World Health Organization
Representative Office for the Philippines

Framework for Community Based Mental Health Programs in the Philippines

A GUIDEBOOK

First Printing, 2021

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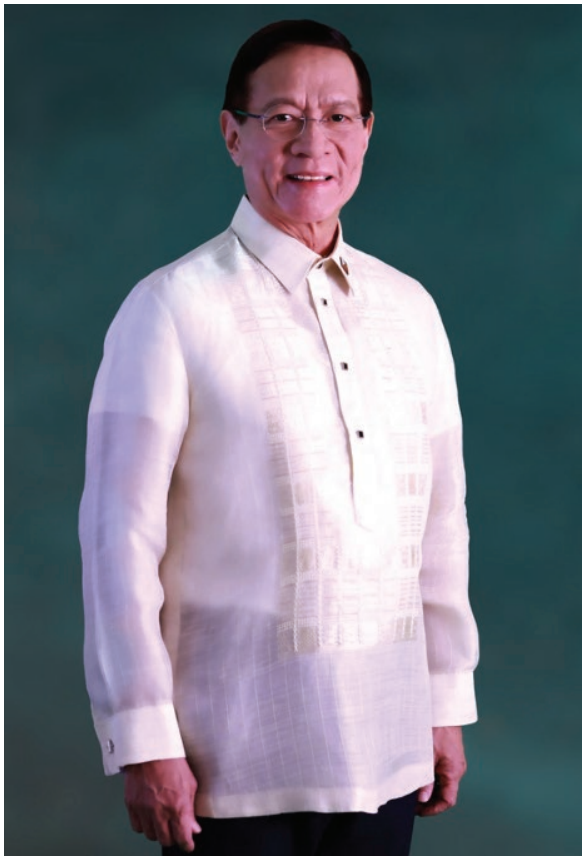
MESSAGE FROM THE SECRETARY OF HEALTH



Sound mental health is important for an individual to have a good quality of life, and must be given the same care, maintenance, and value as is given to physical health. One of the ways to be able to achieve this is by creating a community that is enabling and wholly supportive of nurturing the mental health of individuals.

As social beings, we are not meant to live solitary lives, thus placing the community in a vital role in maintaining individual mental health. The community is essential in enabling us to thrive, particularly in aiding those with mental illness recover from the common symptoms of loneliness and isolation.

In this light, the establishment of a Community-Based Mental Health (CBMH) program becomes undeniably relevant, especially at this time when both our physical and mental health are being seriously challenged by a near-constant stream of negative events, such as natural calamities and the global COVID-19-pandemic.

CBMH is a system of care in which the service-users' community, not a specific health facility, becomes the primary provider of care for people with mental illness, thereby offering much more than simply providing outpatient psychiatric treatment. Mental health promotion is a major component of the CBMH that encourages and promotes healthy behavior, strengthens the policy environment, and promotes population health at different levels to reduce risk factors and prevent onset of mental health illness.

This system of care shall allow those with mental disorders to maintain family relationships, friendships, professional careers, and ably perform daily functions while receiving treatment. It will also facilitate early rehabilitation and a holistic means of care. Through the community set-up, it can promote mental health care among the residents as well, and will likely reduce symptoms of ill mental health and prevent mental disorders in the future.

However, establishing a mental health care system at the local setting is not going to be an easy feat. This is why the Department of Health, in collaboration with the World Health Organization and mental health experts, has produced a guidebook entitled "Framework for Community Based Mental Health Programs in the Philippines" for reference in forming a CBMH program.

This framework for CBMH programs in the Philippines was conceptualized by a multidisciplinary team of specialists covering the fields of psychology, psychiatry, and community development, and was guided by a review of literature on CBMH programs and services, shared on-ground experiences, and a focus group discussions with service users, family members who take care of patients, as well as interviews with key informants who are already practicing mental health care in their community, long before the advent of the Philippine Mental Health Law.

The CBMH Program Framework drew lessons from global and local experiences in implementing CBMH programs. The framework builds on the multi-dimensional concept of a community and the various complementary perspectives that have emerged from decades of work on CBMH services.

While we are still far from stopping all mental health illnesses and conditions from developing, the right approaches and strategies will better allow us to prevent the development of these conditions. Putting in place a resilient mental health system can change not only the way we manage and attend to the needs of Filipinos who have been afflicted by these conditions, but also establish safe and healthy environments for our minds. We also aspire to have an environment that promotes healing, while at the same time being neither stigmatizing nor dehumanizing.

On behalf of the Department of Health, I am expressing my full support to this endeavor and am confident that this guidebook will be valuable in the establishment of the CBMH program, especially in areas in need of a local-based mental health care system.

Maraming salamat, at mabuhay tayong lahat!

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

MESSAGE FROM THE WHO REPRESENTATIVE ON COMMUNITY-BASED MENTAL HEALTH

In the recent years, the burden of mental health conditions has had evident health and economic impact. Anxiety and depression as the two most common mental health condition account for over 800,000 years of life lived with disability (in 2017), while estimates in 2019 indicate cost to the Philippine economy of 68.9 billion Php, equivalent to 0.4% of the gross domestic product (GDP) due to losses on economic productivity.[1] Social, biological, and environmental factors exacerbate the burden of mental health conditions, affecting an individual's ability to cope with stress, be productive, and make contributions to the community.

Initiatives to advance Mental Health and well-being in the Philippines have made significant progress since the signing of the Mental Health Act (RA 11036) of 2018. Focus in narrowing the gap between people suffering from mental health condition requiring care and those with access to care is directed by expanding and scaling up access to quality mental health services and intervention. WHO's support in this endeavour is articulated in several key documents and programs, including the "*For the Future: Towards the Healthiest and Safest Region*" and the "*Comprehensive Mental Health Action Plan 2013-2030*". The WHO's Special Initiative for Mental Health was established in 2018 as a measure to accelerate actions for mental health.

In light of the efforts and leadership towards providing quality mental health treatment and support, we extend our appreciation and commendation to the individuals, organization, National Government Agencies, the academe, and stakeholders whose contributions cultivate innovations in mental health. The Community-based Mental Health Program framework sets the foundation for an evidence- and rights-based model of community-based mental health treatment and support, building up from different community-based models in the Philippine context. As people suffering from mental health conditions continue to be challenged with stigma and discrimination, we need to ensure that safeguards that promote and protect their rights and dignity are in place.

Many mental health conditions can be addressed by treatment and evidence-based interventions in a community setting. The limited mental health workforce in the Philippines necessitates the transition of mental health care from specialized institutional and segregated settings to non-specialist care in the community. This highlights the need to accelerate efforts to integrate mental health care to primary health care and strengthen the capacity to provide services at the community.

1 Prevention and management of mental health conditions in the Philippines: The case for investment. 2019

We recognize that there is still much that need to be done to make mental healthcare universally accessible in the country. WHO remains committed to supporting the Department of Health in achieving its goal that mental health conditions are treated and prevented, and persons affected by mental health conditions are able to exercise their full range of human rights.

Dr Rabindra Abeyasinghe

WHO Representative to the Philippines

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LIST OF ABBREVIATIONS

ACT	Assertive Community Treatment
ADMU	Ateneo de Manila University
AFFMH	Alliance of Filipino Families for Mental Health
BHW	Barangay Health Worker
BK	Balay Kalipay
CAM	Combined and Alternative Medicines
CBMH	Community based Mental Health
CBMHET	Community-based Mental Health Evaluation Tool
CBT	Cognitive Behavior Therapy
CHR	Commission on Human Rights
CHW	Community health worker
CMH	Community Mental Health
CMHC	Community Mental Health Center
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Service Organization
CSWDO	City Social Work and Development Office
DBT	Dialectic Behavior Therapy
DDAPT	Dangerous Drug Abuse Prevention and Treatment Program
DMHP	District Mental Health Program
DOH	Department of Health
DPO	Disabled Persons Organizations
EJK	Extra-Judicial Killings
FGD	Focused Group Discussion
FSG	Family Support Group
GIDA	Geographically Isolated and Disadvantaged Areas
HCW	Health Care Workers
HWC	Health and Wellness Centre
IEC	Information, Education, Communication
IOM	International Organization for Migration
KII	Key Informant Interview
KKDK	Katatagan Kontra Droga Sa Komunidad
LCE	Local Chief Executive
LDNA	Learning and Development Needs Assessment
LGBT	Lesbian Gay Bisexual Transgender
LGU	Local Government Unit
LMIC	Lower-and Middle-Income Countries
MAG	Medical Action Group
MH	Mental Health

MHC	Mental Health Continuum
mhGAP	Mental Health Gap Action Program
mhGAP-IG	Mental Health Gap Action Program Intervention Guide
MHO	Municipal Health Officer
MHPSS	Mental Health Psychosocial Support Service
MNS	Mental, Neurological and Substance Abuse Disorders
MOA	Memorandum of Agreement
NCD	Non-communicable diseases
NCMH	National Center for Mental Health
NCR	National Capital Region
NGO	Non-government organization
NPS	National Psychosocial Support
PAP	Psychological Association of the Philippines
PCHRD	Philippine Center for Health Research and Development
PCMH	Philippine Council for Mental Health
PDZ	Permanent Danger Zone
PHC	Primary Health Centre
PPE	Personal Protective Equipment
PSA	Philippines Statistics Authority
PSR	Psychosocial Rehabilitation
PTSD	Post-traumatic Stress Disorder
RHU	Rural Health Unit
SAMHSA	Substance Abuse and Mental Health Services Administration
SHG	Self-help groups
SIMH	Special Initiative for Mental Health
SMI	Severe Mental Illness
SU	Substance Abuse
TA	Technical Assistance
TAG	Tulong Alalay at Gabay
TWG	Technical Working Group
UHC	Universal Health Care
UN	United nations
UNICEF	United Nations Children's Fund
UP	University of the Philippines
USAID	United States Agency for International Development
WAPR	World Association for Psychosocial Rehabilitation
WHO	World Health Organization
WPA	World Psychiatric Association

EXECUTIVE SUMMARY

Toward scaling up access to quality mental health interventions and services in the country, the Department of Health has developed a framework for Community based Mental Health (CBMH) programs. This is part of the **WHO Special Initiative for Mental Health** in support the overall effort to implement the strategic plan to operationalize the Philippine Mental Health Law (Republic Act 11036) of 2018. The WHO Philippines has provided technical assistance to formulate an evidence- and rights-based model of Community-based Mental Health services.

What is CBMH? The definition of CBMH is numerous and varied. Deriving from these varied definitions, a CBMH program is defined as a mental health delivery framework, with a set of activities, in a geographically defined community, identifying its unique mental health needs and utilizing its innate strengths, deriving resources from both government and non-government sectors, to deliver mental health services to the population and individual level, including promotion, prevention, treatment, recovery assistance and rehabilitation, according to identified needs, resulting in a population where individuals realize their own potentials, copes adequately with the daily stresses of life, displays resilience in the face of extreme life experiences, and works productively and fruitfully and able to participate in the community.

Why Community Based Mental Health Programs*?* CBMH programs were born out of several confluent factors such as concerns about human rights of service users, the political and economic thrust of the deinstitutionalization movement, and the search for better models of mental health care.

Deinstitutionalization had its share of criticisms, namely concerns that service users who used to be in the mental institutions found themselves in dire situations of homelessness or incarceration and federal funding for mental institutions declined over time. In the lower to middle income countries, the health system's lack of mental health resources, manpower, and policies posed severe constraints in providing much needed mental health care. Thus, Community based Mental Health Care was a response to these needs by shifting the much-needed mental health care to non-specialists in the community, also referred to as task sharing.

In the Philippines, community based mental health programs and services are in their infancy. Yet the demand for mental health care is great due to the risk of disasters, security and manmade risks (e.g., internal displacement due to armed conflict) and relatively high prevalence of alcohol and substance use. This gives a picture of the high demand for mental health care against a backdrop of underdeveloped community based mental health programs and services. The need for CBMH intensified with the onset of the COVID19 pandemic as media and anecdotal reports of mental health problems and suicide increased. Added to this is the unknown mental health impact of the pandemic in the long term.

There have been sub-national initiatives in community-based interventions in the context of disaster response and drug recovery. These initiatives provide the proof of concept that, at least, some components of the CBMH are feasible in the Philippine context. What remains to be done is to scale up these initiatives to create a critical mass of LGUs with CBMH programs and institutionalize them in local communities. This CBMH program development framework is meant to guide this process.

This CBMH Program Framework draws lessons from global and local studies. The concept of community is vital in defining community-based mental health care. A community, in its widest sense, refers to a group whose members share certain commonalities such as geographical location, location of place of origin, language, interests, beliefs, values, political affiliation, ethnic or cultural origin, sense of belonging – Communities are characterized by interrelations and interactions in each context…Identity is important in the psychosocial wellbeing of individuals. (IOM Manual MHPSS, 2019: 15)

From the standpoint of mental health care, the characterization of communities as having a common geographical location, interactions, interrelations, interconnectedness, and sense of belonging are vital in developing a place-based mental health services and facilitation of people's access to mental health care. In this regard, the active group participation or participation of a person as representative of the group in activities where they not only provide ideas but are also involved in community-based interventions to make mental health services available and accessible to the community residents is vital.

The term community-based has a wide range of meanings and investigators suggest a four-fold view: community as setting, community as target, community as agent, and community as resource.

As the setting for interventions, the community is primarily defined geographically and is the location in which interventions are implemented. As target, it refers to the goal of creating healthy community environments through broad systemic changes in public policy and community-wide institutions and services. As resource, the community is seen as having assets and resources that can be harnessed for attaining desired development outcomes. As agent, emphasis is on respecting and reinforcing the natural adaptive, supportive, and developmental capacities of communities.

A major insight from these multiple meanings of community-based is that it views community as an active rather than passive recipient of social and health interventions and that the community is both a beneficiary as well as the maker of the desired outcomes. Notably, the community itself is the factor in ensuring long-term sustainability.

Perspectives in CBMH Care. There have been a lot of rethinking in the field of mental health. The literature speaks of perspectives that have a direct bearing on community based mental health care, namely: *rehabilitation and recovery; balanced care; integration of mental health into primary health care systems; digitalization of mental health care and positive psychology*.

Rehabilitation and Recovery Approach. The WHO advocates for a rehabilitation and recovery approach in health care, including mental health care. Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment".

"Psychosocial rehabilitation (PSR) utilizes what is known as the recovery model of mental illness. Full recovery is frequently the goal, but full recovery is seen as a process rather than an outcome. This approach is centered on the person's potential for recovery and focused on providing empowerment, social inclusion, support, and coping skills."

Recovery oriented services commonly center around the following five dimensions, Connectedness, Hope and Optimism, Identity, Meaning and Purpose, and Empowerment.

Social Ecology Approach. "Models such as social ecology provide us with not only a systems framework for thinking about behavioral change as an outcome of community-based interventions but also a framework for thinking about healthy communities....the goal of community-based interventions is not only to change individual perceptions and behaviors but also to embed public health values in our social ecology, including families, social networks, organizations, public policy, and ultimately our culture—how we think about things.

Mental health is the result of the person's characteristics and her environment. Social conditions like poverty, unemployment, literacy, climate change related disasters, cultural beliefs around mental illness, and the like impact on a person's mental health.

Integration in primary health care. Mental health scholars, researchers and psychiatrists support the use of the primary care setting as an appropriate platform to address both physical and behavioral health conditions,

which recognizes the comprehensive, whole-person focus of primary care and the observation that the primary care setting is currently the point of care for many patients with behavioral health problems.

The degree of integration of behavioral care into the primary care setting can vary from selective screening, diagnosis, brief treatment, and referral to a truly integrated care approach in which all aspects of primary care recognize both the physical and behavioral perspectives. Another sense of integration is that within one and the same person, health care takes into account the physical and mental health of a person.

Balanced Care. Drawing lessons from the more than half a century of experience with community mental health services, Thornicroft, et. al. (2016) stated that "(T)o scale up services to the quantum required necessarily means providing most services not in specialist care settings, but in primary, community health care services, and in population-level and community-level platforms..."

"Mental health care should consist of a careful balance of hospital and community care, with most care provided at or near to people's homes.

Value for money in providing treatments to people with mental illness means both investing in evidence-based care, and disinvesting in harmful, ineffective or less-effective interventions. At present, in countries of all resource level, understanding of how to implement good practice is not well developed. Hospital-based and community-based mental health care are not mutually exclusive; they are complements rather than substitutes.

Digitalizing Mental Health Care Delivery. Technology has the potential to advance many of the goals of community-based mental health care and the COVID pandemic protocols have made the use of telehealth imperative. Community mental health services are now found in cyberspace and not necessarily in one physical location. In the era of digital technology, communities could transcend or cross geographic and physical boundaries. Telemedicine has become the norm and mental health services such as counseling and therapy are being delivered through a variety of technologies such as hotlines, text messages, zoom conversations, and the like.

Positive Psychology. Positive mental health is a resource for everyday living and results from individual and community assets. The health promotion theories, methodologies, and populations available through public health partners offer greater reach for positive psychology practitioners to implement and evaluate their interventions across diverse sociodemographic subgroups and community settings that currently receive little attention. Likewise, the asset-based and affirmation paradigms of positive psychology offer additional strategies for mental health promotion.

A Framework for CBMH Programs in the Philippines**.** The six elements of the CBMH Program Framework are:

1. **Community Engagement is both a process and outcome.** When the community is engaged in the widest possible sense, the CBMH Program is likely to be sustained. At the minimum, engagement should be done with the duty bearers and the "well" population. At the community, the duty bearers for health care are the Local Chief Executive, the Municipal Health Officer as well as the Local Health Council. In addition, the Barangay Health Workers serve to augment the rural health staff in cities and municipalities.

2. **Build capacity for MH Care in the community** One major lesson learned during the past decades since deinstitutionalization is that non-specialists can deliver mental health services. The effectiveness of various community-based interventions by non-specialists has been examined. "Community champions from self-help groups and farmers' club were found to be effective in facilitating mental healthcare services in rural and remote areas, which significantly increased adherence, follow-ups, and reduced disability. Other studies found that trained lay health worker, lay counsellors, non-specialist health workers effectively provide basic mental healthcare services in rural areas significantly increase access

to psychiatric services. This culturally contextualized mental health service delivery model has been found to be feasible, acceptable, and cost-effective."

3. **Family and community support.** The family is the main locus of support in many low- and middle-income countries like the Philippines and India. In addition to the family, there are community institutions such as peer support groups, civic & corporate groups, church groups, non-government organizations that provide social support to persons with mental health concerns. Social support refers to the psychological and material resources provided by a social network to help individuals cope with life's stresses and challenges. Support services may include: mobile outreach services, drop-in centers, group programs, personalized support services to enable people to remain in their home or local community, and programs for families and carers.

4. **Empower the service users.** Service users refer to those persons with lived experiences of mental disorders. They may have undergone mental health screening, diagnosis, referral, education, counseling, and treatment in the hands of specialists. The community consists of a variety of individuals and groups who are "users" of mental health services. It can be argued that everyone is a user of education and information pertaining to mental health. Of interest are specific population groups known to face risks of mental ill health and/or who are vulnerable to stresses due to their demographic and socio-economic circumstances. Among these vulnerable groups are: senior citizens (above 65 years old) and the elderly; the LGBT community; the youth, families and relatives of drug surrenderers, and people living in poverty, the homeless and people suffering from mental ill-health.

5. **Recovery Assistance and Reintegration.** Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. CBMH programs must assist the recovery process by providing aftercare services. Aftercare usually pertains to the package of mental health services afforded a service user as he finds his way to recovery. This may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other methods, connections to local mental health service provider(s), linking with service users' organizations, temporary housing and introduction into possible leisure activities. Further into the recovery process, a service user can be aided to enable more participation in the community, including employment, livelihood and vocational training, advocacy, and similar activities that will facilitate reintegration into the community.

6. **Monitor & Evaluate.** The overarching process in the five pillars of the community-based mental health program framework is monitoring and evaluation. It is planned that at the end of key informant interviews, community assessment, and service user focus group discussions, success indicators and means of verification will be developed. It is clear from the Social Ecological model that a multi-level appreciation of the community-based mental health program allows for greater clarity when it informs policymaking, program reevaluation and analysis. Success indicators of the CBMH models vary depending on the strategy and thrust of the program. Indicators may be established at different levels.

Non-specialists can be trained to deliver mental health care in the communities. The Philippines has a shortage of mental health specialists like many low- and middle-income countries. Hence, training of non-specialists is imperative. The capacity building program must include guidance counselors in schools, the parents, and surrogate parents i.e. mothers, fathers, caregivers in households, human resource managers and staff in workplaces, and non-government staff running day care centers for children and adults.

In the public sector, the DOH has been training municipal health officers using the WHO's mhGAP training. This effort can be complemented by training the informal health care workers in the community who can be harnessed to spur and sustain the continuity of care in the community.

A checklist of competencies for non-specialist community health workers in mental health care was developed and the competencies are grouped into three clusters: 1) *Knowledge and basic understanding of mental health conditions*[1] . This covers the identification of signs and symptoms, their treatment and management both at the individual, family, and community level. It includes interviewing skills, ability to listen empathetically, establishment of rapport, provision of appropriate counselling and psychosocial support, and respect for human dignity and right as an individual. 2) *Basic psychosocial intervention skills* appropriate for the general health worker. Relative to this, a biopsychosocial spiritual framework is adopted and includes skills in identifying and providing advice on necessary medications. The said framework was officially adopted by the Philippine Council for Mental Health. Also, it is recognized that a person with a mental health condition is interconnected with his social environment, including those around him, his family at home, and his neighbors in the community. Hence, non-specialists must acquire basic skills in appreciating the need for working with and collaborating with the family, neighbors, and the general community. 3) *Positive attitude* towards anything "mental." It is crucial that the prevailing negative attitude, misconceptions, and prejudice (stigma) among health workers is overcome. They must talk of mental health conditions (i.e. depression, etc.) the same way they speak of diabetes or hypertension – that these are health conditions that can be rightfully identified, treated, and recovered from. A corollary skill is advocating changes in attitudes to mental health such as "there is no health without mental health and well-being."

This Guidebook provides some tools for capacity building such as the Learning & Development Needs Assessment, Checklist of Competencies and a model curriculum for Competency-based Training on Mental Health Care for Non-specialists. These tools have been tried in the municipality of Lemery in Batangas. The training program for barangay health workers and barangay officials was pilot tested in five barangays of Lemery, a coastal municipality in the province of Batangas[2] . By the 2020 census, it has a population of 93,186 (Philippine Atlas 2020)[3], representing 3.46% of the total population of Batangas province, and it has a total of 46 barangays.

The pilot training was held in the last two weeks of June 2021. In accordance with the request of the barangay captains, the *Basic Course for Community Health Workers on Community Mental Health Care* was conducted via Zoom in four half-day sessions from 1:00 to 5:00 pm on 17, 18, 25 & 26 June 2021. Each barangay group assembled in one designated place and the participants shared one computer device. There were occasional glitches in connectivity but nevertheless, the training proceeded as planned.

The participants consisted of barangay health workers (BHWs), the barangay officials (e.g. barangay captain, secretary, chairperson of the Barangay Health Council, including the barangay nutrition scholar) as well as some representatives from schools and workplaces. There were 47 participants from the five barangays and they were noted to be mostly (60 %) high school graduates while some (38%) are college graduates.

On the last training day, each barangay group produced an action plan that identified activities following the CBMH Framework. They were given one month from the end of the training to implement their action plans and they were to report on the progress of their implementation by the end of the month.

During the field monitoring, all the groups reported the completion of their action plans despite practical drawbacks during the period. A storm hit Lemery and one of the barangays has had to evacuate and relocate some of their barangay households.

1 Twelve mental health conditions are included in the MHGAP intervention guide. This means that competency in knowledge of mental health conditions expected of the health workers focus on the ICD 10 Primary Care Version that include *depression, chronic psychosis, unexplained somatic symptoms, alcohol abuse, mental retardation common mental disorders in children and epilepsy.* Since they are not to be specialists, they do not need to have knowledge of all the psychiatric disorders…they only need to know the 6 conditions included in the Primary health care Version of the ICDX.

2 DILG LGU Profile. https://lgu201.dilg.gov.ph/view.php?r=04&p=10&m=12

3 https://www.philatlas.com/luzon/r04a/batangas/lemery.html

A results-based monitoring and evaluation (M&E) framework was drawn up to guide the process on the ground. The expected outcomes and indicators for each of the CBMH elements were defined and this is shown in the Monitoring Matrix in chapter 6.

The first level of evaluation involved getting the reactions of the participants to the training. The participants were very grateful for the training and expressed general satisfaction at the way the training was conducted. They also expressed the need to learn more about mental health care in order to gain self-confidence in performing the tasks.

One long-term outcome and impact of CBMH program initiatives is institutionalizing mental health programs and services in barangays and communities. For this to happen, the program manager (e.g., MHO) needs to ensure the sustainability of the CBMH initiatives in the course of program monitoring.

The essential elements of sustainability are: adoption of a mental health policy by the local executives and the local council; the inclusion of mental health in the barangay health development plan; allocation of a budget to support the mental health program; and the capacity building of human resources e.g. specialists and non-specialists in providing mental health services.

Lessons Learned. In general, the pilot training was useful in demonstrating the practical utility of the CBMH program framework to catalyze the setting up of community mental health services.

The Lemery training validated the Competency based Training on Mental Health Care as well as the tools for monitoring and evaluation.

The pilot training also shed light on necessary adjustments in the training program for non-specialists such as improvements in the training design, instructional materials, and delivery. The pilot training was done in only one municipality, Lemery, in Luzon. It is expected that as the CBMH Program is rolled out, there will be more experiences that could inform the training design and delivery. Thus, the training design must be considered as a living document that must be contextualized to the LGU's conditions at the time of implementation.

The pilot training made it clear that community development workers such as the BHWs can be purposively harnessed in providing CBMH services provided they are given prior orientation and mental health competency training. Capacity-building of non-specialists on community mental health services is worth pursuing to enable the scaling up of mental health services.

The social factors influencing mental health and health-seeking behavior were evident in Lemery. It is likely that these factors will be found in other municipalities and barangays. For example, poverty, lack of community mental health services, stigma, and the continuing environmental risks and threats, including the pandemic, were found in the five participating barangays. These have a direct bearing on the provision of CBMH services. For example, in the recovery of patients, rebuilding their economic lives is crucial to build their self-esteem, empowering them to live independently, afford their continuing medication and rehabilitation, and enable their healing and full reintegration into the community.

There are attendant governance concerns that must be addressed. Stakeholders must be involved because one cannot do mental health promotion alone. It is a journey for the long haul. Lemery has affirmed that: Mental health is everyone's business. It will not work if we do it alone.

Ensure sustainability of the CBMH programs once it is planted in the LGU grounds. This entails a number of action points.

- **Adopt a policy to institutionalize CBMH at the local level.** LGUs should pass a local ordinance adopting CBMH programs as a matter of local development policy. In particular, mental health

services should be integrated in primary health care. Underpinning this is their obligation to provide community mental health services for their constituents as stipulated in the Philippine Mental Health Law.

- **Develop people support and capacity for delivering mental health programs in the community.** LGUs must have a continuing program for developing the competencies in mental health care among the community development workers, including those in schools, workplaces and communities. Competency building is a lifelong process and should factor in the role of technology in delivering mental health services. The training courses should include a mentoring phase so that the trainees' skills get honed and sharpened in the course of their practice.
- **Integrate mental health in LGU health programs.** LGU officials and their respective Health Development Councils/Committees should integrate community mental health programs in their local health program, which is developed annually.
- **Budget.** The municipal development council should appropriate LGU funds to support the community mental health programs and services.
- **Enabling mechanisms.**
    - The planning, programming, and budgeting processes of LGUs must include mental health as a regular part of their development agenda. They should have a way of tracking progress and development in the community mental health programs and services.
    - Institutionalize a monitoring and evaluation system at the LGUs.
    - Develop a referral system at national and sub-national levels. This will facilitate the management of cases that require specialist care.
- Address governance concerns attendant to the establishment and implementation of CBMH programs and services.

DOH must strongly encourage LGUs to mainstream or include CBMH services in their local health development policies, plans, programs, and budget. This is to ensure continuity of the programs and services across political regimes. Some practical measures needed are: massive information dissemination, for example, a forum with local chief executives (municipal mayors and barangay captains) could be held as a precursor to the issuance of a directive for LGUs to set up their community mental health services.

LGUs must recognize that stigma against mental illness remains entrenched in communities. The health workers and community development workers must be properly oriented to the reframing of mental health, which is stated in the PCMH Resolution No. 3, adopted in 2021. Workers in the field of mental health and the general community must be brought to this common understanding of mental health.

Setting up CBMH services can be incentivized through the mechanism of the DILG. For example, it could be incorporated as one criterion for granting the Seal of Good Local Governance, which has an accompanying financial grant or award. The DOH can advocate this to the DILG.

Aside from disseminating, the DOH can proactively advocate to the LGUs and communities the adoption of the CBMH program. However, this should be accompanied with technical assistance to LGUs wanting to initiate their own CBMH program. Setting up a CBMH Programs can be methodically approached following the following practical steps: social preparation, capacity building, application of competencies, monitoring and evaluation and reintegration of service users.

A mechanism for tracking progress in the roll out of CBMH programs all over the country should be part of a Monitoring & Evaluation program that defines DOH's expected outcomes on the CBMH roll out. This will aid in assessing the results and outcomes of the CBMH programs.

CHAPTER 1.
WHAT IS COMMUNITY-BASED MENTAL HEALTH CARE?

WHAT IS MENTAL HEALTH CARE?

The terms 'mental health program', 'mental health services', and 'mental health care' are used interchangeably. Mental health care is the broader terminology and is delivered through mental health programs and services.

For common understanding, we shall follow the definitions in the Philippine Mental Health Law of 2018:

- Mental health includes neurologic conditions, which were previously outside the notion of mental health;
- Instead of mental illness, disturbances in behavior are referred to as mental health conditions; and
- Mental health illness and considers promoting well-being as important as reducing symptoms of mental disorders.

Section 4 of the IRR of the Philippine Mental Health Law of 2018 defines key concepts and terminologies.

TEXT BOX 1. WHAT IS MENTAL HEALTH?

Mental health is a state of well-being in which the individual realizes one's own potentials, copes adequately with the daily stresses of life, displays resilience in the face of extreme life experiences, works productively and fruitfully and contributes to the community.

Mental health conditions refer to a neurologic or psychiatric condition characterized by the existence of a recognizable clinical disturbance in an individual's cognition, emotional regulation or a behavior that reflects a genetic or acquired dysfunction in the neurobiological, psychosocial or developmental underlying mental functioning. The determination of neurological or psychosocial is based on scientifically accepted medical nomenclature and best available scientific and medical evidence.

Mental Health Services refer to psychosocial, psychiatric or neurologic activities and programs along the whole range of mental health support services including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals.

Noteworthy is the notion of behavioral health, which the American College of Physicians has broadened. According their position paper (2015),

> Behavioral health care includes care for patients around mental health and substance abuse conditions, health behavior change, life stresses and crises, and stress-related physical symptoms. Mental and substance use disorders alone are estimated to surpass all physical diseases as a major cause of worldwide disability by 2020.
>
> Behavioral health care is defined as a "broad term used to encompass care for patients around mental health, and substance abuse conditions, health behavior change, life stresses and crises, as well as stress-related physical symptoms
>
> The literature recognizes the importance of the health care system effectively addressing behavioral health conditions. Recently, there has been a call for the use of the primary care delivery platform and the related patient-centered medical home model to effectively address these conditions (Crowley et al., 2015, p. 1).

Promoting mental health and preventing mental disorders are just as important as reducing or eliminating the symptoms of mental ill health. The big practical challenge is how to promote mental wellness and well-being. To achieve this, mental health programs and services must be provided and offered at people's doorsteps. CBMH services must therefore be relevant, appropriate, and if possible, cost effective. CBMH is meant to make mental health care available and accessible, especially among the vulnerable and marginalized in society.

Usually, the vulnerable and the marginalized include people living below the poverty line, children, women, indigenous or ethnic groups, farmers and fisherfolk, people with disabilities, and those in rural communities. In the Philippines, these also include those in geographically isolated and disadvantaged areas (GIDA), a term used in the Philippine Development Plan published by the National Economic Development Authority (NEDA). This geographic disadvantage limits the reach of health and social services to the population in GIDA areas.

WHAT IS A CBMH PROGRAM OR SERVICE?

CBMH programs deliver mental health services outside the hospital setting. Since the deinstitutionalization movement in the 1960s, mental health services have been offered outside hospitals. Activities like awareness-raising, psycho-education, skills training, rehabilitation, and psychological treatments are done in homes, schools, refugee camps, or over technology (Kohrt et al., 2018).

CBMH services are integrated into primary health care. In high-income countries such as the US, CBMH care is included in primary care settings and targeted towards wellness and prevention (Lake, 2017). Community components, however, are variably integrated in primary care services (Kohrt et al., 2018).

CBMH principles and practices have been articulated by experts based on worldwide experiences over the past decades. Graham Thornicroft et al (2016) stated the principles and practices needed to promote mental health for a local population in a community mental health program. A CBMH program addresses population needs in ways that are accessible and acceptable.

Community mental health care encompasses a population approach, views patients in a socio-economic context, individual as well as population-based prevention, a systemic view of service provision, open access

to services, team-based services, a long-term, longitudinal, life-course perspective, and cost-effectiveness in population terms.

- Addresses the needs of traditionally underserved populations, such as ethnic minorities, homeless persons, children and adolescents, and immigrants, and to provision of services where those in need are located and in a fashion that is acceptable as well as accessible.
- Building on the goals and strengths of people who experience mental illnesses. Community mental health care focuses not only upon people's deficits and disabilities (an illness perspective), but also upon their strengths, capacities and aspirations (a recovery perspective). Services and supports thus aim to enhance a person's ability to develop a positive identity, to frame the illness experience, to self-manage the illness, and to pursue personally valued social roles.
- Promoting a wide network of supports, services and resources of adequate capacity; and includes the community in a broadly defined sense. As a corollary of the second point, it emphasizes not just the reduction or management of environmental adversity, but also the strengths of the families, social networks, communities and organizations that surround people who experience mental illnesses.
- Emphasize services that are both evidence-based and recovery-oriented. Community mental health care melds evidence-based medicine and practical ethics. A scientific
- approach to services prioritizes using the best available data on the effectiveness of interventions.
- At the same time, people who experience mental illnesses have the right to understand their illnesses (to the extent that professionals understand them), to consider the available options for interventions and whatever information is available on their effectiveness and side effects, and to have their preferences included in a process of shared decision making. (Thornicroft et al., 2016, p. 1)

The CBMH program augments the programs and services offered by mental health facilities and hospitals. In an archipelagic country like the Philippines, this is a significant contribution as it makes mental health services accessible to people. Usually, it is a challenge to transport medical patients from rural to urban centers like Manila where most mental health facilities and specialists are based.

In other words, CBMH is a measure to promote social equity in the population. It is one strategy to fulfill the Sustainable Development Goals (SDG) by 2030.

Vital to any CBMH program is our appreciation of the community, not only as a venue for delivering mental health services.

WHAT IS A COMMUNITY?

The concept of community is vital in defining community-based mental health care. There have been numerous efforts to break down the concept of community, which is seen to be multi- dimensional.

In the field of social work, Pradeep and Sathyamudi (2017) underscored that the concept of community is associated with a number of elements, namely: geographical location, common characteristics or ties, social networks, and relationships, and shared sentiments. Communities are comprised of people that share the same set of social representations.

In a wider sense, the International Organization for Migration (IOM) also elucidates the same definition. It refers to community as,

> A group whose members share the certain commonalities, such as geographical location, location of place of origin, language, interests, beliefs, values, political affiliation, ethnic or cultural origin, sense of belonging – Communities are characterized by interrelations and interactions in a given context... Identity is important in the psychosocial well-being of individuals (IOM, 2019, p. 15).

From the standpoint of mental health care, the characterization of communities as having a common geographical location, interactions, interrelations, interconnectedness, and sense of belonging are vital in developing place-based mental health services and in facilitating people's access to mental health care. In this regard, the active participation of a group or a group's representative in activities are important, where they not only provide ideas but are also involved in community-based interventions to make mental health services available and accessible to community residents.

WHAT IS COMMUNITY-BASED?

McLeroy et al (2003) classified community-based projects into four categories: community as setting, community as target, community as agent, and community as resource. Each category is briefly discussed below:

a. As the setting where interventions are implemented, the community is primarily defined geographically. Such interventions may be city-wide using mass media or other approaches, or may take place within community institutions, such as neighborhoods, schools, churches, work sites, voluntary agencies, or other organizations. Interventions may be introduced at different levels but the main focus is to change individuals' behavior as a method for reducing a populations' risk of diseases.
b. *As target, community* refers to the goal of creating healthy environments through broad systemic changes in public policy and community-wide institutions and services. In this model, the health status characteristics of the community are the targets of interventions, and community changes, particularly changes thought to be related to health, are the desired outcomes, which go beyond using individual behaviors as primary outcomes. Strategies are tied to selected indicators, and success is defined as improvement in the indicators over time.
c. As *resource,* the community have assets and resources that can be harnessed to attain desired development outcomes. Interventions and programs are aimed at directing these internal assets towards a set of health-related priorities. This usually involves external resources and actors that share the same goals of achieving health outcomes in the community. This concept of the community is commonly applied in community-based health promotion because of the widely endorsed belief that a high degree of community ownership and participation is essential for sustained success in population-level health outcomes.
d. As *agent,* the emphasis is on respecting and reinforcing the natural adaptive, supportive, and developmental capacities of communities. These resources are provided through community institutions including families, informal social networks, neighborhoods, schools, the
e. workplace, businesses, voluntary agencies, and political structures. These naturally occurring *units of solution* meet the needs of many, if not most, community members without the benefit of direct professional intervention.

From the description above, McLeroy et al (2003) highlights the aim of this model of community- based programs:

> The goal... is to carefully work with these *naturally occurring units of solution* as our units of practice, or where and how we choose to intervene. This necessitates a careful assessment of community structures and processes, in advance, of any intervention. It also requires an insider's understanding of the community to identify and work with these naturally occurring units of solution to address community problems. Thus the aim is to strengthen these units of solution to better meet the needs of community members. This approach may include strengthening community through neighborhood organizations and network linkages, including informal social networks, ties between individuals and the organizations that serve them, and connections among community organizations to strengthen their ability to collaborate. The model also necessitates addressing issues of common concern for the community, many or most of which are not directly health issues. In other words, this view necessitates *starting where people are (McLeroy et al., 2003, p.1).*

A major insight from these multiple meanings of 'community-based' is that it views community as an active rather than a passive recipient of social and health interventions. Also, community is both a beneficiary and maker of desired outcomes. Notably, the community itself is the factor in ensuring long-term sustainability.

TEXT BOX 2. WHAT IS THE CURRENT STATE OF AFFAIRS IN THE PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES IN THE PHILIPPINES? THE BASELINE SITUATION IN 2020

A recent DOH-commissioned study, Analyzing Mental Health Services in the Philippines: Perception, Access and Delivery (2020) by the Ateneo de Manila University observed that: "Mental health services are (also) provided in the primary care level through outpatient services in the city health office and the different rural health units. Among those in the study sites,[1] almost all are able to provide consults for patients with mental health complaints. These municipalities are usually staffed by general physicians who were trained in Mental Health Gap Action Program (mhGAP)[2] which serve as the reference for assessment and treatment of patients with mental health concerns in the community.

As of 2019, only 30% of the RHUs have already been covered. The goal is by 2022, all RHUs should have been trained with the basic knowledge on assessment and management of mental health conditions. Staff such as nurses and Barangay Health Workers (BHWs) are also trained in MHPSS which focuses on psychosocial interventions and skills training.

Since training has not been completed in all areas, establishment of an efficient and working referral system is important in order to manage the service users better. Currently, no unified and formal referral systems have been established in all the areas that are part of this study. However, a common pattern can be seen.

1 There were 10 study sites.

2 This was adopted from the WHO training program.

TEXT BOX 2. WHAT IS THE CURRENT STATE OF AFFAIRS IN THE PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES IN THE PHILIPPINES? THE BASELINE SITUATION IN 2020 *(continued)*

In some areas particularly Pampanga, Northern Samar, Misamis Oriental, Zamboanga del Norte, and Surigao del Norte, faith healers and albularyos are one of the first point of contact of patients being suspected of mental health problems. In the sites in Mindanao as well, before being brought to any religious or medical person, they are being isolated, chained or kept away from people. Once these do not work, in almost all areas, it is the BHWs, midwives and community workers who are being tapped upon for possible medical advice.

Barangay captains have also been important gatekeepers in other areas such as in Northern Samar and Marinduque. Frontline workers then refer the patient to the RHU/MHO which provide initial assessment and management for the patient. Depending on the need for specialized care or inpatient care, these patients are referred to psychiatrists or long- term stay facility usually provincial or regional hospital as discussed above for further management. They are then asked to follow-up in the RHU after treatment is done. For those areas with no inpatient facility such as Marinduque, they are referred to the NCMH for long-term stay care."

The same study noted that mental health services in the Philippines are still generally hospital or facility-based.

While there are health institutions providing mental health services in different settings from informal community care, primary health care, general hospitals, and long-stay and specialized facilities, mental health services are inequitably distributed and concentrated mostly in the cities".

"Government long-term stay facilities are generally located at the national and regional level, the biggest of which is the National Center for Mental Health in Mandaluyong City with around 4200 bed capacity and serving around 56,000 inpatients annually. This serves as the national catchment area of patients that are referred for long-term management. Also, Mariveles Mental Wellness and General Hospital, a custodial psychiatric care facility located in Mariveles, Bataan province can accommodate more than 500 inpatients. Other regional hospitals under the jurisdiction of the central office of the Department of Health and many LGU-controlled hospitals have mental health

services which have mostly served through outpatient consults. Basic services provided are usually general outpatient consultation, neuropsychiatric screening, counseling, psychoeducation, and psychotherapy.

While all facilities that were part of the study provide general outpatient services, only a few have specialty clinics. Majority of them have addiction clinics while others have child & adolescent and geriatrics services. For most areas, these facilities are the regional or provincial hospitals. On the other hand, in Albay and Misamis Oriental, these include private facilities such as Holy Face Rehabilitation Center for Mental Health and Cocoon Foundation for Substance Abuse Inc.

TEXT BOX 2. WHAT IS THE CURRENT STATE OF AFFAIRS IN THE PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES IN THE PHILIPPINES? THE BASELINE SITUATION IN 2020 *(continued)*

Among the government general hospitals, only those in Region V, Region VI, and Region VIII provide dedicated inpatient beds for psychiatric patients, and they are mostly acute and short-term stay. Others either admit patients with mental health conditions mixed with medical patients or have them referred to consultation liaison psychiatry. Specific number of beds per facility per region is not provided since data are lacking. Bicol Regional Teaching and Training Hospital (BRTTH) and West Visayas Medical Center (WVMC) are considered as community- based facilities as they provide inpatient care for the management of mental disorders within a community-based facility. These mental health services in general hospitals are manned by psychiatrists with the help of other allied health workers. Almost all psychiatrists who have government practice also have private psychiatric practice. Among all the regions, Region V and Region X are distinct as they have the most number of private psychiatric facilities which also offer long-term stay for the patients.

Overall, the national mental health programs and initiatives are spearheaded by the Department of Health with the help of other agencies and organizations that advocate for mental health. The administrative structure is under the Disease Prevention and Control Bureau, a division of the Essential Non-Communicable Disease Bureau in the DOH Central Office led by a Chief Health Program Officer. From the central office, programs are promulgated to the regional mental health coordinators which then advocate this down to the provincial and municipal level (ADMU, 2020, in annex A, p.4)

Source: Annex A. ADMU, Analyzing Mental Health Services in the Philippines: Perception, Access and Delivery, 2020. 7th Progress Report to the DOH. Unpublished report.

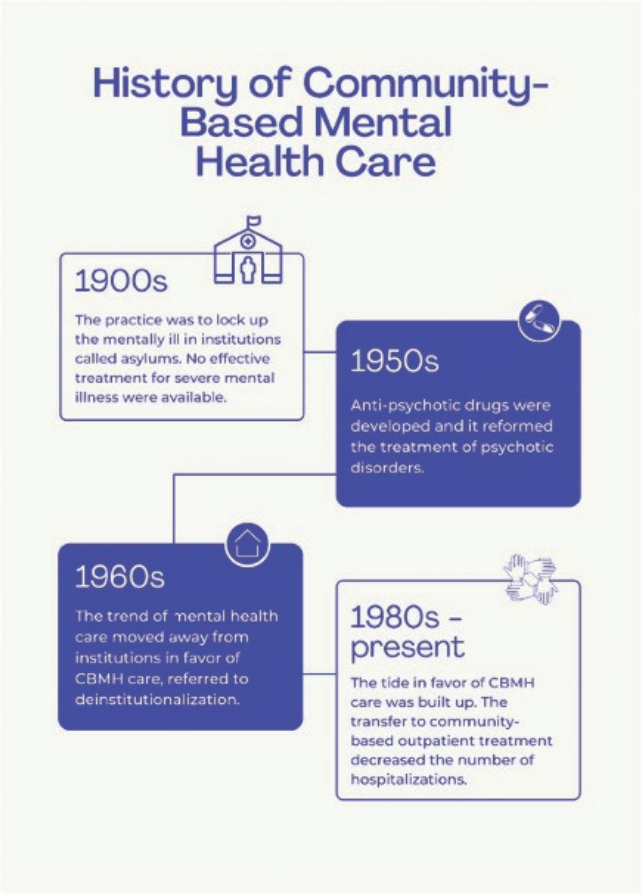
It must be noted that during the COVID 19 pandemic, the push toward telemedicine and telepsychiatry has intensified due to the mobility restrictions to prevent the spread of the virus. Hence, community mental health services are now found in cyberspace and in various physical location. In the era of digital technology, communities could transcend or cross geographic and physical boundaries. For example, self-harm or suicidal cases can be referred to hotlines such as those of the NCMH. During the pandemic, local hotlines were reported to have emerged in different regions of the country. The DOH website lists mental health service providers. There are non-government groups and private business offering mental health-related services. In addition, there are hotlines that provide counseling services.

THE CASE FOR CBMH IN THE PHILIPPINES

CBMH programs and services are in their infancy in the Philippines (Hechanova, 2019). The need for community mental health programs became urgent and stark when Typhoon Haiyan hit the Philippines. The need was reinforced with the launching of the government's anti-drug war in 2016 and intensified with the onset of the COVID-19 pandemic, which triggered mental health issues, including increasing incidence of suicides that were reported through the media or anecdotally.

What remains to be done is to scale up these initiatives in order to create a critical mass of LGUs with CBMH programs and institutionalize them in local communities. This CBMH Program Framework is meant to guide this process.

Figure 1. Historical Milestones in CBMH



Sources: Thornicroft, 2016; Eaton, 2019; Vita & Barlati, 2019

LINKING CBMH PROGRAMS TO PHILIPPINE NATIONAL POLICIES

The foremost argument for CBMH Programs is the current national policy, the Philippine Mental Health Law of 2018 (RA 11036), which stipulates the establishment of CBMH services. In sections 16 and 17 of the said law, it stated:

> Responsive primary mental health services shall be integrated as part of the basic health services at the appropriate level of care, particularly at the city, municipal and barangay levels. The standards of such services shall be determined by the DOH in consultation with stakeholders.
>
> Mental health services at the community level that encompass wellness promotion, prevention, treatment and rehabilitation shall be inclusive and responsive to the needs of the vulnerable population.

The law stipulates the government's responsibility in promoting the well-being of people by ensuring the value, promotion, and protection of mental health. According to experts, this can lessen the stigma around mental health and ensure the access and delivery of mental health services to every Filipino.

The law also aims to ensure that delivery of, and access to, psychiatric, psychosocial, and neurologic services happen in regional, provincial, and tertiary hospitals. Apart from this, the law also supports the presence of mental health services embedded in school systems and the teaching of mental health in all education levels.

RA 11036 took nearly 30 years for it to become law. It is praised for being the first legislation to recognize the fundamental right of all Filipinos to mental health services. By law, every Filipino has the right to mental health care but there is a shortage of mental health services at the community level and there is a severe shortage of mental health specialists. Access to mental health care is fraught with practical obstacles and social barriers (Lally et al., 2019).

In addition to the Mental Health Law is the Universal Health Law that was passed on February 2019. Under this law, all Filipino citizens will be automatically enrolled in an "essential health benefit package" under the existing National Health Insurance Program (NHIP), without regard to the individual's contribution record with the NHIP.

NHIP membership will be simplified into two groups: 1) direct contributors (those who are gainfully employed or self-employed with the capacity to pay health care payroll contributions, and lifetime members — i.e., retirees receiving a social security pension — and their dependents); and 2) indirect contributors (others who are not direct contributors).

The essential health benefit package includes (but is not limited to) primary care services, medicines, diagnostic and laboratory services, as well as preventive, curative and rehabilitative care. The system will also provide mental health, dental care, and emergency services. A comprehensive outpatient benefit package including prescriptions and emergency medical services is due to be implemented and rolled out within two years of the effective date of the act.

The DOH is expected to establish city- and province-wide health care systems based on primary care provider network services. The Philippine Health Insurance Corporation (PhilHealth), which contracts services for NHIP, will be responsible for contracting with public, private, or mixed service provider networks, financing of service primarily via pre-payment mechanisms, including public and private health insurance (PHI), and health maintenance organization (HMO) plans. Since the passage of the Universal Health Act, PhilHealth has been developing health service packages for mental health conditions (B. Azucena, NCMH, personal communication, April 2021). Patients are required to select a primary care physician (public or private) to act as gatekeeper and coordinator of services.

Zoe Andin (2020) notes, however, that with mental health care, PhilHealth only covers the hospitalization cost of up to Php7,800, excluding consultations and medication. And despite provisions in the Mental Health Law calling for accessible mental health resources, she points out that national mental healthcare centers in the country have insufficient resources and private clinics often charge more.

MENTAL HEALTH TREATMENT GAP IN THE PHILIPPINES

The mental health situation in the Philippines shows a severe treatment gap. This presents a primary justification for augmenting mental health services through CBMH programs. This was the finding of the WHO analysis of the mental health situation in the Philippines in March 2020, under a preparatory study for

the multi-country program, SIMP (WHO, 2020). The study affirms the findings of this literature review. It is useful to note that the Philippine case mirrors the situation in low- and middle-income countries.

The Global Scenario. The case for CBMH interventions has been built on the realities in low- and middle- income countries, namely: 1) scarcity of mental health services; 2) limited availability of mental health specialist and professionals; and 3) underfunding of mental health services in LMIC.

Mental illness is the pandemic of the 21st century and will be the next major global health challenge, as underscored by Rathod et al. (2017):

> Experts predict that by 2030, depression alone is likely to be the third leading cause of disease burden in low-income countries and the second highest cause of disease burden in middle-income countries (Mathers & Loncar, 2006). Depressive disorders, schizophrenia, bipolar disorder, and alcohol use disorders are among the top 10 causes of disability due to health-related conditions in LMICs, representing a total of 19.1% of all disability related to health conditions.
>
> The high incidence of mental illness and substance abuse disorders in low- and lower- middle-income countries can lead into an economic trap of disease burden and social decline. As an example, people with lower socioeconomic status (SES) are at eight times greater risk of developing schizophrenia than those of the highest SES. But a study in Poland found that 95% of employers said that they would not want to employ for any position a person with schizophrenia.[3] This spiral of the poorest in our societies being at the highest risk of developing debilitating disorders that deny them of employment opportunities traps them within poverty (Rathod et al., 2017, p. 1).

TEXT BOX 3: THE MENTAL HEALTH TREATMENT GAP PERSIST AND MAY BE EXPANDING DUE TO THE PANDEMIC

In many low-income countries, only around 15 per cent of people receive the mental health care they need. This unacceptable treatment gap slows global development, prevents some people from participating in community life, and may even cause exclusion. There is increasing research demonstrating the neglect of mental health globally. Growing advocacy and action by people affected by mental distress has led to a movement for coordinated action for mental health and scale-up of mental health services, especially in low and middle-income countries (LMICs, Box 24.1, in Eaton, 2019)

There remains an enormous unmet need for treatment of depressed mood despite the availability of antidepressants. "It is estimated that 350 million individuals experience depression annually. On average, it takes almost 10 years to obtain treatment after symptoms of depressed mood begin, and more than two-thirds of depressed individuals never receive adequate care. Enormous psychological, social, and occupational costs are associated with depressed mood, which is the leading cause of disability in the US for individuals aged 15 to 44 years with annual losses in productivity in excess of $31 billion.

3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5398308/#bibr6-1178632917694350

TEXT BOX 3: THE MENTAL HEALTH TREATMENT GAP PERSIST AND MAY BE EXPANDING DUE TO THE PANDEMIC *(continued)*

Suicide is currently the second leading cause of death in 15 to 29 year old, resulting in enormous social disruption and losses in productivity. Between 10 and 20 million depressed individuals attempt suicide every year and approximately 1 million complete suicide. In response to these alarming circumstances, in 2016 the World Health Organization declared depression to be the leading cause of disability worldwide.

We are witnessing the mental health crisis unfolding simultaneously with the pandemic. The data points out the consequences the world will face if mental health takes the back seat. We are left with a simple conclusion: simply put, there is no health without mental health!

Source: Rialda Kovacevic. Mental health: lessons learned in 2020 for 2021 and forward. Blogs.worldbankg.org.|FEBRUARY 11, 2021.

The Philippine scenario. Mental illness is the third most common disability in the Philippines. Demand for mental health is growing, more so in the context of the pandemic. According to the Philippine Statistics Authority (PSA), suicide has become the 27th leading cause of death in the country (from 31st in 2019) after rising 25.7% in 2020, and there were around 3,529 recorded cases of self-harm in 2020 (Rivas, 2021).

At the March 19, 2021 hearing of the House of Representatives' Committee on Health, this trend was corroborated. The Committee chair, Congresswoman Helen Tan, stated that reports of suicide among the youth in her jurisdiction (Quezon province) have reached her but these are unverified informal reports, highlighting the need for a suicide surveillance system.

There have also been media reports that mental illnesses and suicide cases among the youth have increased in the last few years (Tomacruz, 2018). In 2004, DOH reported over 4.5 million cases of depression while in 2012, WHO reported over 2,000 suicide cases from 2000 to 2012. Majority of those who died by suicide were between 15 to 29 years old.

Fast forward to the present, the numbers were most likely higher since many who suffer from depression often hesitate to seek help due to stigma around mental disorders. Additionally, the COVID-19 pandemic has likely heightened the need for mental health services, as noted in television broadcasts and social media.

There are numerous risk factors that trigger or contribute to mental ill health. Social factors such as poverty, unemployment, homelessness, and food insecurity are seen to impact mental health. In the Philippines, environmental factors such as climate change-induced disasters, as well as the COVID-19 pandemic, have brought stressors that strained the psychosocial coping capacities of individuals. Economic factors, as well as neighborhood factors (i.e. housing conditions, congestion, pollution) also bring major stressors to a person's mental health. Cultural factors like beliefs about mental illness and the stigma attached to it tend to discourage help-seeking behavior. Other factors are demographic in nature (i.e. age and sex). For example, the Philippines is an ageing population, which makes mental health issues, particularly, dementia, an extant concern. Globally and nationally, research and evidence of these linkages need to be compiled, organized, and analyzed. This is a new endeavor or field of work in global mental health.

- The supply of mental health services in the public and private realms of the existing health delivery system in the Philippines leaves a lot of unmet needs.

The majority of mental healthcare is provided in hospital settings and there are underdeveloped community mental health services causing a huge gap in mental health care in the country.

The National Center for Mental Health was previously estimated to account for 67% of the available psychiatric beds nationally (Conde, 2004). More recent data indicate that there are 1.08 mental health beds in general hospitals and 4.95 beds in psychiatric hospitals per 100 000 of the population (WHO, 2014). There are 46 outpatient facilities (0.05/100 000 population) and 4 community residential facilities (0.02/100 000) (WHO, 2014). There are only two tertiary care psychiatric hospitals: the National Center for Mental Health in Mandaluyong City, Metro Manila (4200 beds) and the Mariveles Mental Hospital in Bataan, Luzon (500 beds). There are 12 smaller satellite hospitals affiliated with the National Center for Mental Health which are located throughout the country. Overcrowding, poorly functioning units, chronic staff shortages and funding constraints are ongoing problems, particularly in peripheral facilities (Lally et al., 2019, p. 1).

According to Estrada et al. (2020), special attention is needed for Filipino children and adolescents as the country reported 16% prevalence of mental disorders among children.

In addition, the latest Global School-based Student Health Survey found that 16.8% of students aged 13 to 17 attempted suicide one or more times during the 12 months before the survey... Currently, there are only 60 child psychiatrists in the Philippines, with the majority practicing in urban areas such as the National Capital Region. In addition, there are only 11 inpatient and 11 outpatient facilities for children and adolescents, while only 0.28 beds in the mental hospitals are allocated for children and adolescents (Estrada et al., 2020, p. 1).

Mental health facilities are Manila-centered and difficult to reach for those in the outlying provinces and municipalities.

Lally et. al. (2019) captured the current realities in mental health services in the Philippines:

> *There is a shortfall of mental health specialists*: Nationally, there are a little over 500 psychiatrists in practice and 1600 psychologists which falls short of the WHO-recommended global target of 10 psychiatrists per 100 000 population. These translate into two to three mental health workers per 100,000 population (WHO & Department of Health, 2006) - ratios of 0.52 psychiatrists (Isaac *et al*., 2018) and 0.07 psychologists per 100 000 inhabitants, and 0.49 mental health nurses per 100 000 of the population (a reduction from 0.72 per 100 000 in 2011) (WHO, 2014) In addition, these ratios pale in comparison to ASEAN countries like Malaysia (4.9 mental health workers per 100 000 population) and Indonesia (3.1 per 100 000 population).
>
> In 2021, the Filipino population has grown to more than 100 million, and a good number of its medical talents have migrated and the remaining mental health specialists are unevenly distributed – most of them are in Metro Manila.
>
> *Mental health remains poorly resourced*: Only 3–5% of the total health budget is spent on mental health, and 70% of this is spent on hospital care (WHO & Department of Health, 2006).
>
> Although there is a Department of Health Medication Access Program for Mental Health, there are funding issues that deter access to medications, especially the newer ones.
>
> Help-seeking for mental health concerns is constrained by unavailability, unaffordable and/or inaccessibility of mental health services. Stigma against mental illness is entrenched in the culture and deters people with mental health issues from seeking professional help.

Estimating the Burden of Mental Ill health is challenged with data deficits. The Philippines, a low middle-income country, has a population of more than 100 million and precise data on the prevalence of mental health conditions is yet to be gathered; in fact, this is work in progress.

In the past decades, mental health information were generated through special surveys as and when data are required. With the reforms in mental health governance, it is expected that mental health data collection will be institutionalized. In fact, the Philippine Statistics Authority (PSA) approved on 20 February 2020 the conduct of National Survey on Mental Health and Well-Being (NSMHW) Phase II of the Philippine Council for Health Research and Development (PCHRD), in partnership with the University of the Philippines - Manila (UP Manila), which will undertake the field operations. The results of the NSMHW will be used to estimate the national and regional lifetime and 12-month prevalence of selected mental, neurological, and substance use (MNS) disorders among Filipinos. Further, the survey will determine the impact of these conditions as well as the health services utilization among those with MNS disorders.

A total budget amounting to PHP 40.1 million was allocated for the survey. The pandemic has interrupted the data gathering in the field; hence the survey results are delayed as of the time of writing in April 2021.

The burden of mental ill health is increasing but official attention is wanting.

There is little epidemiological evidence on mental disorders in the Philippines; however, some important data are available. For example, 14% of a population of 1.4 million Filipinos with disabilities were identified to have a mental disorder (Philippines Statistics Authority, 2010).

The National Statistics Office identified that mental illness is the third most prevalent form of morbidity, however the finding that only 88 cases of mental health problems were reported for every 100 000 of the population (DOH, 2005) is likely an underestimate of the true extent of these issues.

The 2005 WHO World Health Survey in the Philippines identified that, of 10 075 participants, 0.4% had a diagnosis of schizophrenia and 14.5% had a diagnosis of depression. Of those with a diagnosis of schizophrenia, 33.2% had received treatment or screening in the past 2 weeks, compared with 14% of those with a diagnosis of depression. Recent data from the Philippine Health Information System on Mental Health identified that (from 14 public and private hospitals surveyed from 2014 to 2016) 42% of the 2562 surveyed patients were treated for schizophrenia.

Between 1984 and 2005, estimates for the incidence of suicide in the Philippines have increased from 0.23 to 3.59 per 100 000 in males, and from 0.12 to 1.09 per 100 000 in females (Redaniel *et al*, 2011). The most recent data from 2016 identified an overall suicide rate of 3.2/100 000, with a higher rate in males (4.3/100 000) than females (Placeholder1)(2.0/100 000) (WHO, 2018).

CHAPTER 2.
APPROACHES, PERSPECTIVES AND PRINCIPLES OF CBMH PROGRAMS

What we know about CBMH programs come from studies over the last decades. The literature on CBMH is vast, spanning from the rise of the asylum, to its decline, to the trend towards balanced care. Over time, the attitude toward deinstitutionalization and the thinking about community mental health programs evolved.

CBMH services are global concerns emphasized in the WHO's Mental Health Action Plan, the World Bank's Disease Control Priorities, and the Action Plan of the World Psychiatric Association (Thornicroft et al., 2016).

Synthetic and integrative studies like those of Thornicroft et al. (2016), Kohrt et al. (2018), and Eaton (2019) are very useful in appreciating the incremental progress of CBMH and in understanding the global scenario.

Thornicroft's study (2016) noted the wide variability in the development of CBMH services worldwide. He catalogued the obstacles, challenges, lessons learned, and solutions in implementing CBMH services in the context of the work of the World Psychiatric Association (WPA) Task Force on the Steps, Obstacles and Mistakes to Avoid. This is part of the work to develop community mental health models in low- and middle-income countries.

The WHO World Mental Health Atlas summarizes the key characteristics of national mental health systems across the world and the most recent edition (2014) includes data from 171 of the 194 member states of the United Nations.

Kohrt et al. (2018) sought to map community interventions in low- and middle- income countries (LMICs), identify competencies for community-based providers, and highlight research gaps. Their study used a review of reviews strategy and identified 23 reviews for the narrative synthesis.

In 2019, Julian Eaton came up with a practical guide on setting up CBMH programs and services, which is contained in the fourth edition of the publication *Setting up Community Health Programmes in Low and Middle Income Settings.* The guide covers the initiation, management, and sustainability of health care programs in developing countries and takes into account the Millennium Development Goals, Sustainable Development Goals, and Universal Health Coverage.

In mid-2021, the WHO published the *Guidance on community mental health services: Promoting person-centered and rights-based approaches* as part of its *Guidance and technical packages on community mental health services* set of publications. The publication provides a comprehensive account of person-centered and human rights-based approaches in mental health and highlights good practices from around the world. Cases of integrated regional and national networks of CBMH services are introduced. Recommendations and action steps towards the development of rights- based CBMH services focused on recovery are presented. Technical packages on setting up mental health services are also provided.

PERSPECTIVES IN CBMH PROGRAMS

Mental Health is a human right. The WHO *Quality Rights Toolkit* requires the establishment of community-based, recovery-oriented services. Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD) asserts that persons with disabilities, including psychosocial disabilities, should be provided with support to live independently in the community.[1] Adopted in 2006, its purpose is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those with long-term physical, mental, intellectual, or sensory impairments. They are usually subject to multiple and aggravated forms of human rights violation, including the neglect of their most basic survival-related needs. These human rights violations do not only occur in far off places that lack enlightened legislation and policies or the resources needed to meet their basic needs.

People with disabilities have the right to: 1) have their welfare and wellbeing recognized as a paramount concern; 2) make decisions or choices that may not necessarily be the decision or choice staff would make as long as safety, health, and group living considerations are taken into account; 3) an adequate standard of living; and 4) participate in political and public life, including the right to vote. The fulfilment of these rights and freedoms is essential for the attainment of full human dignity by all persons with disabilities. Article 19 of the CRPD recognizes 'the equal rights of all persons with disabilities to live in the community, with choices equal to others'.

Mental health is one of the Sustainable Development Goals. The past decade has seen an increasing focus on mental health by governments, non-governmental organisations (NGOs), and multi-lateral bodies such as the UN and the World Bank. In 2013, the Comprehensive Mental Health Action Plan 2013-2020 was endorsed by the World Health Assembly (WHA) and the Plan was further extended until 2030 by Member States at the 72nd WHA in 2019 (WHO, 2013; WHA, 2013).

Specific references to mental health have been included in international development agendas such as the SDGs, specifically Goal 3.4, which states that by 2030, pre-mature mortality from non-communicable diseases (NCDs) will be reduced by one-third through prevention and treatment, and promote mental health and wellbeing. Mental health is also highlighted in resolutions (UN, 2019) related to Universal Health Coverage (UHC) to make UHC a reality.[4] As a result, governments are being called to prioritize mental health and well-being in their health strategies and plans to expand UHC (WHOb, 2013).

Attaining the Sustainable Development Goals by 2030. Scale up and speed in addressing mental illness are essential to achieve the SDGs, ensuring healthy lives and well-being for all at all ages by 2030. Failure to do so could have devastating socio- economic impacts. Investing in health reaps benefits both within and outside of the health sector.

4 UHC means that all individuals and communities can access the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

Quality mental health care is a continuing challenge. Reports from high-, middle-, and low-income countries around the world highlight the extensive and wide- ranging violations and discrimination that exist in mental health care settings. These include the use of coercive practices such as forced admission and treatment, as well as manual, physical (or mechanical), and chemical restraint and seclusion.[5]

In the larger community context, people with mental health conditions also experience wide ranging violations. They are excluded from community life, stigmatized, and discriminated against in the fields of employment, education, housing, and social welfare on the basis of their disability. Many are denied the right to vote, marry, and have children. These violations not only prevent people from living the lives they want, but they are also marginalized from society, denied of opportunity to live and be included in their own communities on an equal basis with everyone else (Funk et al., 2021; WHO, 2010).

In some developed countries like Australia and the UK, mental health service standards have been defined and codified. LMICs like the Philippines can derive inspiration and lessons from them.

The literature speaks of some perspectives that have direct bearing on community-based mental health care, namely: *rehabilitation and recovery; social ecology approach; balanced care; integration of mental health into primary health care systems; digitalization of mental health care; and positive psychology.* These are briefly explained below:

REHABILITATION AND RECOVERY APPROACH

The WHO (2021) advocates for a rehabilitation and recovery approach in health care, including mental health care. Rehabilitation is defined as "*a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment*".

Rehabilitation is an important part of universal health coverage and is a key strategy for achieving SDG 3: Ensure healthy lives and promote well-being for all at all ages.

Psychosocial rehabilitation (PSR) is a process that facilitates opportunities for individuals who have experienced mental ill-health to reach their optimal level of independent functioning. It means developing personal competencies as well as introducing environmental changes that will enable the person to cope with the challenges of day to day living.[6]

The PSR approach builds on the person's potential for recovery and focused on providing empowerment, social inclusion, support, coping skills and building resiliency.

5 **Manual restraint** refers to interventions done with hands or bodies without the use of any device to control a person's behaviour or movement. It is sometimes called "holding").

Physical (or mechanical) restraint commonly refers to interventions undertaken with the use of devices to immobilize the person or restrict a person's ability to freely move part of their body. Restrictive devices generally include belts, ropes, chains, shackles and tightened cloth. Physical restraints also comprise disabling clothing such as straightjackets, disabling gloves, disabling furniture such as cage-beds, net-beds or immobilization chairs. Tying someone to a tree or to another object is also a form physical restraint.

Chemical restraint is broadly defined as the use of medication that deviates from the evidence based therapeutic indication for the medication and is used for the sole purpose of restraint.

Seclusion is broadly defined as isolating an individual away from others by physically restricting the individual's ability to leave a defined space (confinement). It may be done by locking someone in a specific space (e.g. room, shed, cell) or containing them in an area by locking access doors, telling them they are not allowed to move from that area or threatening or implying negative consequences if they do.

For more information see the WHO Quality Rights specialized training Strategies to end seclusion and restraint. Course guide. Geneva: World Health Organization; 2019. https://apps.who.int/iris/bitstream/handle/10665/329605/9789241516754-eng.pdf

6 in http://www.wapr.org/wp-content/uploads/WHO_WAPR_ConsensusStatement_96.pdf.

The recovery approach does not solely depend on mental health services. Many individuals can and do create their own pathway to recovery, can find natural and informal support from friends and family and social, cultural, faith-based, and other networks and communities, and can join together for mutual support in recovery. Introducing the recovery approach within mental health service settings is an important means to ensure that the care and support provided to people who wish to access to mental health services consider the person in the context of their entire life and experiences.

Although the recovery approach may have different names in different countries, services adopting this approach follow certain key principles. Such services are not primarily focused on "curing" people or making people "normal again". Instead, these *services focus on supporting people to identify what recovery means to them.* They support people to gain or regain control of their identity and life, have hope for the future, and live a life that has meaning for them whether through work, relationships, community engagement, etc. They acknowledge that mental health and wellbeing do not depend predominantly on being 'symptom free'; people can experience mental health issues and still enjoy a full life (WHO, 2019).

Recovery-oriented services commonly center around five dimensions discussed below (Leamy et al., 2011; Slade & Wallace, 2017):

- *Connectedness*. This means that people need to be included in their community on an equal basis as with all other people. This may involve developing new meaningful relationship, reconnecting with family and friends, and connecting with peer support groups or other groups in the community.
- *Hope and Optimism*. Although hope is defined differently by people, the essence of hope is the affirmation that living a full life in the presence or absence of "symptoms" is possible. It also implies the belief that one's circumstances can change and/or that one will be able to manage or overcome a situation. As such, dreams and aspirations need to be encouraged and valued.
- *Identity*. The recovery approach can support people to appreciate who they are, strengthen their sense of self and self-worth, and to overcome stigma, external prejudices, as well as self-oppression and self-stigma. Recovery is based on the respect for people and their unique identities and self-determination, and acknowledges that people themselves are the experts on their own lives. This is not just about personal identity but is also about ethnic and cultural identity.
- *Meaning and Purpose*. Recovery supports people in rebuilding their lives and gaining or regaining meaning and purpose according to their own choices and preferences. As such, it involves respect for forms of healing that can go beyond biomedical or psychological interventions.
- *Empowerment*. Empowerment has been at the heart of the recovery approach since its origins, and posits that control and choice is central to a person's recovery and is intrinsically tied to legal capacity (Chamberlin, 1997). Currently, there is a significant urge to help people living with mental health conditions live independently and be integrated in their communities (Cherry, 2020).

SOCIAL ECOLOGY APPROACH TO MENTAL HEALTH SERVICE DELIVERY/CARE

Models such as social ecology provides us with not only a systems framework for thinking about behavioral change as an outcome of community-based interventions, but also as a framework for thinking about *healthy communities*. The goal of community-based interventions is not only to change individual perceptions and behaviors but also to *embed public health values in our social ecology, including families, social networks, organizations, public policy, and ultimately our culture—how we think about things*. Although we lack an effective method for estimating effects, perhaps we should think in terms of community-based interventions as part of the social

ecology and in terms of the cumulative effects of multiple community trials rather than the effects of a single project (Cherry, 2020; McLeroy et al., 2003).

Mental health is the result of the person's characteristics and her environment. Social conditions like poverty, unemployment, literacy, climate change related disasters, cultural beliefs around mental illness, and the like, impact on a person's mental health.

Eaton (2019) stresses that people with mental health conditions can be trapped in poverty and in the same way, poverty can increase people's risk of developing mental illness, thereby making community development challenging. He expounds that many mental health issues affect people at a young age, consequently affecting their productive years where they should be earning for themselves and their families.

Figure 2-1. Mental ill health and poverty form a vicious cycle

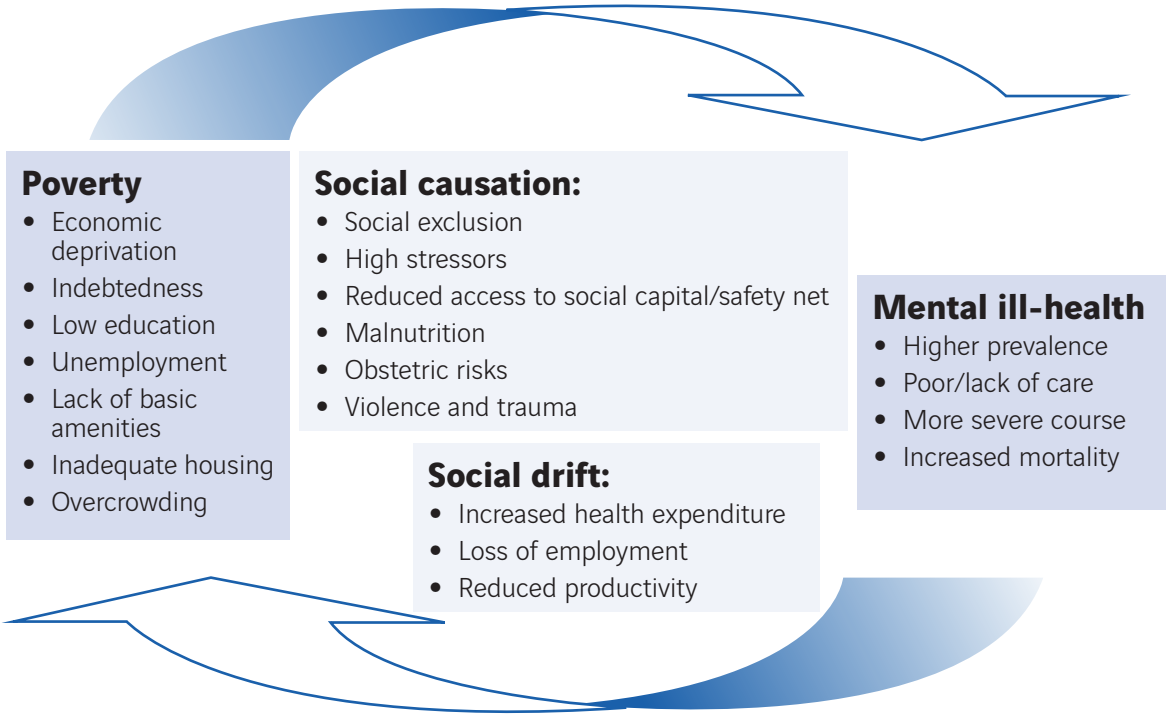


Figure 2.1 (based on Figure 24.1 Mental ill health and poverty form a vicious cycle, each reinforcing the other negatively. Reproduced courtesy of Crick Lund, University of Cape Town. This image is distributed under the terms of the Creative Commons Attribution Non-Commercial 4.0 International licence (CC-BY- NC), a copy of which is available at http://creativecommons.org/licenses/by-nc/4.0/.

Source: Julian Eaton, 2019. Setting up Community Mental Health (CMH) Programmes, https://oxfordmedicine.com/view/10.1093/med/9780198806653.001.0001/med-9780198806653- chapter-24?print=pdf

INTEGRATION IN MENTAL HEALTH CARE

There are different senses of integration that is advocated vis a vis mental health care. One view proposes to *make mental health care part of the general health systems and primary health care.* This strategy endeavors to reach the unreached sections of society. Over the years, the message of integration has been advocated and echoed by mental health professionals. It is especially relevant and meaningful in low and middle income countries, where the avowed mission and commitment under the SDGs is to promote social equality & equity, implying the need to reach the unreached.

The degree of integration of behavioral care into the primary care setting can vary from selective screening, diagnosis, brief treatment, and referral to a truly integrated care approach, in which all aspects of primary care recognize both the physical and behavioral perspectives. Available research supports the effectiveness of various approaches to integrated care, but there are several barriers to implementation, including insurance and payment issues, long-standing conflicting treatment cultures, stigma, and workforce issues (Crowley & Kirschner, 2015).

Another sense of integration is synonymous with collaborative care which involves a team of health care professionals providing care to the patient and systematic effort to provide high quality care to a patient and improve both mental and physical health outcomes…However, there is no single agreed on definition of collaborative care. (Lake, et.al. 2020:5)[7]

Integrative mental health care emphasizes wellness and healthy lifestyle choices while addressing the range of complex biological, psychological, cultural, economic, and spiritual or religious factors that affect general well-being and mental health. As such, integrative mental health care is an evidence-based, research- driven paradigm that acknowledges the legitimacy of conventional Combined and Alternative Medicines (CAM) treatments and recommends specific treatment combinations supported by research findings.

There are evidences that collaborative care has many advantages: it is cost effective, reduces health care disparities in patients from different ethnic and socio- economic backgrounds; it is more effective in the treatment of depressed mood, anxiety disorders, bipolar disorder and schizophrenia and practitioners and patients report high levels of satisfaction with the management of depressed mood (Lake, 2017; Lake et al., 2012).

Integration of mental health in primary health care has been explored in a number of African countries. In Asia, one example of an LMIC that has succeeded in integrating mental health in the comprehensive primary health care is India.

TEXT BOX NO. 4. INTEGRATING MH IN PRIMARY HEALTH CARE: INDIA

In this context, innovations like mobile tele-mental healthcare service, mobile phone for mental health risk identification, referral, follow-up as well as for data management at HWC is feasible. PHCs can be equipped with essential psychotropic drugs and teleconferencing or video conferencing for specialist consultation by psychologists and psychiatrists on a fortnightly or monthly basis from District or State level healthcare facility. Using tele-mental health technology (NIMHANS ECHO model), district level general health, and mental health personnel can be trained periodically. The District Hospitals and Hospital for Mental Health can be strengthened by collaborative care model (community-based care and facility-based care services) under district mental health program with a telepsychiatric mobile van, adequate financial resource, and the training. These hospitals can be linked with civil service organizations (CSO) offering mental health care services, PHC and HWC. Such programming, complimented with focused information, education, and communication (IEC) activities to eliminate mental health stigma/discrimination and improve access to mental health services can aid the effective implementation of the DMHP.[13,20]

Source: Apurvakumar Pandya,[1] Komal Shah,[1] Ajay Chauhan,[2] and Somen Saha[1] Examples of community based mental health programs India: Innovation in CMH. Innovative mental health initiatives in India: A scope for strengthening primary healthcare services.

7 Ee et al. Int J Ment Health Syst (2020) 14:83 https://doi.org/10.1186/s13033-020-00410-6

THE BALANCED CARE MODEL

Drawing lessons from the more than half a century of experience with community mental health services, Thornicroft, et. al. (2016) stated that in order to scale services to their proper scope, it is vital to provide services not in specialist care settings but in community health care settings and in population- and community-level platforms. This is particularly appropriate in low-resource countries where mental health provision is done through primary health care and community settings. The limited number of MH specialists can only provide training and supervision of primary care staff, consultation-liaison for complex cases, and outpatient and inpatient assessment and treatment for cases which cannot be managed in primary care.

Hospital-based and community-based mental health care are not mutually exclusive; they are complements rather than substitutes. Perera (2020) emphasizes that mental health care needs to be inherently balanced between hospital and community care, with the greatest care provided in the community and at home.

The balanced care model describes mental health service components relevant for low- income, medium-income, and high-income country settings and across the community, primary health care, secondary health care, and tertiary health care settings.

In the low-income settings across the community, the mental health service components may include: Basic opportunities for occupation/ employment and social inclusion; Basic community interventions to promote understanding of mental health; Interventions to reduce stigma and promote help-seeking; Range of community-level suicide prevention programmes (eg, reduce access to pesticides); Early childhood and parenting intervention programmes; Basic school-based mental health programs; Promotion of self-care interventions; Integration of mental health into community-based rehabilitation and community-based inclusive development programmes; Home- based care to promote treatment adherence; Activating social networks.

In the medium-income settings across the community, the mental health service component may include the services as provided in low-resource settings and: Coordinated opportunities for occupation/employment and social inclusion; Coordinated community interventions to promote understanding of mental health; Coordinated interventions to reduce stigma and promote help- seeking; City-wide and district-wide coordination of integrated mental health-care plans; Attention to mental health in policy across all sectors; Range of independent and supported accommodation for people with long-term mental disorders; Drug and alcohol use prevention programs; Range of services for homeless people with mental or substance use disorders; Community-based rehabilitation for people with psychosocial disabilities.

For children and young people, improved integration of mental health care is needed across a range of platforms that address their concerns, notably in education, child protection, primary and child health care, and social care settings.

This model envisages that there is a progressive trend across the range of resource settings for diverse delivery platform components—for example, from initiating, developing, and then consolidating the move of inpatient wards from psychiatric hospitals to general hospitals.

Where institutions remain a major form of service provision, a structured process of moving people into community settings is a priority." (Vikram Patel, 2018; Thornicroft, 2012)

In the Philippines, the Mental Health Law subscribes to a balanced care model.

DIGITALIZING MENTAL HEALTH CARE DELIVERY

Digital technology-based mental health interventions (diagnosis, treatment, and prevention) with online, text messaging, and telephone support have promising outcomes in low-resource settings. Mobile technology can play an important role in scaling up and integrating mental health services with the primary health center (McLeroy et al., 2003). Reaching out to vulnerable communities for the early detection and treatment of psychosis is an effective approach to reduce treatment gaps.

Telehealth can be adapted to address technologic or psychosocial barriers. For example, the pandemic has necessitated increased practice of telemedicine. Telepsychiatry can be used when appropriate. While most community mental health care services can shift to telehealth practices, a significant group of clients will continue to need in-person services to help meet basic needs. They may also lack access to the required technology or data plans needed to engage in telehealth.

TOWARD POSITIVE PSYCHOLOGY

Positive mental health is a resource for everyday living and can draw from individual and community assets. Positive psychology shifts attention to the psychosocial strengths of the person and reduces the highly pathologic orientation in mental health. Rather than focus treatment on symptoms, positive psychology focuses on emotional stability, resilience building, management of expectations and constructive or positive thinking. Positive psychology focuses on happiness and wellbeing and how to attain them.

Greater synergy between positive psychology and public health might help promote positive mental health in innovative ways that can improve overall population health. (Kobau et al., 2011).

The above perspectives show areas that have been overlooked in the mental health field: little attention to social determinants of mental health; the overemphasis on pathology rather than positive psychology, need for population- and community-level platforms to use contact-based interventions to reduce stigma and discrimination; and harnessing technology for MH service delivery. Evidence-based interventions need to be provided at the population and community levels to reduce stigma and discrimination experienced by people with mental illness.

ELEMENTS OF A CBMH PROGRAM

There is a wide variability in the development of CBMH services worldwide (Thornicroft, 2016). Over the past three decades, studies explored how mental health services can be established in low- and middle-income countries. WHO and the World Psychiatric Association have sponsored systematic studies to evolve principles for CBMH in underdeveloped countries in Africa and Asia that lack specialists and have low resources and investment on mental health.

Julian Eaton's (2019) observations are instructive in identifying the vital elements of CBMH programs:

1. Support from families, caregivers, and community support groups is vital. They are important for people with mild or short-term mental distress. For more serious illness, it is crucial that they work alongside professional care. Health programs can recognize and support families and informal carers in many

ways. One is through training them with skills on how to take care of their own mental health and understand their relative's illness.

Various community organizations can play a role in mental health. These organizations include government services, civil society organizations (CSOs), disabled persons' organizations (DPOs), advocacy organizations, and groups working in other sectors, e.g. education.

2. Ensuring that care is continuous and integrated. Many mental health conditions are chronic and differ in severity over time and for these issues, continuity of care is vital. This is ensured through review, follow-up, and easy access to medication (ideally near the patients' homes). Continuity of care includes practical measures to make medication affordable and available to service users and regular follow up visits.

   Empowering service users. The most important thing is to show that people with mental illnesses can participate in all aspects of community life. This can be done by, for example, inviting them to participate in activities like livelihood programs or community celebrations, and to join disability rights organizations and community groups.

   In the past, service users are in no capacity to make decisions about their treatment and give consent for medicines and other support. This is now being challenged. Toward empowering service users, their peer groups and fellow service users who have recovered could provide mutual support and encouragement. This can come in the form of their common involvement in livelihood and income-earning projects that will enable the recovering service users gain self-confidence. These groups can allow members to share their preferences about how they live in their communities—something always denied to them.

3. *Mental health care must be holistic and integrated. This means including mental health in medical, psychological and social care.*

   Medical care is essential in severe mental illness like epilepsy, schizophrenia or depression**.** Psychosocial intervention will work well when the person's symptoms have been stabilized.

   Psychological care involves talking to the patients to provide counseling, advice and psychoeducation. Alongside any medical or psychological treatment, there are some essential messages for the patient and carer on how to improve their health. For example: preventing relapse (how to avoid falling ill again); how to take medication safely and manage side effects; what to do in an emergency; how to avoid causes of stress or triggers for epileptic seizures; how to care for a family member with dementia; and how to manage difficult behaviour.

   Social care entails giving support to people with mental health conditions in order to facilitate their return to normal social life such as employment, marriage, schooling, etc. This could be done by linking with the appropriate organizations and institutions in the public and private sectors.

   Service users can access local medical and psychosocial services through a referral mechanism. For example, municipal health officers in the Philippines, who are usually general physicians, must have a directory of specialists and nearby facilities where their community members can be referred for mental health care services. If no local primary mental health care or psychiatric services can be found, it is necessary to establish an independent service with suitably qualified staff, e.g. psychiatric nurses trained in prescribing, a primary care doctor, a psychiatrist.

4. **Community-based rehabilitation is a particularly effective model for ensuring all relevant aspects of patients' needs are considered**. It focuses on social inclusion and empowerment, but also ensures that there is relevant access to medical care, education, livelihood assistance, and other support where necessary. (Eaton, 2019: p. 13)

5. **Engaging the community includes assessing the community situation relative to mental health needs.**

Assessing the mental health situation in the community. This implies discovering the type and the extent of mental health needs in the community, which are often hidden. Available resources in the community or within its reach given support and training must be assessed. The table below gives some guidance on information to consider as part of the situation analysis.

Context	Population demographics. Health indicators. Social indicators.
Need for care	Prevalence of different conditions. Current proportion of people accessing care. Risk factors for mental illness in the target area.
Policy and legislation	Political support. Mental health policy and plans. Mental health legislation.
Human resources	Personnel at different grades and locations • availability for programme/costs.
Health system infrastructure	Administrative structures for health. Services providing mental health care at different levels of system, public and private, NGO in specialist and general health care.
Health information system	Indicators that should be collected by services for health system, and to measure expected impact.
mCommunity	Local beliefs about mental illness cause, treatment and stigma, community and family support, discrimination and abuse. Traditional care availability and its use.
Other sectors	Availability of welfare, livelihood support, special education, access to rights, justice system.
Key stakeholders	Health system leaders, mental health professionals, potential service users, community and traditional leaders

6. **Action planning to respond to the mental health needs of the community.** Involve various stakeholders in the analysis and planning on mental health-related actions in order to promote greater understanding of the situation and foster broad-based ownership of the change process, enhance coordination, and avoid duplication and confusion in the community.

Based on the situation analysis, the community workers and stakeholders could decide on priorities, taking into account the available human and material resources. Also, potential risks, constraints, and challenges in implementing the CBMH actions can be anticipated.

In drawing up the action plans consider the following:

- Understanding what services need to be delivered at each level of a health system, e.g. community, health post, referral center, and evaluating tasks that each member of the team might be able to do.
- Preventing mental illness and promoting good mental health are always top objectives.
- Using local resources and partnerships to increase impact and efficiency.
- Integrating mental health into wider health and social care as far as possible. This means avoiding a separate, vertical programe (or silo) that suggests mental health is in some way unique, which can reinforce stigma.
- Plans must be practical and should include funding, human resources, management, supervision and monitoring & evaluation.
- Plans need to be structured in a clear way with timelines, allocation of duties, and the people responsible for those duties named. These action plans will be the basis for monitoring and evaluating the progress of CBMH programs.

7. Monitoring and evaluation of programmes should be installed at the design stage of the program. This helps define clearly the expected impact of the program and it can guide the setting up of CBMH programs.

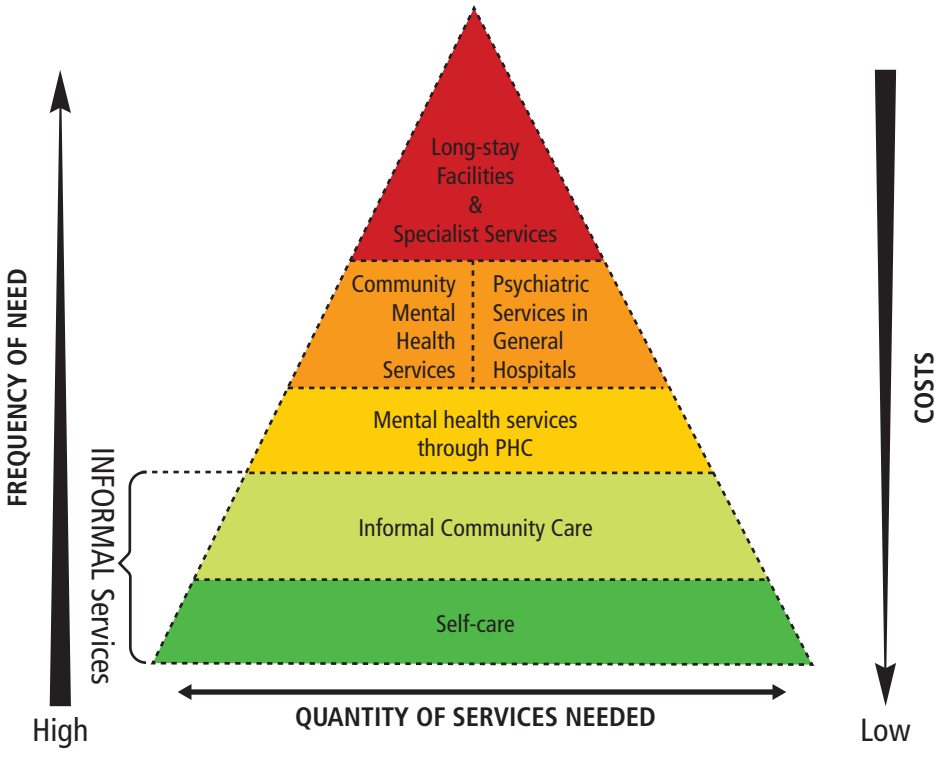
   Any health program requires regular oversight and adaptation to make it work well. Routine and systematic program monitoring is essential to keep activities aligned to its objectives. Periodic evaluation, taking into account information that has been routinely collected, allows for assessment of progress and responding to any problems identified. Such M&E is also used to keep programs and services accountable to those who are funding the work. An important addition to this is giving a voice to those who are using services, and taking their feedback seriously.

   Useful information to obtain are basic service use statistics, service quality, resource availability, and mental health outcomes.

CHAPTER 3.
NON-SPECIALISTS CAN DELIVER CBMH CARE

In many low and middle-income countries like the Philippines, mental health specialists are chronically insufficient for the needs of the population. WHO fully recognizes this situation and has recommended an optimal mix of services that depends less on MH specialists as shown in Figure 3-1 below. On the one hand, specialist facilities and services tend to be expensive and the need for it comes from a small segment of the population. On the other hand, a greater number of the population would need some form of mental health support and this can be obtained through self-care and informal community care. Mobilizing non-specialists to help provide mental health care in communities is therefore appropriate and practical for LMICs.

Figure 3-1. Optimal mix of mental health services



Source: https://www.Researchgate.Net/figure/optimal-mix-of-services-pyramid-the-mental-health-decree-and-the- who-action-plan-have-set_fig5_330752712

MOBILIZING NON-SPECIALISTS FOR CBMH CARE

The Philippines has a shortage of mental health specialists. We can lessen our dependence on specialists by training non-specialist to augment our mental health workforce. Therefore, we can train non-specialists to deliver mental health care.

Who should be the service provider in the community? What capacities for what purpose?

Figure 3-2. Health Service Provision in the Local Communities in the Philippines

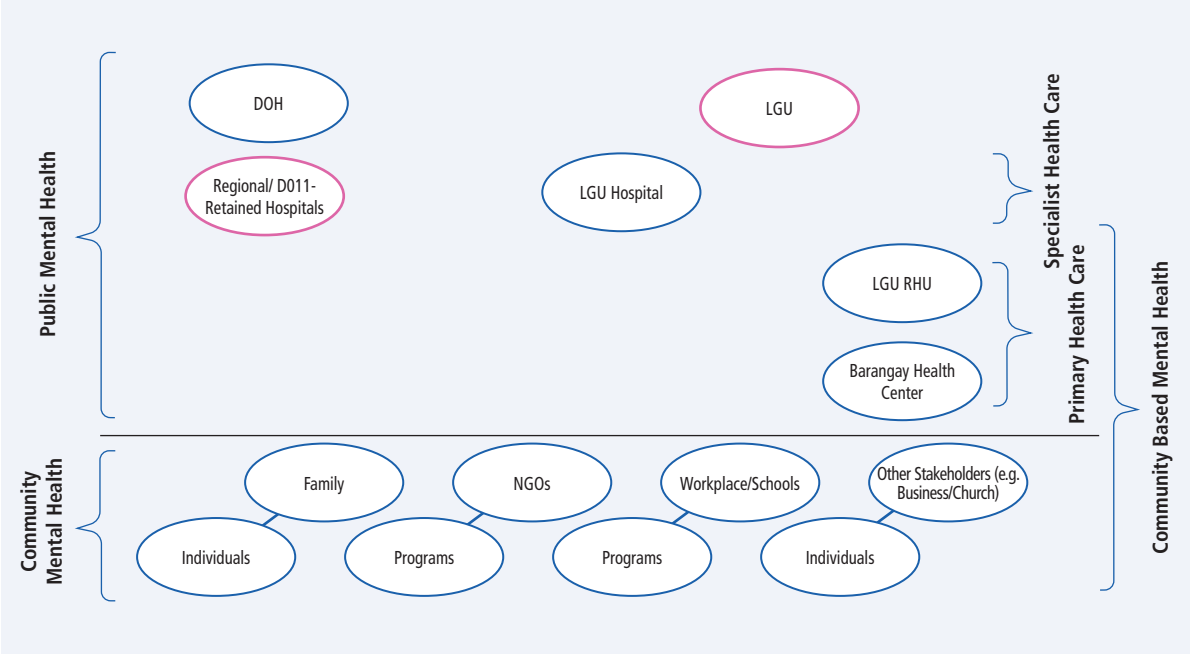


Figure 3-2 shows that in the Philippines, there are health providers in the public and private domains. In the Philippine context, health services are delivered at the barangay level through the RHUs and Barangay Health Centers (BHC). Each town or municipality must have a municipal health unit and BHCs in the town's villages or barangays. These health units and centers usually have general physicians and nurses who are not necessarily trained in mental health services i.e. non- specialists. Thus, municipalities and barangays do not offer mental health services due to lack of trained personnel such as psychiatrists and psychologists.

The RHU staff are augmented by BHWs who are largely volunteer workers. While they are given allowances, the meager amount is not commensurate with their workload. This is an area of concern in health governance. In the Philippine public health system, community mental health work is often loaded onto the many tasks of the BHWs assisting in the implementation of some 30 DOH programs on a small stipend per month. Also, BHWs are coterminous with the barangay captain who is responsible for recruiting them. Changes in political regime may mean new BHWs, which could erode the gains of capacity building interventions.

In a community, there could be informal providers of mental health services such as the church, existing civil society groups, or private facilities in the community, if at all. There could also be mental health carers within a household or family or guidance counselors in schools or work places. These human resources in the community may well be non-specialists as they are likely not have been trained in mental health care.

Putting mental health care in the hands of the non-specialists in the public and private domains imply that their capacities must be built. Given the shortage of mental health specialists all over the country, the task is to build the capacity of the community's human resources in community mental health care. The capacity building program must include guidance counselors in schools, the parents, and surrogate parents i.e. mothers, fathers, caregivers in households, human resource managers and staff in workplaces, and non-government staff running day care centers for children and adults.

In the public sector, for those in primary health care, the WHO's mhGAP was precisely designed to train them. In fact, the DOH has been implementing mhGAP training for MHOs.

The informal health care workers in the community can complement and support the results of CBMH services in the primary health care system. This way, the informal health workers can spur and sustain the continuity of care in the community.

Training non-specialists in mental health care

One major lesson learned during the past decades since deinstitutionalization is that non- specialists can deliver mental health services, a strategic solution to the shortage of mental health specialists in many developing countries. The effectiveness of various community-based interventions by non-specialists has also been examined.

Non-specialists include volunteers, champions from self-help groups, traditional healers, parish priests, village chiefs and civil society organizations who are trained to facilitate mental healthcare services in rural and remote areas. Services of traditional healers are being used as part of community care in many countries such as Cambodia, Guinea, Niger, Nigeria, and Senegal (Saxena & Sharan, 2008). In Bali, local spiritual healing practices were successfully integrated with biomedical services to reduce physical restraint amongst people with severe mental illness.

In addition, civil society organizations (CSOs) are important resources because they have been involved in the care and can be effectively harnessed to deliver mental health care in communities.

CSOs could deliver MH care through the half-way home, day care centers, suicide prevention, disaster care, and school health programs.

Parents and teachers, for their part, can focus on preventive efforts. They can be equipped with knowledge about mental health as this could strengthen children and prevent them from developing full-blown mental disorders. Being able to discern suicidal tendencies among children and students is a skill worth imparting especially in these times when reports of youth suicide is becoming rife.

"Training non-specialist workers in mental healthcare is an effective strategy to increase global provision and capacity, and improves knowledge, attitude, skill and confidence among health workers, as well as clinical practice and patient outcome. Areas for future focus include the development of standardised evaluation methods and outcomes to allow cross-comparison between studies, and optimisation of course structure." (Caulfield, et al, 2019, p. 1)

In the Philippines, the need to train lay health workers to deliver mental health services became stark during disasters and anti-drug campaigns. It became apparent that mental health is not just the role of doctors or clinical psychologists – the whole community (including families, teachers, and even students themselves) needs to play a role. Everyone must participate in fighting the rise of mental illnesses and suicides among the youth during the Covid-19 pandemic.

Thus, the CBMH initiatives in the country conducted capacity building of general health workers and lay people to establish common ground. *Katatagan* trained facilitators to conduct resiliency training for disaster survivors and recovering drug users; *Urabay* trained lay counselors to counsel disaster survivors; *Ginhawa*, PMHA and NCMH trained MHOs, general physicians, and nurses to detect mental health conditions among clients who consult them for primary health care; and the Epilepsy Manager Program trained municipal health workers as epilepsy managers. In these CBMH programs, the functions performed by the non-specialist varied with respect to the thrust of the program.

There is sufficient basis to believe that the capacity building of non-specialists is feasible in the Philippine context. What needs to be done is to have a specification of the mental health tasks that will be assigned to non-specialists.

In some countries, [community health workers] CHWs are already being given a more extended role, including diagnosis and initiating or following up medical treatment. There is huge potential in this as CHWs become an increasingly important part of health systems; however, there is an important need *to establish clear guidelines for treatment and adequate support mechanisms.* Even if *t*his is formally the case, it is often necessary to ensure training and skills are up to date, and support is available, e.g. supervision and medication supply. Senior health workers like nurses and doctors should also consider psychological and social aspects of care when formulating treatment plans (Eaton, 2019, p. 14-15).

In the Philippines, the PMHA, a 71-year-old NGO, now maintains a unit that takes charge of CBMH programs. In its central office in Metro Manila, there are four program officers that take on the function of implementing, monitoring, and evaluating CBMH programs launched by their chapters at the LGUs. There is a counterpart designated for the community mental health officer at the cities and municipalities.

The community health worker (CHW) is usually a person based in the community and performing health promotion functions. In the Philippine context, this may include the MHO, the social worker, and the BHWs. The first two could be regular government staff of the municipality while the BHW is essentially a volunteer who receives a stipend of PHP500.

CHWs are well placed to know who in the community might require mental health care and what may be needed to promote mental health in their community. To ensure that they effectively perform mental health care, their roles and responsibilities need to be defined and be given the resources required to perform mental health service function. They also require careful training, supervision, and teaching about how and when to refer patients if their needs become too great to cope with.

To improve mental health and reduce the risk of mental illness, the CHW can perform a number of tasks. Among these are specific evidence-based ways to promote mental health and prevent illness that have been catalogued by Eaton (2019): help change community attitudes, reduce suicide rates, reduce alcohol use, develop school-based life skills education and early interventions (i.e. helping mothers develop positive ways of interacting and supporting their children).

If these are the tasks, what are the *required competencies* to deliver community mental health services?

COMPETENCIES IN COMMUNITY MENTAL HEALTH PROGRAMS AND SERVICES

Implementing community-based mental health care usually falls on the designated community health workers of the existing health system. For example, in the Philippines, that would be the Municipal Health Officer (MHO), the staff of the Rural Health Unit (RHU) and the Barangay Health Worker (BHW), often stationed at the Barangay Health Center. The MHO is usually a general physician and not a mental health specialist. The RHU and the primary care system is part and parcel of the CBMH system because of its proximity to the people and the presence of a workforce that can be capacitated towards the delivery of mental health.

In the Philippines, the BHWs are frontline public health workers who have a close understanding of the community they serve. This relationship enables them to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of mental health service delivery. BHWs are volunteers that augment the workforce of the public health system in the villages. In general, they are given monthly stipends or allowances but do not enjoy regular salaries and work benefits though they may perform a lot of work.

Additionally, there are private and civil society organizations/NGOs that conduct activities to provide health care, including mental health services, for members of the community. They may engage in a range of activities such as outreach, community education, informal counseling, social support, and advocacy. The NGO sector includes church groups, peer organizations, cooperatives, community groups, and even traditional healers.

The current Philippine Public Health System has been shaped by the policy shifts towards decentralization, devolution, and local government autonomy. The national government's lead health agency is the DOH. For its mental health actions, it relies mainly on the National Mental Health Program, now part of the nascent and still being developed Mental Health Division. The Philippine Council for Mental Health (PCMH) is tasked to oversee the implementation and monitoring of the provisions of the Mental Health Act.

The service delivery in the Public Mental Health System is primarily done through the primary, secondary, and tertiary level hospitals for the national government and for the local government, through the provincial and district/city hospitals and the RHUs. The smallest unit in the public health system is the barangay health station, usually catering to a barangay or a cluster of barangays. Ideally, they are manned by a medical doctor and allied health professionals but in reality, they are catered by a group of BHWs. BHWs are considered as the tip of the public health response, but they are better classified as volunteer health workers with a variety of backgrounds, but mostly high school graduates (Taburnal, 2020).

Community mental health is differentiated from public mental health on the basis of its being community initiated, community-driven, and community-ran initiatives. Ideally, it follows a "for us, by us" approach.

The CBMH is located at the nexus of community health and primary health care. Its targets are the families and individuals, with a special focus on the service users. It will look at the strengths of the community to fill in the needs for mental health care and this requires the orchestration of the different resources and linking with already established programs and realigning them to the mission for mental health. The services to be offered encompass the preventive promotive, curative, and rehabilitative aspects.

In the Philippines, examples of a pure community mental health initiative are difficult to identify. The scoping survey (presented in chapter 3) has revealed that all "community programs" included at least a component of the public mental health system, either through the capacity- building of BHWs or the use of the barangay health station as the point of contact with the community.

What competencies must be developed among non-specialist CMH workers?

Defining the core competencies in mental health of community health workers has been the subject of studies in the last decade. To determine the relevant competencies, one has to look into the role of the Community Health Worker.

The Role of the Community Health Worker (CHW)

CHWs are well placed to know the day-to-day challenges and needs of those in their community. They must be given CBMH competency training but training should take into account their roles, responsibilities and resources in delivering mental health services. They need to know how and when to refer patients if their needs are beyond the competency of the community worker. CHWA require careful training, and supervision.

To improve mental health and reduce the risk of mental illness, CHWs can perform a number of tasks such as helping change community attitudes, reducing suicide rates, reducing alcohol use, conducting early life interventions, and developing life skills.

Through awareness raising campaigns, the stigma and discrimination against the mentally ill can be reduced or eliminated. By improving attitudes, the social environment for people with mental health conditions can become more conducive to recovery and reintegration in the community.

Supporting mothers who experience depression after childbirth can have a positive impact on the socialization of infants early on in life. Likewise, parents of children who have behavioral and emotional problems can learn skills for adjusting behavior, thereby improving family relationships and child mental health.

To reduce suicide rates, especially in the time of the pandemic, one can encourage community residents to talk about how they feel so they can seek help. Also, helping students to think about their emotional well-being, and teaching them to cope with problems constructively, are known to improve long-term mental health.

The CHW has multi-faceted roles as illustrated in Eaton's list of CHW tasks:

Medical aspects:

- Identifying and referring people with mental health needs, and helping them access appropriate services;
- Planning their treatment with them, and considering what to do if the illness gets worse; Educating people and their families about the illness and how to stay well, including the importance of taking medication as prescribed; and
- Following up clients at risk of relapse, especially when they miss clinic appointments.

Psychological aspects:

- Developing long-term trusting relationships with families, and providing basic counselling and messages about maintaining good mental health; and
- If properly trained, provide psychological treatments such as problem management or behavioral activation therapy.

Social aspects:

- Addressing social issues that worsen mental health, e.g., gender-based violence or family conflict;
- Community awareness-raising about mental health and human rights;

- Setting up self-help groups (SHGs) or ensuring that people with mental health problems are included in other community groups; and
- Ensuring that people with mental illnesses or psychosocial disabilities benefit from the same rights as other people, e.g., social welfare benefits, education, employment.

There is huge potential in harnessing CHWs for health service delivery, including mental health services. But this necessitates providing them with clear guidelines and adequate support mechanism for delivering health care. This includes supervision and medication supply. In this regard, senior health workers like nurses and doctors should also consider psychological and social aspects of care when coming up with treatment plans.

Given Eaton's enumeration of tasks above, it is apparent that CHWs must have mental health care competencies. In low- and middle-income countries like the Philippines, building the competency of the CHWS is a vital element in developing CBMH Programs.

In the Philippine context where the health workers are general physicians, or a nurse in the RHU, and some allied medical worker, it is vital to equip them with mental health competencies. Aside from the officially designated health workers, there are community development workers outside the public health system such as members of the church or civil society organization members who may be performing mental health care. They work as private individuals or NGOs to promote health in the community. Mental health promotion could be part of their self- defined brief.

What CBMH Competencies?

As early as 1999, the National Mental Health Workforce Development Coordinating Committee of New Zealand drew up a Competency Framework for the Mental Health Workforce (National Mental Health Workforce Development Coordinating Committee, 1999). Then in 2008, the WHO did a systematic review of the progress for non-specialist workers (Caulfield et al., 2019). Subsequently, in 2012, the US Institute of Medicine (Collins et al., 2015) convened a workshop to establish these competency requirements for service providers classified into the following categories:

1. Community/lay workers (peers, community health workers, and health extension workers);
2. Non-specialized non-prescribing practitioners (pharmacists, social workers, and occupational therapist);
3. Non-specialized prescribing practitioners (clinical offers, nurses, and general medical doctors); and
4. Specialized practitioners (psychiatric nurses, psychologists, neurologists, and psychiatrists).

During the workshop, participants refined the candidate core competencies, which were divided into three categories: *screening and identification, formal diagnosis and referral, and treatment and care.*

Candidate core competencies discussed for all provider types across Mental, Neurological and Substance (MNS) disorders:

I. Screening/identification (SI)
   - SI.1. Demonstrates awareness of common signs and symptoms
   - SI.2. Recognizes the potential for risk to self and others
   - SI.3. Demonstrates basic knowledge of causes
   - SI.4. Provides the patient and community with awareness and/or education SI.5. Demonstrates cultural competence
   - SI.6. Demonstrates knowledge of other mental, neurological, and substance use (MNS) disorders

II. Formal diagnosis/referral (DR)

DR.1. Demonstrates knowledge of when to refer to next level of care/other provider/specialist DR.2. Demonstrates knowledge of providers for specialized care within the community

III. Treatment/care (TC)

TC.1. Provides support for patients and families while in treatment and care

TC.2. Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (e.g. adherence, stigma, finances, accessibility, access to social support)

TC.3. Demonstrates ability to monitor mental status

TC.4. Demonstrates knowledge of how to offer emergency first aid

TC.5. Initiates and/or participates in community-based treatment, care and/or prevention programs

TC.6. Demonstrates knowledge of treatment and care resources in the community

TC.7. Promotes mental health literacy (e.g. to minimize impact of stigma and discrimination) TC.8. Communicates to the public about MNS disorders

TC.9. Monitors for adherence to and/or side effects of medication

TC.10. Practices good therapeutic patient interactions (e.g. communication, relationship, attitude) TC.11. Provides links between patients and community resources

TC.12. Identifies available resources to support patients (e.g. rehabilitation, medication supplies)

TC.13. Promotes activities that aim to raise awareness and improve the uptake of interventions and the use of services

TC.14. Protects patients and identifies vulnerabilities (e.g. human rights)

TC.15. Demonstrates respect, compassion, and responsiveness to patient needs

TC.16. Demonstrates knowledge and skills to use information technology to improve treatment and care

Note: The information above is reproduced from the IOM meeting report, 'Strengthening human resources through development of candidate core competencies for mental, neurological, and substance use disorders in sub-Saharan Africa: workshop summary' (Diana Pankevich et al., Rapporteurs, 2013).

Communication skills is important. The World Health Organization (WHO) *Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) on non-specialized health settings, which offers guidelines for mental health actions in developing countries, underscored that* good communication skills along with respect for the human being and her dignity are important in dealing with *the* people dealing with mental health-related issues.

In practice, this means "preparing an environment that facilitates open communication; being friendly, respectful and non-judgmental; using good verbal communication skills; and being sensitive towards difficult experiences (Endang et al., 2018, p.4).

Eaton (2019) reenforces this view and states that good communication skills can help make an accurate diagnosis, increase the likelihood of people returning for follow up care.

This CBMH Program Framework has formulated a Learning and Development Needs Analysis (LDNA), also referred to as a Competency Framework for a Beginners' Course for Community Health Workers in Community-based Mental Health Care as shown in Annex 1.

CHAPTER 4.
FRAMEWORK FOR COMMUNITY-BASED MENTAL HEALTH PROGRAMS IN THE PHILIPPINES

I. Introduction

This framework for CBMH programs in the Philippines was conceptualized by a multidisciplinary team of specialists in psychology, psychiatry, and community development. The initial formulation of the framework was guided by a review of literature on CBMH programs and services. The literature review is enriched by the ground experiences in the Philippines and was enlightened by FGDs with service users, family carers, as well as interviews with key informants who are already practicing mental health care in their community long before the advent of the Philippine Mental Health Law. The FGDs were organized by the WAPR Team.

The concept of CBMH evolved over time. CBMH services were seen as an alternative to deinstitutionalization. CBMH services in the US was then called community mental health centers (CMHCs) but they fell into disfavor because it became unsustainable.

The search for an alternative to deinstitutionalization spawned many studies, especially in low resource countries in Africa and Asia where mental health services are hardly available. For more than three decades, research on community mental health services in low- and middle-income countries were supported by the WHO and the WPA. In 2021, the WHO published its guidance package on community mental health services.

The CBMH Program Framework drew lessons from worldwide experiences in implementing CBMH programs and experiences in the Philippines. The framework builds on the multi-dimensional concept of community and the various complementary perspectives that have emerged from decades of work on CBMH services. A core concept is the view that the **community** is seen as a *setting, a target, an agent of change and a resource*.

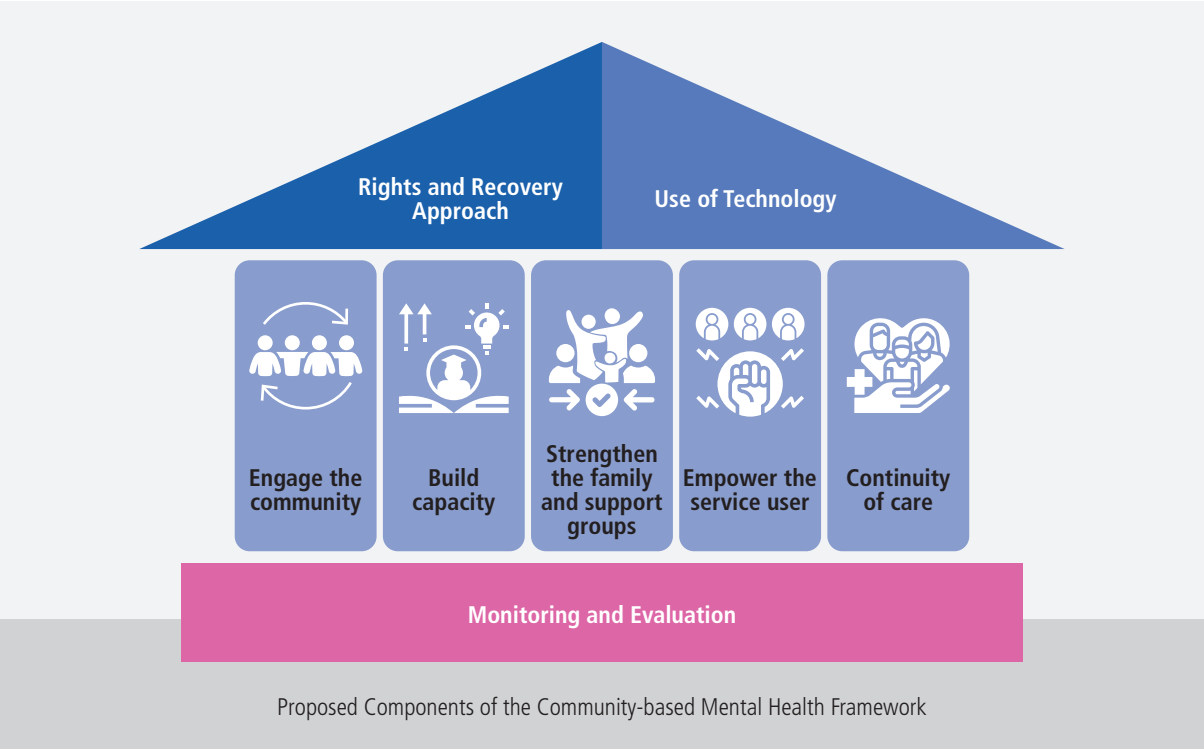
II. The CBMH Program Framework

There are six key elements in the CBMH Program Framework (Figure 4-1):

1. Harnessing the community as a setting, a resource, a target and agent of change;
2. Building institutional and individual capacity among non-specialists in the community;
3. Empowering the service users;
4. Strengthening the family and support groups in the community;
5. Providing post recovery assistance and transition/reintegration to the community; and
6. Monitoring and evaluating the outcomes of CBMH.

The first five elements will be discussed in this chapter. Monitoring and evaluation of outcomes will be discussed in a separate chapter.

Figure 4-1. Elements of a Community-based Mental Health Program



Five complementary perspectives guide this Program Framework. Two of these are overarching viewpoints: 1) the rights and recovery approach; and 2) harnessing technology for the digitalization of mental health services. The rest are strong advocacies articulated in the literature, namely: 3) the integration of mental health care in the general health system, particularly in primary health care; 4) the consideration of social determinants of mental health as articulated in the social ecology approach; and 5) a balanced care approach to rehabilitation and recovery.

A. ENGAGE THE COMMUNITY

What is a community?

In the Philippines, the community may well be located in the barangays or villages, the smallest political unit in the country. Provinces of the Philippines are divided into cities and municipalities, which in turn are divided into barangays (formerly barrios) – villages. As of 7 September 2019, there were 1,488 municipalities across the country. There were 42,046 barangays throughout the Philippines. (DILG, September 2020).[8]

There are different levels of community engagement and the IOM Manual (2019) on Community Based (CB MHPSS) Programming Manual has elaborated this very well. The general principle is to have as much community engagement as possible from the inception of the CBMH Program down to its implementation and evaluation. This is very much in line with the rights-based approach.

Community engagement is both a process and outcome. The three objectives of community engagement are: 1) provide community members with opportunities to contribute to decision making; 2) build capacities and competencies; and 3) strengthen relationships between the agency, the community, and components of the community (IOM Manual, 2019).

There are different levels of community engagement but it is strongly suggested that there should be as much community engagement as possible to foster community ownership and empowerment. When the community is engaged in the widest possible sense, the CBMH program is likely to be sustained.

In the Philippines, integrating mental health into the general and primary health care system must take cognizance of the fact that the delivery of health services is devolved to the LGUs in accordance with the Decentralization Act of 1991 (RA 7160). This means the responsibility and accountability for mental health services in the community is in the hands of the LGU. In fact, this can be leveraged in persuading local chief executives to pledge and commit resources for the CBMH program.

Apart from soliciting commitments and pledges from the LGU, the change agent must endeavor to make known and explain that the CBMH is aimed at making individuals become functional and takes into consideration the social ecology of the individuals, families, and households.

In developing CBMH programs and services, a number of decisions have to be made and it would be wise to have the LGU on board in addressing these decisions and finding solutions. This is corroborated by the observations of the Philippine Mental Health Association (PMHA). In their eight years of programmatic work on CBMH, they observed that the engagement of the LGU is extremely vital in the effectiveness and sustainability of community mental health programs.

Who to engage in the community?

The stakeholders are the duty bearers, the service users and seekers, the family carers, the support groups i.e. peer support groups and civil society organizations would have particular interest in CBMH.

The Duty Bearers (local level)

In the community, the duty bearers for health care are the local chief executive (LCE), the MHO, and the Local Health Council. In addition, the BHWs serve to augment the rural health staff in cities and municipalities. They would have influence in policy making, planning, and implementing health programs for the community.

8 https://www.dilg.gov.ph/facts-and-figures/Regional-and-Provincial-Summary-Number-of-Provinces- Cities-Municipalities-and-Barangays-as-of-30-September-2020/32

As such, their buy-in is vital to the effective mobilization of resources to support community mental health programs and services.

The Service Users

The community consists of a variety of individuals and groups who are *users and seekers* of mental health services. It can be argued that everyone is a user of education and information pertaining to mental health. Of interest are specific population groups known to face risks of mental ill health and/or who are vulnerable to stresses due to their demographic and socio-economic circumstances. Among these vulnerable groups are the senior citizens (above 65 years old) and the elderly; the lesbian, gay, bisexual, transgender, and queer plus (LGBT+) community; the youth; families and relatives of drug users who have surrendered to the authorities; people living in poverty; the homeless; people with disabilities; and people suffering from mental conditions.

Support Groups in the Community

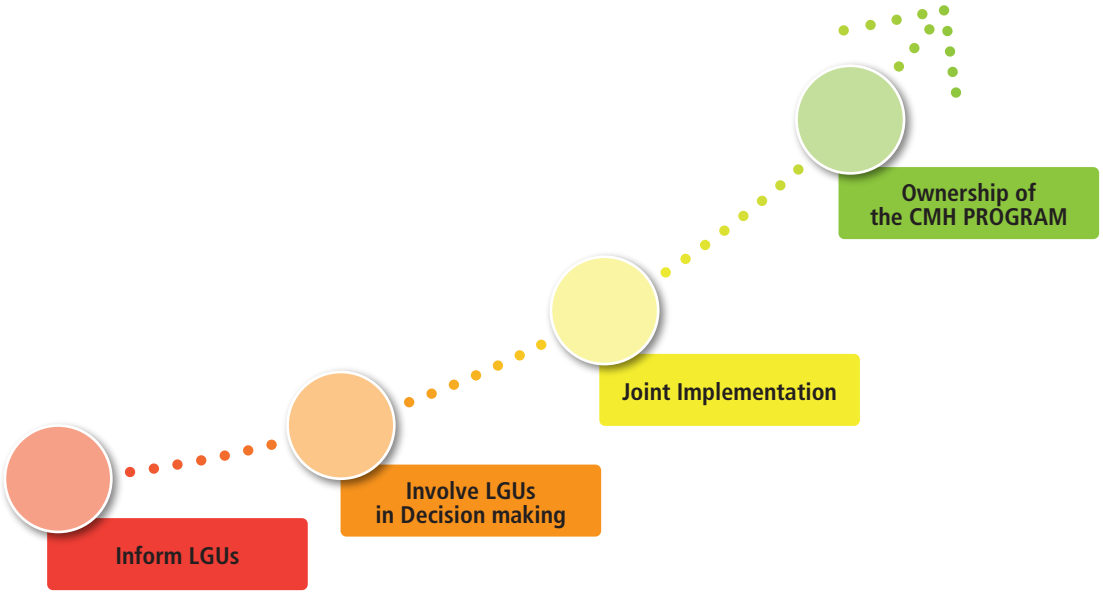
Other groups of interest are church groups, civic organizations, corporate foundations and local and international organizations that could be potential advocates, partners, and collaborators of mental health promotion within the community.

> There may be a variety of organizations in a community with a role to play in mental health. These include government services, CSOs, disabled persons' organizations (DPOs), advocacy organizations, and groups working in other sectors, e.g. education. All these stakeholders should be involved in the analysis and planning. This brings a greater understanding of the situation, but it also helps them to contribute and to own the change process. Full participation also allows co-ordination of efforts and avoids confusion and duplication (Eaton, 2019, p. 21)

This multi-stakeholder engagement has been practiced to some extent in the *Urabayan* Program where "natural nurturers" in the community were identified and trained to become lay counselors.

The Program Framework suggests a **strong multi-stakeholder involvement and LGU ownership of CMH programs**. As shown in Figure 4, the LGU may have varying degrees of involvement and ownership of community mental health programs.

Figure 4-2. Degrees of LGU Engagement



How to engage the community?

The community can be engaged in manifold ways and can be looked upon as a target, agent of change, resource, and setting for mental health services. It is ideal to have the stakeholders involved at the inception of the CBMH program by informing them thoroughly about the program and its desired outcomes.

In setting up CBMH services, there are basic questions to be asked such as: *Which community/barangays and why? Where to locate the CBMH services? What services and for whom?*

Practical decisions need to be made and it is best to consult the community, especially the duty bearers, power holders, and influencers and make them part of the decision- making to deepen their ownership and involvement in the community mental health initiative. The change agents, in collaboration with the service users, must clarify the desired results or outcomes of the CBMH program.

Community Assessment and Situational Analysis

At project inception, the CBMH must be based on an understanding of the community situation relative to mental health programs and services. Hence, a situational analysis must be done to know the context, the need for mental health care, policy and legislation, human resources, health system infrastructure, health information system, stakeholders i.e. duty bearers and service users, and community beliefs about mental illness (Eaton, 2019).

It is essential to know the community's assets, socio-cultural resources, including attitudes toward mental health and potential for establishing and sustaining community mental health services. Community assessment must recognize the strengths and opportunities as much as the deficiencies and needs.

A systematic inventory of community resources that can be mobilized and used in the development of a scalable health service is vital to the design of the CBMH program. Resources may include services, support mechanisms, information, social networks, technology, and infrastructure available and accessible within a specified community. This process is called resource mapping. It allows active participation of the community

in the development of health services. This is relevant in settings with few material resources where, despite improvement in services, the community is likely to carry a substantial proportion of the care burden.

Community assessment could be done using primary and secondary data. Assessment tools can be adapted or new ones can be formulated, depending on the situation at hand. There are existing tools for community assessment and these can be modified as required by the situation.

Engaging the community in mental health programs is one of the best ways of ensuring sustainable, holistic, continuing mental health care.

What mental health services to offer? And where? What is needed by the community?

There is a wide array of mental health services that could be offered: psychoeducation and information, advocacy and training, day care services, counseling and talk therapies, telemedicine, including psychotropic medications. Determining which ones to offer can be the subject of dialogue and consultation during the community assessment stage.

The needs of the people and the community is the prime consideration in determining what mental health services to offer. Demand is the primordial determinant of what mental health services should be offered. In fact, some experts say that the sustainability of CBMH programs lies in the continuing demand from the community itself, especially the service users.

Where to offer mental health services in the community?

Community mental health care can be located in schools, workplaces, and the community. By definition, CBMH programs are those offered outside the hospital. In the case of community mental health programs, the purpose is to make mental health services available and accessible to the prospective service users. Hence, considerations of proximity and accessibility i.e. easy to reach via public transport are to be considered. The local health authorities are well-positioned to determine the appropriate venue or location of the CBMH program. Where the strategy is to integrate mental health in the primary health care system, the RHU is the natural place for the CBMH program. Where necessary and feasible, alternative mental health service delivery modes can be considered such as mobile clinics or tele-mental health programs.

C. EMPOWER THE SERVICE USERS

Who are the service users?

Service users, traditionally referred to as patients, are those persons with lived experiences of mental illness. They may have undergone mental health screening, diagnosis, referral, education, counseling, and treatment by specialists.

Historically, service users have been viewed as passive recipients of mental health services who are assumed to have lost their cognitive capacities and unable to make reasonable judgments. This belief has contributed to abuses and maltreatment of service users, violation of their rights, and disrespect for their dignity. There are media footages of these in the Philippines. During Typhoon Haiyan, the *Ginhawa* team had encountered cases where the patient is caged like an animal because the family feared the patient might harm other people, including their own kin.

Service users do not have a collective voice to speak up against such abuses and seek for corrective measures. This makes it necessary to empower services users and give them the agency to protest and correct improper

treatment. For example, under the Philippine Mental Health Law, the service user has been given power such as, for example, the requirement to have informed consent prior to the administration of treatment procedures.

In the case of the severely mentally ill, the service user could suffer from limitations in the exercise of their rights. People with mental health problems are a very marginalized group, particularly those people living with disability, i.e. those diagnosed with schizophrenia have often been given little choice about their own lives.

What is service user empowerment?

"Empowerment is a core concept of WHO's vision of health promotion. Its importance in disease prevention and health promotion is well recognized in the Declaration of Alma- Ata and the Ottawa Charter on Health Promotion...

In a mental health context, empowerment refers to the *level of choice, influence and control that users of mental health services can exercise over events in their lives*.

Empowerment applies to individual service users as well as to communities. "It is a multidimensional social process through which individuals and groups gain better understanding and control over their lives. Therefore, they are enabled to change their social and political environment to improve their health-related life circumstances.

"At the individual level, empowerment...is the process of taking control and responsibility for actions that have the intent and potential to lead to fulfilment of capacity. This incorporates four dimensions: 1) self-reliance; 2) participation in decisions; 3) dignity and respect; and 4) belonging and contributing to a wider community." (User empowerment in mental health – a statement by the WHO Regional Office for Europe, 2010, p.1.)

Why empower service users?

Two reasons why service users must be empowered are: it is a fundamental human right and better health outcomes at the individual level can be achieved by giving service users the social space and the capacity to determine their life's direction and be able to live independent and productive lives.

Service user empowerment is a *fulfillment of a right* of the service user under the Philippine Mental Health Act. Health is a fundamental human right but claiming it depends on the capacity of service users to claim such rights.

Empowerment is meant to help individuals to regain self-esteem, acquire and adopt self- determination and autonomy, exert more influence on social and political decision- making processes. There is good evidence in mental health literature that positive outcomes result from service user empowerment. Such positive effects include enhanced self-esteem, a greater sense of connectedness and meaningful engagement in society (Yotsidi et al, 2018, p. 1).[9]

But in general, evidence that service user empowerment or involvement leads to better outcomes in the systems level has been lacking (Abayneh et al., 2017).

Communities can support service user empowerment by establishing social networks and mobilizing social support. These promote cohesion between individuals and can support people through difficult transitions

9 Vasiliki Yotsidi[*a], Kalliope Kounenou[b] Experiences of Mental Health Service Users on Their Empowerment and Social Integration in the Community, 2018. https://ejcop.psychopen.eu/article/view/147/html; Haldane V, Chuah FLH, Srivastava A, Singh SR, Koh GCH, Seng CK, et al. (2019) Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. PLoS ONE 14(5): e0216112. https://doi.org/10.1371/journal.pone.0216112

and periods of vulnerability in life. (User empowerment in mental health – a statement by the WHO Regional Office for Europe, 2010: p.2).

How to empower service users?

Empowerment of patients and their families, friends, or other informal carers is a societal task. It encourages all to respect the health and well-being of individuals and populations and act in ways that empower individuals and groups to respect their own and other people's rights to health and well-being.

For the individual, the empowerment process starts with individually-defined needs and ambitions and focuses on the development of capacities and resources that support it. An empowerment approach promotes the recognition and development of the service user's strengths, resources, and skills.

Educating service users, carers and their families. Informing service users and their carers and families about their human rights is the first practical step to ensure that they are properly treated. Knowledge that will protect service users from being violated and abused, as well as health benefits provided in the law, should be part of an orientation in CBMH programs.

Organizing the service users, their carers, and families is one way of empowering service users.

Self-help groups (SHGs) and NGO-run micro-credit schemes have incorporated service users in Nepal, Ghana and India. Through the SHGs, service users get support and encouragement in the form of livelihood, income earning projects and develop their self- confidence in the process. The SHGs gives social space for service users to choose their preferred way of life and living – a decision that people with mental ill health have been deprived of. Service users and their families must be given the option to take charge and ownership of their healing journey. Service users should be centrally involved in the development of mental health-care services and systems.

"We need to challenge the idea that people with disabilities cannot make decisions about their own treatment or understand and give consent for medicines and other support" (Lankester & Grills, 2019).

Mental health professionals sometimes assume that service users and their families lack the ability to make decisions, or to make correct decisions. They may then limit the number or quality of decisions that users and families may make. Or in some instances, mental health professionals restrict information on the pretext of best interest of the service user. Consequently, service users and their families, have limited information and they may make choices that confirm professionals' beliefs in their inadequacy.

Without support in making decisions, users are kept in long-term dependency relationships. People cannot become independent without the opportunity to make important decisions about their lives. Yet, empowerment of people who have mental health services and their carers is an international, European and UK priority (Crepaz- Keay, 2016).

The role of service users in guiding person-centered approaches in mental health services is well established (if not consistently implemented) in Australia, Canada, New Zealand, the UK, and the USA, It is rapidly becoming more common in Scandinavia, and is developing slowly in some Asian and Latin American countries.

Among LMICs, the evidence show limited practice of service user involvement. The Philippines may need some more time for the notion of service user involvement to be a standard practice in the country. Key informants from NCMH and PMHA have suggested the idea of service empowerment as part of community-based MH care.

In the Philippines, there is a nascent initiative to organize and empower the service users. Service users who have recovered and are transitioning back into their communities have been organized into the Alliance of Filipino Families for Mental Health, Inc. (AFFMHI) by a social worker,[10] also a member of the WAPR Board. In the Philippine General Hospital Ward 7, services users and family carers awakened to the need to be organized in order to support each other.

The potential of service user empowerment in the Philippines was demonstrated by a group of service users who shared their views and experiences through a FGD with the WAPR team. Ten service users who have been discharged from the hospital and are now going through the recovery process participated in the FGD. Many were diagnosed with schizophrenia while others have bipolar disorders, anxiety disorder, and depression. After being discharged, the service users were on their own and were cared for by their respective families. They had occasional visits to the hospital as required by their psychiatrists.

The service users had varied experiences in accessing mental health services in their respective areas. In general, none of the service users had initiated contacts with their MHOs or their RHUs to seek for mental health support or service. This pattern is highly indicative of the fact that the RHU is not perceived to be a source of mental health support services.

Service users saw their respective barangays as a source of support. For example, one service user obtained livelihood training in his barangay; in another case, the service user got cash assistance. Some were able to get medical assistance i.e. obtaining prescription or accessing medications through the Alliance (AFFMHI) and the LGU-municipality.

In one case, a foundation gave the service users relief goods as pandemic assistance. In another case, a politician (party list representative) gave cash assistance of PHP1,000. Some service users reported that they could not get any assistance from their LGUs.

One of the service users had become the president of the Persons With Disabilities (PWD) Association in Los Banos, Laguna. Now, he works to obtain assistance from the barangay and advocates to raise awareness on the situation of recovering service users.

During the pandemic, the service users accessed support and services through social media and zoom support groups. Some have had to stop their occupational therapy and socialization such as outings of their service users' group.

Common challenges during the service users' recovery phase were: their family's fear of being stigmatized, lack of economic and financial means (one service user who is a mother reported that the cash assistance she gets is used to feed her children instead of using it for her medication; they have no money for fares to visit drop in centers; there is no support system to facilitate reintegration into the community) and medication is hard to get because it is unavailable. One service user noted that the MHO can dispense medication. Some of them reported that their stressor is their very own family who were unable to understand their condition. Therefore, they feel the need to have a place to retreat from such aggravation. One stated that they have difficulty in social relations and interactions.

Among the services users' expressed needs, wishes, and observations were:

- To have a *drop in center* where they could gather for socialization and for livelihood projects – it can be a multipurpose area to avoid stigmatization and where service users can draw inspiration from each other. It can also serve as a center for making themselves productive through livelihood projects. They

10 Ms. Sally Bongalonta.

used to have a drop in center at the NCMH until the facility had to use it for something else. Every now and then, service users feel the need to have someone to talk to.

- To have a *halfway house* as temporary retreat from family stress and to rest their mind. It should be managed by professionals who can help service users reintegrate into the mainstream and help them recover their self-esteem.
- Economic assistance including job training, rice and relief goods, and cash assistance.
- Have volunteers to give inspiration, like the lectures of Dr. Marissa de Guzman, a psychiatrist at the Philippine General Hospital.
- Have a family support group in every barangay that can help conduct family dialogues in case of conflict.
- Include mental health in schools and reduce stigma.
- To educate the grassroots to 'normalize'(i.e. eliminate the stigma) their views about mental illness.
- To take into account diversity and inclusion in policies.
- To empower service users through education and family therapy and train social workers in counseling. For example, in the town of San Miguel, Bulacan, which has a population of 150,000, there are not enough trained social workers on mental health.
- To explain the link between non-communicable diseases and mental health.
- Mental health services are few and far between in municipalities in the regions of Visayas and Mindanao.

In sum, the service users' experiences and observations point to strategic actions, namely:

- **Explain and assist service users to understand and accept** their mental health condition. Treatment should not be just symptom reduction. Upon discharge, patients do not really have an understanding of their illness because it is not explained to them even though the nurse talks about the medication to be observed upon discharge.
- **Understand the conditions of service users and the social factors** that triggered or led to their condition: poverty, economic deprivation, physical, sexual abuse, perinatal trauma, child abuse, violence against women, undiagnosed mental health conditions at the workplace, and family stressors. Educate employers for them to be more accepting and to assist service users in their recovery and reintegration.
- **Develop community health services to include:**
    a. Economic empowerment of service users – jobs, livelihood
    b. Psycho-education, for example the *Bukas Puso, Bukas Isip in PGH*[11]
    c. Awareness raising
    d. Stigma reduction
    e. Capacity development of social workers
    f. Psychosocial services i.e. drop in centers, halfway Houses.

Service users must be encouraged to reach out to their respective MHOs for mental health support services. If it does not exist yet, this is an occasion to advocate to the MHOs and relevant local officials to initiate a CBMH program.

There should be mental health services per barangay. Each barangay can have PWD groups. Also, consultations can be done online including meetings of family support groups.

A good practice in empowering service users is the AFFMHI's Care Farming Project, which is being continued in the time of the pandemic. Care farming was first tried at the premises of NCMH for two to three years until the

11 It is a program and practice at the Psychiatric Ward of the UP Philippine General Hospital where service users and their family carers are encouraged to attend lectures and learning & psychoeducation sessions to develop their psychosocial knowledge.

subsidy was used up. Also, the land used for the CARE Farming Project was no longer allowed by succeeding NCMH administrations. Hence, the project wrapped up.

In essence, the Care Farming Project allowed recovering patients and their families to cultivate idle urban land and convert them into productive farms. The families and the patients did the land preparation, plant cultivation, and harvested the farm produce, which they then sell to the market. Sales proceeds give the families some income to support the medication of recovering service users. Some of the proceeds are plowed back to maintain and keep the farm productive.

During the pandemic, the AFFMHI collaborated with NGO, *Mga GAWA,* and resumed another CARE Farming Project in an urban community in Antipolo City. Such community- based programs are encouraged in the Philippine Mental Health Law, which AFFMHI campaigned for along with other NGOs.

To foster service user empowerment in the Philippines, people should be self-empowered first, especially those who are well in the community. They could facilitate wider dissemination of the CBMH program. This could include capacity-building activities such as learning sessions on knowing their community; asset and resource mapping; defining and understanding community-based mental health and why it is important; formation of a core group among the users who can act as facilitators to help raise people's awareness of the bio-psycho-social and spiritual aspects of health and illness; providing access to information and technology for medical consultation with health specialists when necessary; and providing access to mental health services in a regular facility as appropriate.

In the long term, practical actions would include: *organization of mental health services in each of the barangay, including the infrastructure that will be available for all people; inclusion of mental health services in the barangay development council; inclusion of the budget for psychotropics at the barangay level; and establishment of a network of agencies that will converge their services for the empowerment of people.*

D. STRENGTHEN THE FAMILY AND SUPPORT GROUPS IN THE COMMUNITY

Support for mental health and well-being come first and foremost from the family unless the family is dysfunctional or is the source of stress of individual service user. The family is usually a person's immediate environment that normally provides physical and psychosocial nurturance. In LMICs such as the Philippines (Hechanova et al., 2018) and India (Avasthi, 2010), the family is the main locus of support for mental health concerns.

WAPR Philippines FGD with Service Users last July 27, 2021

Among Filipinos, the family plays a central role. The literature also suggests that with Filipinos, health and mental health decisions are made with the family. Hechanova et al (2018) observed that those who had sought help for drug-related problems had approached their family (76%), a church (14%), or community member (14%). The majority (60%) of participants stated their family was their motivation to stop. When asked what support they needed, 57% of the participants cited job opportunities and 56% cited emotional support from family and about a third (36%) cited community programs.

In Japan, where deinstitutionalization began in the mid-2000s, family members have historically played a central role in providing care for relatives with severe mental illness. Due to the extensive involvement of family members in mental health care, assertive community treatment (ACT)[12] has been recommended as an essential component of improving mental health care in Japan. This is partially because ACT provides comprehensive mental health care to patients, thereby lightening the burden of care on families, while allowing family members to remain involved in the care of their relatives (Unite for Sight, 2021).

Aside from family, community institutions lend support for mental health and well-being. This includes neighborhood groups (formal or informal), peer support groups and circle of friends, the church, civic or business groups, and NGOs.

According to Cherry (2020), in developed countries like Australia, support groups are organized and offer social support. Social support refers to the psychological and material resources provided by a social network to help individuals cope with life's stresses and challenges. In general, social support helps in coping with stress, in reducing the impact of trauma, and in dealing with grief and adverse life situations. Support can take various forms such as emotional, instrumental, and/or information support. Instrumental support means that the social support groups take care of physical needs and offer a helping hand when needed, such as bringing a hot meal when one is sick. Information support involve providing guidance, advice, information, and mentoring, which could help a person make decisions (Cherry, 2020).

Community support services provide support to individuals, families, and carers to help with mental health, alcohol, or other substance abuse issues. They include: mobile outreach services, drop in centers, group programs, personalized support services to enable people to remain in their home or local community, and programs for families and carers.

There are evidences indicating that social support made a difference in mental health. For example, "research has shown that having strong social support in times of crisis can help reduce the consequences of trauma-induced disorders including PTSD" (Gros et al., 2016).

Research has shown that having a social support system can have a positive impact on overall mental health, especially for women, older adults, patients, workers and students. On a scale of 1 to 10 where 10 was "a great deal of stress" and one is "little or no stress," a 2015 survey found that the average stress level for people with emotional support in place was 5 out of 10 compared to 6.3 out of 10 for people without emotional support (Mental Health First Aid USA, 2020).

12 **Assertive community treatment** (ACT) is a form of community-based mental health care for individuals experiencing serious mental illness that interferes with their ability to live in the community, attend appointments with professionals in clinics and hospitals, and manage mental health symptoms.

Some studies show that unsupportive families often devalue a person's mental health and cause a mental issues to worsen. "Most of the care that mental health sufferers often rely on is from family, so when family members deny this support, the recovery process can be negatively affected"(Mental Health Center, n.d.). Poor social support has been linked to depression and loneliness and has been shown to alter brain function and increase the risk of alcohol use, cardiovascular disease, depression, and suicide.

Care and support from the family and community support groups give a morale boost for people to see themselves as capable of dealing with life's challenges. It also helps maintain motivation in achieving personal goals. For example, talking to people who are going through the same life challenge can be a source of support, empathy, and motivation.

In the Philippines, beyond the family, there are NGOs that provide social support though they remain invisible to the public eye or they may happen on an ad hoc basis. Neighborhood groups could provide social support to community members who are confronted with challenges, both physical and mental. In the context of the anti-drug campaign, this has not happened as much due to fear of law enforcers.

Currently, the DOH adopted the Healthy Settings – healthy homes, healthy workplaces, and healthy communities - approach to promote mental health. The DOH endorses the strengthening of peer support groups as a means for extending psychosocial support at the community level (Mantaring, 2021).

Family support groups exist in the Philippines but has not been given systematic attention in the past years. Family members serve as carers of recovering service users but family carers also need care. This fact became evident in WAPR's FGDs with 10 family carers.[13] The carers are usually the mothers or sibling of the service user. In one case, the carer is the daughter of the service user.

Most of the carers were taking care of patients diagnosed as schizophrenic or with bipolar disorder. In general, the carers had no formal training in psychiatric care except for one who has a doctorate in psychology from Stanford University. The others had attended seminars organized by different government and private agencies/ companies and have attended the Bukas Puso at Isip Family Support Group. One carer had training as a caregiver in Makati for 6 months, where she handled patients with mental health conditions, and observed in NCMH. Another one attended the two-week Related Learning Experience at the NCMH Nursing School and underwent training in Integrative Nutrition for 1 year (Institute for Integrative Nutrition). Others did personal research about mental health or attended the following: Inner Healing and Prayer Counselling (Elijah House Ministries), Glorious Hope Recovery Program (four months), seminars and Mental Health Congress through AFFMH, Psycho Education Seminar, Family Link (four days), and Open Mind Foundation's monthly Psychoeducation and Mood Harmony Psycho Education.

Common challenges of the carers had to do with time, money, and lack of knowledge about the illness of their wards. Mental illness is an expensive illness that can drain a family's financial resources. Medication, hospital, and professional fees are so expensive.

For some carers, it was their first time to encounter mental illness in the family. The illness can challenge their own emotional stability. As the burden of care can be all consuming, some carers had to let go their own careers or defer their own personal development plans. They cannot share the burden with others for a variety of reasons. In one case, a father lacked belief in the illness and sent the patient to a faith healer instead. And because of the stigma around mental illness, carers cannot just unburden themselves to others. One carer reported that the community was of no help. "Often we cannot get help from barangay for transportation to bring our sister to the hospital."

13 FGD held 4 August 2021, 10 am-12 nn

Significantly, the carers stated that they also need support as carers and this may come in different ways and forms such as free seminars on self-care and care for carers like Young Women's Christian Association's (YWCA) *Usap Tayo*. Their other requests are team building activities for carers, organizing support groups for caregivers, continuing education and making carers know that mental ill health can be treated if the patient is given love, support, understanding and patience.

The carers want to gain more knowledge about mental illness. One said , "I need training in Psychosocial rehabilitation therapies (CBT,DBT)." Another idea raised was to be given financial assistance to buy Brain Health Supplements and Healthy Foods. Also suggested was a counseling for Carers when experiencing burn out.

They also feel the need for community assistance. For example, it would help to have DSWD referral, barangay transportation assistance, and DOH free medicine as prescribed by the doctor.

The family carers echo the appeal of the service users to be given financial support and a drop-in center or an alternative home care for patients, especially when they feel depressed.

To enhance community mental health services, the family carers had a long wish list:

1. **Intensify awareness and education programs**
    - Educate the carers on the rights of service users
    - Orientation on mental health for LGU officials, mayors and RHUs.
    - There should be more sensitivity in using the term *"sira ulo"* (mentally ill), which highlights the stigma attached to mental ill-health.
    - Educate the patient and inform their family of the patient's needs, background, about the sickness, how to take care of patients properly, and extend support, understanding and love to their patient(s).

2. **Organize support groups and strengthen them**.
    - Involve the church groups and community volunteers to provide brief visits to patients suffering from withdrawal from society or are in isolation. Pastoral Care for patient, family and carer. Organize family support groups for carers, as well.
    - Organize Family Support Groups (FSG) at the community level. Duly government registered FSGs should be funded by the government. Mental health patients should also have allocated government budget.

3. **Capacity building and continuing education.**
    - Psycho education seminars for family members and carers.
    - Training for BHWs on compassion and understanding of mental illness.
    - Training for Crisis Management for carers, family, and BHWs.
    - Continuous FSG seminars, psycho education, team building, and educational trip.
    - Availability of training about Women's Mental Health for those who are assigned to Women's Help Desk.
    - Training for carers and lay community volunteers for Psychological First Aid, Online support group for carers; Halfway houses, Community Club House; and Women's Life Recovery Center.
    - BHWs to be trained in handling mental health crisis - situations like suicide.

4. **Medicine, economic assistance and free mental health services.**
    - Provide job opportunities for patients. Skills training and other activities.
    - Employment opportunities for recovered patients.

- Free mental health services **-** free mental health assessment by a psychiatrist, free or affordable psychotherapy within the community, and free psychotropic medicines.
- Counselling hotline with trained counsellors.
- Availability of an Occupational Therapist and Recreational Therapists in the community.
- Befriending Program to develop social competence.
- Continuous consultation with doctors of free services.
- 24-hour mental health counseling services

5. **Build "Safe Spaces " for patients, with psychologists or counselors.**
    - Halfway home facility
    - Build rehabilitation center where recovering patients can be provided with therapy.
    - Advocate for the LGU to support such project.

WAPR Philippines FGD with Family Carers of Service Users last August 4, 2021

Where neighborhoods are able to freely organize and mobilize, social support can be extended to those in need.

> Community organizing could range from simple networking and coalition building to resource generation. The common focus is an effort to realign the political, financial, and institutional forces in neighborhoods.
>
> Neighborhood mobilization can occur through at least four mechanisms: (1) community organizing and development, (2) collaboration in service delivery, (3) the implementation of community-based programs, and (4) the involvement of families in school governance and instruction. Fundamental to each strategy is the importance of building on existing resources and engaging the people (National Research Council, 1993).

For example, the *Maginhawa* Community Pantry emerged as a spontaneous initiative of one female citizen during the pandemic in response to the looming food insecurity. This was linked to the massive loss of jobs and livelihood along with rising fuel and food costs that was a major stressor, especially among those who

were already living in poverty even before the pandemic. To help alleviate the distress among many urban poor Filipinos unable to earn a living, one woman put up a small pantry where those in need could simply get free food such as rice, eggs, and vegetables. Good-hearted citizens donated rice, vegetables, medicines, and other food staples. Volunteers have come forward to help in the distribution of food packs to people. This small initiative inspired others to set up a community pantry in their own villages all over the country. In Quezon City alone, there were 136 community pantries set up at the time of writing.

In the Philippines, there are community support services but these have yet to be tracked and documented. The need for community support groups became very apparent when the war against drugs intensified. These neighborhood support groups did not openly emerge in fear of the law enforcers and being red-tagged (i.e. labeled as communist rebels) but there are sympathizers and church groups that covertly help families of extra- judicial killing (EJK) victims.

The need for psychosocial intervention was experienced by those involved in EJK, especially those who witnessed the killing of a loved one. The Commission on Human Rights Office is able to tap the services of the Centers' Management Office and the social workers employed by the CHR Central Office. However, other regional offices do not have such in house support. Instead, clients are referred to the local Municipal/ City Social

Welfare and Development Office (MSWDO/CSWDO) for psychosocial services, or to CSOs such as the Medical Action Group (MAG), AJ *Kalinga* Foundation, and *Balay* Rehabilitation Center.

In this regard, there are gaps in psychosocial intervention such as: livelihood and educational assistance, financial assistance (as the current amounts given are too low), psychosocial assistance (as there are social workers only in the CHR Central Office), spiritual assistance, and medical assistance (as there are medical personnel only in the CHR Central Office). In the area of psychosocial assistance, one interviewee commented that though some clients were referred to the City Social Work and Development Office (CSWDO), the latter only offered limited and not sustained intervention. One other concern is the lack of relocation assistance or change of identify for witnesses in EJK cases. They do not get protection after giving their testimony. (in Ramos, 2019).

One outstanding challenge in strengthening family and community support groups is the sustainability of community programs and interventions. For most NGOs, the programs continue for as long as they are able to generate or solicit donor funding. If they are viewed as extensions of the public health system, then community support groups warrant public investment. For example, Western Australia made such investments:

> Mental ill health represents a significant challenge for the community. In the 2017- 18 Budget the Australian Government committed $80 million over four years for the National Psychosocial Support (NPS) measure and $109 million nationally over three years from 1 July 2019 for the provision of Psychosocial Continuity services (WA Primary Health Alliance, 2021).

E. CONTINUITY OF CARE

CBMH programs must factor in recovery assistance to ensure that service users are able to sustain positive lives after completing their mental health treatments and that they are able to reenter and reintegrate into their community.

> There is no universal definition of recovery, as it is a personal process that has different meanings for different people. While many health professionals consider "recovery" to mean "cure", the concept of recovery goes beyond this and considers all aspects of functioning. Recovery is a process of personal growth and transformation beyond suffering and exclusion – it is an empowering process that emphasize people's strengths and capabilities for living full and satisfying lives. Recovery may be described by people with mental health problems as enjoying the pleasures life has to offer, pursuing personal dreams and goals, developing rewarding relationships, learning to cope with mental health problems despite symptoms or setbacks, reducing relapses, becoming free of symptoms, staying out of hospital, or getting a job... Recovery is a concept that has emerged from people who have first-hand experience of mental health problems.

There are four major dimensions that support recovery: **Health**—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being; **Home**—having a stable and safe place to live**; Purpose**—conducting meaningful daily activities and having the independence, income, and resources to participate in society**; Community**—having relationships and social networks that provide support, friendship, love, and hope (American Psychological Association, 2021).

TEXT BOX 5. COMPONENTS OF MENTAL HEALTH RECOVERY

The 10 fundamental components of mental health recovery include the following principles (National Alliance on Mental Illness, 2021):

- **Self-Direction.** Individuals determine their own path of recovery with autonomy, independence, and control of their resources.
- **Individualized and Person-Centered.** There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.
- **Empowerment.** Consumers have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.
- **Holistic.** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment, and family supports.
- **Non-Linear.** Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience.
- **Strengths-Based.** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support.** Mutual support plays an invaluable role in recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging.
- **Respect.** Eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital.
- **Responsibility.** Consumers have a personal responsibility for their own self-care and journeys of recovery. Consumers identify coping strategies and healing processes to promote their own wellness.
- **Hope.** Hope is the catalyst of the recovery process and provides the essential and motivating message of a positive future. Peers, families, friends, providers, and others can help foster hope.

Source: 10 Fundamental Components of Recovery. https://namitm.org/10fcr/

Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle. Recovery is a *physical, mental, and spiritual process* of ongoing change that involves healing and a re-defining of the self. It is a journey that **is** supported by other allies in recovery.

The recovery model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning (IMHCN, 2021).

One could say that recovery means regaining a person's "wholeness" as a human being.

Why recovery assistance?

Mental health professionals describe the 'recovery model' as a process by which persons who have undergone treatment are enabled to stay in control of their lives despite experiencing a mental health problem. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

Because recovery is not a linear process, assistance is needed to bring service users to a state of stability and consolidate their strengths to face life's challenges. The recovery process:

- provides a holistic view of mental illness that focuses on the person, not just their symptoms;
- believes recovery from severe mental illness is possible;
- is a journey rather than a destination;
- does not necessarily mean getting back to where you were before;
- happens in 'fits and starts' and, like life, has many ups and downs;
- calls for optimism and commitment from all concerned;
- is profoundly influenced by people's expectations and attitudes;
- requires a well-organized system of support from family, friends or professionals; and
- requires services to embrace new and innovative ways of working. (IMHCN, 2021)

> The concept of the recovery approach for service users is founded in human values and their application by the service user, professionals and the service itself. Its objective is to achieve health and wellbeing regardless of the degree of disability or distress of the individual… It requires a paradigm shift in thinking from pathology and illness to self- determination, life stories, human strengths, hopes and dreams, peer support and control by the user with support from professionals as partners, mentors and advocates… It should be rooted in cultural, social, religious and ethnic diversity that gives meaning to the person's identity, belief and circumstance (IMHCN, 2021).

How to promote recovery?

The process of recovery is supported by relationships and social networks that often involve family members who become champions of their loved one's recovery. Families of people in recovery may experience adversities that lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional support that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery (Vanderplasschen et al., 2013).

Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. Research has found that important factors on the road to recovery include: good relationships, financial security, satisfying work, personal growth, the right living environment, developing one's own cultural or spiritual perspectives, developing resilience to possible adversity or stress in the future (IMHCN, 2021).

Further factors highlighted by people as supporting them on their recovery journey include: being believed in, being listened to and understood, getting explanations for problems or experiences and having the opportunity to temporarily resign responsibility during periods of crisis.

Recovery services and supports must be flexible. What may work for adults may be very different for youth or older adults. For example, the nature of social supports, peer mentors, and recovery coaching for adolescents is different than for adults and older adults.

Recovery assistance may include *clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other methods*.[14] In the United States, the Substance Abuse and Mental Health Services Administration (SAMHSA) established recovery support systems to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community (SAMHSA, 2020).

Mental health and addiction services supporting recovery must be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups; actively address diversity in the delivery of services and seek to reduce health disparities in access and outcomes.

To promote the recovery approach staff should reevaluate their role in the treatment process to one of *negotiation, partnership and trial and error*. Service organisations need to allow and support staff in practicing in this way by adopting a culture of creativity, innovation, openness, encouragement for diversity and recognition for good practice. In addition, it is important that anyone who is supporting someone during the recovery process encourages them to develop their skills and supports them to achieve their goals (IMHCN, 2021).

In the Philippines, the service users and the family carers underscore the need for financial and/or social assistance to sustain the medication of the service user, economic assistance to enable them to meet their needs, and psychosocial assistance in the form of having safe spaces e.g. halfway houses and emotional support to stabilize them and facilitate their reintegration into the community.[15]

What is reintegration and why is it Important?

As a service user regains confidence and competence to interact and engage with others in the community, the process of reintegration proceeds the recovery process. The goal of rehabilitation is to reintegrate the recovering mentally ill individual into life in the community.

For example, rehabilitation improves quality of life for people with schizophrenia and reduces relapse and rehospitalization rates. Several types of services are needed. After a psychotic episode, an individual may need to relearn basic social and life skills. In addition, he may need affordable housing, vocational rehabilitation, job placement, and recreational opportunities. Peer support groups provide socialization, emotional support, and give people an opportunity to learn coping strategies that have worked for others. Supportive counselling can help the person accept the fact of his or her illness and deal with the losses it entails.

14 https://www.hhs.gov/opioids/recovery/index.html

15 Based on FGD held on 27 July and 4 August 2021.

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CHAPTER 5.
THE LEMERY EXPERIENCE: COMPETENCY TRAINING FOR COMMUNITY MENTAL HEALTH WORKERS

INTRODUCTION

The CBMH Program Framework is a step closer towards scaling up the provision and availability of community mental health care in the country's more than 42,000 barangays. The framework was derived from empirical experiences worldwide, including programs in the Philippines. Having identified the elements of CBMH Programs, the next challenge is to demonstrate its feasibility and practical utility in enabling local governments and other stakeholders to establish mental health services in their respective jurisdictions.

Demonstrating the framework's practical utility was done by translating it into a 1) competency training for community mental health workers and implementing the training in one municipality in Luzon; and 2) constructing a monitoring and evaluation (M&E) that defines the concrete outcomes in providing mental health care in the communities. These activities comprised the pilot testing of the CBMH Program Framework.

Pilot testing of the CBMH Program Framework entailed several steps: 1) identifying and defining the competencies required in setting up CBMH programs and services; 2) designing a competency-based training; 3) implementing the training; and 4) monitoring and evaluating the results of the training.

IDENTIFICATION OF STAFF COMPETENCIES FOR CBMH PROGRAMS

The WHO (2005) defines competence as "a level of performance demonstrating the effective application of knowledge, skill and management" (p.33). Competencies reflect three elements: 1) **knowledge**, understanding and judgment; 2) cognitive, technical, and interpersonal **skills**; and 3) a range of personal attributes and **attitudes.** Guided by the WHO definition, the project team identified the staff competencies and standards for mental health service and support providers through the review of literature, the key informant interviews, (KII) as well as consultations with service users and family carers.

Implementers of the CBMH programs were interviewed to share their insights on competencies of community mental health workers. These key informants consisted of psychologists and psychiatrists. The common view is that the community mental health workers must have good communication skills.

To identify the CBMH competencies, a Learning and Development Needs Assessment (LDNA) was drawn up (see Annex 1.) This was based on the review of literature and the results of the FGDs and KIIs.

The competencies in mental health for general health workers in the community are grouped into three areas:

1. **Knowledge and basic understanding of mental health conditions**.[16] This covers the identification of signs and symptoms, their treatment and management both at the individual, family, and community level. This includes interviewing, appreciating skills, ability to listen empathetically, establishment of rapport, provision of appropriate counselling and psychosocial support, and respect for human dignity and right as an individual.
2. **Basic psychosocial intervention skills** appropriate for the general health worker. As part of necessary treatment, a biopsychosocial spiritual framework is adopted and includes skills in identifying and providing advice on necessary medications. The said framework was officially adopted by the Philippine Council for Mental Health. Also, it is recognized that a person with a mental health condition is interconnected with his social environment e.g. those around him, his family at home, and his neighbors in the community. This includes basic skills in appreciating the need for working with and collaborating with the family, neighbors, and the general community.
3. **Positive attitude** towards anything "mental" - In developing the health workers' basic competency in mental health, it is crucial that the prevailing negative attitude, misconceptions, and prejudice (stigma) is overcome. They must talk of mental health conditions (i.e. depression, etc.) the same way they speak of diabetes or hypertension – that these are health conditions that can be rightfully identified, treated, and recovered from. A corollary skill is advocating changes in attitudes to mental health such as "there is no health without mental health and well-being."

Derived from the competency framework or LDNA, the chart below lists knowledge, skills, and attitudes that guided the design of the pilot training program.

Table 1. Competencies for Non-specialists in Community Mental Health Programs

KNOWLEDGE	• Concepts of mental health under the Philippine Mental Health Law: Bio-psychosocial-spiritual model • Rationale for community mental health programs • Concept of Community Mental Health Care • Elements of a Community Mental Health Program • Understanding the community • Guiding principles in human and community development • Technology based in mental health service delivery

16 Twelve mental health conditions are included in the MHGAP intervention guide. This means that competency in knowledge of mental health conditions expected of the health workers focus on the ICD 10 Primary Care Version that include *depression, chronic psychosis, unexplained somatic symptoms, alcohol abuse, mental retardation, common mental disorders in children and epilepsy.* Since they are not to be specialists, they do not need to have knowledge of all the psychiatric disorders…they only need to know the 6 conditions included in the Primary health care Version of the ICDX.

TABLE 1. COMPETENCIES FOR NON-SPECIALISTS IN COMMUNITY MENTAL HEALTH PROGRAMS *(continued)*

SKILLS	• Communication and advocacy skills, awareness raising, campaigns, and psychoeducation • Interviewing and communication skill • Identification of mental health conditions and handling psychiatric emergencies and crisis in the community, including utilization of referral mechanisms • Handling psychiatric emergencies and crisis in the community • Community assessment and mobilization (i.e. organizing, education, resource management) • Strengthen the family and support groups in the community • Educate, organize, and mobilize the family, service users, and support groups in the community • Monitoring and evaluation skills
ATTITUDES	• Adopt the concept that there is no health without mental health. • Mental health is a right of every Filipino. • Mental health is everybody's business, including the well and unwell • segments of the population. • Mental health care is an integral part of primary health care and it is not an added task. • Early detection of mental health conditions is better than treatment. • Value of self-care in mental health • Value of mobilizing community resources in mental health • Empathy and supportive attitude toward people with mental health conditions • Recovery and not just symptom reduction is the goal of mental health care. • The attitude to understand that people are interconnected with the environment • Valuing the worth and dignity of all people not just people with psychosocial disabilities

THE COMPETENCY-BASED TRAINING DESIGN

The training design for a basic course on community mental health care for CHWs was designed on the basis of the core competencies (knowledge, skills, and attitudes) identified above.

Learning Objectives. At the end of the course, the participants were expected to:

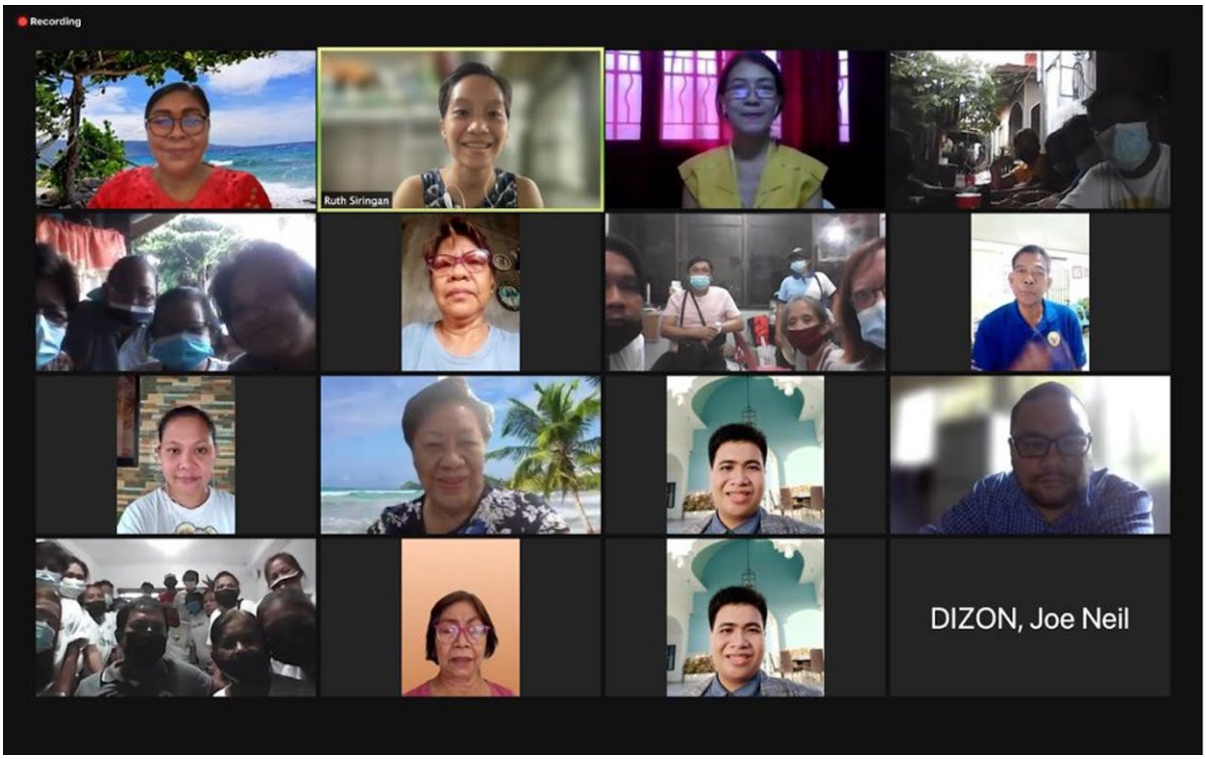
- Appreciate and understand the current concept of mental health in the Philippines
- State and explain why community mental health care is needed in the country
- Define their potential role in providing community mental health care/services
- Identify their strengths and weaknesses in terms of competencies in mental health care
- Define actions to provide or enhance their provision of appropriate mental health care and services
- Classify the community members' mental health conditions using the TAG as a tool
- Set up and/or enhance mental health services in their respective settings and areas

The training program consists of three modules:

- **Module 1.** Concepts and perspectives. This module is intended to impart background knowledge on the need for community mental health based on the Mental Health Law, the treatment gap in the country, and the health promotion strategy of the DOH.
- **Module 2.** Competency in identifying people with mental health conditions in the community and the handling of psychiatric emergencies and crises. This module purports to acquaint the

participants with the common signs and symptoms of people with mental health conditions. A layman's approach using a set of four questions, referred to as the four-way test for determining the mental health condition of an individual were used, as well as the TAG approach to determine if the person needs non-specialist or specialist assistance. Short case studies were given to facilitate the understanding and assimilation of skills.

- **Module 3.** Engaging the community for mental health care. This module is the core of the CBMH Program Framework. It defines the role of the community and the CHWs in mental health care as well as the required competencies for such. The module defines the practical skills needed in delivering various components of community mental health care such as community assessment (e.g. situation analysis, asset & resource assessment), community organizing, community resource management, empowering the service user, strengthening the support system, ensuring continuity of care, and following up and monitoring.



Organizers and Participants of the Basic Training Course for Community Health Workers in Community Mental Health Care

At the end of module 3, the participants per barangay collectively prepared an action plan for initiating CBMH services in their respective barangays. The action plans served as a basis for monitoring the accomplishment of CBMH actions one month after the training ended.

In the current Philippine context, the essential competency requirements have been adapted to match the current state of development of the mental health field in the country. Efforts are underway to implement the Mental Health Law and the PCMH has enunciated a framework under its Resolution 2020-03. The resolution adopts: 1) a biopsychosocial spiritual framework for mental health; and 2) recognizes that a person with a mental health condition is interconnected with his social environment i.e. those around him, his family at home, his neighbors in the community. This viewpoint includes basic skills in appreciating the need for working with and collaborating with the family, neighbors, and the general community.

An important consideration in competency training is that the planned pilot training is meant to be a beginners' course for non-specialists. At this early stage, the main competency needed is to be able to identify the signs and symptoms manifested by people with mental health conditions.

The training has a generalist orientation. At this point, treatment and intervention by non-specialists such as the BHWs to be trained is **not** expected. Non-specialists can be given further training at an intermediate level and intervention skills can be included. For the pilot training, the minimum expectation is for the BHW to know the conditions or manifested symptoms under which they must refer cases to the specialists.

Proposed Time Allocation	Training Content	Method
Module 1: **4 hours**	**Administer Competency Checklist (as pretest)** **Course Overview** **Why Community Mental Health Care/Services** • Legal Basis: Mental Health Law • Narrowing the Treatment Gap: Mental Health Situation in the Philippines • Institutional Landscape of Mental Health Services in the Philippines **Six Pillars of Community Mental Health Program's Guiding Principles** • The PCMH Conceptual Framework: Bio-psychosocial and Spiritual Framework • Respect for Human Rights • Recovery Oriented Approach • Balanced & Collaborative Care • Social Inclusion	**Interactive Discussion**: Do you think there is a need for mental health care in your community/barangay? Ideas, thoughts, and beliefs of the participants on mental health will be aired, explained, and understood Misconceptions, if any, will be corrected
	Engaging the Community for Mental Health Promotion:	Lecture
	What can the community do for mental health promotion? • What is a community? • Know your community's assets and • resources • Use the existing services and resources in the community • Setting up referral system • Raise awareness on mental health: inform, educate, and advocate: • Mental health is everybody's business; self-care in mental health LGU-supported for mental health • Promote and foster mental health programs in schools and workplaces • Organize service users • Strengthen and support the Health Workers in the Community	To lay the groundwork for Module 3 Appreciate the multiple Functions of the Community in MH Promotion Practical actions that the community can do for MH

Proposed Time Allocation	Training Content	Method
Module 2 **5 hours**	**Identifying people with mental health conditions in the community** • The TAG Approach: Recognize and acknowledge mental health conditions and the required actions • Anxiety and Stress • Depression and Suicide • Prevent substance abuse disorders • Child Development Disorders • Dementia **How to deal with psychiatric emergencies and** • **crisis situations?**	Lecture-discussion
Module 3 **4 hours**	**Strengthening the capacity of community health workers for mental health care** • What to know to be able to promote mental health in the community? • Guidelines in Human Development • Who are the actors/players in the community that can help in Mental Health Promotion? • How to engage the stakeholders • Guidelines in community development • Community Education • Community Organizing • Community Resource Management **Exercise:** *What are the faces of poverty in your community? How does it contribute to mental health/ill health?* Interactive discussion	Lecture Interactive Discussion Small group discussions
	What skills must community health workers have to promote mental health? • General Skills: Communication • How to strengthen the family and support groups • How to ensure continuity of care	Brief group discussion Case study
2 hours	Action Planning by barangay or by setting in the community, e.g. workplace, schools, community Reflections by Participants on their Learning Synthesis and Integration Monitoring and Follow-up (one month after training) Closing Session	Group workshop by barangay Sharing barangay action plans in plenary Sharing of Participants' Reflections

Action Planning was done in breakout groups per barangay. The technical assistance (TA) team's community development specialist gave general instructions on the action planning and a set of guide questions were given to the barangay groups. The groups were asked to identify actions to initiate the development of CBMH

care in their barangays. They were asked to sort and classify their list of actions according to the elements of the CBMH Program Framework, e.g. engaging the community, building the capacity of non- specialists, strengthening support groups, empowering service users and their family, and ensuring continuity of care.

Each WAPR TA team member facilitated one barangay group,[17] where they listed the ideas and suggestions of the participants. The action plans have been consolidated and summarized in Table 2.

Each barangay group shared their planned actions and were then given the homework to identify what resources they need to implement the proposed actions and the timeline to accomplish them. They were informed that the WAPR TA team will follow up on their progress by the end of July 2021.

IMPLEMENTATION OF THE COMPETENCY BASED TRAINING

Training Site. WAPR identified Lemery, Batangas as the project site for CBMH pilot testing for the following reasons: 1) the general health services of Lemery, Batangas do not have the capability to extend mental health as part of its basic health service; and 2) in the last

five years, it has been struck by the devastating effects of disasters, like earthquakes, the eruption of Taal Volcano, and strong typhoons Rolly and Ulysses in 2020 that left people with significant psychosocial consequences and suffering.

Lemery is a coastal municipality in the province of Batangas (DILG, 2013) with a land area of 109.80 square kilometers or 42.39 square miles, which constitutes 3.52% of Batangas's total area. By the 2020 census, it has a population of 93,186 (PhilAtlas, 2021), representing 3.46% of the total population of Batangas province, and it has a total of 46 barangays.

Municipality of Lemery , Batangas

17 Barangay Lucky – Nadja Trinchera; Maguihan – Juliet Bucoy; Maligaya – Lucita Lazo; Rizal – Rodelen Paccial and Wawa Ibaba- Lucita Lazo.

Lemery is a growing urban center in western Batangas. The municipality was named after Captain Roberto Lemery, a commanding officer of the local garrison. He took command of the local military outpost until his death in 1856. It is now a first-class municipality by income class. Poverty incidence is 11.1 % based on the 2015 census.

Health institutions in Lemery are the Batangas Provincial Hospital, Metro Lemery Medical Center, Our Lady of Caysasay Medical Center, Lemery Doctors Medical Center, and the Little Angels Medical Hospital (Buhay Batangas, 2018).

Pilot Barangays/Communities. The TA team decided to have the pilot training in the barangays around the town center where the RHU is located. The assumption was that these barangays have easier access to the RHU due to their geographical proximity.

Lemery Municipal Hall

Of the 46 barangays in Lemery, five were selected to participate in the pilot training. Barangays with relatively high prevalence of symptoms are *Wawa Ibaba* and *Rizal,* as reported in the modified WHO's Self-report Questionnaire (Ignacio, 2021). These two could be the project barangays. The runners-up are Barangays *Lucky and Sambal Ilaya*.

These initial findings were presented to the Association of Barangay Captains (ABC) who vetted the choice of the pilot barangays. Considerations in the selection of these barangays are: safety, security, accessibility, proximity to the RHU, and acceptance by the LGU. Safety, security, and accessibility were particularly important in view of the threat of eruption of Taal Volcano.

As a result of the consultations with the ABC, the project barangays selected were: *Lucky, Maguihan, Maligaya, Rizal,* and *Wawa Ibaba.*

Conduct of the Pilot Training. The situation in Batangas Province was volatile and the continuing alert from the national authorities of an impending eruption of Taal Volcano has shaken the residents, which necessitated the evacuation of people in the high-risk areas. Thus, the actual implementation of the pilot training was

deferred from the last week of May to the last two weeks of June 2021 (June 17 and 18 and July 25 and 26, 2021). This was conducted and completed via the zoom platform.

There are manifold threats in Lemery such as the COVID 19 pandemic, volcanic eruption, and the possibility of floods due to heavy rains. On 22 July 2021, over 30 families in Lemery were evacuated due to incessant rains brought by the southwest monsoons. The población area is a flood-prone area. Add to that, Taal Volcano under Alert Level 3 that time, meaning there was magmatic unrest and that eruption was possible within weeks (PhiVolcs, 2021).

Notwithstanding these challenges, the pilot training was pushed and implemented in the last two weeks of June 2021. In accordance with the request of the barangay captains, the *Basic Course for Community Health Workers on Community Mental Health Care* was conducted in four half-day sessions from 1:00 to 5:00 pm on 17, 18, 25 & 26 June 2021 via Zoom. Each barangay group assembled in one designated place and the participants shared one computer device. There were occasional glitches in connectivity but nevertheless, the training proceeded as planned.

Training Participants. The participants consisted of BHWs, the barangay officials (e.g. barangay captain, secretary, chairperson of the Barangay Health Council, including the barangay nutrition scholar) as well as some representatives from schools and workplaces. The participants signed attendance sheets.

There were 47 participants from the five barangays and they were noted to be mostly (60%) high school graduates while some (38%) are college graduates. (Refer to Annex 5.3 for the Profile of Training Participants).

TRAINING EVALUATION

A. Participants' reactions

1. Satisfaction over the Training Program

A Module Evaluation Form (see Annex 4) was administered for the participants to register their satisfaction over the training. In general, the participants felt that the training objectives were met and that they were happy with the knowledge imparted to them.

In addition, each barangay team was asked to share their feedback and comments on the subject of community mental health care. They were asked to raise questions or any inputs and comments on the presentation. General comments were: 1) they found the topic quite relevant for the times and situation in their barangay; and 2) depression is observable in some barangays and they would like to know what to do.

The Health Committee Chair of Barangay *Wawa Ibaba*[18] mentioned the Philippine Moral Transformation, a project of the Office of the Presidential Adviser for Religious Affairs (OPARA). He noted the adverse impact of the pandemic – men are turning to alcohol; mothers are worried; children are oppressed and yelled at by their parents. This underscored the need to develop spirituality in the community aspect. He also expressed concern about the ill effects of games like the Millennium Legend.

Participants were asked, "What struck you the most?" (*Ano ang naka-antig sa yo?)* Their responses are cited below:

18 Brother Bimbo H. Datinguinoo

Barangay *Rizal*: From module 1, they realized that the community health center is an asset that can enable them to cope with life's challenges. For example, in cases of suicide, they could use the health center for assistance.

Barangay *Wawa Ibaba*:

- To be healthy, the four needs of man must be satisfied.
- It is the duty of LGUs to report about mental health programs. *(Tungkulin ng LGU ang mag-report tungkol sa mental health programs.)*
- Patients have rights. It should be respected. If discriminated against, this could aggravate their conditions.

Barangay *Maguihan:*

- How do we talk to a depressed person? (This was addressed in the Day 2 session).
- A person with mental health conditions like depression can recover. They should be supported by their community. They should not be bullied or discriminated against.
- There should be community mental health service at the RHU.
- Early detection is important.

Barangay *Lucky:*

- The nutrition scholar asked what is the proper approach to mental health without offending the people concerned. (This query was addressed in the day 2 session.)
- Mental health is important *(Mahalaga ang mental health*) in a community because it makes them productive.
- Depression is a common concern in MH during the pandemic.
- RHU, LGU and the academe can help people through counseling and projects.
- Stigma is the root of discrimination.

Barangay *Maligaya*:

- Observed some disorders among some people so they want to be enlightened too.
- Discrimination of people with mental disorder should not be happening. In fact, they need understanding and support to enable them to recover. They need to be enlightened about the importance of life. We should not be afraid of them; in fact, we should help them.
- Where to get mental health services: mayor, teachers, community health workers.
- How can community health workers help the mentally ill? Medicine, livelihood, education.

2. Self-reported Competency Gains Among Participants

Another form of evaluation is the comparison of the participants' competency assessment before and after the training. This is discussed in Chapter 6. (Refer to Annex 2 for the Checklist of Competencies in Community Mental Health Care and Annex 5 for the Summary of Pre- and Post-test Results.)

The LDNA matrix served as a tool for formulating a pre-test questionnaire (self- assessment of competencies) that was administered prior to the training. The same tool was administered as a post-test after training. The pre- and post-test results for each participant were compared to determine their "gains" from the training program. (Refer to Annex 6 for the Percentage Comparison of Pre-Test and Post-Test Results).

All BHWs of the five project barangays were included in the pilot training. On the average, the barangays had five BHWs save for *Wawa Ibaba*, which had a total of 16 BHWs. In addition to the BHWs, the barangay captain, the barangay secretary or treasurer, and the head of the Health Committee were also invited, as well as representatives from the church, school, and private companies.

The quantitative data on competency gains is corroborated by the comments from each barangay. From their self-assessment, the need for knowledge and skills on community mental health is apparent in *Wawa Ibaba, Rizal,* and *Maligaya*.

1. BARANGAY LUCKY

There were six participants from Barangay Lucky, their ages ranging from 38 to 60 years old. Three participants are barangay officials while the other three are health workers. The BHWs are female college graduates aged 41,51, and 60 years old. One is single, one is married, and one is a widow. All of them are Catholics.

Their self-assessment of competencies indicated the following: They know the concepts pertaining to mental health programs. However, one BHW stated she does not know how to use technology for mental health programs. One BHW candidly admitted lack of skills in setting up community mental health programs. Interestingly, three out six said they know the skills already. But all of them said they want to learn more. At least one BHW admitted that she does not know how to set up a referral system and how to conduct monitoring and evaluation. Participants appear to have the current orientation, i.e. rights- based and recovery-oriented view of mental health care.

2. BARANGAY MAGUIHAN

Seven BHWs and three barangay officials from Barangay Maguihan attended the training. The BHWs' ages ranged from 30 to 51 years old, are married or with a live-in partner, and one is a widow. They are all Catholics. Four out seven BHWs are high school graduates; the rest are college graduates.

In most skill areas, four out of the seven BHWs reported they do not know much yet. In the knowledge areas, three to four out of seven BHWs reported they know little and therefore there is scope for reinforcing their understanding.

In terms of attitude, the participants agreed with the rights-based and recovery-oriented approach.

3. BARANGAY MALIGAYA

Three BHWs and three barangay officials attended the meeting. Two BHWs are female adults aged 53 and 57 while one is male, 23 years old, single, and is in third year college. The barangay officials' ages range from 54 to 67 years old. All participants are Catholics.

Of the three barangay health workers, only one reported knowing the community mental health concepts while the other participants, including the barangay captain and the secretary, state they know little about it. Notably, five out of six participants say they do not know the LGU's responsibilities in community health care. Likewise, three to five out of six participants admitted their absolute lack of skills in mental health care.

Attitude-wise, the respondents agree that there is no health without mental health and that everyone has a right to mental health.

4. BARANGAY RIZAL

There were six participants from Barangay Rizal – three are BHWs while the other three are barangay officials. One BHW is a 63-year-old nurse, one BHW is a 62-year-old high school graduate while one BHW is a 42-year-old secretarial graduate. The barangay officials are at college level or are college graduates.

Most (five out of six participants) frankly admitted that they know little about the concepts in community mental health care as well as the CMH skills.

5. BARANGAY WAWA IBABA

Barangay *Wawa Ibaba* has the biggest contingent of BHWs - 16 BHWs have ages ranging from 36 to 66 years old, all female, Catholic, and are at least high school graduates; 11 out of the 16 BHWs are at college level or are college graduates. Including the barangay officials, the total number of *Wawa Ibaba* participants is 19.

Many BHWs in *Wawa Ibaba* report lack of knowledge and skills in community mental health. There are some three BHWS whose beliefs about mental health need to be clarified.

B. Achievement of Action Plans

The TA team conducted follow up and monitoring of the participants' action plans on 30- 31 July 2021, one month after the end of the training. Barangays *Wawa Ibaba* and *Maligaya* requested for an extension of their action plan reporting because they were occupied with the evacuation of flooded households and there was a power outage in *Maligaya*. On 31 July 2021, Barangays *Rizal*, *Maguihan,* and *Lucky* reported that as per their one-month plan, they had essentially completed their actions.

FGD with Barangay Rizal last July 31, 2021

FGD with Barangay Maguihan last July 31, 2021

FGD with Barangay Lucky last July 31, 2021

Table 2. Action plans for initiating community-based mental health services

I. ENGAGING THE COMMUNITY

Barangay	Proposed Actions	Progress after one month
Lucky[19]	Maghanap ng volunteers.	Recruit volunteers to form support group to help build up awareness on mental health Distribute flyers and posters to stir up awareness on mental health Post graphics and information about mental health on the Facebook account of Barangay *Lucky* Cascade to all council members information about mental health discussed during the 4-day training Invite family household members to attend barangay General Assembly where mental health will be introduced Have a Mental Health Desk positioned in the Barangay Hall
Maguihan	Mental health awareness among the critical mass. Organize an assembly in the community and get a resource person for the assembly (WAPR can help organize). Mobilize cluster leaders to help disseminate to have critical mass on mental health. Coordinate with DSWD for social preparation. I-monitor ng Sanggunian ang mga Purok para malaman ang kalagayan. Reactivate and strengthen the cluster leaders. Tulungan ng barangay council ang mga nawalan ng trabaho. Integrate mental health service in their health delivery system through a barangay resolution.	The Cluster leaders went around the community to visit their respective Puroks and integrated in the "kamustahan" , their way of knowing if there are mental health concerns. Although visitation is limited due to Pandemic the leaders are able to conduct this on a weekly basis. Those who were trained conducted the mental health awareness campaign to other members in the community during the home visits based on what they learned from the training.

19 Mga kaso sa Barangay Lucky:

- Tiyuhin ni barangay sec: aware ang barangay sa kondisyon niya
  - Hindi pa sigurado kung maipapadala sa RHU dahil may mga mas nakakatandang tiyuhin pa na magdedesisyon
  - Ang tiyuhin ay masama ang temper kapag may nakikitang ambulance o pulis
  - Hindi rin alam ng RHU ang ibang cases: ang ibang pamilya ang nag-aasikaso (sa private)
- Barok: may epilepsy
  - May medication naman si Barok
  - 35 years old
- Isang case (senior citizen, babae) nasa Mental hospital sa Maynila, hindi pa nakabalik sa Barangay Lucky
- Walang kaso ng substance/alcoholism

TABLE 2. ACTION PLANS FOR INITIATING COMMUNITY-BASED MENTAL HEALTH SERVICES *(continued)*

Barangay	Proposed Actions	Progress after one month
	Provide ng counseling sa mga ka barangay dumaranas ng problema sa kaisipan. Assign a room for counseling to ensure privacy when they vent out their concerns.	
Maligaya	Information campaign on mental health - collect information materials from regional or provincial offices of DOH; disseminate. Siguraduhing malinis ang kapaligiran at sambahayan.	They were able to launch in the first week of July during the senior citizens' prayer meeting. That is convened daily. Twenty to 30 seniors attended when the BHW informed them about mental health. They continue their clean-up program for physical health and environmental cleanliness. This also contributes to mental health.
Rizal	Mental health awareness Screening and monitoring Counseling for service users and their families Recruit new community health workers Substance use prevention	*Barangay* assembly done - 1 week after training, topics included: Introduction of mental health plans and program Mental health information/screening integrated into vaccination information drive Screening done - visited families Posters were created and disseminated Screening results used TAG (positive response) - 100% coverage of households (200 houses/3 BHW/1 day) 1 person screened and connected 2% of population- estimated prevalence that might need "TULONG" 1 household received counselling Substance use prevention part of messaging Recruitment results *10 barangay tanods are* joining the mental health program

TABLE 2. ACTION PLANS FOR INITIATING COMMUNITY-BASED MENTAL HEALTH SERVICES *(continued)*

II. BUILDING CAPACITY OF NON-SPECIALISTS

Barangay	Proposed Actions	Progress after one month
Lucky	Kausapin at pulungin ang mga konsehal para ibahagi ang natutunan sa training, calendared for 11 July, 3:45 pm, meeting of the *Barangay* Council	*Barangay* officials and BHWs underwent training on Basic Course on Mental Health Care for Community Health Workers Residents of *Barangay Lucky* have accepted the mental health condition of two residents in their *barangay*. Residents of the *barangay* "interact" with these two residents with mental health conditions. Both are well accepted by the community.
Maguihan	Build the capacity of the existing cluster leaders to understand the symptoms of mental illness BHW to do psycho education to pregnant women Guidance especially on how to systematize referral systems and how to do the continuity of care	The trained leaders were able to assist 1 patient not from their barangay and did counseling to the patient and the immediate family member. The BHWs did psycho education to the pregnant women in the barangay health center.
Maligaya	More training of BHWs on proper care of patients Orientation of parents	Could not hold it because they do not have a budget yet and they would like to find resource persons. What they learned in the basic course is instructive, but they feel the need for more training. Could not hold it because of the pandemic mobility restrictions.
Rizal	Training for more skills to learn new approaches Recruit new community health workers	Steps to be taken by the *barangay*: Attend Seminar Build Network
Wawa Ibaba	Call for DEDIKASYON AT MALASAKIT: Magbigay ng panahon, puso, at malasakit para maisakatuparan	They were not able to do the planned livelihood training or inventory of possible interests/skills. Steps to be taken by the *barangay*: Livelihood – look for technical help One-stop shop on livelihood (livelihood and trade fair) Look at food processing (longganisa, etc.), pananahi As leisure – *"ma-divert ang isip"*

TABLE 2. ACTION PLANS FOR INITIATING COMMUNITY-BASED MENTAL HEALTH SERVICES *(continued)*

III. EMPOWERING THE SERVICE USERS

Barangay	Proposed Actions	Progress after one month
Lucky	None	
Maguihan	Provide counseling sa mga ka barangay dumaranas ng problema sa kaisipan. Provide support during emergencies Tulungan ipagamot ang mga may sakit sa kaisipan Tulungan maka pag- access ng gamot para gumaling	The trained leaders were able to assist 1 patient not from their *barangay* and did counseling to the patient and the immediate family member. The BHWs provided psycho education to the pregnant women in the barangay health center.
Maligaya	Kung mayroon nang napapansin na sintomas, bigyan ng counseling para maagapan at hindi na lumala.	They try to practice this. There is one case of a woman who was described to have behaved oddly: *pasaway*, aggressive, was imprisoned for theft and stabbing (*nanaksak*). They also called her family to manage her misbehavior. She has had lucid moments but appears to have aggressive outbursts. The BHW noted that she needs psychiatric treatment but they do not know whom to refer her or where to get specialist treatment.
Rizal	Counseling for the service user and family Budget for medicines Coordination system	Service User reached known service user (with access to meds but unknown needs) Planning how to help (budget realignment- no amount yet) in the council (Target: September)
Wawa Ibaba	None	They were able to connect to the family members who can provide for the medicines that the patient needs. Accordingly, this patient has dementia and they were able to convince a family member that continued medication will help the patient to contain his sickness. The community members, when they see this patient roam around the community, they immediately inform barangays officials and the family.

TABLE 2. ACTION PLANS FOR INITIATING COMMUNITY-BASED MENTAL HEALTH SERVICES *(continued)*

IV. STRENGTHENING SUPPORT GROUPS

Barangay	Proposed Actions	Progress after One Month
Lucky	None	There is a plan to conduct basic orientation on mental health for household members to be done by the barangay officials in a general assembly.
Maguihan	Provide ng counseling sa mga ka- barangay na dumaranas ng problema sa kaisipan. Make the barangay patrol car accessible, especially during emergencies. Mag hanap mga organisasyon na pwede maging katuwang sa ibang problema.	The community workers were able to make available the patrol car to return the patient from another barangay. Counseling was provided to the immediate family member on what possible medical intervention can be done for the patient.
Maligaya	Turuan tumawag sa Panginoon hindi lamang kung may problema	They have held daily prayer meetings since the onset of the pandemic.
Rizal	Counselling for Service User and Family – magkaroon ng alternative livelihood and sources of income	Steps to be taken by the barangay.: Livelihood-looking for technical help One-stop shop on livelihood (Livelihood and Trade Fair Looking at food processing (longganisa, etc), pananahi As Leisure- *"madivert ang isip"*
Wawa Ibaba	Alamin ang sitwasyon, magkaroon ng one-on-one para malaman kung ano ang sitwasyon ng pamilya. Kailangan ng kalinga, suporta.	Members of the community who have mental illness are understood by their families and support is given to these patients. They experienced the generosity of the other members of the *barangay* to extend personal assistance for community residents who really need help. In this barangay, all the support that is extended to them by individuals or from the government the officials see to it that the people with mental health problems and their families are prioritized in the list.

TABLE 2. ACTION PLANS FOR INITIATING COMMUNITY-BASED MENTAL HEALTH SERVICES *(continued)*

V. ENSURING CONTINUITY OF CARE

Barangay	Proposed Actions	Progress after One Month
Lucky		
Maguihan	Make the barangay patrol car accessible, especially during emergencies. Maghanap ng mga organisasyon pwede maging katuwang sa ibang problema.	The barangay provided the patrol car to bring back the patient from another community. Counseling was provided to the immediate family member on what possible medical intervention can be done for the patient.
Maligaya	Magtalaga ng cluster leader sa bawat purok upang ang bawat pamilya ay malaman ang sitwasyon ng bawat isa.	They used the cluster leaders per purok organized by DSWD in July, each cluster leader asking the households under their charge if there is anyone suffering from mental health conditions. They noted that there are some 2-3 cases that manifested some symptoms i.e. 'tulala.' (non- responsiveness)
Rizal	Coordination System	To be acted upon in the near future.
Wawa Ibaba	ASSESSMENT: Alamin mabuti ang kalagayan ng pasyente – bisitahin kung kailangan	Continuity of care is given with sustained medicines

Trainers' Observations on the Achievement of the Action Plans

Despite the pandemic and other challenges in Lemery, the trained BHWs were able to deliver on their action plans. Interestingly, Barangay *Wawa Ibaba* did not see themselves as having fulfilled their plans. But as they orally reported what had happened to their community, it was apparent that they were actually helping in mental health promotion. For example, rescuing flooded households reduced the relief and stress of those affected. Yet this was not perceived as a contribution to mental health because it was not in their action plans and were seen merely as evacuation activities.

All the action plans captured the pillars in the framework for CBMH and affirmed that the community is indeed an agent, resource, and setting.

There was a clamor for some financial support and livelihood for those who need treatment to ease their anxieties. This was verbalized by some patients from *Wawa Ibaba* who expressed their inability to go and see a specialist because they do not have the means to do it.

During the one-month implementation of their action plans (July 2021), the trained community health workers realized the importance of mental health – that it is as important as their daily food intake to sustain their lives.

All the barangays sought to raise mental health awareness and endeavored to get the support of the LGU to integrate mental health as a service in their respective barangay health center.

Notwithstanding the challenges, the participants undertook seemingly small actions such as *kumustahan* (asking about the situation of their fellow community residents), which is a gesture of concern for the plight of their neighbors. This simple process led them to discussions about their psychological and emotional conditions in the midst of the pandemic and the storm that struck their communities. This process brought

to light Filipino traits such as *pakikipagkapwa tao , pagmamalasakit,* and *pagmamahal sa kapwa* (human relations, concern for others, and love for one's neighbors and fellow residents.)

There were also verbal statements that their faith helped them keep themselves together despite the serious environmental threats impinging upon them.

Most of the barangays reported one or two cases when there was an outburst of mental ill health in their community. In one case, there was an epileptic attack, in another case, there was demented woman and, in another case, there was a reported violent outburst of one resident.

In one *barangay,* there was one case where a community resident was yelling, aggressive, and walking around naked. The group of BHWs who attended the training tried to pacify that person. The woman really needed professional help. The psychiatrist of the TA team interviewed the *barangay* members on how they dealt with the situation using the TAG approach as their framework.

The trainees made statements of commitment. Spontaneously, the *barangay* captain, with the support of the participating BHWs, remarked that they have seen the need for mental health support in their community and with their learnings from the course, they will continue their initiative to have community mental health actions.

Of course, they noted that they need external support, such as access to medicines as well as information and education campaign materials for distribution at the local level. Relative to this, Barangay *Wawa Ibaba* shared their frustrating experience in their search for information and educational materials. They looked for available flyers and materials on mental health for an awareness campaign. Unfortunately, even the municipal health center does not have such materials for wider dissemination.

The trainers were impressed by the seeming eagerness and commitment of the trained BHWs and *barangay* officials. Despite the current challenges – the pandemic, unemployment, evacuation due to the floods in coastal communities, and continuing threat of Taal volcano - they implemented their action plans and took actions that prevented mental ill-health. Interestingly, in *Wawa Ibaba*, they did not recognize that some of their actions, like the evacuation that relieved the stress of some of their community members, was a promotive action for mental health.

Given this, the team commends the five participating barangays for their heroic efforts in dealing with their situations and day to day challenges.

One common wish among the trainees is to be given more training to further understand the plight of the patients and how to approach them and how to ensure that their rights are upheld and enable full recovery. The need for better communication skills was specifically articulated.

TEXT BOX NO. 6 I AM NOT SURE IF I AM OKAY - YOUTH LEADER IN BARANGAY MALIGAYA.

During the FGD, the facilitator asked how the BHWs were. How is their wellbeing? They simply said, "I am okay." The facilitator asked them to elaborate and explain what they meant by this. Saying "I am okay" is not enough.

One youth leader answered: *"Hindi ko alam kung okay ako dahil eight years na ako may insomnia."* (I am not sure if I am okay because I have been suffering from insomnia for eight years now.) He had once consulted a psychiatrist but decided

not to go back again after being told that he has to think it through and to decide for himself.

Did the youth leader fear being stigmatized? Why did he not seek help for his insomnia? His personal sharing suggests that he himself needs professional help.

The TA team's psychiatrist pointed out that lack of sleep may actually be insomnia and can be assessed and treated. Using the TAG framework, it was demonstrated that in cases like this, this person needs "alalay" (support) and directions for sleep hygiene can be initiated but the community health worker must know what Sleep Hygiene entails. If this advice doesn't work, then "tulong" must be initiated. He should be linked to the RHU so that a physician may assess and treat.

The youth leader must understand that when he accepts to be treated, he can be a more effective advocate for others to come out of their closet and seek professional help to bring back their worth and dignity as human persons. The right to self- determination is of course respected and so he has to decide for himself. He then promised that he will go for medical consultation.

The youth leader seems to have grasped the advice of the WAPR Team. Sensitivity to the mental health condition of the BHWs themselves needs to be sharpened. This is pivotal in their becoming "champions of mental health."

This talking point was also used to emphasize how stigma negatively affects the person and his opinion regarding seeking treatment and how this may be the type of resistance and challenges that will be met in their community mental health program.

The young CHW later realized that as a leader for Mental Health he should champion the cause and he has expanded his view as to what the Mental Health program can deliver for the community.

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CHAPTER 6.
MONITORING AND EVALUATION FRAMEWORK

THE BASELINE SITUATION ON CBMH PROGRAMS

The Monitoring and Evaluation framework is meant to guide incremental long-term progress to ensure the scaling up of mental health services in Philippine communities. However, the journey towards having fully operational CBMH programs may take some time. It will vary from barangay to barangay and will depend on the "baseline health situation" upon the introduction of community mental health programs.

In other words, CBMH programs are not born overnight and will take some time to be fully entrenched in the country's 42,000 barangays.

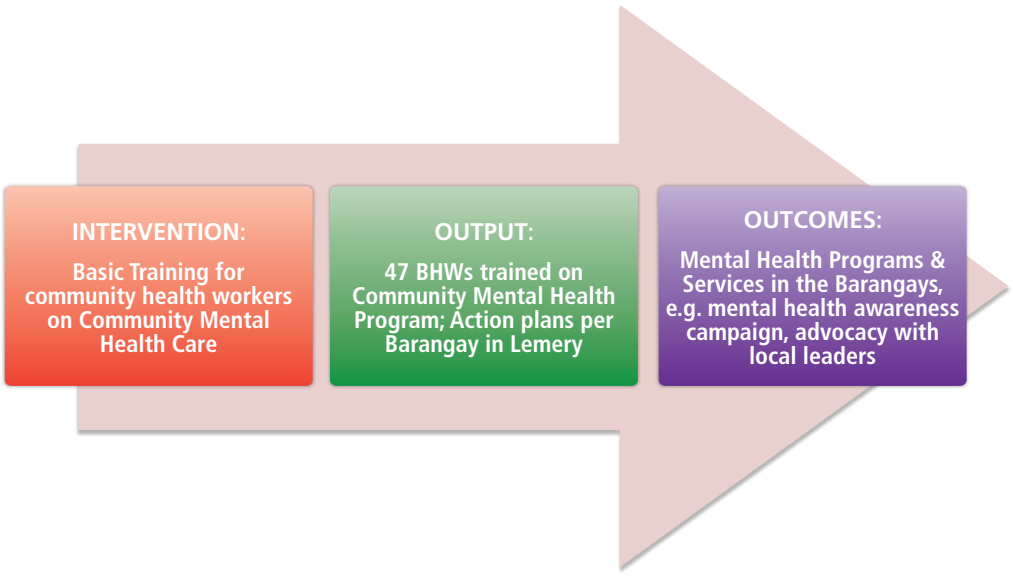
At the time of writing in 2021, the DOH had an ongoing program to train MHOs and barangay health units to apply and use WHO's mhGAP Intervention Guide. Some 70-80 percent of the municipalities in the country have been given such training though unfortunately, Lemery has not yet participated when the CBMH pilot training was conducted. *This situation implies that the RHU, the supervising authority over CBMH programs, needs to undergo the DOH training and familiarize themselves with the CBMH Program Framework*. The training is an immediate imperative because of the critical role they play in fostering the growth and development of CBMH Programs.

Interestingly, the FGDs revealed that the RHU is not perceived as a source of support for mental ill-health. Instead, the tendency is to go out of the municipality and seek help from external facilities. This pattern is affirmed in the FGDs with service users; none of them have approached the RHU to obtain mental health services.

THE PROJECT INTERVENTION

The primary intervention was the training of BHWs who could formulate action plans to be implemented within one month in accordance with the DOH project at Lemery. Figure 6-1 below show the expected results from the training of BHWs in terms of the output and outcome.

Figure 6-1. Expected Results from the Training of Barangay Health Workers



POST-TRAINING EVALUATION

Participants' feedback was obtained at the end of each module using a simple form to get their reactions on the following parameters: were the training objectives met, relevance of the subject matter, training delivery, and participants' involvement.

The feedback was positive. The participants were quite happy with the results of the training. They registered these in the modular evaluation and the reflections at the closing of the training. (See Annex 7 for the Tally of Participants' Responses by Barangay.)

PRE- AND POST-TRAINING COMPETENCY GAINS

The training aimed to achieve the required competencies on CBMH programs and services. Such competencies are clustered around relevant knowledge, skills, and attitudes.

A Checklist of Competencies (see Annex 2) from the Learning and Development Needs Assessment (see Annex 1) was administered before and after training. Participants assessed themselves in terms of their perceived level of competency on various dimensions. Significantly, the participants indicated positive gains

on their self-reported competencies after the training. The ratings shifted upward, meaning there were gains in competencies by a magnitude of less than 50 to 100 percent.

Significantly, the participants spontaneously articulated their insight: they need not be dependent on specialists when mental ill-health befalls anyone in their community. Instead, they themselves could do something about it. This change in attitude is a significant shift that the training endeavored to impart: that mental health is everybody's business.

Notably, in their reporting on the progress of their action plans, some barangays cited concrete cases of mental ill-health and how they dealt with it. For example, one case involved an epileptic seizure, and another involved a violent episode of a woman living by herself.

RESULTS-BASED MONITORING AND EVALUATION: FOCUS ON OUTCOMES

The definition of the desired outcomes is in the monitoring matrix below. The M&E Framework is framed around the pillars of the CBMH Program Framework in Chapter 4 and applied during the pilot training in Lemery.

Table 3. Monitoring Matrix

Monitoring Matrix					
Goals	**Activities**	**Indicators**	**Means of Verification**	**Assumptions**	**Comments**
Engaging the Community	Recruitment of Mental Health Volunteers	No. of Volunteers Recruited for Mental Health	Census/ Logbook/ Volunteer Contract Other means: No. of People attending in community assembly for psychoeducation. No. of Community volunteers assisting people with mental health concerns		
	Mental Health Information and Awareness Campaign OR Mental Health Programs	Number and List of MH Campaigns and Programs launched	Documentation of Activity		
	Clean-up and Beautification Drive	No of Clean-up Drives Done	Documentation of Activity		
	Substance Use Prevention Campaign	No of SU campaigns launched	Documentation of Activity		

TABLE 3. MONITORING MATRIX *(continued)*

Monitoring Matrix					
Goals	**Activities**	**Indicators**	**Means of Verification**	**Assumptions**	**Comments**
	Organizations outside Government Agencies are also involved in the CBMH	No of Organizations recruited for involvement in CBMH	Documentation of Meetings/ MOA		
	Allocation of budget for Mental Health Services or Programs or Activities	Amount of Budget specific for Mental Health	Documentation thru Minutes of the Meeting or Publication of Budget		
	Emphasis of Mental Health in Health Policy	List and Description of Mental Health Policy or Legislation	Documentation thru Minutes of the Meeting or Publication of Ordinance		
Capacity Building of Non-specialists	Screening and Monitoring using TAG	No of people screened using TAG by Volunteers	Logbook/ Census/Reports		
	Psychoeducation of Community Leaders (i.e., Brgy Capt and Councilor)	No of Community Leaders trained in MH Awareness and TAG	Attendance to Training Quality: Pretest and Posttest		
	BHW Mental Health Training on Community Care of the Mentally Ill	No of BHW trained in MH Awareness and TAG	Attendance to Training Quality: Pretest and Posttest		
Empowering the Service User	Counseling/ House Visit for Service Users	No of House Visits done by Volunteers	Logbook/ Census/Report		
	Medication Access	No of Service Users compliant to meds/ No of Service Users in Barangay	Logbook/ Census/Report	Whether out of pocket or sponsored by the government	
	Mental Health Awareness among Service Users	No of Service Users provided awareness training	Attendance to training/ Logbook/ Census/ Report		

TABLE 3. MONITORING MATRIX *(continued)*

Monitoring Matrix					
Goals	**Activities**	**Indicators**	**Means of Verification**	**Assumptions**	**Comments**
	Mental Health Awareness among Family and Carers	No. of Family Members and stakeholders were provided with MH training	Attendance to Training	Can be expanded to Schools and Workplaces	
	Financial Assistance for Service Users	Amount of direct financial assistance given to service user and their families	Documentation		
Strengthening the Stakeholders	Counseling/ House Visit for Family	No of House Visits done by Volunteers	Logbook/ Census/Report		
	Financial Assistance for Families	Amount of direct financial assistance given to service user and their families	Documentation		
	Support through Livelihood Training Programs	Livelihood Programs started	Documentation		
Continuity of Care	Barangay Resources are available for Mental Health Needs (e.g., Barangay Patrol Car for Crisis Response)	No of and types of Barangay Assets available for MH Crisis	Inventory	Stakeholder awareness and understanding of the need for continuity of care	
	Coordination within the Barangay	No of meetings on mental Health Concerns	Minutes of the Meeting/ Agenda of the meeting		
	Coordination with Rural Health Unit and External resources	No of Coordination	Minutes of the Meeting/ Agenda of the meeting		
	Cluster Leader System	No of Cluster Leaders Identified and Oriented	Census		

TABLE 3. MONITORING MATRIX *(continued)*

Monitoring Matrix					
Goals	**Activities**	**Indicators**	**Means of Verification**	**Assumptions**	**Comments**
	Mental Health Service is Integrated into Barangay Health Service	Coverage of Screening Percentage of Screened with a need for G (with symptoms but with no problem in functioning) /A (with symptoms and with some problems in functioning)/T (with symptoms and in crisis)	Census		
	Registry of Service Users	One Registry	Presence of Registry		

RESULTS-BASED MONITORING AND EVALUATION: FOCUS ON IMPACT

Long-term impact can be measured but it will not happen within a short timeline. To produce such impacts will require further development and technical work. The DOH- CBMH project to develop the Framework proceeded from March to October 2021 which was insufficient time to observe the impact of the training of the BHWs mentioned in the previous section. However, a tool for monitoring the results of CBMH programs was designed and used in monitoring the results of the pilot training in Lemery. This tool is in Annex 8.

Table 4. Expected Results by CBMH Component from the Perspective of the Community and the Service Users

CBMH Component	Community	Service User
Engaging the Community	MH literacy and awareness-raising campaign on MH Use of Media and IEC's for Promo Activities	The community is aware of mental health services Basic Case Finding and Monitoring
Building the Capacity of Non-specialist Health Workers	Able to: a) Conduct Mental Health Promotion and Psychoeducational Activities (including suicide and substance use disorders) b) Understanding of the CBMH Framework and its monitoring process	Able to: a) identify and refer cases to MH Center/ RHU b) Assist the service user and enjoyment of rights
Service User Empowerment	Service User's Rights are respected psychoeducation about service users' rights	Presence of service user organization Assistance to Creation and repository of Advance Directives

TABLE 4. EXPECTED RESULTS BY CBMH COMPONENT FROM THE PERSPECTIVE OF THE COMMUNITY AND THE SERVICE USERS *(continued)*

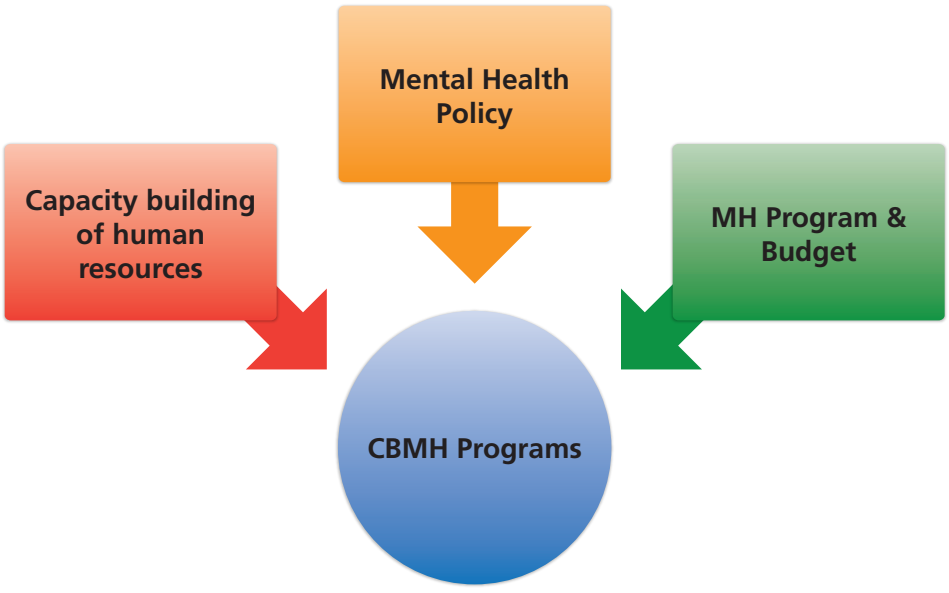
CBMH Component	Community	Service User
Strengthening Family and Stakeholders	Presence of Mental Health Educational Program in Schools, Workplaces, and Barangay Presence of direct links to inclusive community programs for family	Families/ stakeholders prioritize mental health together with mental health Training for Family-based MH Promotion using multimedia or digital technologies
Continuity of Care	Suicide Prevention Program AND Substance Use Prevention Program Presence and awareness of directory of public and community mental health services and facilities access points and referral networks	Integration of Culture and Gender-Sensitive MH Services in PHC Presence of database to monitor referral and aftercare

SUSTAINABILITY

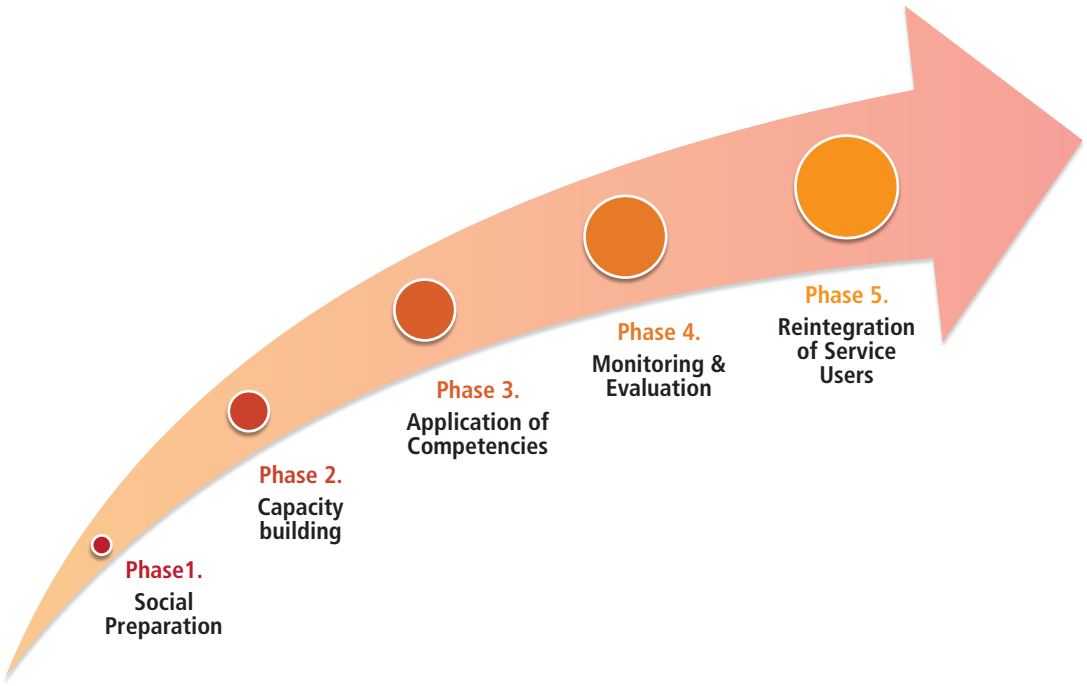
One long-term outcome and impact of CBMH program initiatives is institutionalizing mental health programs and services in barangays and communities. For this to happen, the program manager (e.g., MHO) needs to ensure the sustainability of the CBMH initiatives in the course of program monitoring. The essential elements of sustainability are shown in Figure 6-2 below, namely: adoption of a mental health policy by the local executives and the local council; the inclusion of mental health in the barangay health development plan; allocation of a budget to support the mental health program; and the capacity building of human resources, e.g., specialists and non-specialists in providing mental health services.

Significantly, the action plans of some barangays in Lemery have considered allocating a local budget, advocate to local leaders, and include mental health care in the local health program. The realization of these aspirations will contribute to the continuity of the program in the barangay.

Figure 6-2. Elements of Sustainability



CHAPTER 7.
STEPS IN SETTING UP CBMH PROGRAMS



PHASE 1: SOCIAL PREPARATION

A major step in the social preparation is the selection of the project sites and communities. Conduct initial assessments when choosing project sites and communities. Community assessment provides a framework for identifying solutions to a community's problems. It can reveal a community's strengths and weaknesses and help the Implementing Organization work on solutions to their problems.

An assessment not only helps to better understand the dynamics of the community but allows the project beneficiaries to make informed decisions about service priorities. By taking the time to learn about the

community, proponents of the project can discover the best opportunities for service and maximize efforts to make an impact.

Steps in Community Preparation:

1. Forge agreement among collaborating organizations (DOH, LGU, and Implementing Organization) of the objectives and plan of implementation of the project.

   Key Activity: Solicit political support. This entails dialogue with the Local Chief Executive, local councils and other stakeholders in health service provision to secure willingness and buy-in of the Local Government Units (LGUs) to embark on the project. Collaborating/Implementing Organization should be able to explain to local officials, including those in the barangays, that mental health is an integral component in promoting the general health and well-being of the people.

   Note: The Implementing Organization should be able to present themselves as provider of technical support with trained "specialists" who can implement and manage the project.

2. Conduct preliminary data gathering by the Implementing Organization on the possible project areas through community assessment. Identify where support is most needed.

   Key Activity: The sites will be profiled and assessed in terms of the potential impact of the project. The population, socio-economic conditions, and the perceived or expressed need for mental services such as the neighborhood's conditions, availability of basic services, and exposure to disasters, environmental risks and hazards.

3. Establish rapport and relationship with the local City/Municipal Health Officer.

   Key Activity: Look into the existing general health care system and how mental health services can be integrated into primary health care services.

4. Identify and profile the community health workers who will be trained for the community mental health care services.

   Key Activity: Administer pre-training "Competency Checklist" to would-be trainees.

5. Determine the availability of technological infrastructure needed in the community for virtual trainings and assess the readiness of the project areas for tele-mentoring of the trained of health workers.

   Key Activity: Since the project will involve conduct of virtual trainings, the communities would need technological infrastructure and connectivity. An assessment of the baseline status of the project communities at project inception will be essential.

6. Ensure LGU's provision of support and involvement in the sustainability of the project.

   Key Activity: Obtain commitment of local officials of their support through the passage of local ordinance on mental health program.

PHASE 2: CAPACITY BUILDING OF COMMUNITY HEALTH WORKERS IN DELIVERING MENTAL HEALTH CARE SERVICES

This will be the actual conduct of the training for those who will be actively involved in the provision of mental health care services either in the city health unit or to follow-up on and visit patients in the community. Community health workers who will participate in this training will be expected to know the basic concepts of mental health and the means of identifying people with mental health conditions at their level of primary health care. They will also be able to work closely with the families of the patients and participate in community programs that will address the social stresses in daily living of the people in the community.

Key Activities:

1. Design training modules that are contextualized and customized according to the needs of the community health workers who will be participating in the training
2. Define the competencies to be acquired by the community health workers
3. Define the performance indicators and how to measure training effectiveness/success
4. Conduct virtual training for the community health workers
5. Conduct post-training debrief for trained community health workers

PHASE 3: APPLICATION OF THE COMPETENCIES LEARNED DURING THE TRAINING, POST- TRAINING SUPERVISION AND MENTORING

The regular post-training supervision and mentoring by the experts/trainers will provide the trainees the opportunity to sustain their provision of mental health care in the community. It will simultaneously give them the capacity to understand that mental health care does not focus on the individual alone. Hence, they will also acquire the understanding of the patient's external environment in his community that they will need to support so that mental health can be sustained.

Key Activities:

1. Ensure that the acquisition of the knowledge from the training is put to practice.
2. Conduct regular post-training supervision and mentoring of trainees to sustain their acquisition of knowledge and skills in mental health care and their positive attitude towards anything "mental".
3. Involve community health workers in the asset mapping of their respective barangays based on the knowledge handles learned from the training.
4. Develop proper recording system for documentation of the Mental Health Program being integrated in the community.
5. Ensure the submission of monthly written reports by BHWs to the Health Committee Chair of each barangay for proper documentation.

PHASE 4: MONITORING AND EVALUATION

Ideally, the RHU, municipal health center, or barangay health center shall lead the monitoring and evaluation efforts, collecting data, and sharing their reports and findings with the Office of the Mayor.

A system of recording patient data in the community should be integrated in the current system of health recording in the RHU, municipal health center, or barangay health center (as determined by the existing DOH/PHO Management Information System). This is an indication that the mental health program is being integrated in the data base of the health center and in the community.

The report on actual patient data should cover the following:

1. Socio-demographic profile
2. Identification of mental health problem
3. Statement of mental problem or diagnosis
4. Management of mental health problem in the community or health center

Key Activity: Provide appropriate evaluation of the community mental health project to ensure its support and sustainability at the local government level. Evaluation tools should include clear and measurable goals.

PHASE 5: REINTEGRATION ACTIVITIES FOR SERVICE USERS

1. Provide psychotropic medicines in the first 6 months of the recovery period through the RHU support at the same time engage them in sustainable livelihood programs that are appropriate to the recovered patients.
2. Conduct developmental and rehabilitative activities within the community
3. Showcase "talents" of the recovered patients (e.g. Mini-Olympics, Talent Search, Inter-barangay Competition, sports activities etc.)

CHAPTER 8.
STORIES FROM LEMERY AND LESSONS LEARNED

INTRODUCTION

The CBMH Program Framework was tested in Lemery, Batangas, particularly in five barangays that were selected based on their responses to the WHO Modified Self-report Questionnaire. A pilot training on community mental health care was conducted involving 47 barangay health workers from the participating barangays. In general, the pilot training was useful in demonstrating the practical utility of the CBMH program framework to catalyze the setting up of community mental health services. The pilot training also shed light on necessary adjustments in the training program for non-specialists.

Challenges in capacity-building during a pandemic

The CBMH program model was conceptualized and tested under very challenging times. Foremost, the restricted mobility and social interaction due to the COVID-19 pandemic constrained training and research. At the same time, there was the looming threat of the Taal Volcano erupting and the floods caused by typhoons and monsoon rains. All of these environmental risks diverted the attention of the community residents. There were also occasional power and connectivity issues that interrupted FGDs and caused delays in the project implementation.

For the trainers, this meant reliance on the verbal statements and responses of the trainees. Non-verbal behavior could not be used as basis for gauging attention to the discussions and constrained interactive discussions. Social investigations on the ground and discussions with the LGU officials to re-enforce their buy in could not be pursued due to the pandemic restrictions in mobility.

LESSONS LEARNED

The pilot training in Lemery validated the need for Community Mental Health Services and the CBMH Program Framework. As envisaged, the elements of the program framework encompassed the proposed community level action plans of the trained barangay health workers.

The three arguments for having community health services were affirmed: 1) knowledge among the barangay officials regarding their responsibilities under the Philippine Mental Health Law needs major improvement; 2) the burden of mental ill-health is perceived to exist in the barangays as they know of existing cases that require psychosocial assistance but do not know where to refer them or what to do in cases of outbursts (each barangay shared at least one case of a serious mental case. For example, in Barangay Maligaya, there was one seeming case of a psychotic breakdown that needed professional assistance); and 3) the supply of mental health services is nil. In general, the municipal health office and RHUs are **not** seen as a mental health service provider and are not entities approached for mental health services in the community.

Relative to this, the MHO in Lemery needs to undergo the DOH training on the mhGAP, which is vital in enabling them to perform their oversight functions of mental health services. Likewise, health staff of the RHU and barangay health centers must be trained.

Community development workers such as the BHWs can be purposively harnessed in providing CBMH services provided they are given prior orientation and mental health competency training. It is worth the investment to build the capacity of the BHW, especially the young ones. In some barangays, some BHWs are nearing retirement age but since they are volunteers, they have been accommodated into the pool of health workers.

TEXT BOX 7. ''BAKUNA NA, MENTAL HEALTH PA''

Just like any LGU, Barangay *Rizal* had to handle the pandemic on top of any programs they were doing. Driven by their new learning and enthusiasm for mental health, the barangay captain and his team of health workers and promptly put the mental health program in their primary care agenda. In their next general assembly, they discussed the CBMH program to spread and foster awareness.

In Barangay *Rizal*, the Health Team was activated for the Vaccine House-to-house Education – an opportunity they seized to piggy back and insert the TAG approach as they screened everyone in the community. The Mental Health Screening yielded

insights for the Health Team as they realized that although most of their neighbors do not have a history of being a service user, many are either coping or struggling in the pandemic.

They were also able to obtain information on the current situation of a known service user in the area and have decided to discuss how to help him in accessing psychotropic medications in a sustainable manner. The barangay captain promptly committed to realign some of their budget to empower this service user but she looks forward to submitting a proposal for a CBMH program for next year's budget cycle.

They were also mentored on the importance of monitoring and evaluation and were encouraged to record these data for future reference and data-driven governance.

Capacity-building of non-specialists on community mental health services is worth pursuing to enable the scaling up of mental health services. Based on the participants' testimonies and their feedback in the modular evaluation, as well as the pre- and post-test competency gains, the basic course has proven to be a good introduction into community mental health programs and services. In the course of their sharing in the FGDs, it became apparent that the BHWs learned what they ought to do when they are confronted with cases of mental ill-health; in particular, this meant the application of the TAG (Vives, Lachica, and Peabody, 2019) approach that was taught during the basic training.

TEXT BOX 8. "IT PAYS TO TRAIN NON-SPECIALISTS"

Barangay *Maguihan* woke up to a challenge a few days after the CBMH training concluded. A 15-year old girl was endorsed to the barangay hall of by residents of nearby Barangay *Sambal Ilaya*. Because of the coincidence that they had just finished their training, the community health workers' first thought was: *Is this a surprise test from the WAPR training team?*

However, they realized the gravity of the case when the girl had an episode of seizure. Luckily, one of the BHWs who happened to be at the hall knew how to handle the situation from previous training and experience. They first offered safety, a bath, a comfortable set of clothes, and a hot meal. They also offered a place to rest as the barangay health team huddled.

The BHWs tried to recall their training. They gathered and formulated a plan for the wandering guest. To them, it was obvious that the young woman needed help or "*Tulong*". After this initial care, they need to refer this girl in crisis.

The council member on duty and the BHW coordinated with their local DSWD. Good thing that the girl knows her full name and through DSWD's network, it was discovered that the girl has been missing for three days! She was brought home by the DSWD officer, the council member, and the BHW to her parents who are residents of Biñan, Laguna. The barangay's patrol van was used to transport the girl.

The real surprise for the BHWs was that it wasn't a surprise test from the WAPR trainers after all! It was amusing to hear the remarks made by the council member and BHWs who have attended the WAPR training: *Akala namin ay binigyan kami ng test ng WAPR kung paano maghandle ng ganitong sitwasyon. Ito agad ang pumasok*

sa aming isipan dahil naganap yung pangyayari kinabukasan matapos ang last day ng aming training. (We thought the WAPR was giving a surprise test on how to handle situations like this – that was the first thought that came to our minds because the event happened a day after the training concluded.)

Because of their training, they were able to recognize the girl's symptoms and decide the next steps for her care. The BHWs declared: "*Nag-epilepsy po siya".* They have also shown the ability to be flexible and creative in their care.

An important insight gained by the participants is that the BHWs and barangay officials realized they have the potential to provide CBMH services and that they can intervene in the crisis before referring to mental health specialists. This helps a community become more self-reliant and hopefully lead to the decongestion in the higher referral nodes. The participants imbibed this key message of the training and it is a strategic attitudinal change that should be propagated and continuously supported.

While the basic course is useful, **the participants expressed the need for more training in order to develop their confidence and their skills** in providing mental health services at the community level. For example, the BHWs in Barangay *Maligaya* categorically stated this is one of their action plans.

Further training is also needed to broaden and deepen the community workers' understanding of mental health, including the "know what and know how." For example, a young male BHW

shared that he has been struggling with insomnia for the past 8 years. Such seemingly common situation is actually part of mental health yet it was not recognized as such. He was advised by the WAPR Team to seek professional advice to address his personal concern.

Ideally, health staff in the public and private/NGO sector should be trained on community mental health care in order to have a pool of non-specialists that can help provide mental health care. Those in the public sector are being addressed by the DOH through their mhGAP training – the MHO in Lemery must undergo the DOH training on the use of the mhGAP Intervention Guide and other relevant trainings offered by the DOH.

The social factors influencing mental health and health-seeking behavior were evident in Lemery. It is likely that these factors will be found in other municipalities and barangays.

Poverty, lack of community mental health services, stigma, and the continuing environmental risks and threats, including the pandemic, were found in the five participating barangays. These have a direct bearing on the provision of CBMH services. For example, in the recovery of patients, rebuilding their economic lives is crucial to build their self-esteem, empowering them to live independently, afford their continuing medication and rehabilitation, and enable their healing and full reintegration into the community.

Sustained public education and advocacy are necessary to melt down the entrenched stigma against mental illness. To begin with, the BHWs own attitudes need to be processed so that they can persuade others to regard mental health like physical health that needs to be addressed properly and promptly.

The need for assistance in medication and livelihood are oft-repeated themes in the participants' action plans (at least in three out of five participating barangays). These were echoed by service users and family carers in the FGDs.

TEXT BOX 9. "IS MENTAL HEALTH FOR THE HAVES? WHAT ABOUT THE HAVE NOTS?"

In one barangay, a father suffered a stroke and manifested behavioral disturbances: "*Umiihi siya sa kahit saang lugar na naisin niya kahit sa harap ng mga tao.*" (He urinates anywhere, even in front of other people.) He is believed to be suffering from dementia.

One day, he was nowhere to be found by his children, who were noted to be all professionals and are known to have economic means. One of his children approached the

barangay hall to ask for help. As news spread about him having been missing, the residents took turns in keeping a close watch of where he might have gone.

Toward the end of the day, one of the residents found the missing father and brought him back to his house. After this incident, the officers of the Barangay Council oriented the residents about the mental health condition of the father and requested them to keep a watchful eye on the old man if they happen to see him wandering around. His children had his name and address tattooed on his arm to make sure that people are able to bring him back to his house should he get "lost". (This could be seen by some as a violation of rights.)

It was noted that none of the residents took advantage of the old man's mental health condition and it is believed that this is because the family has good economic standing in the community. The community health workers pondered and said, "*Mabuti na lang at may kaya yung pamilya. Paano yung walang kakayanan? Ano ang mangyayari sa taong may sakit sa kaisipan?*" (It is a good thing they are well off. What if they do not have the economic means? What would happen to people without means?)

There are attendant governance concerns that must be addressed.

Bring the stakeholders on board because one cannot do mental health promotion alone. It is a journey for the long haul. Lemery has taught this lesson:

"MENTAL HEALTH" IS EVERYONE'S BUSINESS: IT WILL NOT WORK IF WE DO IT ALONE.

Of the five barangays, there was one that did not do well during the monitoring period. They were unable to execute any of their plans and were apologetic about it.

When the WAPR team probed this lack of progress, it was apparent that it was because of the lack of participation of the other barangay leaders and the community in general. The active person is the Barangay Executive Secretary. He was the one who attended the meetings, drafted the plans, started to design the informational materials, who tried to do screening, and almost all things related to their initial plan. "*Mahirap po magrecruit*," (It's difficult to recruit) he said.

Highlighted in this case is the need for an awareness campaign and a recruitment of volunteer community workers who will help deliver CBMH. In the case of this barangay, it only highlighted the importance of conducting an awareness campaign to convince neighbors that mental health is everyone's business.

Intensive advocacy of Local Chief Executives and barangay officials is warranted in order to get the community's buy in of CBMH services. DOH could consider mounting a massive campaign with the LGUs to mainstream mental health in their development processes, i.e., planning, programming and budgeting. Having CBMH programs is the gateway to covering the mental health needs of the have nots. CBMH program is therefore a practical measure for greater social equity.

THE CONDITIONS OF WORK OF BHWS

The situation of BHWS needs to be revisited because their work status is far from decent. A review of their workload and the corresponding emoluments given to them may not be fair and just.

BHWs have been in existence for four decades now and have helped expand primary health care in the Philippines. In fact, their participation is seen as a success story in expanding primary health care in the country.

The Barangay Health Workers' Benefits and Incentives Act or RA 7783 has provided the following: hazard allowance, subsistence allowance, educational programs, continuing education, study and exposure tours, training, grants, field immersion, scholarships benefits in the form of tuition fees in state colleges to be granted to one child of every barangay health worker who will not be able to take advantage of the above programs and special training programs such as those on traditional medicine, disaster preparedness and other programs that address emergent community health problems and issues.

In a similar vein, a study noted:

> [W]hile it is acknowledged that CHWs in LMICs can effectively support a range of community-based programmes targeting NCDs, including tobacco cessation, diabetes and hypertension control, evidence emerging from mainly high-income settings also suggests that, with sufficient training, supervision and definition in roles, they may also be effectively integrated into the provision of other primary care services, **including mental health and drug rehabilitation**... However, CHWs should not be used as a remedy for reducing the burden of other health workers or other symptoms of a weak health system... Involving BHWs in efforts to expand programmes (like those mentioned above) such "expansion should not result in *task overload*, which could reduce productivity and worsen health population health outcomes (Mallari et al., 2020, p. 8).

Mallari et al (2020) documented the experiences of BHWs and noted the conditions of their work:

1. BHWs are appointed by the Barangay Captain. Therefore, they are vulnerable to replacement every time a new barangay captain is elected every 3 years, after the local elections. BHWs can be dismissed when their political alliance does not match that of the incumbent barangay captain. Hence, BHWs' positions is very insecure.
2. BHWs perform a variety of health tasks activities. They serve as the bridge between the community residents and the health center. They also perform health surveillance functions. BHWs were commonly assigned a variety of tasks such as immunization, maternal care, family planning and hypertension management. "Their weekly schedules varied from barangay to barangay, but they typically spent the whole day in health centres 2–3 times a week" (p. 5).
3. BHWs are not government employees but regarded as part-time, volunteer workers. Hence, they do not have a regular salary.

   However, BHWs from rural areas reported being given honoraria and allowances of PHP 1,150.00 (USD 24) each month; in urban communities honoraria were also paid but their size, and that of any other allowances, varied depending on whether they were contracted by city or barangay administrations, with the latter having smaller budgets. Although urban BHWs all perform similar duties and report to local health centres, the financial incentives, in the form of honoraria to acknowledge their voluntary contributions and allowances to cover the incidental costs of carrying out their assignments (e.g.

transport), varied by location. For barangay-funded BHWs, the combined lump sum was reported as PHP 2,300.00 (USD 50) per month distributed in cash by barangay offices, and PHP 3,000.00 (USD 60) for city-funded BHWs paid through a designated local bank. In addition to honoraria and allowances, city-funded BHWs are provided with PhilHealth membership, the national social health insurance programme (p. 5).

SOME MENTAL HEALTH PROBLEMS ARE UNATTENDED AND MERITS ATTENTION.

Barangay *Rizal* is drug-free but they noted that alcoholism among their menfolk is quite prevalent. They have resolved that they will incorporate alcoholism in their CBMH program – *Stop Alak-Singko*.

During the CBMH training, they were given a case vignette about substance abuse and its relation to gender-based and intimate partner violence. This case was intentionally designed to show that mental health issues, like substance abuse, are linked with the greater problems of society. And it hit close to home.

"*Tatapusin na po namin ang kinaugalian na alak-singko*". (We will seek an end to the five o'clock drinking habit.) Five'o'clock is a pun, the usual time men went home from the farm. And on their way home, they will make a stopover at a friend's house to drink alcohol. By the time they got home, they are drunk and this oftentimes leads to domestic violence.

Hence, in Barangay Rizal's CBMH plan, they plan to address mental health and substance use through education and awareness campaigns and through a personal approach.

RECOMMENDATIONS

1. Improvements in the training design, instructional materials, and delivery

The pilot training was done in only one municipality, Lemery, in Luzon. It is expected that as the CBMH Program is rolled out, there will be more experiences that could inform the training design and delivery. Thus, the training design must be considered as a living document that must be contextualized to the LGU's conditions at the time of implementation. Lessons from the pilot training in Lemery led the WAPR team to the following suggested revisions:

BASIC COURSE FOR COMMUNITY HEALTH WORKERS ON COMMUNITY MENTAL HEALTH CARE

Version as of 27 AUGUST 2021

Proposed Time Allocation	Original Program	Proposed Revision after the pilot training
Module 1: 4 hours	Administer Competency Checklist (as pretest) Course Overview Why Community Mental Health Care/ Services • Legal Basis: MH Law • Narrowing the Treatment Gap: MH Situation in the Philippines • Institutional Landscape of MH Services in the Philippines Six Pillars of CMH Programs Guiding Principles • The PCMH Conceptual Framework: Bio- psychosocial and Spiritual Framework • Respect for Human Rights Recovery Oriented Approach Balanced & Collaborative Care • Social Inclusion	Administer Competency Checklist as part of the Learning Needs Assessment Module 1: (Day 1, 2 hours) Introduction (1 hour) Welcome Participants and Barangay Officials Expectation Check • What do you expect to get from this training? (If face to face training, use meta cards; if virtual use whiteboard or record responses on power point; project on screen so the participants can see; facilitator discusses & summarizes) Course Introduction (45-60 minutes) Course Objectives Course Overview • Why CMH: RA 11036, The Treatment Gap, DOH Health Promotion Approach (Healthy Settings) • PCMH Resolution #3: Reframing Mental Health • The Bio-Psychosocial-Spiritual Dimensions • Definition of Terms: mental health, community MH, CMH worker Interactive Discussion: • In the past, have you had any situations where you had to deal with a person with MH conditions? • Where did you get mental health service in those situations? ENERGIZER (physical activity)

Basic course for community health workers on community mental health care *(continued)*

Proposed Time Allocation	Original Program	Proposed Revision after the pilot training
	Engaging the Community for Mental Health Promotion: What can the community do for MH promotion? • What is a community? • Know your Community's • Assets and Resources • Use the Existing Services and Resources in the Community • Setting up referral system • Raise awareness on MH: Inform, educate and advocate: • MH is everybody's business • Self-care in MH LGU support for MH • Promote and foster MH programs in schools and workplaces • Organize service users • Strengthen and support the Health Workers in the Community	Module 2: How to Identify MH Conditions (Day 1, 3 hours; Day 2, 4-5 hours) What are MH Conditions? MNS Disorders The TAG Approach, The "Apat na Tanong" Method Communication Skills as a Vital Competency in Identifying MH Symptoms of • Anxiety and Stress • Depression • Substance & Alcohol Abuse • Psychosis • Dementia Exercise: Case Studies • Psychosis • Epilepsy • Substance Use Disorder • Children's Developmental Disorders (ADHD) • Dementia What to do in psychiatric emergencies and crisis? • Suicide • Violence against Women & Children • Disaster • Trauma Demonstration: e.g. Role Play Setting up a Referral Mechanism for MH Crisis Module 2 Evaluation
Module 2 **5 hours**	How to Detect MH Conditions in the Community	Module 3: Basic Competencies in Community Mobilization for Mental Health Care (Day 3, 4-5 hours)

Basic course for community health workers on community mental health care *(continued)*

Proposed Time Allocation	Original Program	Proposed Revision after the pilot training

	• Recognize and acknowledge MH conditions and the required actions: TAG Approach
	• Anxiety and Stress
	• Depression and Suicide
	• Prevent substance abuse disorders
	• Prevent suicide
	How to deal with psychiatric emergencies and crisis situations
		• The Community, Change Agent in CMH: Four- fold functions of the Community
		• Guiding Principles in Human Development (4 dimensions of man using PCMH Resolution)
		• Guiding principles in community development]
		  • Community Education
		  • Community Organization
		  • Community Resource Management
		• Guiding principles in CMH Care
		  • Quality Rights
		  • Recovery-oriented Approach
		Workshop: Community Assessment of Your Barangay Instructions: Take stock of your community's situation, assets and resources?
		• What is the face of poverty in your barangay? What are the main factors affecting mental health in your community?
		• What are the community assets, opportunities and resources for MH programs and services?
		Plenary Session: Sharing of Assessment

Basic course for community health workers on community mental health care *(continued)*

Proposed Time Allocation	Original Program	Proposed Revision after the pilot training
Module 3 **8-10 hours** **(2 half day sessions)**	Strengthening the Capacity of Community Health Workers for Mental Health Care What to know to be able to promote MH in the community? • Who are the actors/players in the community that can help in MH • How to engage them – • Examples of community mental health (CMH) models Issues and challenges: Take Stock of Community Assets and Resources in MH Care Exercise 1: Community Assessment or Interactive discussion What skills must community health workers have to promote mental health? • How to strengthen the family and support groups • How to empower service users • How to ensure continuity of care and how to set up a referral system • How to advocate and campaign for MH • How to follow up, monitor and evaluate Exercise 2: To be developed	Engaging the Community (continuation, Day 4, 4.5 hours) • Recap: Community Development (Education& Organization) • Empowering Service Users • Strengthen Support Groups (Exercise) • Ensure Continuity of Care (Case Study) Interactive Discussion: Issues and Challenges in Setting up CMH • Programs in your Barangay • How can you overcome these? Summation: • Elements of CMH Programs • Overcoming the Issues and Challenges in CMH Care Summation: Know what, Know why and Know how
2-3 hours	Action Planning by barangay or by setting in the community i.e. workplace, schools, community Synthesis and Integration	Action Planning by Barangay Breakout Groups Plenary Sharing Monitoring & Evaluation Follow up Module 3 Evaluation CLOSING • Remarks from Participants on their Learnings • Competency Gains: Changes in Pre- and Post- test Scores

Notes:

1. The program will invest at least one hour in the introduction of participants to foster acquaintance, break the ice, build rapport, generate political support from the barangay officials, and get their expectations. If the training is done face-to-face, a structured learning exercise (SLE) can be used to generate physical movement and some fun. For example, a straw ball can be thrown to a participant who then begins by introducing herself or himself. Some variation can be introduced like: "Choose an adjective that best describes you."

2. Module 1 will focus on the why of community mental health. Other conceptual inputs will be infused in Module 3 to make it easier for the participants to internalize. The framework for community mental health programs will be used as a tool for summation and synthesis at the end of the course. It will be referred to as the elements or components of the community mental health program.

3. Module 2 will be presented as early as day 1 of the training. More interactive discussions through the case studies will be incorporated into the course design. For example, the participants will be assigned to identify the mental conditions described in the illustrative case studies. This module will point out how a referral system can be set up.

4. Module 3 will endeavor to lay the ground for community engagement and mobilization of community mental health through activities like assessing the community situation in terms of poverty and other social factors; assets and resources for mental health care; and what the community mental health worker should endeavor to do, i.e. organizing and empowering service users; strengthening social support for mental health; and ensuring continuity of care. This module will prepare the barangay for action planning. This will be the basis for follow up and field monitoring.

5. Energizers will be interspersed in the activities as needed, preferably those that are culturally appropriate to the trainees.

6. Barring limitations such as the pandemic, for greater effectiveness, the training MUST be done face-to-face for the trainer to observe the non-verbal behavior of the trainees. This serves as 'feedback' to the trainer on how the participants are reacting to the training. The utility of the interactive exercises can also be optimized.

7. Pre- and post-test assessment of competencies can be discussed with the participants as part of the concluding activity.

8. Facilitation of breakout groups must be standardized in order to ensure common inputs and the appropriate and relevant information are obtained from the participants. Action plans should describe the demographic and social context for the proposed actions.

9. Population, literacy level, age and sex composition, health assets and facilities, number of BHWs, and the like should be included in the final action plan to be submitted.

10. For the guidance of the trainers, a basic demographic profile of the participants should be obtained prior to the training, i.e. age, sex, education, religion and length of time in the position of health worker

11. The topics on how to develop a referral mechanism can be integrated into the exercise on community resources. Guide questions must be formulated to elicit the desired response.

12. Consider negotiating with the target municipality for five half-day sessions, which is slightly longer than the program that was conducted in Lemery.

2. **Ensure sustainability of the CBMH programs once it is planted in the LGU grounds.** This entails a number of action points. DOH must strongly encourage LGUs to mainstream or include CBMH services in their local health development policies, plans, programs, and budget. This is to ensure continuity of the programs and services across political regimes.
    - *Adopt a **policy** to institutionalize CBMH at the local level.* LGUs should pass a local ordinance adopting CBMH programs as a matter of local development policy. In particular, mental health services should be integrated in primary health care. Underpinning this is their obligation to provide community mental health services for their constituents as stipulated in the Philippine Mental Health Law.

    - *Develop **people support and capacity for delivering mental health programs in the community.*** This includes a number of actions:
        - *Stakeholder Engagement.* Raise community awareness on mental health among the duty bearers and the constituents or community inhabitants. Engage everyone because mental health is everybody's business.
        - Conduct dialogues and coordination between the RHUs, barangay health centers, and the non-government service providers to define coordination mechanisms, develop and disseminate a referral mechanism, and smoothen out the bottlenecks in the implementation of the CBMH services.
        - *Capacity building of non-specialists.* Community development people in both the public and private domain should be trained to providing community mental health services. A design for the basic training course for non-specialists has been proposed above. The MHO, staff of the rural health unit, and barangay health centers should undergo the DOH trainings on mhGAP and other related programs. This is to ensure that the MHO and the community health workers will be able to mutually support each other.

LGUs must have a continuing program for developing the competencies in mental health care among the community development workers, including those in schools, workplaces and communities. Competency building is a lifelong process and should factor in the role of technology in delivering mental health services.

The training courses should include a mentoring phase so that the trainees' skills get honed and sharpened in the course of their practice. The pilot training in Lemery did not include the mentoring phase as the DOH project timeline was limited to 6 months plus the limitations in connectivity and mobility restrictions due to the pandemic. Ideally, a mentoring phase should be part of the training program, if circumstances allow.

- *Integrate mental health in LGU health* programs**.** LGU officials and their respective Health Development Councils/Committees should integrate community mental health programs in their local health program, which is developed annually.
- Budget. The municipal development council should appropriate LGU funds to support the community mental health programs and services.
- **Enabling mechanisms.**
  - The planning, programming, and budgeting processes of LGUs must include mental health as a regular part of their development agenda. They should have a way of tracking progress and development in the community mental health programs and services.
  - Institutionalize a monitoring and evaluation system at the LGUs.
  - Develop a referral system at national and sub-national levels. This will facilitate the management of cases that require specialist care.

3. Address governance concerns attendant to the establishment and implementation of CBMH programs and services.

Social Preparation of Communities and Information Dissemination to LGUs

LGUs must recognize that stigma against mental illness remains entrenched in communities. The health workers and community development workers must be properly oriented to the reframing of mental health, which is stated in the PCMH Resolution No. 3, adopted in 2021. Workers in the field of mental health and the general community must be brought to this common understanding of mental health.

Massive Information Dissemination

A forum with local chief executives (municipal mayors and barangay captains) could be held as a precursor to the issuance of a directive for LGUs to set up their community mental health services.

DOH can come up with communication materials to **build the case for CBMH Programs** at the LGU level. To facilitate the adoption of the CBMH Program, DOH could develop a guidebook that contain the practical guidelines for this undertaking. It must be underscored that the LGUs are vital duty bearers in delivering mental health services under the Philippine Mental Health Law. They have accountability for setting up CBMH programs and services.

Incentive for CBMH Programs

Setting up CBMH services can be incentivized through the mechanism of the DILG. For example, it could be incorporated as one criterion for granting the Seal of Good Local Governance, which has an accompanying financial grant or award. The DOH can advocate this to the DILG.

Currently, one of the criteria is related to health. In the 2021 draft of the DILG memorandum on the SGLG, it stated that one criterion to qualify for the SGLG is:

> Health Compliance and Responsiveness: *Set-up, implement, and sustain health policies and programs that would strengthen and promote the well-being, healthy lifestyle, and safety of the public, while ensuring that all individuals, especially the vulnerable, have fair opportunities for better health without causing financial hardship through the organization of an integrated health care delivery system (DILG, 2015).*

Incentives for Barangay Health Workers

The Barangay Health Workers' Benefits and Incentives Act of 1995 or R.A.7883 grants benefits and incentives to accredited BHWs for voluntary health services rendered to the community. It is worth revisiting to explore ways of realizing more benefits for the BHWs.

In 2018, a similar recommendation was made in a study on strengthening the local health system:

> *Amend the Barangay Health Worker's Act (RA 7883), particularly the granting of the hazard pay and rationalization of health manpower complement at the barangay level.* Considering the huge budgetary requirements, the following are recommended: 1) possible fund subsidy from the Department of Health (DOH) to the barangay health workers (BHW), like the subsidy local agriculture officers get from the Department of Agriculture; 2) rationalize the functions of the BHWs and the barangay nutrition scholars who may have overlapping functions (Nivera et al., 2018)

4. Adopt, Replicate and Scale-up the CBMH Program all over the country

Aside from disseminating, the DOH can proactively advocate to the LGUs and communities the adoption of the CBMH program. However, this should be accompanied with technical assistance to LGUs wanting to initiate their own CBMH program.

a. Harnessing the community as a setting, a resource, a target and agent of change - the community is the setting and target of development intervention with the view of catalyzing processes towards making available mental health services at the frontline. The community has multiple functions and its human resources and physical assets can be mobilized to attain the desired outputs.
b. Building institutional and individual capacity among non-specialists in the community – there is a shortage of mental health personnel all over the country. A measure to address this is to select community workers, usually the BHWs, to function as mental health frontliners for community residents, including both the well and unwell segments of the population.
c. Empower the service users – the patients can be organized and mobilized in order to give them the voice and the agency to express and state their needs to the duty bearers and they can serve as a mutual support group that can facilitate their recovery and healing; this is premised on the notion that mental health is everybody's business and ensures that patients' rights are properly respected.
d. Strengthen the family and support groups in the community – there are groups such as family, peer support groups, church groups, civil society and NGOs that can extend support to the service users and these should be harnessed. The first line of support is the family who provides care in cases of mental ill health. But family carers should also be given support to ensure that they are able to effectively discharge their role and ensure that their own mental health is not compromised.
e. Continuity of care – After a patients' discharge, there is a need to provide post-recovery assistance and transition/reintegration to the community. This includes ensuring that the patient takes in the prescribed medications and enabling the person to become a self-sufficient member of their community. This includes empowering the person in various ways, i.e. economic, social, and psychosocial. Livelihood and employment are essential interventions that can enable a person to live independently and afford the necessary medications.
f. Monitoring and evaluation – within the community, there should be a mechanism for tracking the progress of the service users and providing the necessary mental health support as required. Monitoring includes checking on the emergence of mental conditions in the community, especially in times of disaster and the pandemic. Such a mechanism can be institutionalized within the RHUs or the barangay health center and requires that the community workers are appropriately trained.

5. The DOH must set up a mechanism for tracking progress of the roll out of CBMH programs all over the country. In essence, this implies having a Program Monitoring & Evaluation Scheme that defines DOH's expected outcomes out of the CBMH roll out. This should be aligned with the PCMH Strategic Framework Plan and Operational Indicators. Data from such M&E Scheme should aid in assessing the results and outcomes of the CBMH programs.

The old practice in the bureaucracy is to evaluate after the program roll out. Instead, it is strongly suggested that the Program Evaluation be conceptualized and designed earlier to ensure that outcomes are defined clearly and the right data are collected for the purpose of evaluating the effectiveness of the program.

ANNEXES

Annex 1. Competency Framework For A Beginners' Course For Community Health Workers In Community-Based Mental Health Care

Domains	Key Tasks	Competencies (Knowledge, Skills and Attitudes)	Performance Criteria/Indicators	Means of Verification
A. ENGAGING THE COMMUNITY				
Mental health literacy and attitudes	Teaching basic mental health literacy Reducing stigma against persons with mental illness Psychoeducation Respecting the rights of persons with mental illness Awareness and reporting of human rights abuses Promoting social inclusion Awareness of co-occurring and chronic illnesses affecting mental health Awareness of human rights abuses	**Knowledge**: What is mental health and the need for community mental health, the MH Law **Skills**: Communication **Attitude**: Listening and Empathy	Volunteers Recruited for Mental Health Campaigns launched Clean-up Drives Done SU campaigns launched Organizations recruited for involvement into CBMH Local officials accept their duties and responsibilities in MH promotion and systematically identify community assets and resources for mental health care	No. of Specific people attending in community assembly for psycho education. No. of Community volunteers assisting people with specific mental health concerns. No. of patients seeking help and consultation in the community No. of People are in the Census/ Logbook/Volunte er Contract. Recorded patients are documented, and minutes of Meetings are ready for evidence.
Mental health promotion	Promoting hope, coping behaviors and self-care Training adolescents and adults on life skills Delivering parenting programs Promoting community policies and legislation for risk reduction	**Knowledge**: What is mental health and how people can attain well being, practical ways for coping with stress and anxiety and building resilience Learn to use the TAG as a tool for identifying people with MH conditions **Skills**: communication **Attitude**: Non- judgmental , right to privacy, MH is everybody's business, self-care in mental health, less dependence on MH specialists	Community health workers systematically identify community members with mental health conditions using a tool such as the TAG Community members appreciate the importance of and their role in mental health, especially parents, teachers and local officials i.e. barangay captains, municipal mayor	No. of regular community meetings on mental health for all constituents No. of Community workers and volunteers involved in mental health promotion are increasing. No. of listed patients visited and recorded in the logbook. No. of MOA or Ordinance to promote MH properly documented in the barangay.

Annex 1. Competency Framework For A Beginners' Course For Community Health Workers In Community-Based Mental Health Care *(continued)*

Domains	Key Tasks	Competencies (Knowledge, Skills and Attitudes)	Performance Criteria/Indicators	Means of Verification
			Mental health is included in the agenda of the Barangay Health Committee and the Municipal Health Development Plan	No. of Minutes of meeting on the allocation of budget for psychotropic medicines. No. of partnerships/network to help for the psychotropic medicines
B. CAPACITY-BUILDING FOR NON-SPECIALISTS				
Mental Health Needs Assessment of individuals and communities	Assessment of Community needs in mental health care Assessment of community assets and resources for mental health care Training, mentoring and coaching of volunteers and non-specialists in MH care Community Mobilization and Development for Mental Health Care Monitoring and evaluation of the results of CMH care	**Knowledge**: Signs and Symptoms of Common MH Conditions Role of non- specialists in community MH care Basic counselling Social Mobilization **Skills**: Use of tools i.e., Social Development Checklist for gauging prevalence of mental health conditions in the community; psychological checklist **Attitude**: Openness and empathy, Respect for dignity and rights of people with mental health conditions	Community Leaders are trained in MH Awareness and TAG BHWs trained in MH Awareness, use of TAG, Psychological Checklist , use of Social Checklist and similar tools Community assets are identified by the barangay workers and other leaders Violations of human rights of people with mental health conditions identified and acted upon	No. of Volunteers can conduct psychoeducation on the symptoms and causes of mental health conditions/ illness. Psychological and social checklist is understood, demonstrated and used by the community workers and those in the RHU. Number of people found and recorded with psychosocial disabilities .

Annex 1. Competency Framework For A Beginners' Course For Community Health Workers In Community-Based Mental Health Care *(continued)*

Domains	Key Tasks	Competencies (Knowledge, Skills and Attitudes)	Performance Criteria/Indicators	Means of Verification
C. EMPOWERING THE SERVICE USER				
Increase participation of the service users in their own recovery	Counselling/ House Visit for Service Users Medication Access Mental Health Awareness among Service Users Mental Health Awareness among Family and Carers Financial Assistance for Service Users	**Knowledge**: counselling techniques are used during home visits Information on the Medicine Access Program **Skills**: Handling in identifying if symptoms are considered high risks or not using the TAG approach. Regular psycho education among families is appreciated by the Carers. Community workers can secure financial help through established networks. **Attitude**: Openness and Resiliency, person-centered	leaders are trained to help in counselling the service users Community residents who accessed the service of the health center for medication and treatment . found patients who have recovered and are interested in livelihood. List networks/organization that can help people with psychosocial disabilities	No. of service users willingly send themselves for medication and treatment. No. of people doing counselling after being trained . No. of established networks of the Barangay and for the Medicine Access program. No. of sessions conducted by community workers on psychoeducation to service users and the family carers. No. of cross cutting issues that are recommended for help with other line agencies
D. STRENGTHENING THE STAKEHOLDERS (FAMILIES, PEERS, NGOS AND OTHER SUPPORT GROUPS)				
Networking, Partnerships and collaboration with organizations, families, service users, support groups, & service providers	Engaging families, peer, and support groups in the community Empowering and organizing service users Engaging with social service sectors to ensure continuity of care: education, livelihood, employment, and social welfare	**Knowledge**: What is a community and the role of the community and community workers in mental health care, DOH Health Promotion Strategy, Elements of CMH Care, Community based participatory techniques, community mobilization **Skills**: Communication Skills, People or	Existing NGOs & support groups in the community identified and harnessed for MH care services Community assets are mapped and for patients with mental health issues. Identified networks are invited for mental health awareness sessions. Organizing and establishing networks	No. of Established partners in CBMH No. of patients helped using the TAG and those referred by the community workers. No. of patients received continuity of care from the BHWs and the leaders in the barangay . No. of patients given livelihood or assisted in any alternative livelihood.

Annex 1. Competency Framework For A Beginners' Course For Community Health Workers In Community-Based Mental Health Care *(continued)*

Domains	Key Tasks	Competencies (Knowledge, Skills and Attitudes)	Performance Criteria/Indicators	Means of Verification
		human relations Skills, Networking Skills **Attitude**: Collaborative, able to motivate stakeholders to work together, build teams	of volunteers (individuals and organizations) in providing MH care Networks committed to assist in the CMH programs.	Number of self-help groups formed Systematized the use of social and psychological checklist during intake of during the community sessions No. of recorded patients written in the community logbook including those that are referred for treatment .
Screening and Monitoring using TAG approach	Identification of people with mental health conditions in the community Managing psychiatric emergencies and crisis Facilitating treatment initiation and referrals to ensure entry into care	**Knowledge**: Signs and symptoms of common mental disorders; the TAG approach **Skills**: Documentation and interviewing Attitudes: individualized approach in dealing with service users Acceptance and recovery – oriented	Community Workers are provided awareness training using the TAG approach Service users are more acquainted with the TAG approach.	No. of trained community leaders and Carers can use the TAG approach in doing initial assessment.
Psychoeducation of Community Leaders (i.e., Brgy Captain. and Councilors) and the community residents	Train local leaders and BHWs for mental health awareness and advocacy		Family Members and stakeholders provided with MH training Information and educational materials in the local dialect/ language is distributed among the community members	Key leaders and the residents of the community are aware of the importance of MH

Annex 1. Competency Framework For A Beginners' Course For Community Health Workers In Community-Based Mental Health Care *(continued)*

Domains	Key Tasks	Competencies (Knowledge, Skills and Attitudes)	Performance Criteria/Indicators	Means of Verification
E. CONTINUITY OF CARE				
Assistance to Service Users for Community Reintegration and Continued Care	Training of BHWs to manage and assist people with psychosocial disabilities or service users toward healing and recovery Organize self-help groups among service users and other community stakeholders Sustain the integration of mental health services in the general health care system Built-in support mechanisms from the LGU (includes LGU tracking patients seeking help and treatment and address their concerns) Budget allocation is earmarked on yearly basis Barangay Resources are available for Mental Health Needs (e.g., Barangay Patrol Car for Crisis Response) Coordination within the Barangay Coordination with Rural Health Unit and External resources Cluster Leader System adopted Mental Health Service is Integrated into Barangay Health Service Registry of Service Users Referral system in place	**Knowledge**: self- care and organizing self- help groups; recovery oriented approach **Skills**: Documentation and interviewing Attitudes: individualized approach in dealing with users. Acceptance and elimination/ reduction of stigma Worth and dignity sustained	Service users given assistance for their medication Amount of direct financial aid given to service user and their families No of House visits done by Volunteers No of and types of Barangay Assets available for MH Crisis No of LGU/ Health committee meetings on mental health concerns Linkages with individuals and agencies concerned with MH No of Cluster Leaders Identified and Oriented Coverage of Screening - include documentation of those using TAG, to be used for follow up Percentage of Screened with need for TAG: T:with symptoms but with no problem in functioning) A: with symptoms and with some problems in functioning) G: with symptoms and in crisis) One Registry of Service Users	No. of referrals made and patients returning to their communities are ensured for the continuity of care. Multi-sectoral networks are set up. i.e., church, school, economic institutions, others Inventory of assets are recorded. Minutes of the Meeting/ Agenda of the meeting. Census are properly documented . No. of self-help groups formed among the service users as well as the community residents to sustain the program Presence of Registry

Annex 2. Checklist Of Competencies In Community Mental Health Care

Date: _____

Name: _____

Age: _____

Sex: Male _____ Female _____

Status: Single _____ Married _____

Religion: _____

Barangay: _____

Position/Designation: Barangay Captain _____
Barangay Health Worker _____
Barangay official (indicate position) _____

Gaano katagal ka nasa pwesto mo? _____ (buwan o taon)

ATTITUDE STATEMENTS

	Kayo ba ay SANG-AYON o HINDI SANG-AYON sa mga sumusunod na pahayag? **Lagyan ng tsek (/) sa tapat ng iyong kasagutan ayon sa iyong paniniwala.**	**Hinding-hindi ako sang-ayon**	**Hindi ako sang-ayon**	**Oo sang-ayon ako**	**Yes na yes sang-ayon ako**	**Hindi ko masagot dahil wala akong alam**
1	Walang ganap na kalusugan kung di maayos ang katinuan ng isip.					
2	Ang mga may sakit sa isip ay dapat unawain at tulungan upang gumaling.					
3	Dahil sa lubhang kahirapan at kasalatan sa buhay, maaring maapektuhan ang lusog- isip o katinuan ng pag-iisip.					
4	Sa ilalim ng ating batas, ang may dinaranas na problema sa pag-iisip ay may karapatan na malaman kung anuman ang pamamaraan na gagawin sa kanya para siya ay gumaling.					
5	Di dapat kutyain ang mga taong nakakaranas ng depresyon, labis na kaba, lumbay, o anumang problema sa isip.					
6	Dapat bigyan ng gabay ang lahat ng Pilipino kung paano mapapanatili ang katinuan or kaayusan ng isip maski pawalang tuwirang problema o sintomas ng mental illness.					

	Kayo ba ay SANG-AYON o HINDI SANG-AYON sa mga sumusunod na pahayag? Lagyan ng tsek (/) sa tapat ng iyong kasagutan ayon sa iyong paniniwala.	Hinding-hindi ako sang-ayon	Hindi ako sang-ayon	Oo sang-ayon ako	Yes na yes sang-ayon ako	Hindi ko masagot dahil wala akong alam
7	Para lubusang gumaling ang taong nakaranas ng mental illness o problema sa pag-iisip, kailangang makabalik siya sa kanyang komunidad at makihalubilo sa kanyang mga kaibigan at kapwa tao.					
8	Bawat Pilipino ay may karapatang pang-kalusugan kasama ang lusog-isip o mental health.					

KNOWLEDGE

	Ang mga sumusunod na pahayag ay mga konsepto at kaalaman na makakatulong sa inyong pagtatag ng Community Mental Health Programs sa inyong komunidad. Alin sa mga sumusunod ang ALAM niyo na o HINDI PA ALAM? Lagyan ng tsek (/) sa tapat ng iyong kasagutan ayon sa inyong kaalaman.	Di ko alam	May Kaunti akong alam	Alam ko na	Marami akong alam	Alam na alam ko na
1	Ang batas tungkol sa Community Mental Health Programs					
2	Mga tungkulin ng barangay health workers sa Community Mental Health					
3	Mga tungkulin at responsibilidad ng LGU sa Community Mental Health Programs					
4	Mga elemento o bahagi ng Community Mental Health Program sa komunidad					
5	Anu-ano ang magagawa ng komunidad para mapalaganap ang mental health sa komunidad					
6	Pang kasalukuyang pagtanaw sa mental health (PCMH Resolution 2020-03)					
7	Karapatang pantao na may kinalaman sa mental health					
8	Paggamit ng teknolohiya para magbigay ng mental health services					
TANONG: Nais mo bang madagdagan ang inyong kaalaman sa bawat konsepto? OO o HINDI?						

SKILL

	May mga kasanayan o "skill" sa pagtatatag ng Community Mental Health Programs sa inyong komunidad. Alin sa mga sumusunod ang ALAM na ninyo o HINDI PA ALAM? Lagyan ng tsek (/) sa tapat ng iyong kasagutan ayon sa inyong kaalaman.	Di ko alam	May Kaunti akong alam	Alam ko na	Marami akong alam	Alam na alam ko na
1	Paano magsimula at magtayo ng Community Mental Health programs *How to set up or establish community mental health programs*					
2	Paano magkampanya para isulong ang adbokasiya para sa pagpapalaganap ng mental health programs *How to raise awareness on mental health*					
3	Paano mag-organisa ng mga mamamayan sa komunidad at maipaunawa ang mga karapatan ng mga taong may karamdaman sa pag-iisip *How to promote human rights in mental health*					
4	Paano mag simula at magpatakbo ng psychoeducation programs *How to conduct psychoeducation*					
5	Paano matukoy kung may karamdaman sa lusog-isip ang isang tao. *How to identify people with MNS conditions.*					
6	Paano palakasin ang pamilya at iba pang grupong makakatulong sa mga taong nakakaranas ng problema sa mental health *How to strengthen the family and support groups in the community*					
7	Paano mapalakas ang mga pasyente/ service users *How to organize and mobilize the service users; how to empower service users*					

	May mga kasanayan o "skill" sa pagtatatag ng Community Mental Health Programs sa inyong komunidad. Alin sa mga sumusunod ang ALAM na ninyo o HINDI PA ALAM? **Lagyan ng tsek (/) sa tapat ng iyong kasagutan ayon sa inyong kaalaman.**	**Di ko alam**	**May Kaunti akong alam**	**Alam ko na**	**Marami akong alam**	**Alam na alam ko na**
8	Paano masiguro na patuloy ang pangangalaga ng lusog-isip kapag gumaling na ang karamdaman sa lusog-isip *How to ensure continuity of care*					
9	Paano mag panimula ng referral system at paano ang pag-refer sa mga kaso ng nangangailangan ng espesyalista *How to set up a referral system/ mechanism*					
10	Paano magbigay ng kagyat na lunas kapag may krisis o emergency *How to handle psychiatric emergencies and crisis*					
11	Paano mag subaybay at suriin ang resulta at kaganapan ng mga Community Mental Health Programs *How to monitor and evaluate the results of CMH programs*					
12	Paano matunton at matukoy ang mga "assets" at "resources" ng komunidad na maaaring magamit para sa mental health care (Halimbawa ng "assets" sa komunidad: Mental Health Specialists, paglalaan ng budget sa mental health galing sa LGU, gamot para sa may karamdaman sa pag iisip, impormasyon tungkol sa mental health galing sa Municipal Health Center) *How to assess community assets & resources for mental health care*					
TANONG: Nais mo bang madagdagan ang inyong kaalaman sa bawat kasanayan? OO o HINDI						

Annex 3. Modular Evaluation Forms

Modular Evaluation

Module 1, 17 June 2021

Were the training objectives met?		
1. Layon ng module na ito na maipaliwanag ang mga konsepto at prinsipyo ng community mental health care. Sa iyong palagay, natupad ba ang layuning ito?	Oo	Hindi
Relevance of subject matter		
2. Ang mga paksang tinalakay ay mahalagang malaman ng komunidad para makagawa ng mental health program na akma para sa kanilang barangay.	Oo	Hindi
Training Delivery		
3. Tama lang na sa Pilipino ang talakayan.	Oo	Hindi
4. Naiintindihan naming mga kalahok (participants) ang pagpapaliwanag ng mga tagapag-salita (speaker)sa mga sumusunod na paksa:		
4.1. Ano ang community mental health care	Oo	Hindi
4.2 Ano ang mga karunungan (competencies) Na kailangan sa community mental health care	Oo	Hindi
4.3. Mga tungkulin ng LGU sa community mental health	Oo	Hindi
4.4. Engaging the community	Oo	Hindi
4.5. Bakit kailangan ang community mental health care	Oo	Hindi
5. Ang mga resource persons ay maalam o eksperto sa kanilang mga paksa.	Oo Oo	Hindi Hindi
6. Ang mga katanungan naming mga kalahok ay nasagot nang maliwanag.	Oo	Hindi
Participants		
7. Ang mga kalahok sa training ay matiyagang nakinig.	Oo	Hindi
8. Ang mga kalahok ay interesadong magkaroon ng kaalaman sa mental health.	Oo	Hindi
9. Gusto ko sanang madagdagan pa ang paliwanag sa mga: (Ilista ang mga paksang gusto pa ninyong maliwanagan.) _____		
10. Mga mungkahi para mapahusay pa ang module I: _____		

Modular Evaluation

Module 2, 18 June 2021

Were the training objectives met?		
1. Layon ng module na ito na maipaliwanag ang mga konsepto at pagpapakahulugan ukol sa iba't ibang sakit sa pag-iisip (mental illness) at kalusugang pangkaiisipan. Sa iyong palagay, natupad ba ang layuning ito?	Oo	Hindi
Relevance of subject matter		
2. Ang mga paksang tinalakay ay mahalagang malaman ng komunidad upang mabigyan ng akma at agarang gabay, alalay at tulong ang miyembro ng komunidad o barangay na nakararanas ng mga sintomas ng sakit sa pag-iisip.	Oo	Hindi
Training Delivery		
3. Tama lang na sa Pilipino ang talakayan.	Oo	Hindi
4. Naunawaan naming mga kalahok (participants) ang pagpapaliwanag ng mga tagapag-salita (speaker) ukol sa mga sumusunod na paksa:		
4.1 Konsepto at kahulugan ng sakit sa pag-iisip	Oo	Hindi
4.2 Pagpapakilala sa balangkas ng Tulong-Alalay-Gabay sa konsepto ng kalusugang pangkaisipan	Oo	Hindi
4.3 Mga sintomas ng sakit sa pag-iisip	Oo	Hindi
5. Ang mga "resource persons" ay maalam o eksperto sa kanilang mga paksa.	Oo	Hindi
6. Ang mga katanungan naming mga kalahok ay nasagot ng maliwanag.	Oo	Hindi
Participants		
7. Ang mga kalahok sa training ay matiyagang nakinig.	Oo	Hindi
8. Ang mga kalahok ay interesadong magkarn ng kaalaman sa mental health.	Oo	Hindi
9. Gusto ko sanang madagdagan pa ang paliwanag sa mga: (Ilista ang mga paksang gusto pa ninyong maliwanagan.) _____		
10. Mga mungkahi para mapahusay pa ang module 2: _____		

Modular Evaluation

Module 3, 25 June 2021

PANGALAN _____ BARANGAY _____

Were the training objectives met?		
11. Layon ng module na ito na maipaliwanag ang mga sumusunod. Sa iyong palagay, natupad ba ang layuning ito?		
(1) Konsepto at pagpapakahulugan ukol sa iba't ibang sakit sa pag-iisip (Mental Health Conditions) at kalusugang pangkaisipan	Oo	Hindi
(2) Pagpapaunlad ng "kasanayan" (skill) bilang Community Mental Health Worker	Oo	Hindi
(3) Pagpapalalim sa pag-unawa sa kahulugan ng komunidad	Oo	Hindi
(4) Gabay sa pag-unawa at pagpapa-unlad ng ating pagkatao	Oo	Hindi
Relevance of subject matter		
12. Ang mga paksang tinalakay ay mahalagangmalaman ng komunidad upang mabigyan ng akma at agarang gabay, alalay at tulong ang miyembro ng komunidad o barangay na nakararanas ng mga sintomas ng sakit sa pag-iisip.	Oo	Hindi
Training Delivery		
13. Hindi dapat sa Wikang Pilipino ang talakayan.	Oo	Hindi
14. Naunawaan naming mga kalahok (participants) ang pagpapaliwanag ng mga tagapag-salita (speaker) ukol sa mga sumusunod na paksa:		
14.1 Mga sintomas ng sakit sa pag-iisip	Oo	Hindi
14.2 Kasanayan (skill) ukol sa konsepto ng Tulong-Alalay-Gabay sa pagtugon sa miyembro ng komunidad na nakararanas ng mga sintomas ng sakit sa pag-iisip	Oo	Hindi
14.3 Kahulugan ng komunidad at ang dapat gawin ng bawat miyembro ng komunidad	Oo	Hindi
14.4 Pagpapaunlad ng "kasanayan" (skill) bilang Community Mental Health Worker	Oo	Hindi
14.5 Gabay sa pagpapa-unlad ng ating pagkatao	Oo	Hindi
15. Kulang sa kaalaman ang mga speakers sa pagtalakay sa kanilang mga paksa.	Oo	Hindi
16. Ang mga katanungan naming mga kalahok ay hindi nasagot ng maliwanag.	Oo	Hindi
Participants		
17. Ang mga kalahok sa training ay matiyagang nakinig.	Oo	Hindi
18. Hindi interesadong matuto at magkaroon ng kaalaman sa bawat paksang tinalakay.	Oo	Hindi
19. Nais ko sana na madagdagan pa ang paliwanag sa mga paksa (Mahalaga na tukuyin at ilista ang mga paksang gusto pa ninyong maliwanagan.) _____		
20. Mga mungkahi para mapahusay pa ang pagtalakay sa mga paksang nakapaloob sa Module 3: _____		

Modular Evaluation

Module 4, 26 June 2021

PANGALAN _____ BARANGAY _____

Were the training objectives met?		
21. Sa iyong palagay, natupad ba ang layunin ng module na ito na maipaliwanag ang mga sumusunod na paksa?		
(5) Pamamaraan ng pagpapa-unlad ng komunidad sa pamamagitan ng pag-oorganisa, edukasyon at pagtukoy sa yaman ng komunidad	Oo	Hindi
(6) Pagpapalakas ng suporta na magmumula sa pamilya at mga samahan na kinabibilangan ng miyembro ng komunidad	Oo	Hindi
(7) Pamamaraan sa tuloy-tuloy na pangangalaga sa mga taong nakararanas o nakaranas ng sakit sa pag-iisip	Oo	Hindi
(8) Pamamaraan ng pakikipag-ugnayan sa RHU o Mental Health Expert/ Specialist	Oo	Hindi
Relevance of subject matter		
22. Meron pang higit na mahalagang usapin sa kalagayan ng bawat barangay bukod sa mga paksa ng module na ito	Oo	Hindi
Training Delivery		
23. Hindi dapat sa Wikang Pilipino ang talakayan.	Oo	Hindi
24. Naunawaan naming mga kalahok (participants) ang pagpapaliwanag ng mga tagapag-salita (speaker) ukol sa mga sumusunod na paksa:		
24.1 Pag-oorganisa sa komunidad	Oo	Hindi
24.2 Pagpapa-igting ng kaalaman ng bawat miyembro ng komunidad sa pagpapa-unlad ng pamayanan	Oo	Hindi
24.3 Pagtukoy sa yaman ng komunidad	Oo	Hindi
24.4 Pagpapalakas ng suporta na magmumula sa pamilya at mga samahan na kinabibilangan ng mga miyembro ng komunidad	Oo	Hindi
24.5 Gabay sa tuloy-tuloy na pangangalaga sa mga taong nakararanas o nakaranas ng sakit sap ag-iisip	Oo	Hindi
25. Kulang sa kaalaman ang mga speakers sa pagtalakay sa kanilang mga paksa.	Oo	Hindi
26. Ang mga katanungan naming mga kalahok ay hindi nasagot ng maliwanag.	Oo	Hindi
Participants		
27. Hindi sumasang-ayon sa pananaw o opinion ng mga Speakers.	Oo	Hindi
28. Hindi interesadong matuto at magkaroon ng kaalaman sa bawat paksang tinalakay.	Oo	Hindi
29. Nais ko sana na madagdagan pa ang paliwanag sa mga paksa (Mahalaga na tukuyin at ilista ang mga paksang gusto pa ninyong maliwanagan.) _____		
30. Mga mungkahi para mapahusay pa ang pagtalakay sa mga paksang nakapaloob sa Module 4: _____		

Annex 4. Summary Table of Pre- and Post-Test Results

SUMMARY TABLE OF PRE-TEST RESULTS

ATTITUDE: OO sang-ayon ako						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	Walang ganap na kalusugan kung di maayos ang katinuan ng isip.	3/6 = 50%	4/10 = 40%	2/6 = 33.33%	4/6 = 66.67%	11/18 = 61.11%
2	Ang mga may sakit sa isip ay dapat unawain at tulungan upang gumaling.	2/6 = 33.33%	4/10 = 40%	1/6 = 16.66%	3/6 = 50%	12/19 = 63.16%
3	Dahil sa lubhang kahirapan at kasalatan sa buhay, maaring maapektuhan ang lusog-isip o katinuan ng pag-iisip.	4/6 = 66.67%	10/10 = 100%	5/6 = 83.33%	6/6 = 100%	11/19 = 58%
4	Sa ilalim ng ating batas, ang may dinaranas na problema sa pag- iisip ay may karapatan na malaman kung anuman ang pamamaraaan na gagawin sa kanya para siya ay gumaling.	4/4 = 100%	8/10 = 80%	5/6 = 83.33%	4/6 = 66.67%	12/19 = 63%
5	Di dapat kutyain ang mga taong nakakaranas ng depresyon, labis na kaba, lumbay, o anumang problema sa isip.	2/6 = 33.33%	5/7 = 71.43%	2/6 = 33.33%	4/6 = 66.67%	11/19 = 57.9%
6	Dapat bigyan ng gabay ang lahat ng Pilipino kung paano mapapanatili ang katinuan or kaayusan ng isip maski pawalang tuwirang problema o sintomas ng mental illness.	4/6 = 66.67%	8/10 = 80%	6/6 = 100%	4/6 = 66.67%	15/19 = 78.95%
7	Para lubusang gumaling ang taong nakaranas ng mental illness o problema sa pag-iisip, kailangang makabalik siya sa kanyang komunidad at makihalubilo sa kanyang mga kaibigan at kapwa tao.	4/6 = 66.67%	9/10 = 90%	4/6 = 66.67%	6/6 = 100%	12/19 = 63%
8	Bawat Pilipino ay may karapatang pang-kalusugan kasama ang lusog-isip o mental health.	1/6 = 16.66%	9/10 = 90%	6/6 = 100%	4/6 = 66.67%	8/19 = 42.11%

SUMMARY TABLE OF PRE-TEST RESULTS

KNOWLEDGE: Di ko alam + May kaunting alam						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	CMH Law	2/6 = 33.33%	4/10 = 40%	6/6 = 100%	1+4 = 5/6 83.33%	18/18 = 100%
2	BHW Duties	1/6 = 16.66%	4/10 = 40%	5/6 = 83%	1+4 = 5/6 83.33%	16/19 = 84.2%
3	LGU Duties	–	4/10 = 40%	5/6 = 83%	0+5 = 5/6 83.33%	16/18 = 88.88%
4	CMH components	1/6 = 16.66%	4/10 = 40%	6/6 = 100%	2+3 = 5/6 83.33%	15/18 = 83.33%
5	What can the community do to promote MH	2/6 = 33.33%	4/10 = 40%	4/6 = 66.66%	1+2 = 3/6 50%	16/19 = 84.2%
6	PCMH Resolution 2020-03	3/6 = 50%	–	6/6 = 100%	3+2 = 5/6 83.33%	17/19 = 89.47%
7	Human rights in MH	1/6 = 16.66%	–	5/6 = 83%	0+5 = 5/6 83.33%	16/19 = 84.2%
8	Use of technology in MH	3/6 = 50%	2/10 = 20%	5/6 = 83%	3+2 = 5/6 83.33%	14/18 = 77.77%

SUMMARY TABLE OF PRE-TEST RESULTS

SKILLS: Di ko alam + May kaunti akong alam						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	How to set up or establish community mental health programs	1/6 = 16.66%	6/10 = 60%	5/6 = 83.33%	3+3 = 6/6 100%	18/18 = 100%
2	How to raise awareness on mental health	2/6 =33.33%	5/10 = 50%	2/6 = 33.33%	3+3 = 6/6 100%	17/18 = 94.44%
3	How to promote human rights in mental health	2/6 =33.33 %	5/10 = 50%	6/6 = 100%	0+6 = 6/6 100%	17/18 = 94.44%
4	How to conduct psychoeducation	2/6 =33.33 %	5/10 = 50%	6/6 = 100%	3+3 = 6/6 100%	18/18 = 100%
5	How to identify people with MNS conditions	2/6 =33.33 %	3/10 = 30%	6/6 = 100%	1+5 = 6/6 100%	19/19 = 100%
6	How to strengthen the family and support groups in the community	2/6 =33.33 %	3/10 = 30%	6/6 = 100%	2+4 = 6/6 100%	17/19 =89.47%
7	How to organize and mobilize the service users; how to empower service users	1/6 = 16.66%	4/10 = 40%	6/6 = 100%	2+4 = 6/6 100%	17/19 =89.47%
8	How to ensure continuity of care	2/6 =33.33%	5/10 = 50%	6/6 = 100%	2+4 = 6/6 100%	17/19 =89.47%
9	How to set up a referral system/ mechanism	3/6 = 50%	4/10 = 40%	6/6 = 100%	1+4 = 5/6 83.33%	17/19 =89.47%
10	How to handle psychiatric emergencies and crisis	3/6 = 50%	3/10 = 30%	6/6 = 100%	1+5 = 6/6 100%	17/19 =89.47%
11	How to monitor and evaluate the results of CMH programs	3/6 = 50%	5/10 = 50%	6/6 = 100%	2+4 = 6/6 100%	17/19 =89.47%
12	How to assess community assets & resources for mental health care	3/6 = 50%	4/10 = 40%	6/6 = 100%	2+4 = 6/6 100%	19/19 = 100%

Summary of Post-Test Results

SUMMARY TABLE OF POST-TEST RESULTS

ATTITUDE: OO sang-ayon ako +Yes na yes sang-ayon ako						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	Walang ganap na kalusugan kung di maayos ang katinuan ng isip.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
2	Ang mga may sakit sa isip ay dapat unawain at tulungan upang gumaling.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
3	Dahil sa lubhang kahirapan at kasalatan sa buhay, maaring maapektuhan ang lusog-isip o katinuanng pag-iisip.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
4	Sa ilalim ng ating batas, ang may dinaranas na problema sa pag-iisip aymay karapatan na malaman kung anuman ang pamamaraaan na gagawin sa kanya para siya ay gumaling.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
5	Di dapat kutyain ang mga taong nakakaranas ng depresyon, labis na kaba, lumbay, o anumang problema sa isip.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
6	Dapat bigyan ng gabay ang lahat ng Pilipino kung paano mapapanatili angkatinuan or kaayusan ng isip maski pawalang tuwirang problema o sintomas ng mental illness.	6/6 = 100%	10/10 = 100%	5/6 = 83%	6/6 = 100%	19/19 = 100%
7	Para lubusang gumaling ang taong nakaranas ng mental illness o problema sa pag-iisip, kailangang makabalik siya sa kanyang komunidad at makihalubilo sa kanyang mga kaibigan at kapwa tao.	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
8	Bawat Pilipino ay may karapatang pang-kalusugan kasama ang lusog-isipo mental health.	6/6 = 100%	10/10 = 100%	4/6 = 67%	6/6 = 100%	19/19 = 100%

SUMMARY TABLE OF POST-TEST RESULTS

KNOWLEDGE: May kaunting akong alam + Alam ko na						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	CMH Law	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
2	BHW Duties	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
3	LGU Duties	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
4	CMH components	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
5	What can the community do to promote MH	6/6 = 100%	9/9 = 100%	5/6 = 83%	6/6 = 100%	19/19 = 100%
6	PCMH Resolution 2020-03	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
7	Human rights in MH	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
8	Use of technology in MH	6/6 = 100%	9/9 = 100%	4/6 = 67%	6/6 = 100%	19/19 = 100%

SUMMARY TABLE OF POST-TEST RESULTS

SKILLS - May kaunti akong alam + Alam ko na						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
1	How to set up or establish community mental health programs	6/6 = 100%	9/9 = 100%	5/6 = 83%	5/6 = 83%	19/19 = 100%
2	How to raise awareness on mental health	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
3	How to promote human rights in mental health	6/6 = 100%	9/9 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
4	How to conduct psychoeducation	6/6 = 100%	9/9 = 100%	4/6 = 67%	5/6 = 83%	19/19 = 100%
5	How to identify people with MNS conditions	6/6 = 100%	9/9 = 100%	6/6 = 100%	5/6 = 83%	19/19 = 100%
6	How to strengthen the family and support groups in the community	6/6 = 100%	9/9 = 100%	6/6 = 100%	5/6 = 83%	19/19 = 100%

SKILLS - May kaunti akong alam + Alam ko na						
		LUCKY	MAGUIHAN	MALIGAYA	RIZAL	WAWA IBABA
7	How to organize and mobilize the service users; how to empower service users	6/6 = 100%	9/9 = 100%	6/6 = 100%	5/6 = 83%	19/19 = 100%
8	How to ensure continuity of care	6/6 = 100%	10/10 = 100%	6/6 = 100%	6/6 = 100%	19/19 = 100%
9	How to set up a referral system/ mechanism	6/6 = 100%	10/10 = 100%	5/6 = 83%	5/6 = 83%	19/19 = 100%
10	How to handle psychiatric emergencies and crisis	6/6 = 100%	10/10 = 100%	5/6 = 83%	5/6 = 83%	19/19 = 100%
11	How to monitor and evaluate the results of CMH programs	6/6 = 100%	10/10 = 100%	5/6 = 83%	4/6 = 67%	19/19 = 100%
12	How to assess community assets & resources for mental health care	6/6 = 100%	10/10 = 100%	5/6 = 83%	5/6 = 83%	19/19 = 100%

Annex 5. Percentage Comparison of Pre-test and Post-test Results

Attitudes

PERCENTAGE COMPARISON OF PRE-TEST AND POST-TEST RESULTS

	ATTITUDE	LUCKY			MAGUIHAN			MALIGAYA			RIZAL			WAWA IBABA		
		PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE
1	Walang ganap na kalusugan kung di maayos ang katinuan ng isip	50%	100%	50%	40%	100%	60%	33%	100%	67%	67%	100%	33%	61%	100%	39%
2	Ang mga may sakit sa isip ay dapat unawain at tulungan upang gumaling.	33%	100%	67%	40%	100%	60%	17%	100%	83%	50%	100%	50%	63%	100%	37%
3	DAhil sa lubhang kahirapan at kasalatan sa buhay, maaring maaperktuhan ang lusog-isip o katinuan ng pag-iisip.	67%	100%	33%	100%	100%	0%	83%	100%	17%	100%	100%	0%	58%	100%	42%
4	Sa ilalim ng ating batas, ang may dinaranas na problema sa pag-iisip ay may karapatan na malaman kung anuman ang pamamaraan na gagawin sa kanya para siya ay gumaling.	100%	100%	0%	80%	100%	20%	83%	100%	17%	67%	100%	33%	63%	100%	37%
5	Di dapat kutyain ang mga taong nakakaranas ng depresyon, labis na kaba, lumbay, o anumang problema sa isip.	33%	100%	67%	71%	100%	29%	33%	100%	67%	67%	100%	33%	58%	100%	42%
6	Dapat bigyan ng gabay ang lahat ng Pilipino kung paano mapapanatili ang katinuan or kaayusan ng isip maski pawalang tuwirang problema o sintomas ng mental illness.	67%	100%	33%	80%	100%	20%	100%	83%	-17%	67%	100%	33%	79%	100%	21%
7	Para lubusang gumaling ang taong nakaranas ng mental illness o problema sa pag-iisip, kailangang makabalik siya sa kanyang komunidad at makihalubilo sa kanyang mga kaibigan at kapwa tao.	67%	100%	33%	90%	100%	10%	67%	100%	33%	100%	100%	0%	63%	100%	37%
8	Bawat Pilipino ay may karapatang pang-kalusugan kasama ang lusog-isip o mental health.	17%	100%	83%	90%	100%	10%	100%	100%	-33%	67%	100%	33%	42%	100%	58%

Knowledge

PERCENTAGE COMPARISON OF PRE-TEST AND POST-TEST RESULTS

	KNOWLEDGE	LUCKY			MAGUIHAN			MALIGAYA			RIZAL			WAWA IBABA		
		PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE
1	CMH Law	33%	100%	67%	40%	100%	60%	100%	100%	0%	83%	100%	17%	100%	100%	0%
2	BHW Duties	17%	100%	83%	40%	100%	60%	83%	100%	17%	83%	100%	17%	84%	100%	16%
3	LGU Duties	–	100%	100%	40%	100%	60%	83%	100%	17%	83%	100%	17%	89%	100%	11%
4	CMH components	17%	100%	83%	40%	100%	60%	100%	100%	0%	83%	100%	17%	83%	100%	17%
5	What can the community do to promote MH	33%	100%	67%	40%	100%	60%	67%	83%	16%	50%	100%	50%	84%	100%	16%
6	PCMH Resolution 2020–03	50%	100%	50%	–	100%	100%	100%	100%	0%	83%	100%	17%	89%	100%	11%
7	Human rights in MH	17%	100%	83%	–	100%	100%	83%	100%	17%	83%	100%	17%	84%	100%	16%
8	Use of technology in MH	50%	100%	50%	20%	100%	80%	83%	67%	-16%	83%	100%	17%	78%	100%	22%

Skills

PERCENTAGE COMPARISON OF PRE-TEST AND POST-TEST RESULTS

	SKILLS	LUCKY			MAGUIHAN			MALIGAYA			RIZAL			WAWA IBABA		
		PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE	PRE-TEST	POST-TEST	CHANGE IN SCORE
1	How to set up or establish community mental health programs	17%	100%	83%	60%	100%	40%	83%	100%	0%	100%	83%	-17%	100%	100%	0%
2	How to raise awareness on mental health	33%	100%	67%	50%	100%	50%	33%	100%	67%	100%	100%	0%	94%	100%	6%
3	How to promote human rights in mental health	33%	100%	67%	50%	100%	50%	100%	100%	0%	100%	100%	0%	94%	100%	6%
4	How to conduct psychoeducation	33%	100%	67%	50%	100%	50%	100%	100%	-33%	100%	83%	-17%	100%	100%	0%
5	How to identify people with MNS conditions	33%	100%	67%	30%	100%	70%	100%	100%	0%	100%	83%	-17%	100%	100%	0%
6	How to strengthen the family and support groups in the community	33%	100%	67%	30%	100%	70%	100%	100%	0%	100%	83%	-17%	89%	100%	11%
7	How to organize and mobilize the service users; how to empower service users	17%	100%	83%	40%	100%	60%	100%	100%	0%	100%	83%	-17%	89%	100%	11%
8	How to ensure continuity of care	33%	100%	67%	50%	100%	50%	100%	100%	0%	100%	100%	0%	89%	100%	11%
9	How to set up a referral system/ mechanism	50%	100%	50%	40%	100%	60%	100%	83%	-17%	83%	83%	0%	89%	100%	11%
10	How to handle psychiatric emergencies and crisis	50%	100%	50%	30%	100%	70%	100%	83%	-17%	100%	83%	-17%	89%	100%	11%
11	How to monitor and evaluate the results of CMH programs	50%	100%	50%	50%	100%	50%	100%	83%	-17%	100%	67%	-17%	89%	100%	11%
12	How to assess community assets & resources for mental health care	50%	100%	50%	40%	100%	60%	100%	83%	-17%	100%	83%	-17%	100%	100%	0%

Annex 6. CBMH Evaluation Tool

COMMUNITY-BASED MENTAL HEALTH EVALUATION TOOL (CBMHET)

NAME OF COMMUNITY: _____ DATE: _____

INSTRUCTIONS FOR USE OF THE TOOL: _____

The CBMHET is a simplified tool to evaluate a community-based mental program based on the proposed framework for CBMH. The framework proposes six main components, which form the six items below. The purpose of the tool is to evaluate if the program has the minimum standards for a CBMH and guide communities in developing their own CBMH.

1. Is the community engaged, aware, or committed to mental health?

2	1	0
Full	Partial	None
Evidence of Mental Health in Programs, Policies, Budgets AND Active Engagement of the Community[20]	Some Activities are launched with Mental Health as Goal or Focus	No Evidence

2. Are the non-specialist community workers (e.g., Barangay Health Worker, Barangay Nutrition Scholar, Barangay Officials, and Volunteers) capacitated with Mental Health Competencies?

2	1	0
Full	Partial	None
Regular and Updated Capacitation of Non-specialist Community Worker AND can apply competencies in CBMH activities[21]	Some Evidence of Capacitation of Non-specialist Community Worker	No Evidence

3. Are Service Users in the community empowered?

2	1	0
Full	Partial	None
Service Users are empowered thru access to information and psychoeducation, prevention and monitoring, and livelihood support services[22]	Some Activities specifically addressed to service users	No Evidence

20 Evidence of Community Awareness, Engagement or Commitment are, but not limited to, the following: Recruitment of Mental Health Volunteers, Mental Health Awareness (including Mental Health Literacy, Service User Rights and Abuses, Advocacy, among others), Mental Health Information and Awareness Campaign OR Mental Health Programs, Clean-up and Beautification Drive, Substance Use Prevention Campaign, Organizations outside Government Agencies are also involved in the CBMH, Allocation of budget for Mental Health Services or Programs or Activities, Emphasis of Mental Health in Health Policy

21 Evidence of Capacitation of Non-specialist Community Health Worker are, but not limited to, the following: Screening and Monitoring using TAG Framework, Psychoeducation of Community Leaders, BHW Mental Health Training on Community Care of the Mentally Ill

22 Evidence of Service User Empowerment are , but not limited to, the following: Counselling/ House Visit for Service Users, Medication Access, Mental Health Awareness among Service Users, Financial Assistance for Service Users

4. Are Families, Carers, and other Stakeholders (FCS) being strengthened and /or supported?

2	1	0
Full	Partial	None
FCS are empowered thru access to information and psychoeducation, mental health support, and livelihood support services[23]	Some Evidence of Activities specifically addressed to FCS	No Evidence

5. Is there Continuity of Care?

2	1	0
Full	Partial	None
Service Users have access to preventive, promotive, curative, and rehabilitative services thru the community and its primary health framework[24]	Some Evidence of mental health services and integration into primary health care	No Evidence

6. Is there a monitoring and evaluation plan?

2	1	0
Full	Partial	None
Documentary and other forms of evidence are available and accessible AND regularly monitored and evaluated[25]	Some evidence is available that are ad hoc, informal, and/or inaccessible	No Evidence

EVALUATOR: _____

DESIGNATION: _____

INTERPRETATION:

Sum up the scores and compute the average in the five pillars.

The score is 2 – The CBMH program is of a good standard with a high probability of effectiveness, sustainability, and/or utility to the community

The score is <2 and no score lower than 1- The CBMH program has met the minimum standard for a CBMH program, but some areas need to upgrades to improve the effectiveness, sustainability, and/or utility to the community

The score is <1 OR there is a score lower than 1- The CBMH program is not functioning due to deficiencies in one of the pillars of the CBMH framework, which make it at risk for ineffectiveness, being unsustainable, and/or of poor utility to the community

23 Evidence of Strengthening the FCS are, but not limited to, the following: Counselling/ House Visit for Family Financial Assistance for Families, Support through Livelihood Training Programs

24 Evidence of Capacitation of Continuity of Care are, but not limited to, the following: Barangay Resources are available for Mental Health Needs (e.g. Barangay Patrol Car for Crisis Response), Coordination within the Barangay Coordination with Rural Health Unit and External resources, Cluster Leader System, Mental Health Service is Integrated into Barangay Health Service, Registry of Service Users

25 Evidence of Capacitation of Monitoring and Evaluation are, but not limited to, the following: Logbooks, Registries, Minutes of the Meeting, Videos, Photographs, Recordings, Clippings

Annex 7. WHO Modified Self-report Questionnaire

The WHO Self-report Questionnaire was used to aid in selecting the barangays for the pilot testing. A copy of the SRQ is shown below.

"The SRQ was originally designed as a self-administered scale, but was also found to be suitable as an interviewer administered questionnaire. Because of the low literacy rate in some developing countries, respondents may have to have their questionnaires read to them. In order to keep the results comparable within any one study, it is imperative to use the SRQ either as a self-administered questionnaire for all respondents or as an interviewer administered questionnaire for all, and not to mix the two in a single study. When questions are read out to respondents, it presents the researcher with the problem of the influence of subjective elements stemming from the different backgrounds of the research workers. This can interfere with the way items are read, the way they are answered by the patients and on how the answers are finally scored...

Scoring

Each of the 20 items is scored 0 or 1. A score of 1 indicates that the symptom was present during the past month, a score of 0 indicates that the symptom was absent. The maximum score is therefore 20.

SRQ as a screening instrument

In order to standardize the way in which the questionnaire is answered, it is essential that respondents receive the same instructions. Therefore, the following instructions should be added to the SRQ:

> *"Please read the entire introduction before you fill in the questionnaire. It is very important that everyone taking the questionnaire follows the same instructions.*
>
> *The following questions are related to certain pains and problems, that may have bothered you the last 30 days. If you think the question applies to you and you had the described problem in the last 30 days, answer YES.*
>
> *On the other hand, if the question does not apply to you and you did not have the problem in the last 30 days, answer NO.*

> *Please do not discuss the questions with anyone while answering the questionnaire.*
>
> *If you are unsure about how to answer a question, please give the best answer you can.*
>
> *We would like to reassure that the answers you are going to provide here are confidential.*

SRQ as a training instrument

Screening of patients in general health clinics in the participating countries within the collaborative study showed that a significant proportion of mental symptoms were reported by patients but were not being picked-up by the health workers (Climent et al., 1980; Harding et al., 1980; Ladrido-Ignacio et al., 1983).

The involvement of primary health workers in mental health care has made clear the need for simple and reliable instruments for their training, so that they can improve their diagnostic skills. In that respect, the SRQ is useful as a training device for several reasons.

For more details on the SRQ, refer to: A USER'S GUIDE TO THE SELF REPORTING QUESTIONNAIRE (SRQ) WHO/MNH/PSF/94.8.

SRQ-20

A copy of the English version of the **Self** Reporting Questionnaire-20 is shown below.

1.	**Do you often have headaches?**	**yes/no**
2.	Is your appetite poor?	**yes/no**
3.	Do you sleep badly?	**yes/no**
4,	Are you easily frightened?	**yes/no**
5.	Do your hands shake?	**yes/no**
6.	Do you feel nervous, tense or worried?	**yes/no**
7.	Is your digestion poor?	**yes/no**
8.	Do you hove trouble thinking clearly?	**yes/no**
9.	Do you feel unhappy?	**yes/no**
10.	Do you cry more than usual?	**yes/no**
11,	Do you find it difficult to enjoy your daily activities?	**yes/no**
12.	Do you find It difficult to make decisions?	**yes/no**
13.	Is your doily work suffering?	**yes/no**
14.	Are you unable to ploy o useful port In life?	**yes/no**
15.	Hove you lost Interest In things?	**yes/no**
16.	Do you feel that you ore a worthless person?	**yes/no**
17.	Hos the thought of ending your life been on your mind?	**yes/no**
18.	Do you feel tired all the time?	**yes/no**
19.	Do you hove uncomfortable feelings in your stomach?	**yes/no**
20.	Are you easily tired?	**yes/no**

A USER'S GUIDE TO THE SELF REPORTING QUESTIONNAIRE (SRQJ)
WHO/MNH/PSF/94.8

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