

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN THE PHILIPPINES**



**DEPARTMENT OF HEALTH**

# **WHO–AIMS REPORT ON MENTAL HEALTH SYSTEM IN THE PHILIPPINES**

*A report of the assessment of the mental health system in the Philippines  
using the World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS)*

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**Department of Health**

*WHO, Philippines Office  
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WHO Department of Mental Health and Substance Abuse (MSD)*

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The project in The Philippines was implemented by WHO-AIMS country team headed by Wilfredo R Reyes, MPH, with the following members: Ditas Purisima T. Raymundo, RND, MPA; Remedios S. Guerrero, RSW; Nelson R. Mendoza; and Ma. Cristina L. Raymundo, RN, MAN. The team was composed of staff of the National Mental Health Program of the Department of Health – Philippines.

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website: [http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena

## Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Philippines. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable the Philippines to develop information-based mental health plans with clear baseline information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

The Philippines have a National Mental Health Policy (Administrative Order # 8 s.2001) signed by then Secretary of Health Manuel M. Dayrit. There is no mental health legislation and the laws that govern the provision of mental health services are contained in various parts of promulgated laws such as Penal Code, Magna Carta for Disabled Person, Family Code, and the Dangerous Drug Act, etc. The country spends about 5% of the total health budget on mental health and substantial portions of it are spent on the operation and maintenance of mental hospitals. The new social insurance scheme covers mental disorders but is limited to acute inpatient care. Psychotropic medications are available in the mental health facilities. A Commission on Human Right of the Philippines exists, however, human rights were reviewed only in some facilities and only a small percentage of mental health workers received training related to human rights. These measures need to be extended to all facilities.

The National Program Management Committee of the Department of Health (DOH) acts as the mental health authority. Forty-six outpatient facilities treat 124.3 users per 100,000 populations. The rate of users per 100,000 general population for day treatment facilities and community based psychiatric inpatient units are 4.42 and 9.98, respectively. There are fifteen community residential (*custodial home-care*) facilities that treat 1.09 users per 100,000 general population. Mental hospitals treat 8.97 patients per 100,000 general population and the occupancy rate is 92%. The majority of patients admitted have a diagnosis of schizophrenia. There has been no increase in the number of mental hospital beds in the last five years. All forensic beds (400) are at the National Center for Mental Health. Involuntary admissions and the use of restraints or seclusion are common.

There was an effort by the National Mental Health Program in the mid 1990's to integrate mental health services in community settings through trainings of municipal health doctors and nurses on the identification and management of specific psychiatric morbidities and psychosocial problems. However, at present it appears that the majority of the trained community-based health workers are no longer in their place of duty, and the current primary health care staff seem to have inadequate training in mental health and interaction with mental health facilities is uncommon.

There are 3.47 human resources working in mental health for 100,000 general population. Rates are particularly low for social workers and occupational therapists. More than fifty percent of psychiatrists work in for-profit mental health facilities and private practice. The distribution of human resources for mental health seems to favor that of mental health facilities in the main city. There is a consumer association involved in planning and implementing policies and plans. Family associations are present in the country but are not involved in implementing policies and plans, and few interact with mental health facilities. Public education and advocacy campaigns are overseen by the DOH and coordinated in the regional offices. Private sector organizations do their share in increasing awareness on the importance of mental health, but they utilize different structures. There

are mental health links with other relevant sectors, but there is no legislative or financial support for people with mental disorders.

Non-standardized data are collected and compiled by facilities to a variable extent. Mental health facilities transmitted data to the government health department. There have been several studies done on mental health but not all were published in indexed journals. Some studies on non-epidemiological clinical /questionnaires assessments of mental disorders and services have been conducted.

In the Philippines, the mental health system has different types of mental health facilities, and some need to be strengthened and developed. At present, mental hospitals are working within their capacity (in terms of number of beds/patient), even though there has been no increase in number of beds in the last 5 years. Some facilities are devoted to children and adolescents. Access to mental health facilities is uneven across the country, favoring those living in or near the National Capital Region. There are informal links between the mental health sector and other sectors, and many of the critical links are weak and need to be developed (i.e., links with the welfare, housing, judicial, work provision, education sectors). The mental health information system does not cover all relevant information in all facilities.

In the last few years, the numbers of outpatient facilities have slightly grown throughout the country from 38 to 46. Moreover, efforts have been made to improve the quality of life and treatment of patients in mental hospitals. Some aspects of life in hospitals have improved, but the number of patients has grown steadily. Unfortunately, the low priority on mental health is a significant barrier to progress in the treatment of patients in the community.

In order to put the information contained above into context, comparisons with regional norms are made. The Philippines, like most countries of the Western Pacific region, have a national mental health policy. However, in comparison to other countries, it was put into operation relatively recently. Community care for patients is present, but as seen in many low and lower middle income countries, it is limited. Unlike the majority of countries in the world and the region, the Philippines have no mental health law. The poor involvement of primary health care services in mental health is also a feature shared with many low and lower middle resource countries. The number of psychiatrists per 100,000 general population is similar to the majority of countries in the Western Pacific region and about average for lower middle resource countries in the world (Mental Health Atlas WHO, 2005).

# WHO-AIMS COUNTRY REPORT - PHILIPPINES

## Introduction

The Philippines is an archipelago and is geographically located between latitude 4°23'N and 21°25'N and longitude (approximately) 112°E and 127°E. It is composed of 7,107 islands with a land area of 299,764 square kilometers. Its length measures 1,850 kilometers, starting from the point near the southern tip of Taiwan and ending close to northern Borneo. Its breadth is about 965 kilometers. The Philippine coastline adds up to 17,500 km. Three prominent bodies of water surround the archipelago: the Pacific Ocean on the east, the South China Sea on the west and north, and the Celebes Sea on the south.<sup>1</sup>

The two main languages used in the country are Filipino, the national language, and English. Both languages are widely used and are the medium of instruction in secondary and tertiary education. Historically, the Filipinos have embraced two of the great religions of the world, Islam and Christianity (of which 5/6 are Roman Catholic).

The country has over a hundred ethnic groups and a mixture of foreign influences that have molded a unique Filipino culture. It has a population of 84,241,341 (2005 estimate)<sup>2</sup>. The proportion of population based on age structure is as follows: 0-14 years, 37.1%; 15-64 years, 60.6%; and 65 years and over, 4%. The literacy rate is 92.5% for men and 92.7% for women.

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 169 international \$, and the per capita government expenditure on health is 77 international \$ (WHO 2004). The life expectancy at birth is 65.1 years for males and 71.7 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 62 years for females (WHO, 2004).

There are 7.76 hospital beds and .41 psychiatrists per 100,000 general population in the public sector. In terms of primary health care, there are 1,087 doctors and 35,691 non-physicians /non-nurses working in primary health care clinics in the last year. There is a ratio of 3.21 psychiatrists per 100,000 general population working in mental health facilities that are based in the largest city which congregate 11.79% of the country's population (2005 estimate).

Data were collected in 2006-2007 and is based on the year 2005.

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<sup>1</sup> "General Information about the Philippines" from The Official Website of the Republic of the Philippines

<sup>2</sup> Projected Population (Based on 1995 Census) : The Philippine Countryside in Figures, 2004 Edition ; Population Statistics – Commission on Population

## Domain 1: Policy and Legislative Framework

### Policy, plans, and legislation

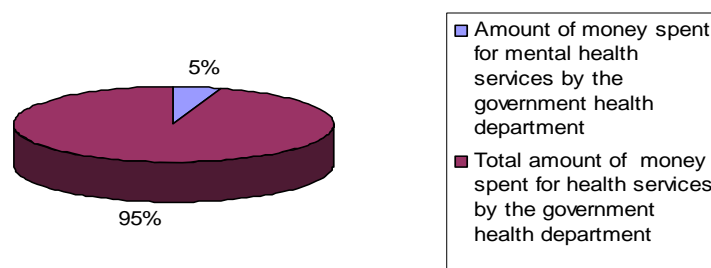
The Philippine Mental Health Policy was drafted in 2001 and signed by then Secretary of Health Manuel Dayrit. It has the following policy statements: (1) leadership, (2) collaboration and partnership, (3) empowerment and participation, (4) equity, (5) standards for quality mental health services, (6) human resource development, (7) health service delivery system, (8) mental health care, (9) stability and sustainability, (10) information system, (11) legislation, and (12) monitoring and evaluation. There is no mental health legislation, but different stakeholders are currently working toward the passage of a mental health act.

The last revision of the mental health plans took place in 2005 to be consistent with the National Objectives for Health (NOH) 2005-2010. The mental health plans reaffirmed both the National Mental Health Policy and the NOH 2005-2010, which outlined the goals and objectives to be achieved by the health sectors by 2010. It also specified strategies for national reform from an institutionally based mental health system to one that is consumer focused with emphasis on supporting the individual in the community. There is disaster/emergency preparedness plan for mental health. The present national therapeutic drug policy/essential list of drugs in the country was formulated in 1988.

### Financing of mental health services

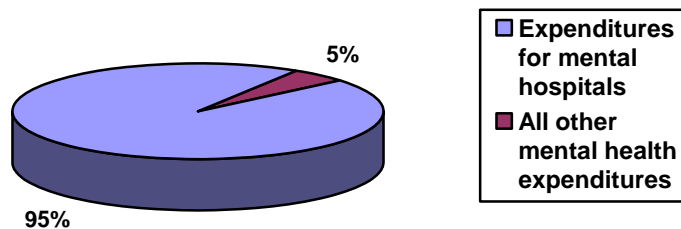
Five percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures on mental health, 95% are spent on the operation, maintenance and salary of personnel of mental hospitals. The percentage of the population that has free access (at least 80%) to essential psychotropic medicines is unknown. For those that pay out of pocket, the cost of antipsychotic medication is 0.46% and of antidepressant medication is 11.14% of the minimum daily wage (approximately US\$ 0.035 per day for antipsychotic medication and US\$ 0.75 per day for antidepressant medication). The Philippine Health Insurance Corporation recently covered mental illness but limited only to patients with severe mental disorders confined for short duration.

**GRAPH 1.1 - HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**





**GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS**



## **Human rights policies**

The Philippines has a Commission on Human Rights, a constitutional body tasked to, “*provide appropriate legal measures for the protection of human rights of all persons within the Philippines, as well as Filipinos residing abroad, and provide for preventive measure and legal aid services to the underprivileged whose human rights have been violated or need protection*”<sup>3</sup>. The commission crafted the Philippine human rights plan by sectors in 1995 and includes, among others, the mentally disabled as one of the sectors. The sectoral plan was intended to be implemented from 1996 to 2000. However, the commission responded, upon inquiry, that they had not performed a review or inspection of mental hospitals nor conducted training to staff of mental hospitals on human rights protection of patients with mental disorders. On the other hand, at the local level, one out of the two mental hospitals claimed they have had at least one review/inspection of human rights protection of patients in the year of assessment, while 9% of community-based inpatient psychiatric units and residential facilities had such a review. Likewise, one of the two mental hospitals claimed they had conducted at least one day training, meeting, or other type of working session on human rights protection of patients in that year. Twenty one percent of community in-patient psychiatric units and community residential facilities had such training.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

The Department of Health institutionalizes the National Mental Health Program through organization of functional management structures that groups mental health stakeholders into different committees. The national program management committee acts as the main authority and facilitates the overall implementation of priority targets and strategies aligned to health systems goals of improving the health status in the country. They are composed of mental health advocates from central and regional units of the Department of Health, the Director of the National Center for Mental Health, mental health experts from the medical centers, academe, consumer groups and professional organizations as well as representatives from other government agencies.

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<sup>3</sup> 1987 Philippine Constitution, Art. III, Sec. 18

## **Mental health outpatient facilities**

There are 46 outpatient mental health facilities available in the country, of which 28% allocate units that are for children and adolescents only. These facilities treat 124.3 users per 100,000 general population. Of all users treated in mental health outpatient facilities 43% are female and 8% of all contacts were children or adolescents.

The leading diagnoses of users treated in outpatient facilities are mainly schizophrenia and related disorders (57%) and mood disorders (19%). Information on diagnosis is based on number of users treated. The average number of contacts per user is 1.87. Twenty four percent of outpatient facilities provide follow-up care in the community, while 11% have mental health mobile teams. In terms of available treatments, a majority (51-80%) of the patients received psychosocial treatments. All (100%) mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

## **Day-treatment facilities**

There are four day-treatment facilities available in the country, which treat 4.42 users per 100,000 general population. Of all users treated in day-treatment facilities, 44% of them are female and 7% are children or adolescents. There is one day-treatment facility (25%) that devotes a unit for children and adolescents only. On average, users spent 2.59 days per year in day treatment facilities.

## **Community-based psychiatric inpatient units**

There are 19 community-based psychiatric inpatient units available in the country for a total of 1.58 beds per 100,000 general population. Only 1% of beds are reserved solely for children and adolescents. Thirty seven percent of admissions are female, while 6% of admissions are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatient are primarily from the following two diagnostic groups: schizophrenia and related disorders (63%) and mood disorders (24%). On average patients spend 69.65 days per admission.

The majority (51-80%) of patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All of community-based psychiatric inpatient units have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

## **Community residential facilities**

There are fifteen community residential facilities, or what is casually referred to in the Philippines as “*home-care facility*”. They are mostly available in urban areas. They provide for a total of .61 beds/places per 100,000 general population. About 3% of the beds in community residential facilities are reserved for children and adolescents only. Thirty three percent of users treated in community residential facilities are female and only 2% are children and adolescents. The number of users in community residential facilities is 1.09 per 100,000 general population.

## **Mental hospitals**

There are two mental hospitals available in the country for a total of 5.57 beds per 100,000 general population. Two percent of these beds are reserved for children and adolescents only. Thirty eight percent of admissions in mental hospitals are female. The two hospitals are organizationally integrated with mental health outpatient facilities. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia and related disorders (71%) and mood disorders (18%). The number of patients in mental hospitals is 8.97 per 100,000 general population.

The average number of days spent in mental hospitals is 209. Sixty-four percent of patients spend less than one year, 18% of patients spend 1-4 years, 13% of patients spend 5-10 years, and 5% of patients spend more than 10 years in mental hospitals. Some (21-50%) patients in mental hospitals received one or more psychosocial interventions in the last year. One hundred percent of mental hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

There has been neither an increase nor a decrease of number of beds in the last five years. The occupancy rate is about 92%.

## **Forensic and other residential facilities**

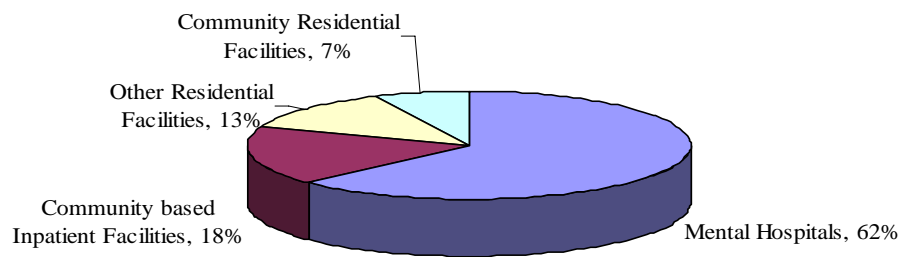
In addition to beds in mental health facilities, there are also 400 beds (0.47 per 100,000 general population) for people committed by courts for confinement in forensic inpatient units. All forensic beds are located at the National Center for Mental Health. Thirty three percent of patients spend less than one year, 38% of patients spend 1-4 years, 25% of patients spend 5-10 years, and 4% of patients spend more than 10 years.

There is only one residential facility (with 540 beds) specifically for people (of any age) with mental retardation. This facility is managed by the government social welfare service, which now operates beyond its bed capacity. There are six facilities (250 beds - private and public combined) specifically for people with substance abuse problems. There is one facility that cares for senior citizens aged 60 and above, both male and female, who are abandoned, neglected and mostly suffering from dementia.

## **Human rights and equity**

Forty eight percent of all admissions to community-based inpatient psychiatric units are involuntary. The proportion of involuntary admissions to mental hospitals is seventeen percent. The status of voluntary/involuntary admission to other facilities is in general not taken into account. However, it is estimated that the majority of admissions are involuntary. Over 20% percent of patients admitted at the mental hospitals were either restrained or secluded on admission due to violent and uncontrolled behaviors. In comparison to community-based psychiatric inpatient unit, it is estimated that 11-20% of patients were either restrained or secluded at least once within the last year. Seventy one percent of psychiatry beds in the country are located in or near the largest city. Such a distribution of beds prevents access to mental health services for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

**GRAPH 2.1 BEDS IN MENTAL HEALTH FACILITIES and OTHER RESIDENTIAL FACILITIES**

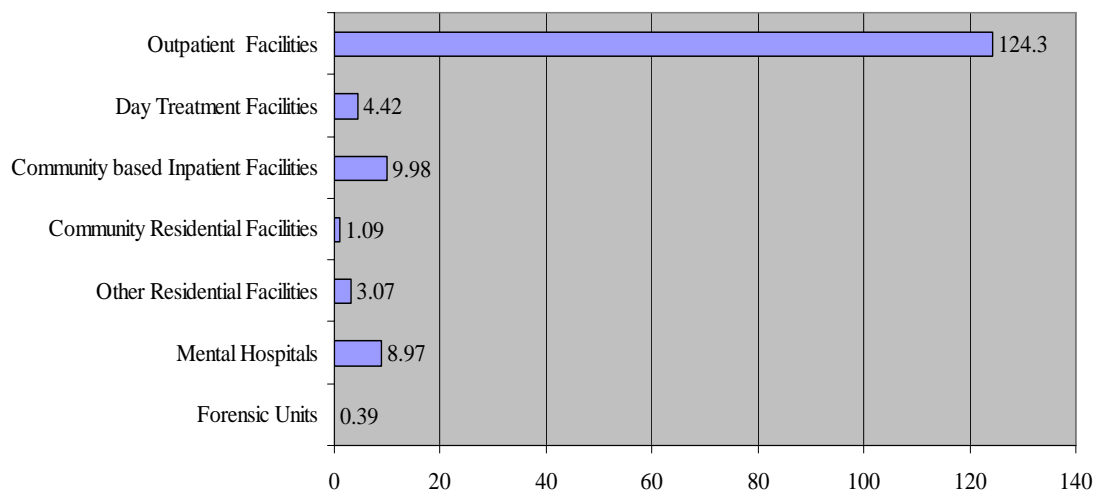


### Summary for Graph 2.1

The majority of beds in the country are provided by mental hospitals, followed by community inpatient facilities and other residential facilities.

**Note:** The beds for forensic inpatient units are located in the mental hospital.

**GRAPH 2.2 PATIENTS TREATED IN MENTAL HEALTH FACILITIES**  
(Rates per 100,000 population)

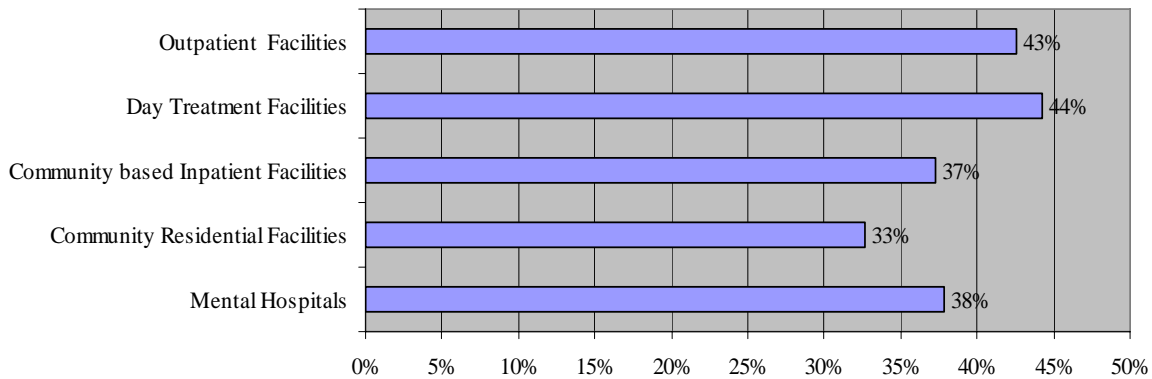


### Summary for Graph 2.2

The majority of the users are treated in outpatient facilities and in community inpatient facilities and mental hospitals, while there are fewer users treated in other residential facilities and day treatment facilities.

**Note:** In this graph the rate of admissions in inpatient units is used as a proxy of the rate of users admitted in the units.

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES**

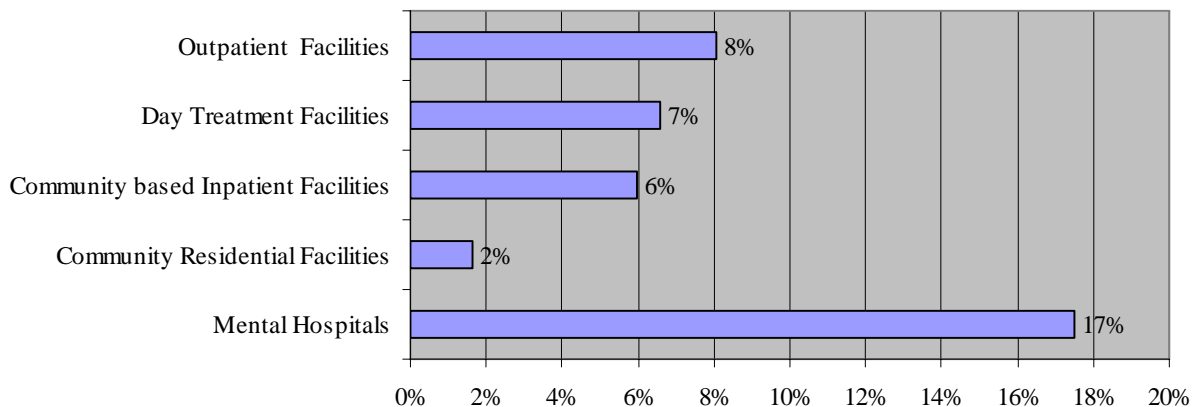


**Summary for Graph 2.3**

The proportion of female users in the out patient facilities and day treatment are nearly equal. Likewise, the percentage of female users in mental hospitals and community inpatient facilities are almost the same. The percentage of female users is lowest in community residential facilities.

**Note:** In this graph the percentage of female users' admissions in inpatient units is used as a proxy of the percentage of women admitted in the units.

**GRAPH 2.4 - PERCENTAGES OF CHILDREN and ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES**

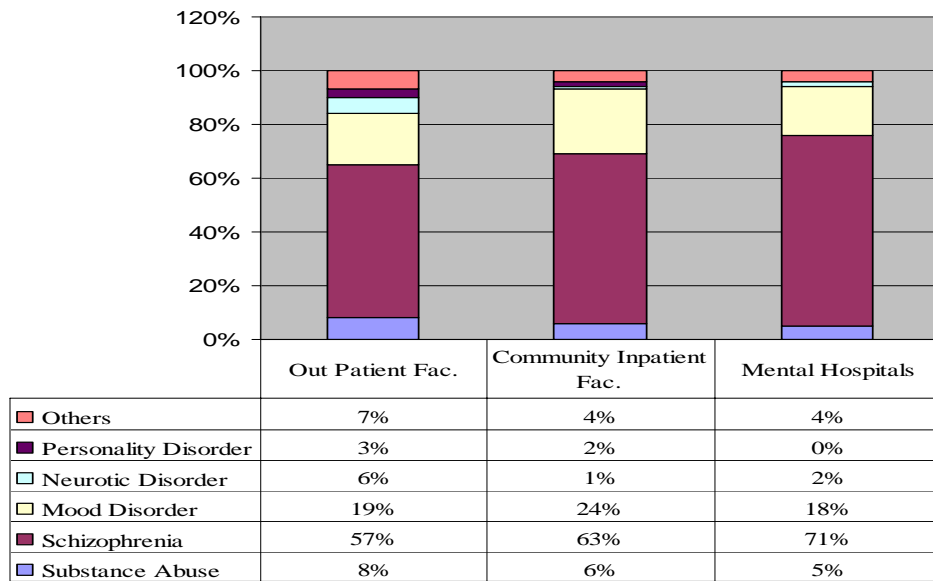


**Summary for Graph 2.4**

The proportion of children users is highest in mental hospitals and lowest in community residential facilities. The other facilities have almost the same percentages. It should be taken into consideration that more than half of the general population is less than 20 years old.

**Note:** In this graph the percentage of children and adolescents' admissions in inpatient units is used as a proxy of the percentage of children and adolescents admitted in the units.

**GRAPH 2.5 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**

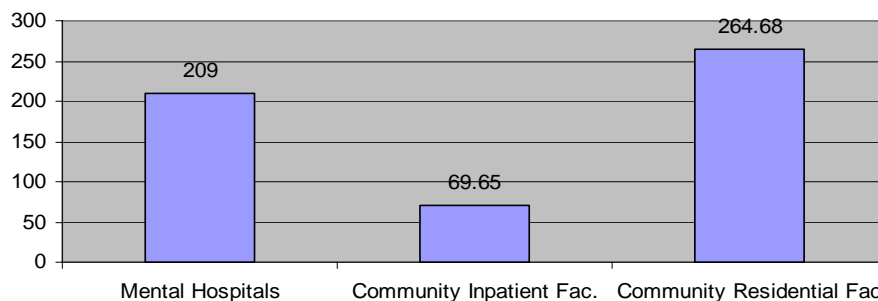


**Summary for Graph 2.5**

The distributions of diagnoses across facilities appear to be following same pattern. Schizophrenia is by far the most frequent diagnosis, followed by mood disorders. On the other hand, outpatient facilities receive more patients with diagnoses of substance abuse and neurotic disorders than mental hospitals and community inpatient facilities.

**Note:** In this graph the percentage of admissions in inpatient units by diagnosis is used as a proxy of the percentage of users admitted in the units. The diagnosis for each contact is used as an approximation of the proportion of admissions in each diagnostic category.

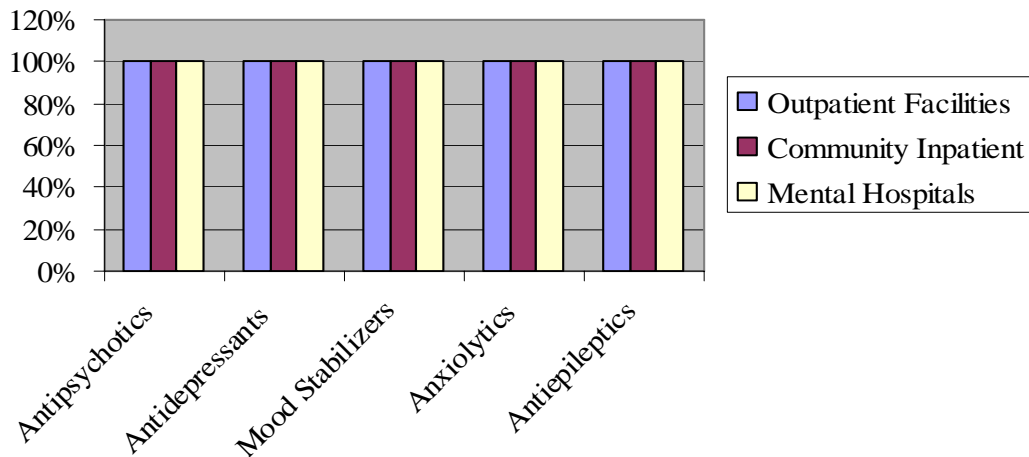
**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES  
(days per year)**



**Summary for Graph 2.6**

The longest length of stay for users is in Community residential facilities, perhaps because these facilities also function as custodial care. Mental hospitals also have long-staying patients because most patients have a chronic condition.

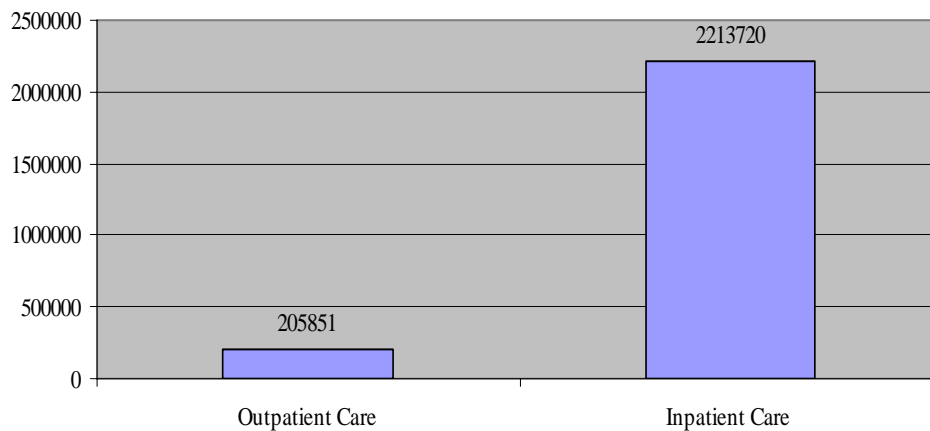
**GRAPH 2.7 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES**



**Summary for Graph 2.7**

Psychotropic drugs are widely available in all types of facilities.

**GRAPH 2.8 - INPATIENT CARE VERSUS OUTPATIENT CARE**



**Summary for Graph 2.8<sup>4</sup>**

The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, general hospital with psychiatric inpatient units and other residential facilities) is an indicator of extent of community care: in this country the ratio is 1:10.7

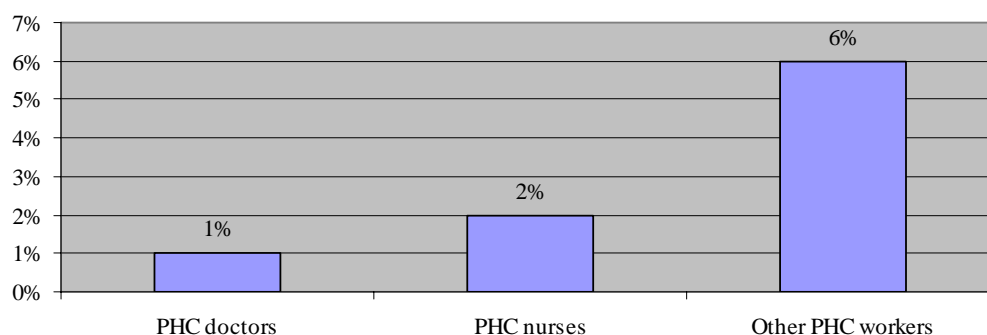
<sup>4</sup> Graph derived from Lund C, Fisher AJ. Community hospital indicators in South African public sector mental health services. J Ment Health Policy Econ. 2003; 6(4); 181-7.

## Domain 3: Mental Health in Primary Health Care

### Training in mental health care for primary care staff

Four percent of the training for medical doctors is devoted to mental health, in comparison to 5% for nurses. In terms of refresher training, 1% of primary health care doctors have received at least two days of refresher training in mental health, while 2% of nurses and 6% of non-doctor/non-nurse primary health care workers have received such training.

**GRAPH 3.1 - PERCENTAGES OF PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR**

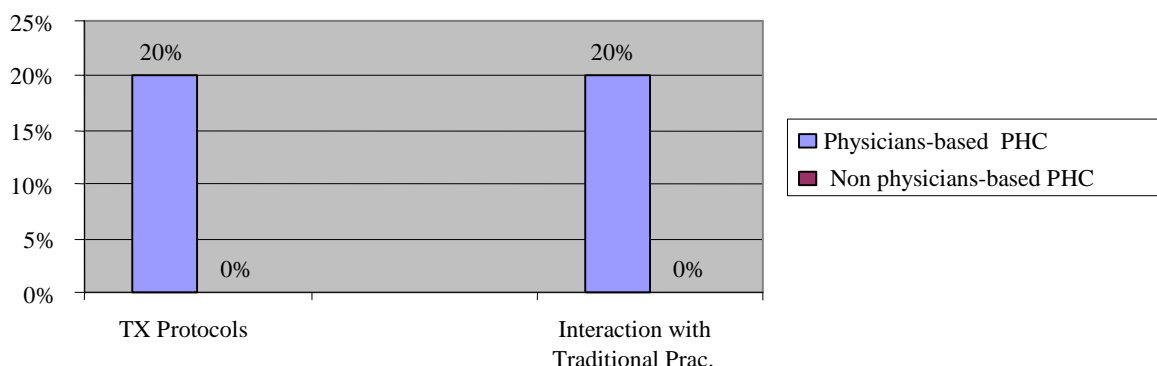


### Mental health in primary health care

Both physician-based primary health care (PHC) and non-physician-based PHC clinics are present in the country. In terms of physician-based primary health care clinics, few (<20%) have assessment and treatment protocols for key mental health conditions, in comparison to 0% for non-physician-based primary health care clinics. None of the physician-based primary health care clinics make at least one monthly referral to a mental health professional. This is also true for non-physician-based primary health care clinics. As for professional interaction between primary health care staff and other care providers, none of primary care doctors have interacted with a mental health professional at least monthly in the last year. Whereas a few (1 – 20%) of the physician-based PHC facilities have had interaction with a complementary/ alternative/ traditional practitioner, none of the non-physician-based PHC clinics, or mental health facilities have had such interactions.



**GRAPH 3.2 - COMPARISON OF PHYSICIAN BASED PHC WITH  
NON-PHYSICIAN BASED PHC**



### **Prescription in primary health care**

Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctors are allowed to prescribe psychotropic medications with restrictions. As for availability of psychotropic medicines, few (<20%) physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic), while there are no psychotropic medications in non-physician-based primary health care clinics.

## **Domain 4: Human Resources**

### **Number of human resources in mental health care**

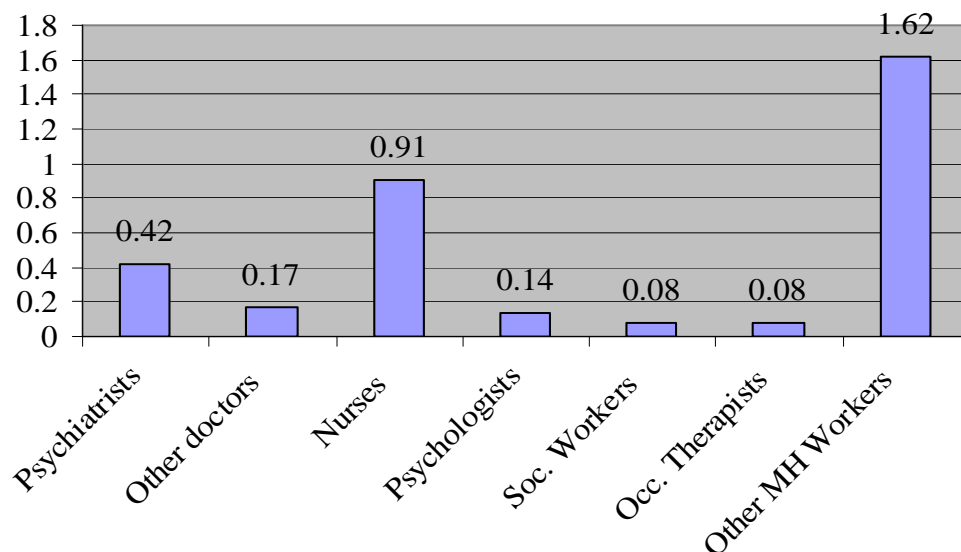
The total number of human resources working in mental health facilities or private practice per 100,000 general population is 3.43. The breakdown according to profession is as follows: 0.42 psychiatrist, 0.17 other medical doctors (not specialized in psychiatry), 0.91 nurses, 0.14 psychologists, 0.08 social workers, 0.08 occupational therapists, 1.62 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). Thirty percent of psychiatrists work only for government administered mental health facilities, 59% work only for NGOs, for-profit mental health facilities and private practice, while 11% work for both sectors. Fifty six percent of psychologists, social workers, nurses and occupational therapists work for government administered mental health facilities, 26% work only for NGOs, for-profit mental health facilities and private practice, while 18% work for both sectors. The figures provided are best estimates based on official registration and data from professional associations.

Regarding the workplace, 161 psychiatrists work in outpatient facilities, 130 in community-based psychiatric inpatient units and 61 in mental hospitals. As for other medical doctors (i.e., those not specialized in mental health), 52 work in outpatient facilities, 56 in community-based psychiatric inpatient units and 14 in mental hospitals. There are 116 nurses working in an outpatient facility, 201 in community-based psychiatric inpatient units and 354 in mental hospitals. As for other mental health professionals, there are 88 psychologists, social workers and occupational therapists working

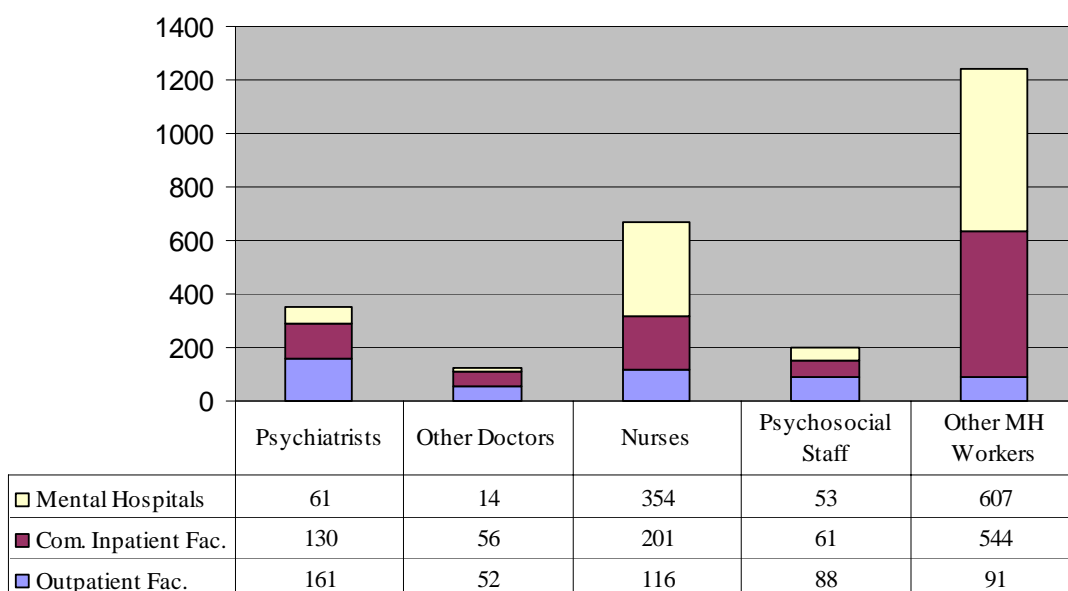
in outpatient facilities, 61 of these professionals work in a community-based psychiatric inpatient unit, and 53 of these professionals work in mental hospitals. Finally, regarding other health or mental health workers, 91 work in outpatient facilities, 544 work in community-based psychiatric inpatient units, and 607 work in mental hospitals. These figures do not include private practice.

In terms of staffing in mental health facilities, there are 0.10 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 0.15 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.08 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.05 per bed for community-based psychiatric inpatient units, and 0.01 per bed in mental hospitals. There is an inequitable distribution of human resources between urban and rural areas: there are 3.21 times more psychiatrists and 4.31 times more nurses working in or near the largest city than in the rest of the country. It should be taken into consideration that psychiatrists, psychologists and social workers work only for an average of 40 hours per week in government administered facilities.

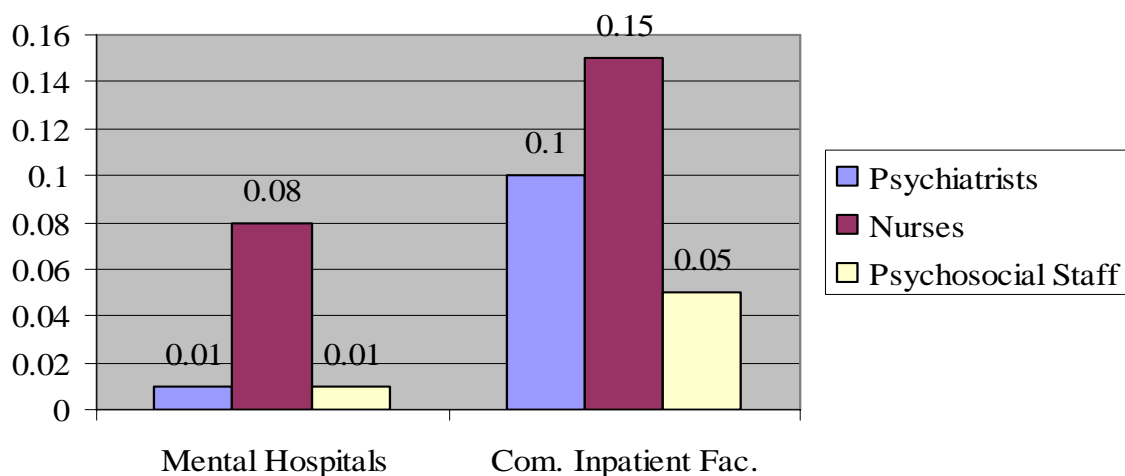
**GRAPH 4.1-HUMAN RESOURCES IN MENTAL HEALTH (rate per 100,000 population)**



**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(Percentage in graph, number in table)



**GRAPH 4.3 - RATIO OF HUMAN RESOURCES/BEDS**



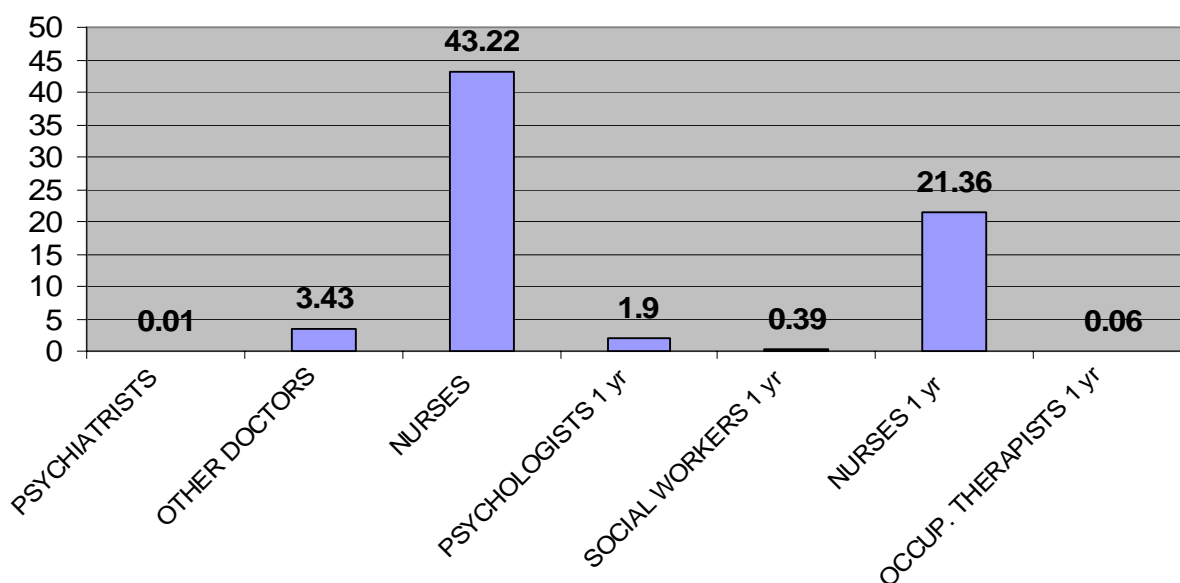
### Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 0.011 psychiatrists, 3.43 medical doctors, 43.22 nurses, 21.36 nurses with at least 1 year training in mental health care, 1.90 psychologists with at least 1 year training in mental health care, 0.39 social workers with at least 1 year training in mental health care, 0.06 occupational

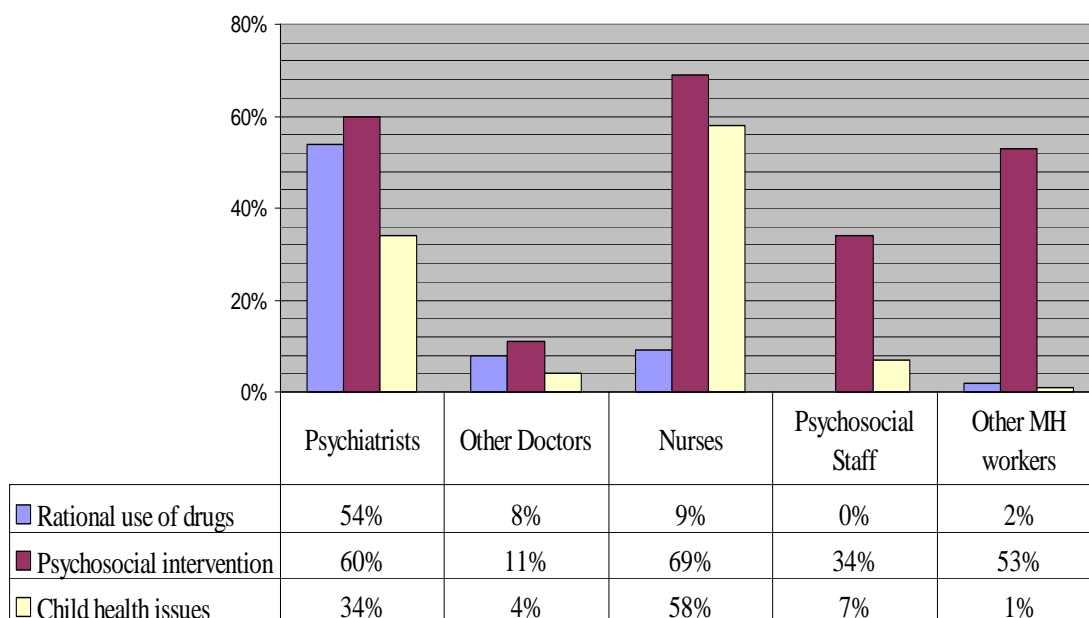
therapists with at least 1 year training in mental health care. Few (<20%) psychiatrists emigrate from the country within five years of the completion of their training.

Fifty four percent of psychiatrists, 8% of medical doctors, 9% of nurses and 2% of other mental health workers attended refresher training on the rational use of drugs. Sixty percent of psychiatrists, 11% medical doctors, 69% of nurses, 34% of psychosocial staff and 53% of other mental health workers attended at least two days of refresher training on psychosocial (non-biological) interventions. On the other hand, 34% of psychiatrists, 58% of nurses, 7% of psychosocial staff and only 4% of medical doctors and 1% of other mental health workers attended at least 2 days of refresher training on child/adolescent mental health issues.

**GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)**



**GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**



### **Consumer and family associations**

There are an unaccounted number of consumer and family associations. Most family associations include family and friends of users. The government does not provide economic support for either consumer or family associations. Some consumer associations have been involved in the formulation or implementation of mental health policies, plans, or legislation within the past two years. Few mental health facilities interact with these associations. In addition to family/consumer associations, there are four other NGOs in the country involved in individual assistance activities such as counseling, housing, or support groups.

## **Domain 5: Public Education and links with other sectors**

### **Public education and awareness campaigns on mental health**

There are coordinating bodies that oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, and private foundations have promoted public education and awareness campaigns, in their own capacity, in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups, including health care providers and teachers.

## **Legislative and financial provisions for people with mental disorders**

At the present time, there is legislative support for equal opportunity for employment<sup>5</sup> and provision against discrimination against differently-abled persons at work, but these provisions are rarely enforced. On the other hand, there are no provisions for housing, or provisions against discrimination in housing for people with mental disorders.

## **Links with other sectors**

In addition to legislative and financial support, there are collaborations with various departments/agencies responsible for primary health care/community health, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, and criminal justice. However, these collaborations have to be formalized and strengthened. There is a part-time or full-time mental health professional in 60% of primary and secondary schools. Some primary and secondary schools (21-50%) have school-based activities to promote mental health and prevent mental disorders. The proportion of prisoners with psychosis and mental retardation is estimated to be less than 2% for each diagnosis. Regarding mental health activities in the criminal justice system, less than 20% of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, few (less than 20%) police officers, judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, there are no mental health facilities that have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, there are social welfare benefits for mentally disabled persons, provided that they are members of the government social security system. However, the exact numbers of beneficiaries are unknown.

## **Domain 6: Monitoring and Research**

A formally defined list of individual data items that ought to be collected by all mental health facilities exists and includes the number of psychiatric beds, number of admissions, number of days spent in hospital and diagnoses. As shown in the table 6.1, the extent of data collection varies among mental health facilities. The government health department received data from 100% mental hospitals, 58% community based psychiatric inpatient units, and 65% mental health outpatient facilities.

However, no report was produced using the data transmitted to the government health department. Research in the Philippines is focused on non-epidemiological clinical/questionnaires assessments of mental disorders and services research. The research consists of monographs, theses, and publications in non-indexed journals. There are mental health research publications in indexed journals (e.g., *Philippine Journal of Psychiatry* is indexed in the Western Pacific Regional Index Medicus).

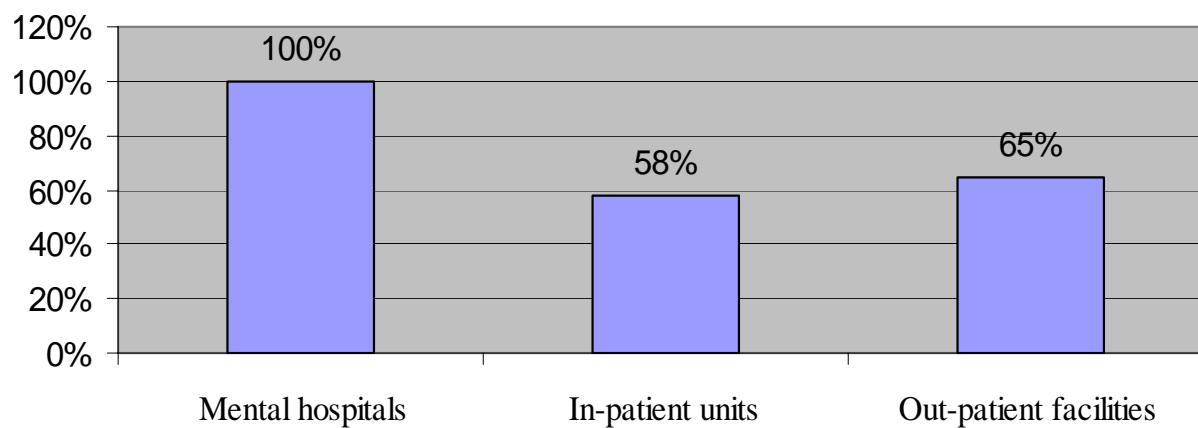
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<sup>5</sup> Magna Carta for the Disabled Person, chapter 1. section 5 & 6

**Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information**

	<b>Mental Hospitals</b>	<b>Community Inpatient Units</b>	<b>Outpatient Facilities</b>
N° of beds	100%	68%	-----
N° inpatient admission/ users treated in outpatient facilities	100%	72%	96%
N° of days spent/user contact in outpatient facilities	100%	52%	73%
N° of involuntary admissions	100%	32%	----- -----
N° of user restrained	50%	8%	-----
Diagnoses	100%	60%	93%

**GRAPH 6.1 - PERCENTAGE OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT**



## **Strengths and Weaknesses of the Mental Health System in the Philippines**

It is apparent that the elements necessary for pursuing an effective mental health program in the Philippines are in place. The major resource in the Philippines is its highly literate population who also values education and professional development. Academic institutions and training centers have in the last 4 decades developed good programs to educate and develop the mental health human resources, specifically psychiatrists, psychologists, social workers, nurses and allied mental health professionals. These have developed a multidisciplinary group of professionals to address the mental health needs in the country, and have broadened the scope of the national mental health program. In some ways these changes have advanced the understanding of mental health disorders so that other agencies have initiated mental health programs relevant to their special needs. The challenge is motivating these professionals to stay in the country and sustain their involvement, especially in the community setting, because the country is continuing to lose this valuable and crucial resource to overseas employment.

The Philippines has a constitutionally created Human Rights Commission, but the body should have the authority to oversee regular inspections and provide sanctions. The majority of mental health facilities are still located in the National Capital Region. Hence, access to mental health facilities is uneven across the country, favoring those living near the main cities. In the mid 1990's, the Mental Health Program made some efforts to strengthen services in the community through trainings of local health professionals. Essential psychotropic medications are available in all the facilities. In terms of support for child and adolescent health, a psychosocial care system in schools has been established through collaboration with the Department of Health and different government agencies and NGOs. However, psychosocial support in schools is mainly delivered by teachers and only a few schools have part-time or full-time mental health professionals.



## **Next Steps in Strengthening Mental Health System**

1. Push for Legislation of Mental Health Act
2. Strengthen the organizational set-up for mental health in the Department of Health with a clear structure, manpower and budget to support its operation nationwide
3. Link with other sectors to strengthen school and workplace mental health programs
4. Establish, strengthen and monitor community mental health
5. Institute surveillance for specific mental disorders in the community in collaboration with National Epidemiology Center of Department of Health and College of Public Health in different institutions
6. Develop training manuals for psychiatrists, psychiatric nurses, psychologists and psychiatric social workers
7. Educate the public by providing IEC Materials regarding mental health promotion and prevention of mental disorders
8. Provide seminars to the community regarding mental health to reduce stigma and initiate acceptance of the notion that mental disorders are just like any other illnesses.
9. Strengthen family education regarding signs and symptoms of mental illness, as well as impending relapse of the improved patient
10. Provide technical assistance to projects that would integrate mental health care in general hospital, i.e., Acute Psychiatric Units
11. Strengthen the community outreach service of mental hospitals through effective networking with non-government organizations and local government units
12. Institute cost effective management of common mental health disorders in PHC through capacity building of community-based health workers using:
  - Locally developed training materials
  - Refresher course to PHC physicians and other health care providers
13. Provide community care services in coordination / collaboration with local government units and other organizations
14. Conduct activities that will facilitate the re-entry of the patients into the community by holding socialization, livelihood projects and other group services
15. Decongest outpatient services in the Mental Hospitals by referring patients for follow-up consultations to the Acute Psychiatric Unit in general hospitals and medical centers nearest to their home

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Philippines including the policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and links with other sectors, and monitoring and research.

The Philippines is a tropical country of 7,100 islands with a total land area of 300,000 square kilometers lying in the Western Pacific Ocean. It is the only predominantly Christian country in Asia, with an estimated population of over 84 million in 2005. The two main languages used in the country are Filipino, the national language, and English.

The Philippines have a National Mental Health Policy since 2001, which addresses the main issues of mental health in the country. There is no mental health legislation, but different stakeholders are currently working towards the passage of a mental health act. A regular budget allocation exists for mental health. In 2005, over 10 million US dollars (five percent of the total health budget) was directed towards mental health. There is a Commission on Human Rights mandated to review/inspect human rights protection of patients.

The Philippines has all types of mental health facilities. At present, there are 2 mental hospitals, 46 outpatient facilities, 4 day treatment facilities, 19 community-based psychiatric inpatient facilities and 15 community residential (custodial home-care) facilities. The only mental hospital in the National Capital Region houses 4,200 beds, while almost all mental health facilities are located in major cities.

The total number of human resources working in mental health facilities or private practice is 2,900, including 353 psychiatrists, 141 other doctors not specialized in psychiatry, and 769 nurses. Coordinated and sustained efforts are needed to strengthen the mental health system in the Philippines.