epidemiological survey. Knowledge of the level of psychosocial impairment associated with psychosis is important in evaluating the impact of the illness on those affected. The survey can help in providing a public health perspective for service planning with information derived from representative samples of patients.

Policy no. 5. Advocating for a recovery-oriented medical care for those suffering from serious mental illness

People with severe mental illness such as schizophrenia or bipolar disorders are not identified and provided with appropriate treatment or care. Many of them experience numerous care transitions into and out of hospital, which often lead to a negative effect that impacts on poor medication adherence and follow-ups. As a result, this gives rise to the "revolving door" phenomena. Unfortunately, families and communities are not equipped and prepared to receive these persons back giving rise violations of their human rights. Public misconceptions and stigma for this population have led to social withdrawal and have hindered re-integration into the community (Lin, Hsiung, Lin, & Hwu, 2002). In the urban areas, there are no provisions (e.g., food and shelter) for the homeless mentally ill who are left to fend for themselves. Chaining , locking up and restraining those who are seriously ill are still commonly practiced in the rural areas and health-care facilities. With the integration of mental health into general health-care settings, continuity of care can be provided for persons and their families through recovery model programs (e.g. by assisting family support groups through psychoeducational programs, promote psychosocial rehabilitation, provide funding and support for locally-based NGOs to provide community resources for employment and social support to those in need etc.) for those with serious mental illness with the hope of improving their quality of life.

1. The need to develop and implement community-based care for persons with schizophrenia and bipolar disorder within the community. This move towards community re-integration is predicated on the continuity of psychiatric care from the hospital to the community
2. LGUs, NGOs, and professional organizations can provide community support through public education and awareness campaigns, employment, and medical services   in order to allow patients with schizophrenia and bipolar disorder to receive continuing treatment and care so that the physical, mental, and social conditions for having "quality of life" within the community can be restored. These programs are particularly effective in reducing burden and can improve mental health.

Policy No. 6. Providing a comprehensive, integrated and responsive mental health services in disasters and emergencies

The Philippines is prone to earthquakes, tsunamis, typhoons, floods and other natural disasters which have resulted in loss of lives and serious damage and destruction to infrastructure, facilities and homes. The psychological impact of disaster varies widely and are dependent on individual factors, such as age, ,gender, culture, socio-economic class, etc. Many people are resilient and will naturally return to their pre-disaster level of functioning. But about 30% of direct victims of disaster will experience one or more disorders such as PTSD, depression or anxiety. About 5 -10% of people in the community at large, 10 - 20% of first responders are at risk, and children emerge with greater risk (Galea, 2005). Early intervention is deemed necessary to reduce risks of developing mental health problems.

Mental health interventions and psychosocial support have to be a part of immediate and long-term responses to disasters and emergencies. Disasters also provide a unique opportunity local government official to recognize and address broader mental health and psychosocial needs of the community by providing comprehensive, integrated and responsive mental health care and services in community-based settings.

There is a need to provide mental health support to disaster survivors and responders across the disaster continuum of preparedness, response and recovery.

Disaster Mental Health Response through with a Three-Component Intervention Strategy
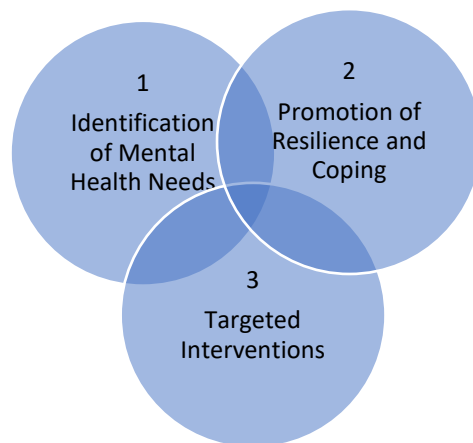
1. Identification of mental health needs, especially those who present themselves with significant stress symptoms. There is a need to monitor areas with vulnerable populations through mental health surveillance
2. Promote resilience and coping by providing psychological first aid for direct victims. The LGUs can help communities normalize stress reaction through public health information and consultation.
3. Targeted interventions can be provided with referrals for secondary assessments, the need to community resources (e.g., medication access), casualty support for physical rehabilitation.

VI.   Conclusion

National policies for mental health in the Philippines lay a strong groundwork for increasing access to mental health care services across the country. The policy states that mental health care is a universal right. Following the policy, legislation that demands integrating mental health services into primary health care and decentralizing services to local government units offers opportunity for the expansion of community-level mental health programs. The advantages of integrating mental health care into general health services, particularly at the primary health care level, includes less stigmatization of patients and staff, improved screening and treatment and better treatment of mental aspects associated with physical problem. For the local government units, shared infrastructure can lead to cost efficiency and savings and the use of community resources which can partly offset limited mental health staff. Given the structural and cultural changes, these will allow the integration of different stakeholders into service provision, so that no one is excluded, especially people living with mental illness.

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