STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES

for children and adolescents in East Asia and Pacific Region

PHILIPPINES

COUNTRY REPORT
2022

Prepared for the UNICEF East Asia and Pacific Regional Office and UNICEF Philippines by:

Research Institute for Mindanao Culture, Philippines
4/F Social Science Bldg
Xavier University
Cagayan de Oro City, Philippines
(088) 953–9800 loc 9275

Burnet Institute
85 Commercial Rd, Melbourne, Victoria, Australia
+61 3 9282 2111
www.burnet.edu.au

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UNICEF East Asia and the Pacific Regional Office
Phra Athit Road, Bangkok, Thailand 10200
Email: eapro@unicef.org
www.unicef.org/eap/

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This project was jointly led by the Research Institute for Mindanao Culture, Xavier University (Philippines) and the Burnet Institute (Australia), in partnership with UNICEF East Asia and Pacific Regional Office. The study team comprised:

Research Institute for Mindanao Culture
Chona R. Echavez
Magdalena C. Cabaraban
Chona Castillo
Jennefer Lyn Bagaporo
John Mari Migallon
Michael Lou Montejo
Sean Renee Duay
Vergil Boac
Burnet Institute
Elissa Kennedy
Peter Azzopardi
Miika Coppard
Vinay Menon
Nisaa Wulan
Julie Hennegan
Murdoch Children's Research Institute
George Patton
Monika Raniti
Monash University
Jane Fisher

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Regional Technical Advisory Group	Philippines Technical Advisory Group
Janelle Babb (UNESCO)	Margarita Teresa C. A. Ocampo (National Center for Mental Health)
Roshni Basu (UNICEF)	Marie Michelle Munoz Quezon (UNICEF)
Francisco Benavides (UNICEF)	Ray Alyannah Lagasca (Youth for Mental Health Coalition, Inc.)
Michelle Dynes (UNICEF)	April T. Obtinario (Department of Education)
Akihiro Fushimi (UNICEF)	Wilma Banaga (Save the Children Philippines)
Zeinab Hijazi (UNICEF)	Ma. Erlinda N. Aguila (Council for the Welfare of Children)
Jennifer Hall (WHO)	Elizabeth P. De Castro (Psychosocial Support and Children's Rights Resource Center)
Kunihiko Chris Hirabayashi (UNICEF)	Joan Grace Llamado (Department of Education)
Jo Lucas (Oxford Policy Management UK)	Ken Aisa Ortiz (Department of Education, Disaster Risk Reduction and Management Service)
Natia Partskhaladze (Global Social Services Workforce Alliance)	Leandra Yu (Department of Education)
Christina Popivanova (UNICEF)	Raymand Roy Sardido (Department of Education, , Disaster Risk Reduction and Management Service)
Maria Qureshi (UNICEF)	Shanaia Kylie V. Pillosis (Department of Education, Disaster Risk Reduction and Management Service)
Cassie Redlich (WHO)	Gian Erik Adao (Department of Education)
Hugh Salmon (Global Social Services Workforce Alliance)	Genesis S. Faderogao (Community and Family Services International)
Martin Vandendyck (WHO)	Jasmine Garcia Vergara (WHO Philippines)
	Esther D. Miranda (Plan International)
	Jezreel Hannah Domingo (World Vision)
	Ronilda Rosario Co (Department of Education)
	Kyrie Eleison A. Taganap (Department of Social Welfare and Development)
	Cecilia A. Tuazon, MD, FPPA (Department of Health, National Center for Mental Health)
	Maridith Afuang (Department of Health, Health Emergency Management Bureau)
	Yvonne Marie Rafol (Council for the Welfare of Children)

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Abbreviations

COVID-19	Corona Virus Disease 2019
Dep Ed	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOJ	Department of Justice
DSWD	Department of Social Welfare and Development
GDP	Gross Domestic Product
LGU	local government unit
MHPSS	Mental Health and Psychosocial Support
NGO	Non-government organization
PhilHealth	Philippine Health Insurance Corporation
RA	Republic Act
Sangguniang Kabataan	Youth Council
Sangguniang Bayan	Municipal Council
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

The mental health of children and adolescents aged 0–18 years is one of the most neglected health issues globally. Before COVID-19, the World Health Organization estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In East Asia and the Pacific as of 2019, almost one in seven boys and one in nine girls aged 10–19 years had a mental disorder, with suicide the third-leading cause of death among youth aged 15–19 years in this region.[1,2] Additionally, many millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but has significant impact on their health, development and well-being. Poor mental health can profoundly affect children's and adolescents' health, learning and participation and thus limit opportunities for them to reach their full potential.

Despite this burden, there is a substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally as of 2020, government expenditure on mental health accounted for only 2 per cent of total health expenditure,[5] even though mental health disorders accounted for 7 per cent of the total burden of disease.[6] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent was less than 0.5 per 100,000 population, and there were fewer than two outpatient facilities for child and adolescent mental health care per 100,000 population as of 2020.[5]

To address mental health and psychosocial well-being of children and adolescents there is a need for a holistic and tiered approach to MHPSS that includes actions to promote well-being; prevent poor mental health by addressing risks and enhancing protective factors; and ensure quality and accessible care for persons with mental health conditions. This requires mobilization of all sectors, including health, education, social welfare and justice, as well as engagement with communities, schools, parents, service providers, children and adolescents.

To support the urgent need to strengthen MHPSS systems and services for children and adolescents in the region, especially in the wake of the COVID-19 pandemic, which has had profound impact on mental health, the United Nations Children's Fund (UNICEF) embarked on a research initiative to identify how MHPSS can be most effectively implemented. Supported by a regional Technical Advisory Group comprising UNICEF, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization and the Global Social Service Workforce Alliance, this initiative included the development of a regional conceptual framework covering a tiered and multisectoral package of MHPSS services to meet the specific needs of children and adolescents; the role of allied sectors – health, education, social welfare and justice – in the delivery of this package; and the legislative, policy and institutional reforms and capacity-building steps required to ensure a multisector mental health system.

Central to this research initiative was the application of the conceptual framework in four countries in the region – Malaysia, Papua New Guinea, the Philippines and Thailand – to explore how MHPSS could be implemented across diverse contexts.

This report documents the application of the conceptual framework in the Philippines and provides country-specific recommendations for strengthening the provision of MHPSS for children and adolescents.

Children and adolescents (aged 0–18 years) experience a high burden of poor mental health in the Philippines. One in eight adolescents aged 10–19 years and one in seventeen children aged 5–9 years are estimated to have a mental disorder (including developmental disorder).[1] Suicide is the fourth-leading cause of death among adolescents aged 15–19.[1] Risk factors for poor mental health, including exposure to violence, peer victimization, bullying, loneliness and social isolation, particularly in the context of the COVID-19 pandemic, are prevalent.

Recognizing this need, the Philippines has made important efforts to address child and adolescent mental health. National policy and legislative frameworks are broadly supportive, acknowledging, at least in part, the specific needs and considerations for this age group and the urgency for a national multisectoral approach to mental health care, prevention and promotion. Although a significant focus of the current response has been on the clinical management of mental health conditions through the health sector, there are many examples of programmes delivered through the education, social welfare and justice settings to improve early identification and assessment and the multidisciplinary management of programmes in school, child protection and justice settings to address risk factors. This has been particularly the response in the context of the COVID-19 pandemic, with several new initiatives (including online programmes) to support children and their families.

Despite the progress, this analysis found important gaps in the current MHPSS response. These include the accessibility and availability of child- and adolescent-friendly and multidisciplinary care for mental health conditions (particularly outside specialized tertiary and institutional settings), comprehensive and coordinated whole-of-education approaches to mental health promotion. It also includes a national (and targeted) approach to support nurturing and responsive care provided by parents and other caregivers and coordinated programmes to support healthy peer relationships and address peer victimization. There are also important gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents, including coordinated programmes and protocols across agencies to support children engaged in the child protection or justice systems.

There are also critical cross-cutting challenges impacting on the implementation of MHPSS. While mental health and well-being are integrated to some degree in the sectoral plans of education, social welfare and justice, the plans generally focus narrowly on specific actions (such as screening or the provision of counselling) rather than encompassing a more holistic vision for mental health and well-being and articulation of each sector's role and response. At the local government level, the lack of clear plans, guidance and structures to support implementation and multisectoral collaboration have contributed to limited coordination. Across all sectors, insufficient numbers and inappropriate distribution of skilled personnel are major barriers to implementation, contributing to heavy workloads, long delays in access to care and fragmented prevention programmes. The limited availability of services responsive to the needs of children and adolescents, particularly in communities. The overreliance on tertiary and institutional-based care contribute to the high unmet needs and delays in access to services through the health and social welfare sectors and the time-consuming referral from other sectors, such as education and justice. Insufficient budget for MHPSS-related programmes and budgeting processes that do not support agenda-based and cross-sectoral budget planning are also challenges.

Overarching recommendations

In addition to specific recommendations to strengthen the multisectoral mental health system, this analysis led to nine overarching recommendations to improve the implementation of MHPSS for children and adolescents in the Philippines.

1. At the national level, strengthen the Mental Health Act to articulate protections for children and adolescents. Consideration should be given to developing a multisectoral child and adolescent mental health strategy that articulates MHPSS actions and details a multisectoral plan (and coordination structure) for implementation.
2. The Government should strengthen or expand the Philippine Council for Mental Health to include the Department of Social Welfare and Development and the justice sectors. The Government should consider establishing a multisectoral coordinating body for child and adolescent mental health, with responsibility for coordinating the planning and implementation of MHPSS for this age group. As per the National Mental Health Strategic Plan, regional mental health councils should be established and should include a multisectoral focus on child and adolescent mental health. These should be supported by national counterparts to provide capacity-building of local government unit officials to improve their awareness of mental health issues and support the development of their multisectoral implementation plans, resource allocation and coordination.

3. The Department of Health, in consultation with other sectors and technical partners, should strengthen national standardized protocols for child and adolescent mental health across agencies, including:
   - validated screening tools for this age group and detailed guidance on use in different settings, such as the Child Protection Units (including consideration of potential harms of screening);
   - referral procedures across sectors;
   - non-specialist management;
   - case-management of children and adolescents engaged in the child protection and justice sectors;
   - greater protection for children in conflict with the law and child victims within the justice system; and
   - national quality service standards for child and adolescent mental health services across sectors.
4. The Government should include mental health services (including outpatient services) within the national health insurance programme and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, consideration should be given to including mental health as a primary programme. A minimum-services package (based on the Regional Conceptual Framework) should be defined and costed, with budget allocation and responsibility defined across the allied sectors. The Government could also consider establishing a national cross-sectoral body or cross-sectoral committee on MHPSS within the Department of Budget and Management to support coordinated and comprehensive budget requests that align with national MHPSS goals.
5. The Department of Health and the Department of Social Welfare and Development should prioritize the integration of MHPSS into primary health care and community-level services for children, adolescents and their families, including through primary health care and community-based approaches to child protection and support for families.
6. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisectoral mental health and psychosocial support workforce through:
   - in-depth mapping to identify roles across sectors against the MHPSS priority actions and the required competencies and intersectoral training needs to support these roles;
   - development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for providers across sectors;
   - integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector officers, teachers and other school-based staff that aligns with roles and responsibilities with respect to MHPSS;
   - strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, justice sector officers, teachers and education staff that is competency-based and aligned with expected MHPSS roles;
   - training provided to relevant department staff within the health, education, social welfare and justice sectors to support planning and development of the workforce and broader MHPSS programmes;
   - expansion of the number of posts at the national and subnational levels; and
   - improved supervision and support for MHPSS providers across sectors, including establishing provider-support networks and multidisciplinary teams, improved remuneration, job security and career pathways and attention to the mental health needs of providers themselves.

7. The Department of Health, in consultation with the Department of Social Welfare and Development, the Department of Education, the Department of Justice and academic and development partners, should improve the collection, use and accessibility of data at the national and subnational levels. This should include data and mechanisms to identify mental health needs, support planning and implementation and track the progress. It also should strengthen data linkages and sharing across agencies, in conjunction with privacy laws to protect children and adolescents. In addition to greater investment in mental health research, national information systems (health, education, child protection and justice) should be strengthened to include a minimum set of child and adolescent MHPSS-related indicators that are harmonized across sectors. A national suicide surveillance system should be established.
8. The Government, development partners and non-government organizations should increase opportunities for children and adolescents (and parents and caregivers) to participate in MHPSS policy and programming, including establishing more formal roles for young people (such as representation on mental health committees and other bodies at the national and subnational levels) and improved child- and adolescent-friendly mechanisms for providing feedback and complaints on MHPSS programmes and mental health services.
9. The Government, with support from development partners and non-government organizations, should expand national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents, parents and other caregivers).

Introduction

The mental health of children and adolescents aged 0–18 years is one of the most neglected health issues globally. Before COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[3] In East Asia and the Pacific as of 2019, almost one in seven boys and one in nine girls aged 10–19 years had a mental disorder, with suicide the third-leading cause of death among 15- to 19-year-olds in the region.[1,2] Many millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but has significant impact on their health, development and well-being.

The Philippines has more than 39 million children and adolescents aged 0–18 years, making up approximately 36 per cent of the nation's population.[2] Children and adolescents in the Philippines experience a substantial burden of poor mental health. Modelled estimates from the 2019 Global Burden of Disease Study indicate that mental disorders and self-harm accounted for around 13 per cent of the total burden of disease among 10- to 19-year-olds, with suicide the eleventh-leading cause of death among 15- to 19-year-olds.[1] The COVID-19 pandemic has heightened the need for mental health and psychosocial support, with significant impact on education, social connectedness, family stressors, inequality and disruption of essential services.

BOX 1. DEFINITIONS OF MENTAL HEALTH

'Mental health and psychosocial well-being' is a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn, and have a positive sense of self and identity.

'Mental health conditions' is a broad term that encompasses the continuum of mild psychological distress through to mental disorders, that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include: difficulties with behaviour, learning or socialization; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, psychosis, bipolar disorder, eating disorders, substance use disorders, conduct disorder, attention deficit/hyperactivity disorder, intellectual disability, autism spectrum disorder, and personality disorders.

Adapted from UNICEF, *The State of the World's Children 2021,* New York, 2021.

Poor mental health can have profound impact on children's and adolescents' health, learning, social well-being and participation, thus limiting opportunities for them to reach their full potential. This age group encompasses a time of critical brain growth and development and when social, emotional and cognitive skills are formed and lay the foundation for adult mental health and well-being. In addition to mental disorders arising during this age, many risk factors for future poor mental health also typically have their onset in this developmental stage.[4,5]

Despite this burden, there is substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally as of 2020, government expenditure on mental health accounted for only 2 per cent of total health expenditure,[6] even though mental health disorders accounted for 7 per cent of the total burden of disease.[7] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent was less than 0.5 per 100,000 population, and there were fewer than two outpatient facilities for child and adolescent mental health care per 100,000 population, as of 2020.[6] There are also many gaps

and missed opportunities to prevent poor mental health and promote well-being, with approaches often fragmented and small in scale. In addition to inadequate human and financial resources, lack of coordination between sectors and substantial stigma remain significant barriers to ensuring that children, adolescents and their families have access to quality services and support.[2,8]

BOX 2. DEFINITION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental health and psychosocial support (MHPSS) refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Originally defined by the Inter-agency Standing Committee Reference Group on mental health and psychosocial support in humanitarian settings, this composite term is now widely used and accepted by UNICEF, partners and practitioners in development contexts, humanitarian contexts and the humanitarian–peace nexus. It serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches to support children, adolescents and their families.

The Philippines has made important efforts to address child and adolescent mental health through the provision of mental health services, school-based programmes to support early identification and prevention of poor mental health and integration of mental health services and support into the social welfare and justice settings to reach vulnerable children. Despite the significant resources invested in mental health, access to services is still far from universal. A greater understanding of how to effectively implement MHPSS for children and adolescents across multiple sectors is required to address these gaps.

To ensure mental health and psychosocial well-being of children and adolescents, there is need for a holistic and tiered approach to MHPSS that includes actions to:

- promote well-being;
- prevent poor mental health by addressing risks and enhancing protective factors; and
- ensure quality and accessible care for persons with mental health conditions.

This requires mobilization of all sectors, including health, education, social welfare and justice, as well as engagement with communities, schools, parents, service providers, children and adolescents. This multisectoral approach is at the core of UNICEF's East Asia and Pacific Regional Conceptual Framework for Mental Health and Psychosocial Support and the Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.[10,11]

Project aims, objectives and approach

Aims and objectives

To support the urgent need to strengthen MHPSS systems and services for children and adolescents in the East Asia and Pacific region, the United Nations Children's Fund (UNICEF) embarked on a research project to identify how MHPSS can be most effectively implemented for those aged 0–18 years. This initiative included the development of the Regional Conceptual Framework to define:

- a tiered and multisectoral package of services required for children's and adolescents' mental health and psychosocial well-being (package of priority actions);
- the systems, structures and resources needed to deliver these services;
- multisectoral roles and responsibilities – for health, social welfare, justice and education – and the role of other allied ministries, departments or agencies, non-government organizations (NGOs), young people, youth organizations, communities and the private sector; and
- legislative, policy and institutional reforms and capacity-building steps required to ensure a multisectoral mental health system.

While the importance of MHPSS in emergency settings is acknowledged, this project focused on implementation of MHPSS in non-emergency contexts.

Central to this research initiative was the application of the conceptual framework in four countries in the region – Malaysia, Papua New Guinea, the Philippines and Thailand – to explore how MHPSS could be implemented across diverse contexts and in parallel to inform the finalization of the Regional Conceptual Framework.

BOX 3. OUTLINE OF THIS REPORT

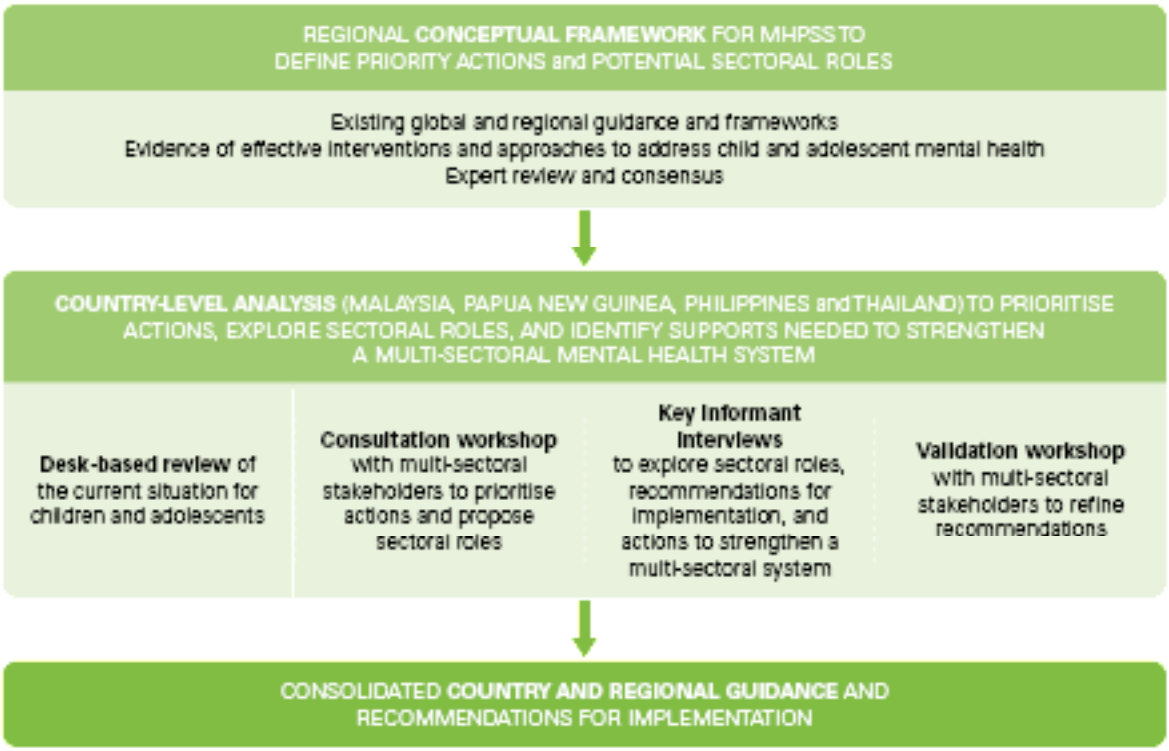
This report provides an overview of the overarching Regional Conceptual Framework for Mental Health and Psychosocial Support and synthesizes the findings of a desk review, consultation and validation workshops and informant interviews to describe:

1. Mental health and psychosocial well-being of children and adolescents: the current situation (needs and policy and programming responses)
2. Priority package of MHPSS actions
3. Recommended sectoral roles
4. Challenges and recommendations for strengthening the multisectoral mental health system

Overview of approach

The project was led by the Burnet Institute, in partnership with UNICEF East Asia and Pacific Regional Office. A regional Technical Advisory Group comprising UNICEF, the United Nations Educational, Scientific and Cultural Organization, the WHO, the Global Social Service Workforce Alliance and sectoral child and adolescent health experts provided overall feedback and guidance on the conceptual framework, project approach and regional findings and recommendations. *Figure 1* outlines the project.

FIGURE 1. OVERVIEW OF THE PROJECT APPROACH



Country-level analysis

The Research Institute for Mindanao Culture and the Burnet Institute, supported by the UNICEF Philippines Country Office and the Philippine Technical Advisory Group chaired by the Council for the Welfare of Children, co-led the Philippine analysis. The UNICEF East Asia and Pacific Regional Office and the regional Technical Advisory Group provided oversight.

Objectives of the country-level analysis:

1. Synthesize existing data to describe mental health needs of children and adolescents in the Philippines.
2. Synthesize policies, services and programmes (government and non-government) related to child and adolescent mental health to describe approaches, experiences and gaps.
3. Identify barriers and enablers of children's and adolescents' access to MHPSS.
4. Define a tiered, multisectoral minimum services package for MHPSS.
5. Explore how the MHPSS regional framework and package of priority actions can be effectively implemented, including identifying opportunities and challenges across the allied sectors (health, education, social welfare and justice), with particular attention to the systems requirements (financial, human and governance) needed to support implementation.

This component included four main activities.

1. Desk-based review

Synthesis and secondary analysis of existing survey data

Priority indicators describing mental health outcomes and risks for children and adolescents aged 0–18 years were identified following a mapping of global and regional mental health indicators. Indicators were populated using available national survey data (from the Global School-based Student Health Survey in 2015 and 2019[12,13] and the National Baseline Study on Violence Against Children in 2016[14]), disaggregated by age and sex where possible. Where data were not available, modelled estimates were sought from the 2019 Global Burden of Disease Study.[1]

Review and synthesis of available literature

To address the gaps and limitations of survey data, published literature was reviewed to describe:

- mental health needs of children and adolescents;
- risks and determinants of mental health and/or psychosocial well-being;
- barriers and enablers to accessing quality MHPSS; and
- evidence of interventions and approaches to address mental health and/or psychosocial well-being.

Medline, Embase, Emcare and PsychINFO were searched for articles published in English as of January 2010. The search strategy involved three main concepts: (i) mental health; (ii) children and adolescents; and (iii) the Philippines. For the first concept, search terms included mental health, psychology, psychosocial care, mental disease, suicidal behaviour, psychotherapy, anxiety management and several mental diagnoses and psychotherapy modalities. Regarding children and adolescents, search terms included child, adolescent and youth. And for the Philippines, search terms included Philippines, Manila and several other Filipino city and province terms, such as Quezon, Davao and Cebu. This review included all relevant studies, narrative reviews, systematic reviews, randomized controlled trials, quasi-experimental trials, observational studies and case series. Studies were included if they were conducted in the Philippines, included children and/or adolescents aged 0–18 years and addressed one or more of the focus areas.

Search results were uploaded to Covidence, with 775 studies imported for screening. Of them, 162 duplicates were removed, 613 studies were screened and 546 were excluded. Only 67 articles were included for full-text screening and extraction to the literature review as appropriate. Manual searching of reference lists from relevant articles was also conducted for additional peer-reviewed literature or grey literature.

Mapping and review of policies, strategies, plans and legislation

Information on government policies, plans, strategies and laws were sought from relevant government websites and United Nations agencies. Relevant government departments in each allied sector (health, education, social welfare and justice) were first identified and websites searched using similar search terms as the desk review to locate relevant documents relating to mental health. Documents were included if they were:

- produced by the Government or described a government policy, plan, strategy or law;
- related to government intentions, actions or decision-making;
- national in scope;
- the most recent available; and
- addressing one or more tiers of the conceptual framework for MHPSS (care, prevention, promotion).

These were then mapped and reviewed to identify: sector; the extent to which they included specific actions for children and/or adolescents aged 0–18 years; conceptual framework tiers addressed; summary of actions in relation to children and adolescents; and targets and indicators (where relevant).

2. Country-level stakeholder consultation workshops

Two half-day online workshops were conducted, on 12 July and 19 July 2021. These were attended by 15 government and non-government organization participants from the education sector (5), the health sector (2) and the social welfare sector (8). The workshops presented and reflected on the Regional Conceptual Framework, identified priority actions for MHPSS for children and adolescents in the Philippines and propose sectoral roles and responsibilities for implementation of the MHPSS package. To facilitate this, participants were invited to complete an online prioritization tool to provide feedback on each proposed MHPSS action and indicate a lead sector. Fifteen participants completed the online tool; the findings were presented and discussed during the second workshop.

3. Interviews with sector stakeholders

Informant interviews were conducted to explore in depth:

- perceptions and understandings of priority child and adolescent mental health needs;
- current programmes and approaches related to MHPSS;
- barriers and enablers impacting implementation;
- recommended sectoral roles and responsibilities; and
- challenges and considerations for strengthening a multisectoral mental health system.

Sector-specific question guides drew on the project's Regional Conceptual Framework and were refined following review by the sector and mental health experts through the regional and country Technical Advisory Groups.

A total of 27 interviews were conducted with participants aged 18 years or older between 26 July and 23 December 2021. These included 11 interviews with government stakeholders from the health (3), education (3), social welfare (3) and justice (2) sectors. Five interviews were also conducted with representatives from United Nations agencies, nine with NGOs and two with youth organizations. All interviews were managed via Zoom due to the COVID-19-related restrictions. Interviews were conducted by the experienced researchers with the Research Institute for Mindanao Culture who had completed a three-day intensive training workshop covering the study objectives, study procedures and ethical considerations. Interviews were audio-recorded and transcribed verbatim in the language the interview was conducted in (English or Filipino). Transcripts in Filipino were then translated into English. Transcripts were analysed thematically using a Framework Method.

All participants provided voluntary informed consent. Ethics approval was obtained from the Alfred Ethics Committee (Australia), with a letter of support provided by the Council for the Welfare of Children in the Philippines.

4. Validation workshop

Following data analysis, a workshop was conducted via Zoom (14 June 2022) with the Philippines Technical Advisory Group and sectoral stakeholders to present and reflect on the findings and refine the recommendations. Twenty-eight participants attended the workshop. There were six participants from health, nine participants from social welfare, five participants from education, one participant each from justice, the Burnet Institute and UNICEF and five participants from the Research Institute for Mindanao Culture.

Limitations

The synthesis of peer-reviewed literature was restricted to studies published in English. However, publications in Filipino relating to the criteria were identified and reviewed by the Research Institute for Mindanao Culture researchers for inclusion in the desk review. Not all policy, strategy or legislation documents were accessible online, so gaps were filled through the informant interviews. But some policies may not have been included. Additionally, the desk review was limited to national and high-level policies – specific details regarding protocols, guidelines, training programmes and standard operating procedures in relation to MHPSS were not included. The informant interviews were limited primarily to national-level stakeholders, so some specific approaches, priorities and challenges at the subnational level may not have been explored in depth. This project also focused intentionally on supply-side priorities and challenges with respect to implementing MHPSS. Representatives from youth-focused organizations and networks were included in the workshops and interviews to provide perspectives on demand-side barriers, enablers and service delivery preferences. Further research is needed to explore these issues in more depth with children, adolescents and their parents or caregivers (including those with lived experience). The impacts of the COVID-19 pandemic and typhoon restricted the availability of some government stakeholders to participate in the workshops and interviews.

Regional conceptual framework for MHPSS for children and adolescents in East Asia and the Pacific

The first phase of the project developed the Regional Conceptual Framework for Mental Health and Psychosocial Support for children and adolescents. It was based on a review and synthesis of global and regional frameworks for mental health and evidence for effective interventions; review and expert consensus provided by the regional Technical Advisory Group and external content experts; and review and feedback from the four country Technical Advisory Groups and stakeholders from the Philippines during the consultation workshops (see Appendix B for details).

An important foundation for the Regional Framework is the UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.[11] The Global Framework defines a range of interventions to promote psychosocial well-being and prevent and manage mental health conditions by providing guidance to support planning and implementation. While the inception of this research initiative pre-dates the finalization of the Global Framework, the Regional Framework sought to include and harmonize actions for MHPSS in East Asia and the Pacific with the global guidance. The purpose of the Regional Framework is to define the MHPSS that is high priority for the region and provide detailed guidance for implementation, description of sectoral roles and recommendations to strengthen a multisectoral mental health system.

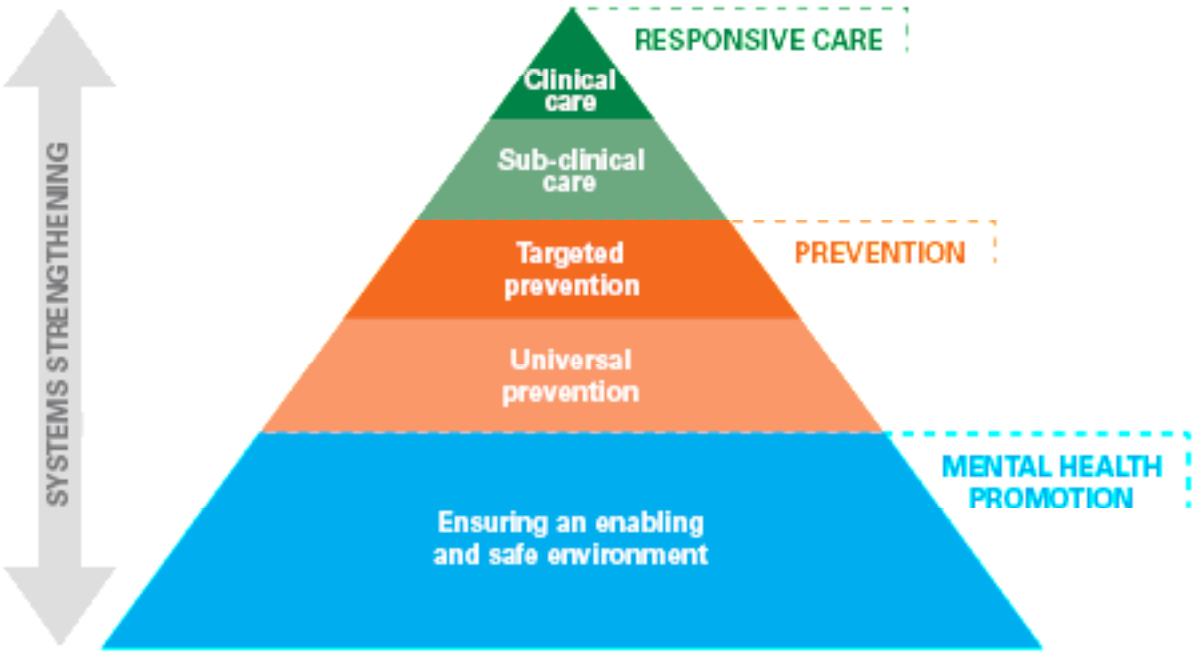
Guiding principles of the framework

Aligned with the Global Framework, the Regional Framework takes a **socioecological approach** to addressing MHPSS, recognizing that the mental health and well-being of children and adolescents are profoundly influenced by individual attributes and experiences as well as relationships with family, peers, communities and the broader environment within which children grow, learn and socialize. Both frameworks consider mental health and well-being across the **life course**, recognizing childhood and adolescence as a critical period of cognitive, social and emotional development that extend into adulthood and for the next generation. Responding to mental health needs and risks must adapt to *developmental stages* rather than follow rigid application of biological age. It also must consider the cumulative impacts of risks (or protective factors) across the life course. And it must acknowledge that there are significant gendered differences in risks, experiences, care-seeking behaviours and outcomes with respect to mental health. Children with disabilities also experience unique mental health needs and barriers in accessing MHPSS. Responses therefore must take specific measures to ensure that MHPSS is **gender-responsive, accessible, inclusive and seeks the active participation** of children, adolescents and their families.

A regional framework for child and adolescent MHPSS

The Regional Framework defines three tiers of actions required to ensure the mental health and well-being of children and adolescents, with systems strengthening as a cross-cutting theme (*see Figure 2*).

FIGURE 2. TIERS OF MHPSS ACTIONS FOR CHILDREN AND ADOLESCENTS



Within each of the three tiers are **domains of action**:

Responsive care for children and adolescents with mental health conditions

This includes care that is age-appropriate and developmentally appropriate, gender- and disability-inclusive and non-discriminatory. Actions include:

- ***Screening, assessment and early identification of mental health needs*** to determine the children and adolescents who are at risk of or have mental health conditions, with a focus on those who would most benefit from care. It also includes the ***referral pathways*** (between and within sectors) for persons requiring specialized care or social support and protection, noting that screening in the absence of referral and accessible care can be stigmatizing.
- ***Management and treatment*** that is responsive to the needs of children and adolescents, including care that is developmentally and culturally appropriate, accessible and comprehensive, including for:
  - ***Clinical mental disorders,*** which refer to clinically diagnosable disorders generally made according to the classification system of the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) or the International Classification of Diseases.
  - ***Subclinical mental disorders and mental health conditions,*** when children and adolescents show signs or symptoms of a mental or psychological disorder but below the clinical threshold for mental disorder.

- ***Continuing care***. Mental health typically fluctuates for individuals over their life cycle. Identified needs may increase and decrease over time and may be exacerbated by stressful life events. Continuing care (that ensures accessible care and support as required) is essential to ensuring the best outcomes for children and adolescents but also for ensuring optimal outcomes across the life course.

Prevention of mental health conditions in the immediate social context

These actions aim to address risk factors for poor mental health and enhance the protective factors. These can be universal (applicable to all children and adolescents, such as limiting access to alcohol and other drugs) or targeted (focused on children and adolescents with high-risk behaviours or in high-risk settings, such as interventions to address harmful substance use). It includes four groups of interventions, coarsely mapped against the socioecological framework.

- **Building individual assets of children and adolescents**, aimed at fostering individual-level assets (physical health, intellectual development, psychological and emotional development and social development). This includes a focus on social and emotional learning, building resilience and improving mental health literacy in children and adolescents.
- **Strengthening positive peer support (including online),** given that peer relationships are a critical protective factor for good mental health. This also includes addressing harmful peer relationships (online and offline), bullying and victimization (cyberbullying).
- **Psychosocial competence-building for parents and caregivers**, including positive parenting practices and improving parents' skills in responsive and nurturing caregiving. This involves a focus on preventing harmful parenting as well as addressing parents' mental health.
- **Safe and enabling learning environment** that ensure a pro-social environment in a setting in which children and young people are connected, supported and not subject to harmful exposures (all forms of physical or mental violence, injury and abuse, discrimination and exclusion, neglect or negligent treatment, maltreatment or exploitation, including online sexual exploitation and abuse).

Ensuring a safe and enabling environment to promote mental health

Through policy, legislation and community engagement, these actions seek to address the structural determinants of mental health and well-being in relation to where children and adolescents live, grow and learn. The determinants of psychosocial well-being are broad, encompassing such factors as secure housing, the environment and climate change; poverty, nutrition, social justice and equality; and disasters, conflict, economic and fiscal contexts and political contexts. Following consultation with the regional Technical Advisory Group and expert advisers, this tier of the framework was narrowed to specifically focus on actions in relation to:

- **Community engagement and participation** – the active involvement of people from communities, including young people and those with lived experience of poor mental health, in the processes for planning, delivering, monitoring and evaluating policies and programmes and in mental health advocacy. The involvement of community members is essential to determine their own priorities in dealing with mental health conditions in their cultural context. Community engagement is also central to addressing harmful norms, attitudes and beliefs that contribute to poor mental health (such as discriminatory attitudes towards non-conforming gender identity or expression), that contribute to poor care-seeking behaviours (for example, harmful norms around masculinity that discourage seeking help) and that contribute to stigma and discrimination against children and adolescents with mental health problems.

- **Policy and legislation** that both *enables and protects* the rights of children and adolescents with mental health conditions, protects children and adolescents from harm and risks associated with poor mental health and provides a clear framework for the system and sectoral roles in responding to and supporting mental health, including sufficient allocation of public resources for MHPSS. Legislation should reflect the values and principles of human rights and the Convention on the Rights of the Child, with the best interests of children and adolescents as a primary consideration. This includes but is not limited to the right to equality and non-discrimination, dignity and respect, privacy and individual autonomy and information and participation.[15]

In addition to identifying what actions are required within each of these tiers, the framework also describes broad roles for allied sectors in implementing MHPSS for children and adolescents (*see Figure 3*). The specific roles and responsibilities of each sector were explored in-depth during country-level analysis, although the Regional Framework proposes broad overarching roles.

The **health sector** has the central role of ensuring accessible and responsive mental health services for children and adolescents with mental health conditions. This includes the delivery of early identification, screening, referral and management by non-specialist providers (general practitioners, nurses, midwives, community health workers and volunteers, auxiliary health providers) as well as specialized care for severe or complex cases by child and adolescent psychiatrists, mental health nurses, neurodevelopment and behavioural paediatricians, clinical psychologists, occupational therapists and speech therapists. The health sector has an important role in prevention targeting young persons at risk of poor mental health (such as the provision of preventive interventions for children and adolescents with comorbid health conditions, young persons identified as pursuing risk behaviours (such as substance use) and young persons in high-risk settings. The sector also can support positive parenting and support parents with mental health conditions as well as promote good mental health (increasing mental health literacy and addressing harmful norms and stigma). The health sector may also take an overall leadership and advocacy role in MHPSS, given the role of the health service in mental health service provision.

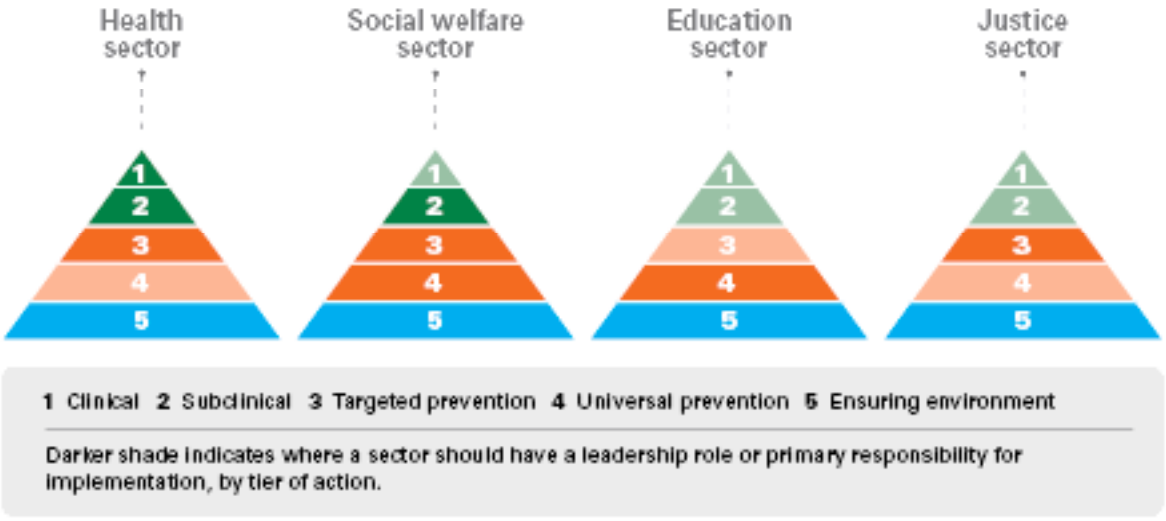
The **social welfare secto**r has a significant role in the delivery of MHPSS. The social service workforce broadly encompasses government and non-government professionals, paraprofessionals and community volunteers who work within social welfare or community development but also may be employed in other sectors (including health, education or justice). Because of the particular focus on child protection and working with families at risk, this sector has a crucial role in the delivery of targeted preventive interventions to address risk factors for children, adolescents and their families, especially those with high-risk exposure to poor mental health (exposed to violence, neglect or exploitation). This also includes delivering and supporting programmes to improve responsive and nurturing caregiving, which may be universal or targeted to those at increased risk (such as parents with mental health conditions). This sector has a role in early identification and screening in some settings, supporting a strong referral system and provision of responsive care for mental health conditions as part of a multidisciplinary team. There is also broader opportunity to ensure an enabling environment for good mental health through social welfare and social protection that addresses the social determinants of health. The social welfare sector also has a role in community-based and national advocacy that can help tackle stigma and harmful norms.

The **education sector** is critical for implementing universal preventive interventions as well as ensuring that school and learning environments promote mental health and well-being. The education sector arguably comprises the biggest mental health and psychosocial support workforce because teachers, school-based counsellors, psychologists and volunteers (such as peer counsellors) have the potential to reach large numbers of children and adolescents. In addition to the delivery of curriculum-based approaches to support social and emotional learning, there is also an opportunity for schools to shape attitudes and norms around mental health and positive relationships that makes an important contribution to building an enabling environment for good mental health. Teachers, school counsellors and school-based psychologists are needed for early identification and assessment of mental health needs, referrals, behavioural management and targeted prevention. Schools have an important role in supporting children and adolescents with mental health needs, including through the formal opportunity for education or alternative learning pathways. Schools may also provide an opportunity for screening, with careful consideration; screening alone, in the absence of accessible

services and support, can be stigmatizing. Additionally, lack of age-, culture- and language-appropriate tools, limited training in their application and lack of confidentiality may contribute to misdiagnosis and the pathologizing of normal behaviours and stigma.

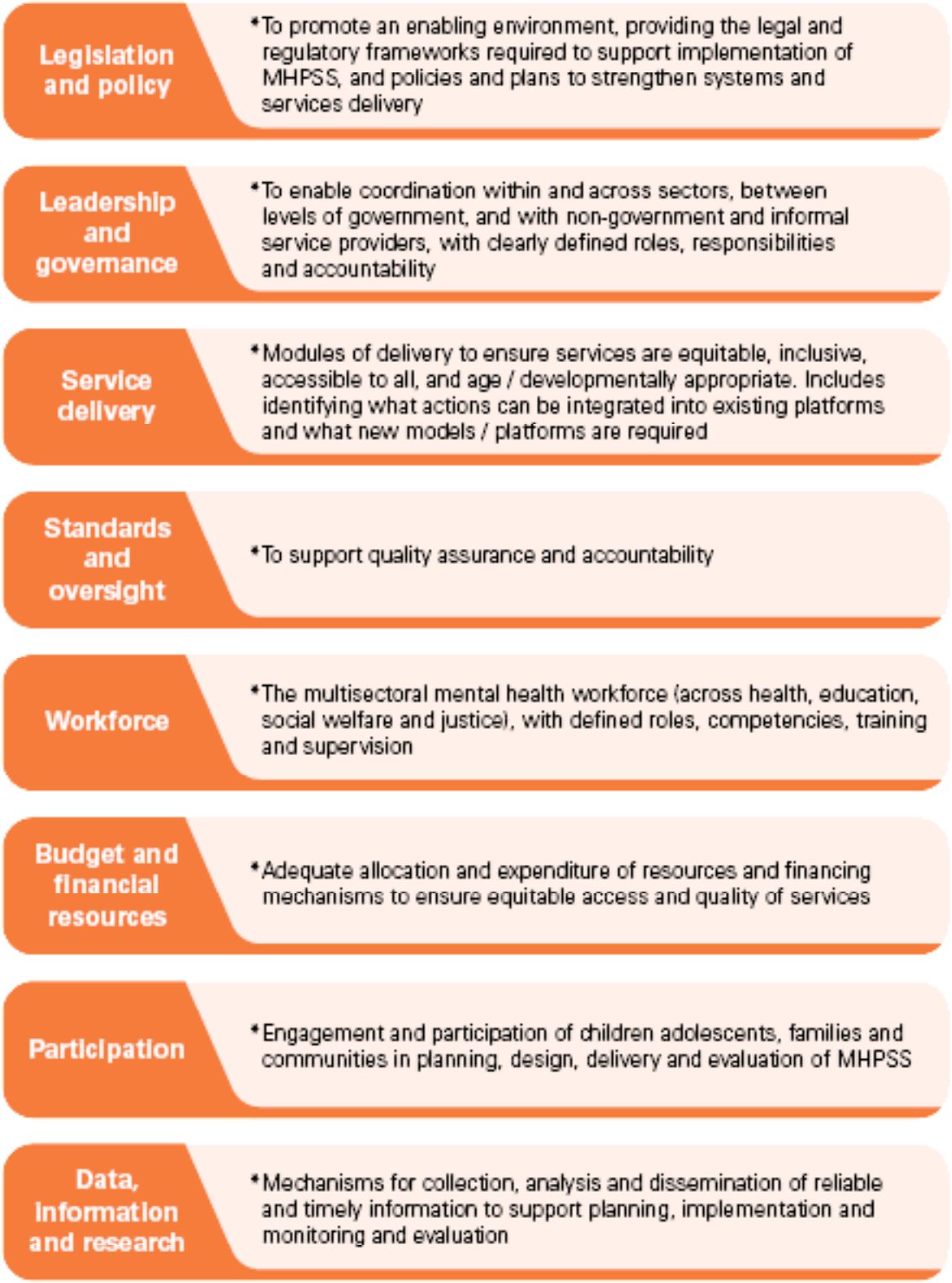
The **justice sector** has a significant role in supporting children and adolescents who are at increased risk of poor mental health, including those who are in conflict with the law and those who are victims (or witnesses) of violence. This includes responding to mental health needs and risk factors (such as exposure to violence or substance misuse) for children in conflict with the law and preventing (or responding to) further harm and risks exacerbated by detention. In collaboration with the social welfare and health sectors, the police, public prosecutors, court psychologists, probation officers, detention centre workers, social service workers and judges could support the delivery of early identification and screening in some settings, referral and links with mental health services and targeted prevention and response in justice settings (including addressing harmful use of substances and programmes to build individual assets and skills).

FIGURE 3. SUMMARY OF BROAD SECTORAL ROLES FOR MHPSS



The regional framework also identifies eight pillars of **systems strengthening** required to enable effective and equitable implementation of these actions within and across the allied sectors (*see Figure 4*). These were explored in more depth during the consultation workshops and the interviews.

FIGURE 4. PILLARS OF SYSTEMS STRENGTHENING



Mental health and psychosocial well-being:

The situation for children and adolescents in the Philippines

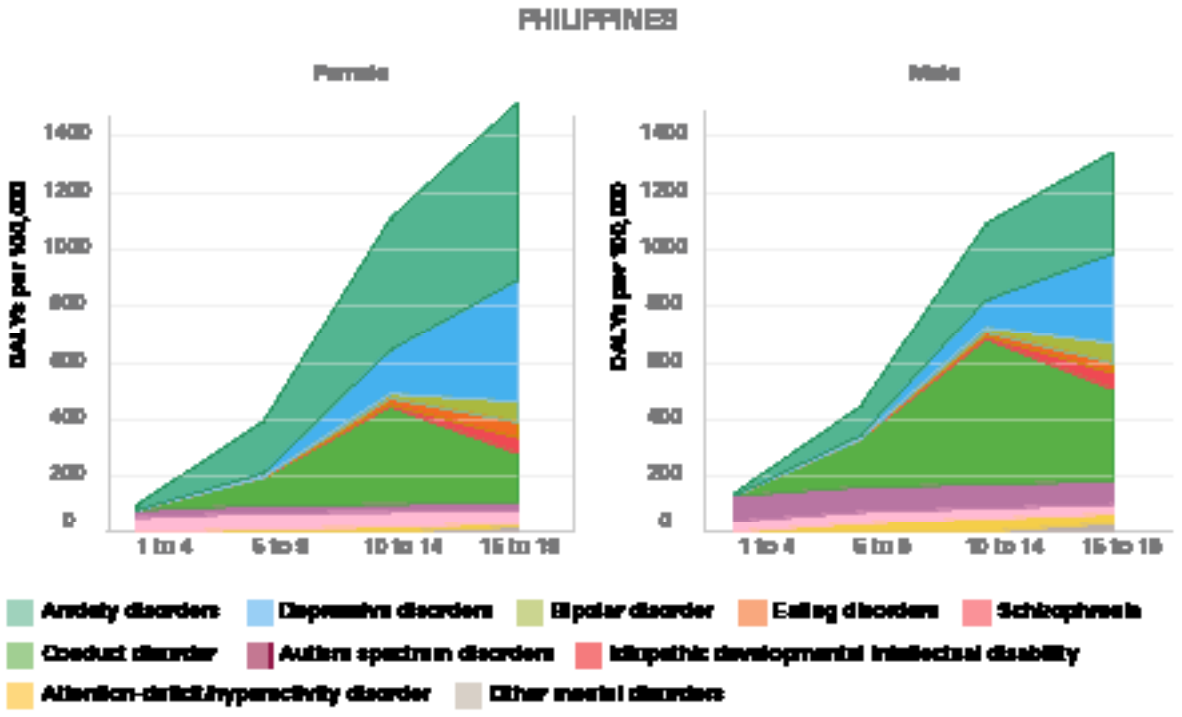
Mental health needs of children and adolescents

Mental health outcomes

Children and adolescents aged 0–18 years in the Philippines experience a substantial burden of poor mental health. Modelled estimates from the 2019 Global Burden of Disease Study indicate that **mental disorders and self-harm accounted that year for around 13 per cent of the total burden of disease among 10- to 19-year-olds**.[1] Among younger adolescents and children aged 5–14 years, mental disorders were the third-leading cause of poor health as of 2019, with conduct disorder and anxiety disorder alone accounting for almost 6 per cent of the total burden of disease in this age group.[1] One in eight adolescents aged 10–19 and one in seventeen children aged 5–9 were estimated to have a mental disorder (including developmental disorder).[1]

Figure 5 shows the burden of disease due to mental disorders across childhood and adolescence, reported as disability-adjusted life years (healthy years of life lost due to either disability (illness) or premature death). Several important observations can be made. First, the burden of disease due to mental disorder increases substantially during childhood and adolescence, with the greatest increases being during later childhood and early to mid-adolescence. Second, the specific causes of poor mental health vary substantially by age: for young children, developmental disorders predominate; for young adolescents there is a sharp increase in conduct disorders, depression and anxiety; for older adolescents and young adults, there is a predominance of depression and anxiety, with an emergence of psychosis and eating disorders. Third, there are important differences in burden and pattern of mental disorder by gender. Girls have an overall larger burden of mental disorder that is mostly driven by excess depression and anxiety, while boys have an excess burden of conduct disorder, autism-spectrum disorders and attention-deficit or hyperactivity disorder (see also Appendix C).

FIGURE 5. MENTAL HEALTH DISORDERS ACROSS CHILDHOOD AND ADOLESCENCE IN THE PHILIPPINES, 2019

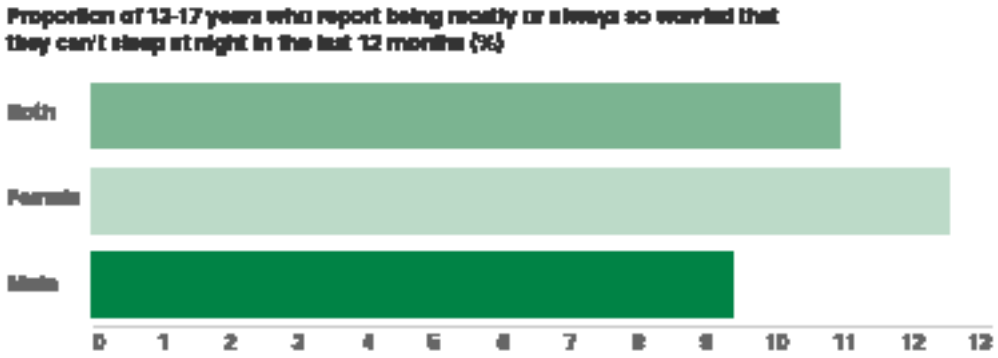


Note: The graph shows disease burden (in disability-adjusted life years, or DALYs, which are the years of life lost to either cause-specific death or disability) due to mental disorders across childhood and adolescence.

Source: Institute for Health Metrics and Evaluation, *Evaluation IfHMa. Global Burden of Disease Data Tool,* IHME, Washington, D.C., 2019.

National data describing mental health outcomes of children and adolescents in the Philippines are limited. According to the WHO's Seven Nations Collaborative Study estimates, 16 per cent of children and adolescents in the Philippines in 2007 had a mental health disorder.[16] The most recent data derive from the 2015 Global School-based Student Health Survey: For example, in 2015, 11 per cent of 13- to 17-year-olds reported **anxiety** so severe that they could not sleep at night most of the time in the previous 12 months. The reports were more prevalent among girls (at 20 per cent) than boys (at 9 per cent) (*see Figure 6*).[12] The Philippine Department of Health (DOH) is undertaking the first national survey to establish the prevalence of mental health conditions.[17]

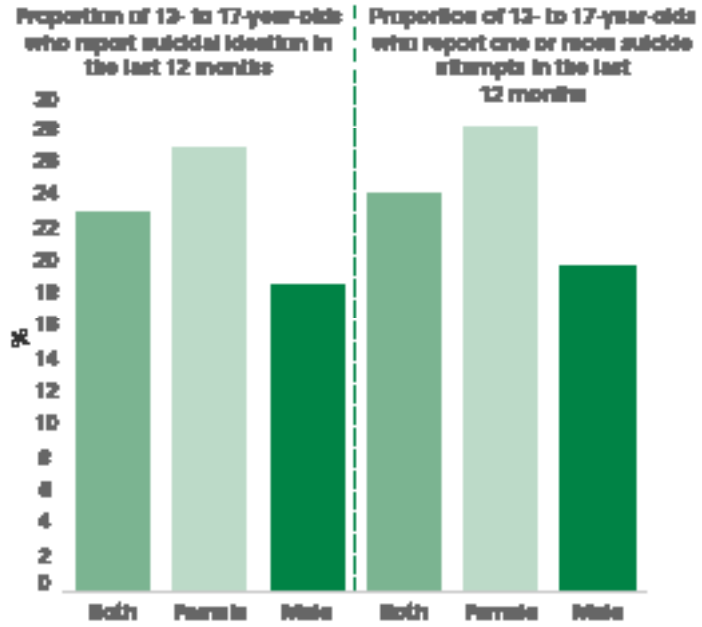
FIGURE 6. PREVALENCE OF SIGNIFICANT WORRYING AMONG 13- TO 17-YEAR-OLDS, 2015



Source: DOH, *Global School-based Student Health Survey 2015,* WHO, CDC, Dep Ed, Manila, 2015.

Suicide is closely related to poor mental health. The 2019 Global School-based Student Health Survey found that 23.1 per cent of school-going adolescents aged 13–17 years in the Philippines had seriously considered suicide in the previous 12 months (an increase from 11.3 per cent in 2015) and 24.3 per cent had attempted suicide at least once (compared with 17 per cent in 2015). The prevalence of suicidal ideation and attempt was higher among girls than boys (*see Figure 7*).[12,13]

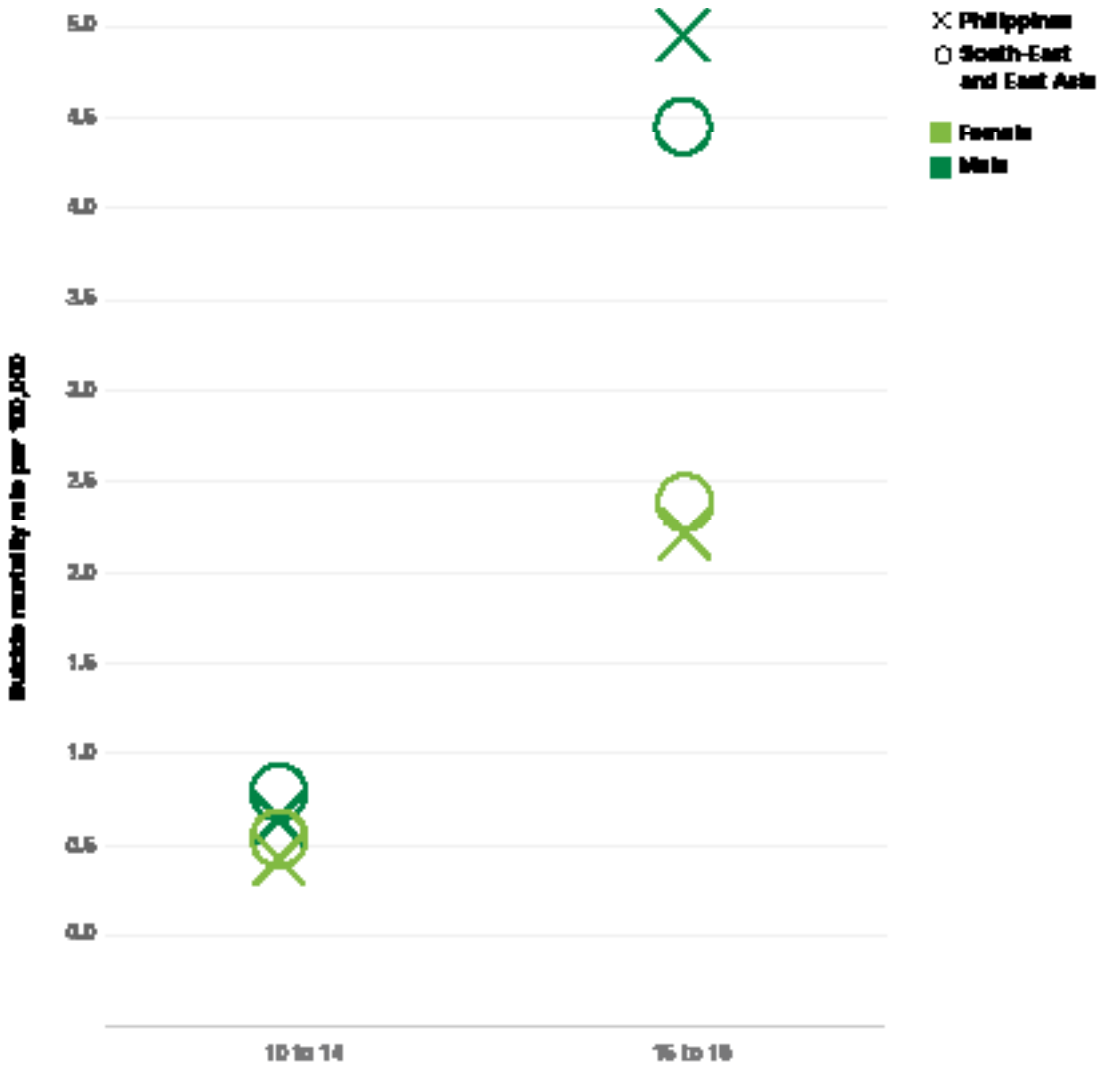
FIGURE 7. SUICIDAL IDEATION OR BEHAVIOUR SELF-REPORTED BY FILIPINO ADOLESCENTS, 2019



Source: DOH, *Global School-based Student Health Survey 2019,* WHO, CDC, Dep Ed, Manila, 2019.

Suicide is estimated to be the fourth-leading cause of death among adolescents in the Philippines,[1] although direct information on suicide mortality among adolescents and children is sparse. The Philippine Statistics Authority reported that the total number of deaths (all ages) due to intentional self-harm rose by 25.7 per cent in 2020, compared with 2019, with more than 3,500 suicide deaths reported.[18] No age-disaggregated data were available. Adjusting for missing data (deaths not reported) or misclassification of cause of death, the 2019 Global Burden of Disease Study estimated that the mortality rate due to self-harm in the Philippines for adolescents aged 10–15 was 0.55 per 100,000 population and 3.62 per 100,000 population for those aged 15–19 (*see Figure 8*). Boys in the Philippines have an excess risk of suicide when compared with girls and an excess risk when compared with other boys in the region.[19]

FIGURE 8. SUICIDE MORTALITY AMONG 10- TO 19-YEAR-OLDS IN THE PHILIPPINES, 2019



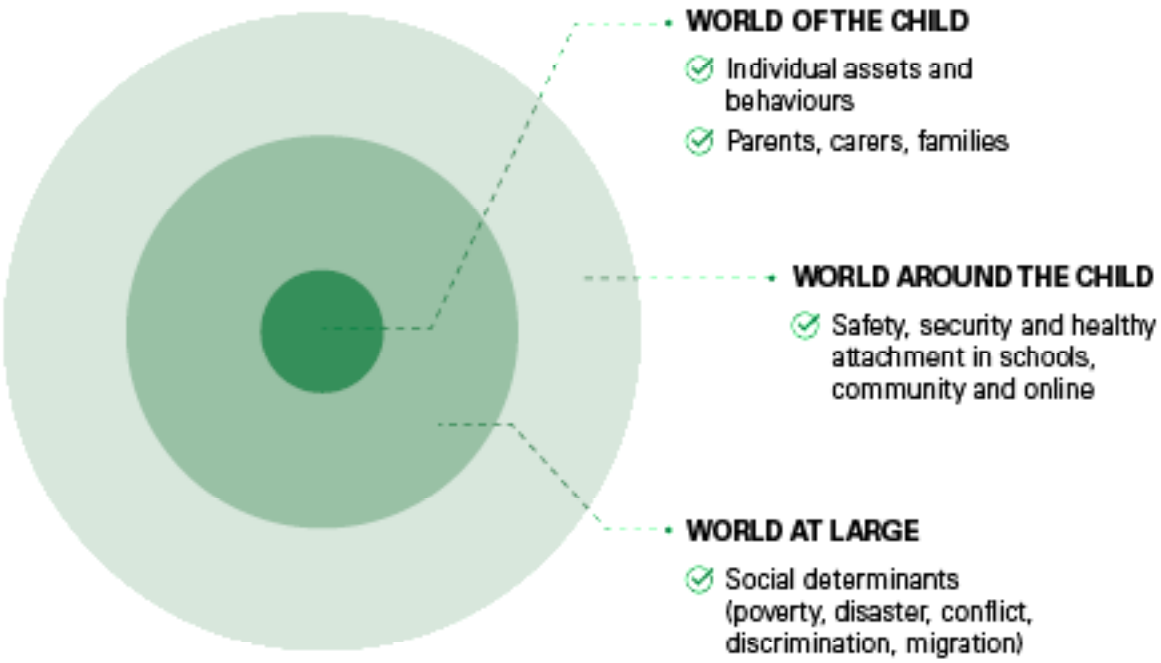
Source: Institute for Health Metrics and Evaluation, *Evaluation IfHMa. Global Burden of Disease Data Tool,* IHME, Washington, D.C., 2019.

Available survey data and published studies of mental health needs in the Philippines most commonly relate narrowly to mental disorder. To explore a broader understanding of mental health needs during childhood and adolescence, stakeholders who participated in the interviews and workshops for this country report were also asked to describe their own understanding of mental health during this age. The most commonly identified mental health needs included anxiety and depression as well as behavioural problems impacting learning.

Risks and determinants of mental health and psychosocial well-being

UNICEF's *The State of the World's Children 2021* report defines three spheres of influence that shape the mental health and well-being of children and adolescents: "the world of the child" (individual assets, parents, caregivers and families), "the world around the child" (safety, security and healthy attachment in school, communities and online) and "the world at large" (social determinants including poverty, disaster, conflict, discrimination and migration) (*see Figure 9*).[2] Childhood and adolescence are times of rapid change in social context and roles, and the timing and nature of exposure from the environment and immediate social context can powerfully shape mental health and well-being for children and adolescents. These risks and protective factors are cumulative across the life course and are often clustered, with children experiencing multiple adverse childhood experiences (abuse, neglect, violence or dysfunction within their family, peers or the community) having the highest risk of poor mental health.[2]

FIGURE 9. SPHERES OF INFLUENCE ON MENTAL HEALTH AND WELL-BEING



Source: Adapted from UNICEF, *The State of the World's Children 2021,* New York, 2021.[2]

The world of the child

For children, **healthy attachment with parents and other caregivers and nurturing, responsive care** are powerful determinants of mental health and well-being. Attachment is the emotional relationship between a child and their parents or caregivers that gives the child a sense of safety and protection and fosters the development of social and emotional skills. Although attachment is crucial and evolving over the course of childhood and adolescence, it is one of the defining influences on mental health and well-being during infancy and early childhood.[2] The mental health of parents and caregivers also impacts on their capacity to provide responsive care and healthy attachment, including for adolescent parents.[20]

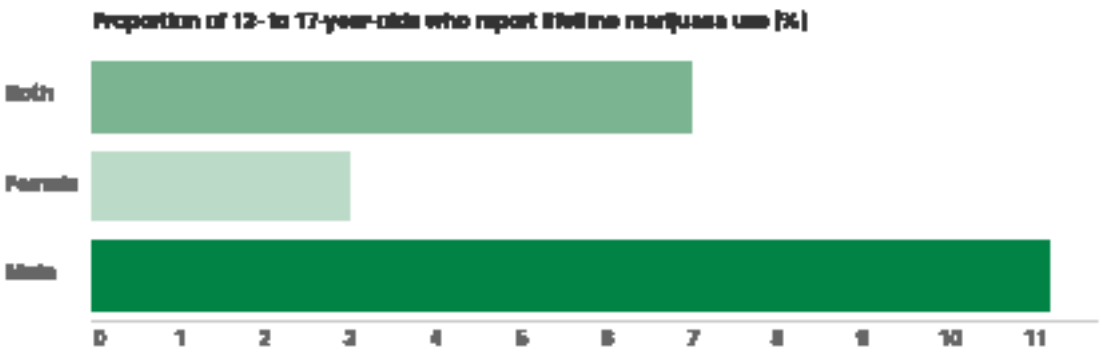
National data describing parental attachment, positive parenting, early stimulation or adequate supervision during childhood are limited. The 2016 National Baseline Study on Violence Against Children found that 7.9 per cent of 13- to 18-year-olds felt or had been abandoned by their parents or caregivers, with 3.3 per cent having been physically abandoned in the previous 12 months.[14] In the 2019 Global School-based Student Health Survey, only 29.4 per cent of school-going adolescents aged 13–17 years reported that their parents or caregivers had understood their problems and worries in the previous 30 days, with similar rates for boys and girls.[13] An estimated quarter of children younger than 18 had one or more parents working overseas as of 2012.[21] In a survey of high school students with parents abroad in 2012, respondents reported higher levels of emotional loneliness and stress than those whose parents lived at home.[21]

Stakeholders who were interviewed for this report also highlighted the importance of family factors for mental health and well-being of children and adolescents. They emphasized the critical influence of parental attachment and quality of caregiving relationships, parental support and guidance, parents' own mental health and mental health literacy and exposure to family violence.

Violence and neglect experienced within households and families are risk factors for mental health conditions.[22,23] In the 2016 National Baseline Study on Violence Against Children, 40 per cent of 13- to 18-year-olds had ever experienced physical violence at home, with almost 5 per cent requiring hospitalization for physical harm. Parents were the main perpetrators of physical violence, with boys slightly more likely to have experienced violence than girls. Almost one in four of the respondents reported experiencing psychological violence (verbal abuse, threats or abandonment), and 13.7 per cent had experienced sexual violence in their home.[14] In addition to being victims of violence, 41.4 per cent of children had witnessed physical violence in the home. Respondents in the baseline study reported that exposure to violence contributed to their low self-esteem, feeling sad, fearful and anxious and to their social isolation.

For older children and adolescents, **substance use and misuse** are important individual-level risk factors for poor mental health.[24] In the 2015 Global School-based Student Health Survey, 7.9 per cent of 13- to 17-year-olds reported having used any drug in the previous 30 days, with 77.7 per cent having first used drugs before the age of 14 years.[12] Among students, 21.2 per cent reported drinking alcohol in the previous 30 days, and 20.7 per cent said that they had ever drunk so much that they were heavily intoxicated (a greater proportion of boys, at 24.5 per cent, than girls, at 16.9 per cent). More than one in ten respondents had ever been in trouble with family or friends, missed school or been involved in a physical fight as a result of alcohol use.[12] The 2019 Global School-based Student Health Survey also found that 7 per cent of adolescents aged 13–17 reported having ever used marijuana (*see Figure 10*)[13] and 4.8 per cent in the 2015 survey had used amphetamines.[12]

FIGURE 10. LIFETIME MARIJUANA USE, 2019 (%)



Source: DOH, *Global School-based Student Health Survey 2019*, WHO, CDC, Dep Ed, Manila, 2019.

Sedentary behaviours and screen time are important influences on psychosocial well-being. The 2019 Global School-based Student Health Survey reported that more than a third (36.4 per cent) of students aged 13–17 years spent three or more hours per day sitting (watching television, playing computer games, doing homework, talking with friends when not in school) and only 6.7 per cent were physically active for at least 60 minutes per day.[13] Excessive internet use and internet addiction are associated with increased risk of attention deficit or hyperactivity disorder, depression and anxiety.[25] A 2014 study of adolescents aged 12–18 years in the Philippines reported that 46 per cent had problematic internet use (withdrawal and social problems, impacts on time management and reality substitution), with 4.9 per cent (the highest in the region) reporting addictive behaviour (significant problems due to excessive use).[26]

Stakeholders cited social media and internet addiction as important contributors to poor mental health, including social anxiety, loneliness and depression. They also noted that the impacts of excessive screen time, exposure to harmful information or social pressures online have contributed to poor mental health among adolescents.

> *One factor that contributes to the poor mental health needs of children and adolescents is that they have heightened exposure to information and images, such as those relating to body images and standards of beauty, in the social media. Children and adolescents cannot always process and do not often understand the information correctly. Hence, [these] are stressors to their mental well-being.* – Social welfare sector representative

Children and adolescents with chronic illness and disability may also experience a higher burden of poor mental health. The 2016 National Disability Prevalence Survey reported that 20 per cent of people older than 15 years and living with a severe disability felt depressed and 24 per cent experienced anxiety.[27] Overall, 5 per cent of the respondents with a severe disability had a mental disorder, although no age-disaggregated data are available. There are no studies describing the specific mental health needs of children living with a disability.

Child marriage and early pregnancy are associated with poorer mental health outcomes. In 2021, 16.5 per cent of Filipino women aged 20–24 years were married before they were 18 and 10.5 per cent had commenced childbearing also by age 18.[28] There are no studies describing mental health needs and outcomes of married adolescents or young mothers.

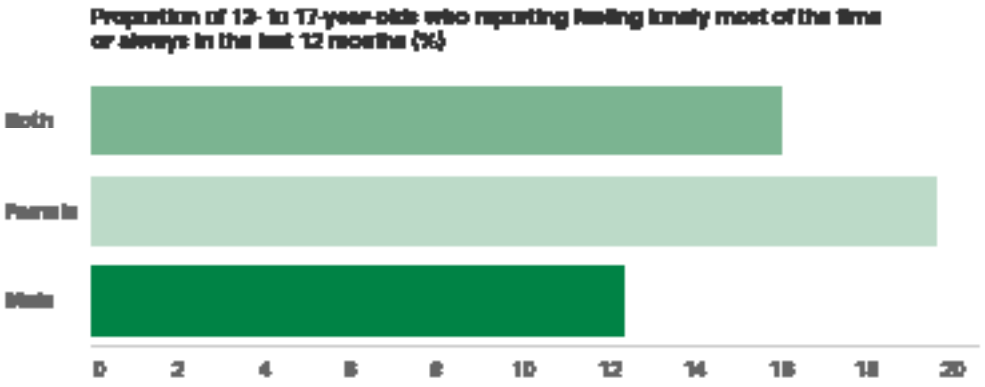
Children and adolescents living in alternative care, including residential care, are at increased risk of poor mental health and exposure to risk factors, such as violence. Accurate data on the numbers of children living in or requiring alternative care are limited. The 2018 UNICEF *Situation Analysis of Children in the Philippines* reported that around 1,500 children were in foster care, more than 2,500 in residential care facilities managed by the Department of Social Welfare and Development (DSWD)

and nearly 6,000 children in the process of being adopted.[29] While published studies examining mental health needs or risks for these children are extremely limited, the United Nations Committee on the Rights of the Child had previously expressed concern regarding the high rate of institutionalization and reports of physical and psychological violence in residential care.[30]

The world around the child

in addition to healthy parent or caregiver relationships, **peer relationships and connectedness** also influence mental health and well-being, particularly during adolescence. The 2015 Global School-based Student Health Survey reported that 16.1 per cent of adolescents said they felt lonely most of the time or always (*see Figure 11*) and 4.4 per cent had no close friends.[12]

FIGURE 11. PREVALENCE OF LONELINESS AMONG 13- TO 17-YEAR-OLDS, 2015 (%)



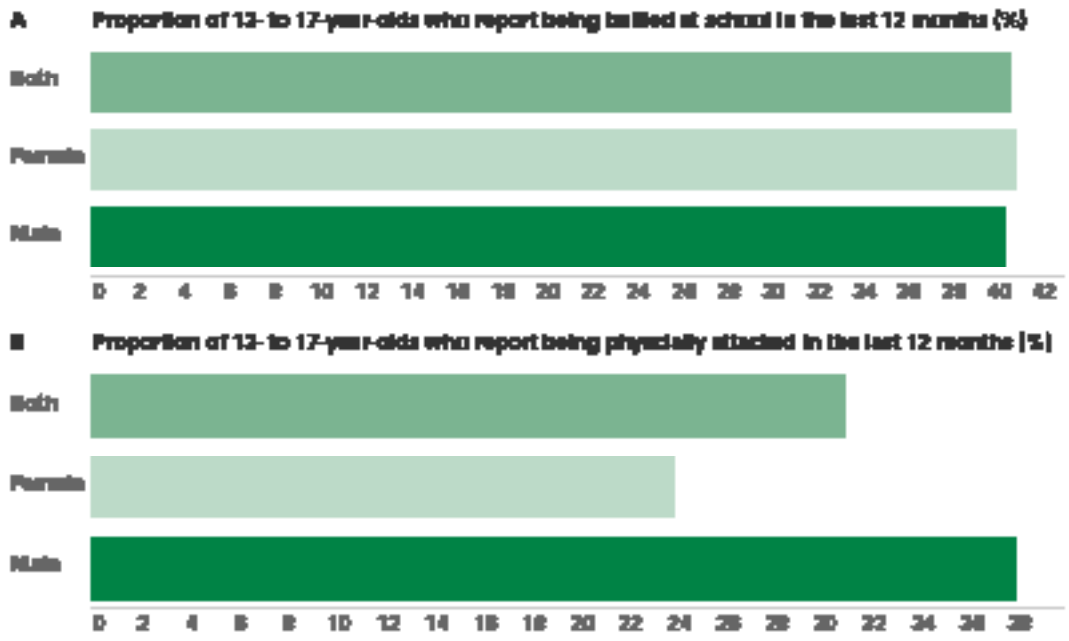
Source: DOH, *Global School-based Student Health Survey 2015*, WHO, CDC, Dep Ed, Manila, 2015.

Exposure to bullying[i]*** behaviour, harassment and violence** are risk factors for poor mental health and are highly prevalent among adolescents in the Philippines. In the 2015 Global School-based Student Health Survey, almost half (48.7 per cent) of students aged 13–17 reported being bullied in the previous 30 days, of which 16 per cent had experienced physical bullying.[12] In the 2019 Global School-based Student Health Survey, 40.6 per cent of 13- to 17-year-olds had experienced bullying behaviour at school in the previous 12 months.[13] Prevalence of experiencing peer victimization was similar between boys and girls (*see Figure 12*). The 2016 National Baseline Study on Violence Against Children also reported a lifetime prevalence of bullying, at around 60 per cent, and which was slightly greater among girls (at 70.5 per cent) than boys (at 59.8 per cent).[14] **Online bullying behaviour and violence** was reported by 43.8 per cent of 13- to 18-year-olds in the National Baseline Study, including verbal abuse and sexual harassment (including receiving unsolicited and unwanted sexual images).[14]

Witnessing, perpetrating or being the victim of **physical violence** is common. In the 2019 Global School-based Student Health Survey, almost a third (31 per cent) of students aged 13–17 years reported involvement in a physical fight within the previous year.[13] Rates were higher among boys, with 38 per cent reporting being physically attacked, compared with 23.9 per cent of girls (*see Figure 12*). In the 2016 National Baseline Study, 15.2 per cent of 13- to 24-year-olds reported experiencing all forms of violence (physical, psychological and sexual) in their lifetime.[14]

i The term 'bullying' is used here because it is consistent with the survey measures referenced. There is an emerging approach to redefine bullying as 'unhealthy relationships or situations', with a focus on the behaviour itself, its determinants and impacts rather than on a child.

FIGURE 12. REPORTED PREVALENCE OF BULLYING (A) AND VIOLENCE (B) AMONG 13- TO 17-YEAR-OLDS, 2019



Source: DOH, *Global School-based Student Health Survey 2019*, WHO, CDC, DepEd, Manila, 2019.

Sexual harassment, sexual violence and intimate partner violence are important risk factors, most notably for adolescent girls. National survey data for 2021 indicated that more than one in eight married or cohabiting girls aged 15–19 years had experienced physical or sexual violence in their lifetime and 2.7 per cent of all adolescent girls aged 15–19 had experienced sexual violence.[28] In the 2016 National Baseline Study on Violence Against Children, 5.3 per cent of 13- to 18-year-olds reported ever experiencing sexual violence at school and 7.8 per cent reported sexual violence in the community. Rates of rape experienced in school were slightly higher among boys (at 1.5 per cent) than girls (at 1 per cent).[14] **Online sexual exploitation** is a significant concern and has been associated with higher rates of post-traumatic stress, low self-esteem and behavioural problems (including sexualized behaviour).[31] A recent study of internet-using adolescents aged 12–17 found that 20 per cent had experienced serious online sexual exploitation in the previous 12 months, including being blackmailed to engage in sexual activities, having sexual images shared without permission or being coerced to engage in sexual activities through promises of money or other gifts.[32]

Safe and enabling learning environments profoundly influence mental health and well-being. Participation in early education and primary and secondary school are important protective factors. In 2019, an estimated 14 per cent of boys and 13 per cent of girls were not participating in early childhood education (one year before primary school entry age). While the majority (97 per cent) of young people were attending primary school, 14 per cent of boys and 7 per cent of girls of that age were not in lower-secondary education, and 24 per cent of boys and 17 per cent of girls of that age were not in upper-secondary education, with an estimated total of 1.2 million children and adolescents out-of-school. (UNESCO, 2022)

Schools are a source of stress for many young people. Stakeholders described academic pressures, competition and family expectations around academic performance contributing to high levels of psychological distress among students. These have been exacerbated during the COVID-19 pandemic due to the increased pressures of remote learning, disruption of normal school routines and social isolation and loss or peer support.

The world at large

National data and published studies exploring the association of social determinants with child and adolescent mental health are limited. Stakeholders cited several factors that are likely to influence mental health and well-being. These include poverty and economic instability (exacerbated by the COVID-19 pandemic), legislative and other barriers that limit access to MHPSS and political unrest and exposure to conflict.

Child labour is likely to be an important contributor to poor psychosocial well-being. There are an estimated 1 million child domestic workers who are at increased risk of social isolation, exploitation and violence in the country.[33] While data on the mental health needs of this group are limited, a 2012 study reported that two thirds of domestic workers were younger than 15 years, among whom feelings of being stressed and overwhelmed were common.[34]

Natural disasters are another significant mental health risk factor. In 2017, the Philippines experienced the second-largest number of people affected by natural disasters internationally, at 6.5 million.[35] A 2021 study found that children and families affected by natural disasters experienced higher rates of parental stress, parental depression, food insecurity, violence at home and being a victim of physical violence.[36]

Stigma and discrimination are important contributors to mental health. Misconceptions and stigma associated with mental health are common and an important contributor to poor access to MHPSS. Stakeholders described shame associated with mental health, social isolation or exclusion of children with developmental disorders and their families. They added that the fear of being labelled 'with mental illness' inhibited children and families from accessing MHPSS and exacerbated ongoing psychological distress. For adolescents in particular, stigma and discrimination experienced by those whose sexuality and/or gender identity do not conform to rigid norms contribute to a high burden of poor mental health.[37]

Covid-19

the pandemic has significantly affected mental health and well-being.[38,39] Public health approaches that limited social interactions and disrupted education and employment (and the resulting isolation and increased use of social media and potential increase in exposure to family violence and conflict) have acutely impacted mental health. The economic uncertainties and projected socioeconomic inequalities will have more long-term implications.[40] The pandemic may also lead to resources being diverted away from mental health and child protection services and, combined with greater need, may result in services being more difficult to access.

The prolonged stay-at-home orders, particularly in Manila, have raised concerns about the short- and long-term impacts on mental health and the cognitive and social development of children. Hospital presentations among adolescents for depression and anxiety at the Philippine General Hospital increased from 17 per cent in 2019 to 27 per cent in 2020, while child helplines experienced a 167 per cent increase in reports of child abuse and a 260 per cent increase in reports of online child sexual exploitation and abuse.[41] In a 2020 survey of nearly 2,000 Filipinos, adolescents and youth aged 12–21 were the age group reporting the highest level of stress (at 19.8 per cent reporting a moderate or more level), anxiety (37.4 per cent) and depression (26.3 per cent).[42] Other qualitative studies also reported high levels of stress and anxiety related to the COVID-19 pandemic, including fear of illness, feelings of hopelessness and isolation, worry related to financial stress and stress related to online learning.[43]

Current responses to the mental health needs of children and adolescents

National policies, strategies and legislation

Table 1 overviews the national policies and legislation relevant to mental health and MHPSS. Documents are summarized by sector.

Table 1. Summary of MHPSS-related legislation and policies

National mental health plan, policy and strategy	The National Mental Health Program aims to promote the overall wellness of all Filipinos; prevent mental, psychosocial and neurological disorders and reduce the burden of disease by improving access to quality care and recovery to attain the highest possible level of good health to participate fully in society.	National Mental Health Policy 2001 and Operational Framework 2016 Mental Health Strategic Plan 2019–2023
Age of majority	18 years old	Civil Code of the Philippines: Emancipation and Age of Majority (RA No. 6809) Special Protection of Children Against Abuse, Exploitation and Discrimination Act (RA 7610) Juvenile Justice and Welfare Act of 2006 (S.4(c))
Age of consent to medical care	Children 14 years or older are presumed to have capacity to consent.	Cardwell v. Bechtol (American case law, but it has been referred to in the Philippines)
Standards of care for mental health	"All persons…shall be presumed to possess legal capacity for the purposes of this Act or any other applicable law, irrespective of the nature or effects of their mental health condition or disability".	Mental Health Act
Protections within mental health legislation	No special protections in the Mental Health Act for minors.	
Prohibition physical restraint for those with acute mental illness	The Act makes provision of treatment without informed consent, during psychiatric or neurologic emergencies or when there is impairment or temporary loss of capacity on the part of a service user. In such instances, "treatment, restraint or confinement, whether physical or chemical, may be administered or implemented pursuant to the following safeguards and conditions:" service user's advance directives; only to the	S.5 Mental Health Act (RA 11036)

	extent that such treatment or restraint is necessary; and only while a psychiatric or neurologic emergency, or impairment or temporary loss of capacity, exists or persists.	
Right to mental health care for those deprived of liberty	Free mental health counselling, education and assessment are to be provided to all incarcerated persons upon entry into the penal system and until one year after release. The law also includes provision of programmes to strengthen family relationships during and after incarceration.	Senate Bill No. 180
Criminalization of suicide	Suicide is not criminalized; however, aiding suicide is criminalized.	Penal Code (Art. 253)
Mental health and education	The Rules and Regulations of RA 11036, released in 2019, stipulate that the integration of mental health into the educational system shall be established within two years after the IRR's effectivity.	S.24 Mental Health Act (RA 11036)
Mental health and child protection	Committee for the Special Protection of Children by order of Executive Order No. 275 (1995) under S.19 Republic Act 7610.	S.19 Republic Act 7610
Rights and protection of children and adolescents	All children shall be entitled to the rights herein set forth without distinction as to legitimacy or illegitimacy, sex, social status, religion, political antecedents and other factors. This includes right of children to assistance, including proper care and nutrition and special protection from all forms of neglect, abuse, cruelty, exploitation and other conditions prejudicial to their development.	Art.3 Presidential Decree No. 603 Philippine Constitution (Art 15(3))
Age of sexual consent	16 years The Act was amended to specify that males can also be the victim of rape.	Anti-Rape Law of 1997 (Art.266) (Republic Act No. 8353 Art 266-A) Republic Act No. 11648
Age of marriage	Age of consent for marriage is 18 years.	Family Code The Family Code of the Philippines (Executive Order no. 209) was signed into law on July 6, 1987.
Prohibition of violence	No torture, force, violence, threat, intimidation or any other means that vitiate the free will shall be used against a person.	Philippine Constitution (Art.3(12)) Special Protection of Children Against Abuse, Exploitation and Discrimination Act (RA 7610); Expanded Anti-Trafficking in Persons Act of 2012 (RA 10364) and Anti-Child Pornography Act of 2009 (RA

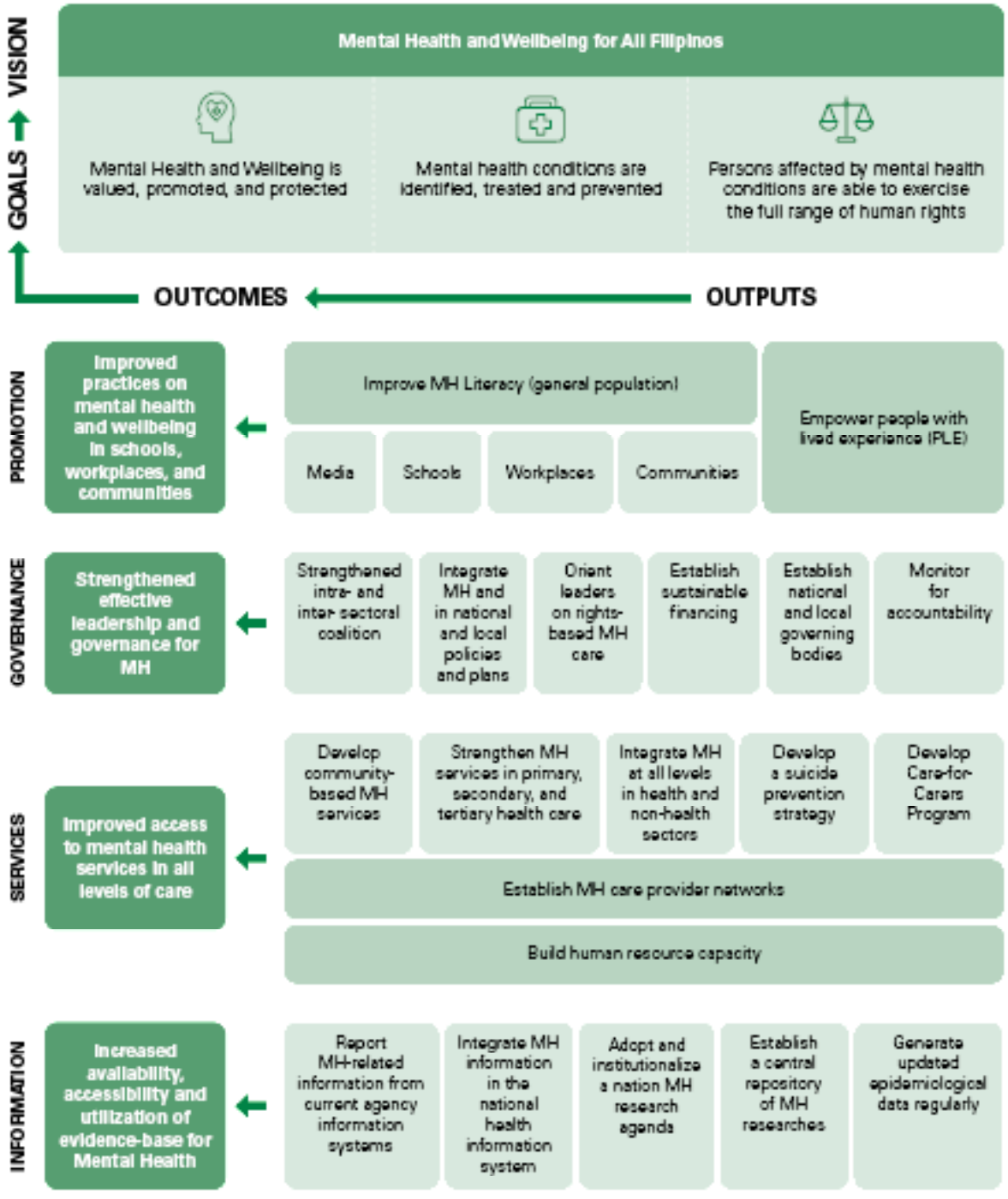
		9775) Anti-Violence Against Women and their Children Act of 2004 (RA No. 9262)
Laws on corporal punishment	Parental authority over children to impose discipline on them as may be required under the circumstances is permitted. Right of parents to discipline the child as may be necessary for the formation of their good character is recognized.	Family Code 1987 (Art. 20) Child and Youth Welfare Code 1974 (Art.45)
Prohibition of recruitment to armed forces	Does not allow any person younger than 18 years to take part in armed conflict; "Children shall not be recruited to become members of the Armed Forces of the Philippines or its civilian units or other armed groups."	S.4 Philippine Army Soldier's Handbook on Human Rights and International Humanitarian Law (2006); Special Protection of Children in Situations of Armed Conflict (RA 11188) S.22 RA No. 7610 (1992)
Minimum age of criminal responsibility	There is a proposal to lower the 15 years of age threshold to 12 years, through House Bill 8858. Mitigating circumstances allowed for consideration of anyone younger than 18 years.	Juvenile Justice and Welfare Act of 2006 (RA 3944) (S.20) Penal Code (Art.13(1))
Child labour	Minimum age for employment is 15 years and children younger than 18 years are protected from hazardous work.	An Act to Regulate the Employment of Women and Children (RA 679 S.3, S.12); An Act Prohibiting the Employment of Children Below 15 years of Age in Public and Private Undertakes, Amending for this Purpose Section 12, Article VIII of RA 7610 (RA 7658)
Criminalization of same-sex consensual sex	Sexual relations between people of the same sex is not prohibited, provided they do not violate provisions of the law that prohibit violence and force that amount to sexual assault or sex in public or sex under scandalous circumstances amounting to grave scandal or sex with a minor, which amounts to child abuse.	
Protection of children in emergency situations	The law requires the State to protect the fundamental rights of children before, during and after disaster and emergency situations when children are gravely threatened or endangered by circumstances that affect their survival and development.	Republic Act 10821 Children's Emergency Relief and Protection Act

Health sector

Mental health legislation and policies have evolved from a focus on mental health response in times of humanitarian crisis or conflict. The National Mental Health Policy of 2001 and the Revised Operational Framework for a Comprehensive National Mental Health Program of 2016 outline the national strategy for promotion of mental health, protection of persons with mental health disorders and provision of mental health care. Although they include general guidelines concerning accessibility of services regardless of age, there are no specific objectives or activities in relation to child and adolescent mental health. In 2018, the Mental Health Act (RA No. 11036) was adopted into law. It includes mandatory provision of psychiatric services in all hospitals, a renewed focus on active treatment of substance-related disorders and a rights-based approach to mental health, including the right to informed consent.[44] It includes provisions relating to child and adolescent mental health. For example, the law requires active incorporation of mental health topics into the educational system, from primary school onwards. The law also specifies the rights of minors to the presumption of capacity to provide consent (although no guidance on age is provided), the rights of children to express their preferences and views on all matters affecting their mental health and for their views to be given due consideration in accordance with their age and maturity.

Following adoption of the Mental Health Act, the national Mental Health Strategic Plan 2019–2023 was developed in 2019 after extensive consultation with stakeholders from across sectors. The goals of the rights-based plan are to ensure that mental health and well-being are valued, promoted and protected; that mental health conditions are identified, treated and prevented; and that persons affected by mental health conditions are able to exercise their full range of human rights (*see Figure 13* for an overview of the plan). The plan includes actions around ensuring age-appropriate mental health education for children and adolescents and a national suicide-prevention programme, with a focus on youth. No further details about delivery of mental health services or other MHPSS for this age group are cited. The plan also sets out requirements for a multisectoral approach to mental health, including a multisectoral technical working group to guide policy and implementation and a proposed structure to support effective national and local governing bodies under the guidance of the Philippine Council for Mental Health (within the DOH).

Figure 13. Overview of the Mental Health Strategic Plan 2019–2023



The Universal Health Care Act of 2018 (RA No. 11223) stipulates that every Filipino is eligible to access preventive, promotive, curative, rehabilitative and palliative care for health services, including mental health care. These are subject to the assessment of the Health and Technology Assessment Council. The Council evaluates the latest health developments and provides recommendations to the DOH and PhilHealth, which is the national health insurance programme. Only inpatient admissions for acute mental disorder are covered by this programme, specifically for disorders or aggressive behaviours that present a danger to self or others; suicidal behaviour; severe depression or mania; serious side effects of medication; or for procedures like electroconvulsive therapy. Outpatients services are not included.

The national Adolescent Health and Development Program of the DOH includes mental health as one of eight components, although mental health is not included as part of the core package of essential health care required to be available at all rural health units or barangay health stations. Rather, district, provincial and tertiary hospitals are expected to provide mental health services and referrals from primary-level facilities. The Adolescent Health and Development Program also defines national standards for adolescent-friendly health services, although it is unclear the extent to which these are also reflected in policy and implementation plans for mental health care.

Education sector

The laws presiding over the education sector include the Fair and Equitable Access to Education Act, the Governance of Basic Education Act and the Government Assistance to Students and Teachers in Private Education Act. These laws do not recognize or specifically refer to the mental health and psychosocial support needs of children or adolescents within the education system. The national Mental Health Strategic Plan, developed with the Department of Education (DepEd), specifies actions for the basic education sector in supporting mental health and well-being. These include:

- developing guidelines, standards and strategies to promote mental health and well-being among educators and learners (policies to address discrimination, promotion activities, early identification and referrals); and
- integrating age-appropriate mental health education into the curricula of primary and secondary education (identify where it could be integrated, develop content and materials).

The Mental Health Act also requires the education sector to integrate mental health through age-appropriate content into curricula at all levels; development of policies and programmes to raise awareness about mental health, identify and support for persons at risk and establish referral mechanisms; and have mental health professionals included as part of the education workforce.

There is no overarching education policy or strategic plan in relation to mental health. There are, however, many DepEd Orders and Memos that relate to some specific functions of the education sector. They include:

- 2020 addition of MHPSS to the existing five umbrella programme of Order No. 20, Series of 2018 Policy and Guidelines on Plans and Programmes;
- Order No. 12, Series of 2020 Adaptation of the Basic Education Learning Continuity Plan for SY 2020–2021 in Light of the COVID-19 Public Health Emergency, articulated in the prioritization of the "promotion and protection of the mental health and general welfare of learners and personnel" during the pandemic;
- Order No. 14, Series of 2020 on Guidelines on the Regional Health Standards in Basic Education Offices and Schools, outlines the provision of mental health and MHPSS to learners and DepEd personnel to increase their mental health resilience; and
- Memo No. 074, Series of 2021, mandates the inclusion and promotion of mental health in all DepEd events and programmes.

Relevant to the education sector, the Anti-Bullying Act of 2013 directs all primary and secondary schools to enact policies prohibiting bullying and cyberbullying, investigating reports of bullying, implementing punitive actions, providing rehabilitation programmes for the bully (and encouraging their parents to also) and providing counselling for bullies and victims.[45]

Social welfare sector

There are several laws and policies to protect children and adolescents from harm. The Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act provides protection from all forms of abuse, neglect, cruelty, exploitation and discrimination and other conditions prejudicial to their development, including child labour. The law promotes the welfare of children and enhances their opportunities for a useful and happy life, *as* articulated in the Convention on the Rights of the Child. The Anti-Violence Against Women and their Children Act of 2004 addresses the prevalence of violence against women and children. This law established the Women and Children Protection Units in DOH-retained and local government unit (LGU)-assisted or supported hospitals, with provision for the training of competent multidisciplinary teams under DOH Administrative Order 2013–0011. The Anti-Trafficking in Persons Act of 2003 specifies actions to eliminate human trafficking, including of children, and the establishment of institutional mechanisms for protecting and supporting trafficked persons.

In settings of humanitarian emergency, the Children's Emergency Relief and Protection Act of 2015 (RA No. 10821) mandates the provision of emergency relief and protection for children before, during and after disaster and other emergency situations when they are threatened or endangered by circumstances that affect their survival and normal development. The law defines the responsibility of the DSWD in overseeing a Comprehensive Emergency Programme for Children, which is to be implemented after a declaration of emergency. It includes actions to protect mental health (evacuation and temporary shelter, delivery of basic services, protection from violence and exploitation) and delivery of essential services, including psychosocial interventions.

There are additional policy and legislative frameworks to protect the rights of people living with mental health conditions. The Expanding the Benefits and Privileges of Persons with Disability of 2016 (RA No. 10754) and the Magna Carta for Disabled Persons of 1992 (RA No. 7277) include the right of those living with mental conditions to protection, services and freedom from discrimination to promote their well-being.

Justice sector

The Family Courts Act of 1997 (RA No. 8369) requires the establishment of a Family Court in every province and city in the country, with exclusive jurisdiction over child and family cases. The law requires the Family Court to be responsible for criminal cases involving children and adolescents younger than 18 years. Related to the law, the Child and Welfare Code provides for the intervention of the DSWD with law enforcement agencies and the courts to prevent reoffending among youth and to reintegrate youth offenders into the community. Within this framework, incarceration and detention are only to be used as a last resort, with priority given to community-based programmes, including counselling, diversion, probation and after-care services. The law also requires a Social Services and Counselling Division to be established under the guidance of the DSWD within each judicial region to provide services to all juvenile and family cases. This includes ensuring that staff trained in behavioural sciences are provided to deliver case management, counselling, assessment and other social services, as well as referral to mental health specialist care as required.

The Juvenile Justice and Welfare Act of 2006 (RA No. 9344) established a comprehensive juvenile justice and welfare system involving children at risk and children in conflict with the law, from prevention to rehabilitation and reintegration. The law mandates the Juvenile Justice and Welfare Council under the Department of Justice (DOJ) (and chaired by an undersecretary of the DSWD) with responsibility for implementing the law. Within this, the law emphasizes:

- protections for children in conflict with the law (child-appropriate proceedings for children at risk or those in conflict with the law, programmes and services for prevention, diversion, rehabilitation and reintegration; rights of children in conflict with the law, including protection from violence or degrading treatment or punishment; and deprivation of liberty as a last resort); and
- prevention (establishment of local councils for the protection of children and education and mass media to prevent children coming into conflict with the law).

The law requires children to have immediate access to mental health assessment and protection from treatment or other acts that may have detrimental impact on psychosocial well-being.

In response to mental health-related policies and legislation, several national bodies have been established to support implementation and monitoring (*see Table 2*).

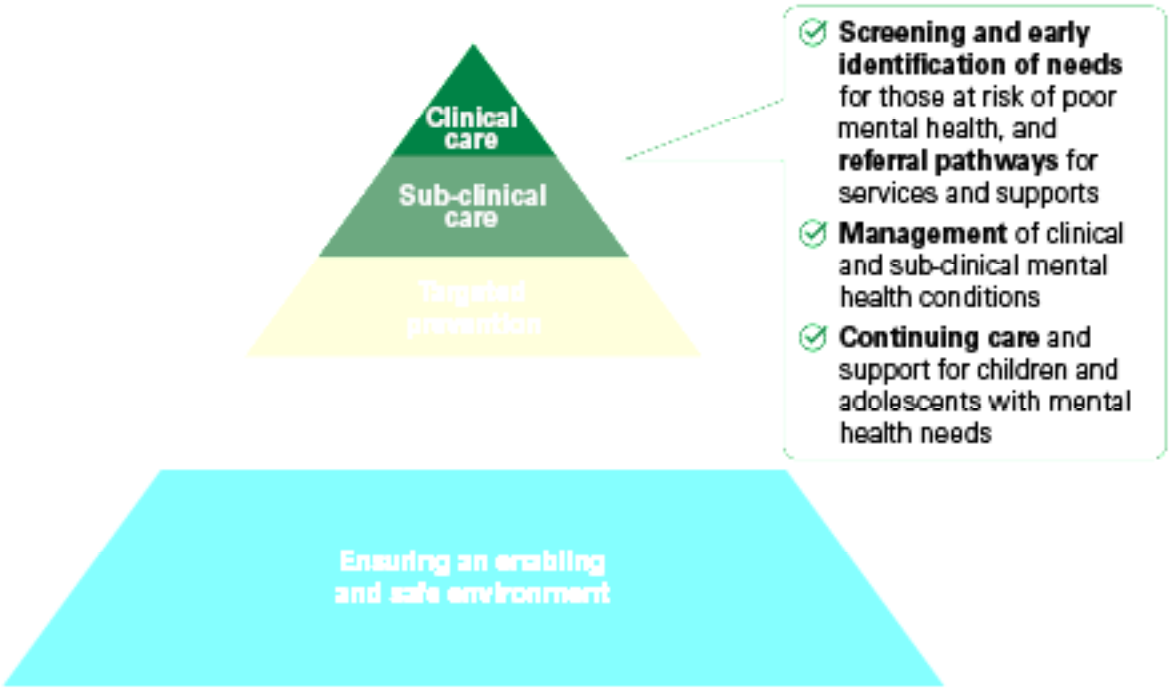
Table 2. National bodies and organizations in relation to child and adolescent mental health

Body	Lead sector	Role
Philippine Council for Mental Health	Health (DOH)	Policy, planning, coordination and advisory body to oversee the implementation of the Mental Health Act and the Mental Health Plan
National Center for Mental Health	Health (DOH)	Special research and training centre and hospital
Council for the Welfare of Children	Social welfare (interagency body)	Child protection, welfare and development policies and advocacy; support networks and coordination mechanisms; monitoring and evaluation; and research and development
Special Committee for the Protection of Children	Justice and social welfare	Initiate and coordinate the Comprehensive Program on Child Protection
Child Protection Network Foundation	Social welfare	Technical and other support to ensure Women and Child Protection Units are established and operational
Inter-agency Council Against Trafficking	Justice (interagency body)	Coordinate and monitor implementation of the Anti-Trafficking in Persons Act
Inter-agency Council Against Child Pornography	Social welfare	Coordinate and oversee the implementation of the Anti-child Pornography Act
Juvenile Justice and Welfare Council	Justice and social welfare	Policy, planning, coordination and monitoring of the Juvenile Justice and Welfare Act
Philippine National Police Women's and Children's Desk	Justice	Address violence, abuse, exploitation and neglect of children
Psychological Association of the Philippines	Health (professional association)	Professional association
Philippine Mental Health Association	Health (non-government)	Non-government, not-for-profit organization providing mental health education, advocacy, interventions and research
Philippine Psychiatric Association	Health (professional association)	Professional association
Philippine Guidance Counselling Association	Health (professional association)	Professional association

Body	Lead sector	Role
Youth for Mental Health Coalition	Youth	Youth network supporting youth advocates and student organizations to increase awareness and address mental health stigma
Society of Adolescent Medicine of the Philippines	Health (professional association)	Promotion of physical and mental health of adolescents, advocacy and development of an adolescent health workforce, including through training and research

Current programmes and approaches to address child and adolescent mental health and psychosocial well-being

Responsive care for children and adolescents with mental health conditions



The DOH coordinates and regulates the clinical mental health system nationally. Within the DOH, the Philippines Council for Mental Health has overarching responsibility for implementation and policy, with the Disease Prevention and Control Bureau responsible for developing service standards and packages, implementation and collaboration with other government agencies. Primary responsibility for delivery of mental health clinical services lies with the LGUs, including responsibility for establishing or upgrading hospitals and mental health facilities and providing trained personnel, equipment and other supplies for service delivery. The Mental Health Act requires LGUs to develop a programme

of mental health services, consistent with the national guidelines for the Council for Mental Health, with particular attention to establishing community-based mental health services. However, much of the current focus of actions related to responsive care is on the delivery of clinical care through mental health services. This is primarily through hospital settings, with integration of mental health into primary-level care and community settings limited.

Screening and early identification of mental health needs

Clinical assessment of mental health is primarily provided by the **health** sector through clinical services. However, there is a limited national approach to early identification or screening of children and adolescents for mental health needs. The Patient Health Questionnaire-9 is required by the Philippine Paediatric Society for screening of all adolescents aged 12–18 years who present to the Paediatric Division of the tertiary-level Philippine General Hospital. This tool screens for depression, substance use and exposure to violence or abuse. Outside of the one hospital setting, the use of the tool is limited by poor access to health providers trained in its application. The national Adolescent Health and Development Program includes a tool (HEEADSSS) for psychosocial and health risk assessment of adolescents aged 10–24, including items covering suicide, self-harm, depression and moods. A suicide screening tool, Ask Suicide Screening Question, was recently validated by the Philippine Children's Medical Centre, but its use is not widespread. The Mental Health Strategy and the Mental Health Act include establishment of drug screening services, requiring all local health care facilities to provide drug screening, although not specific to this age group.

The Philippines has a national mental health crisis hotline (1553) to enable self-identification referral and psychological first aid, is managed by the DOH National Centre for Mental Health. NGOs and local helplines operate other sucide prevention and crisis hotlines (such as Hopeline and In Touch). The national hotline reported that calls to the crisis line had almost quadrupled in 2021 from 2019, with a third of the calls suicide-related and most among persons aged 18–30 years. Many stakeholders noted that these telephone-based hotlines do not target children and adolescents; they are used by older adolescents and young adults, but they are not user-friendly for younger ages. In addition to the mental health hotlines, there are examples of family support or child protection hotlines to report cases that also provide some psychosocial services (including counselling).

Outside of the health sector, the Mental Health Act defines a role for the **education** sector in providing early identification of individuals at risk of mental health. However, there are no validated screening tools or early identification protocols to support identification in public education settings. Education sector stakeholders described a need to partner with the DOH to develop guidelines and protocols for screening. A representative from the private education sector described using a protocol for assessment and referral of students with mental health needs, but this was not standardized across education settings.

Similarly, within the **social welfare** sector, policies define a role for social workers and others engaged in child welfare and child protection in identifying children and adolescents with mental health needs (or at risk). However, there are no standard protocol or tools to support this. As noted, the Juvenile Justice and Welfare Act requires children who come into contact with the law to undergo mental health assessment, primarily provided by a medical and health officer. Stakeholders from the justice sector recognized the sector's role in ensuring access to mental health assessment and in supporting referral for services, but they had mixed opinions on whether it should be the responsibility of the justice sector or the health and social welfare sectors to provide these services. Some stakeholders described limited implementation of mental health assessments and referrals for services for children in conflict with the law (noting that many children have a long-standing engagement in the justice system before mental health needs are identified). They recommended that all juvenile justice practitioners be trained to understand and recognize mental health conditions.

Referral pathways

Referral systems for responsive care exist within sectors as well as between sectors. But they are mostly well established for referrals within the health system for children with severe mental health disorders. The Mental Health Strategic Plan highligted the need for strengthened institutional referral systems and protocols, noting that it is often left to individuals and their families to identify referral networks and available services.

Within the **health** sector, children and adolescents with significant mental health conditions (such as severe mental disorder) identified by non-specialized personnel or at the primary care level are generally referred to specialists within tertiary facilities using clinical pathway protocols. The DOH National Center for Mental Health is the main tertirary referral centre for child and adolescent mental health. Stakeholders described complicated referral mechanisms, from secondary and primary care, limited access to specialists (particualrly outside major urban areas) resulting in referral delays and heavy workloads of specialists. For families, financial constraints and high fees as well as large physical distances to reach specialist care contribute to referral delays. Additionally, stakeholders described private health facilities and specialists as reluctant to accept mental health referrals from public providers. They also described a lack of referral mechisms back to the primary providers and community-based services once a child or adolescent returns from hospital or tertiary care. This, they said, contributes to lack of follow up and rehabilitation services and little feedback to local systems about diagnosis and ongong needs.

As per the Mental Health Act, the **education** sector is required to develop a referral system for children and adolescents with mental health concerns. Education stakeholders confirmed that the DepEd is developing a school-based referral system that is not only activated during and in the aftermath of a disaster but one that can also be used outside emergency settings. This is part of the sector's response to support students in the context of the COVID-19 pandemic. Currently, children or adolescents identified as having significant mental health needs in Metro Manila (or in emergency situations) are referred to the National Center for Mental Health. Education stakeholders noted that this system is not well established. Outside the main urban areas, the education sector relies on referrals to the local Social Welfare and Development officer and the local Health Office. Stakeholders explained that the limited number of trained guidance counsellors and school-based psychologists and the difficulties obtaining parent support (and consent) for referral for children younger than 16 years are challenges.

Within **social welfare,** the Mental Health Act defines a role for the DSWD to refer children within the child protection system to mental health facilities for appropriate clinical care, as well as referral to other psychosocial support (such as housing and livelihood training). Social workers have reported lack of clarity around referral mechanisms, particularly when interagency referral is required.[47]

Children within the **justice** system who have identified mental health needs are referred to the Child Protection Network and Child Protection Units, which comprise medical personnel, social workers and police or the local hospital. Additionally, the Philippine General Hospital also receives direct referrals from the justice sector for children in conflict with the law who are in institutional care (shelters), including children or adolescents who are considered to be at risk of self-harm. These children are usually accompanied to health services by a social worker. A critical bottleneck is the timely identification of children with mental health needs, with many stakeholders noting that prosectors and other justice sector officers are not trained to assess or recognize children with mental health conditions (or risks), which results in delayed referral for services and support.

Management of mental health conditions and continuing care

Clinical management of mental health conditions is largely provided through the **health** sector. The Philippines has one specialist psychiatric hospital, 84 psychiatric units in general hospitals, one forensic inpatient unit and 59 psychiatric residential care facilities.[48] Of these facilities, only 11 inpatient psychiatric facilities cater specifically for children and adolescents. There are 85 mental health outpatient facilities attached to hospitals and 119 community posts offering non-hospital outpatient services. Eleven outpatient facilities are specifically for children and adolescents, including services

for developmental disorders. Most specialist services are provided only in urban areas, with limited availability in rural and remote settings. Limited numbers of services and facilities to provide mental health care has led to poor accessibility and treatment delays, compounded by insufficient funding and staff shortages.[49] As of 2017, there were 2,051 mental health professionals, comprising psychiatrists, other medical doctors, nurses, psychologists, social workers and occupational therapists, with around two mental health workers available per 100,000 population. There were only 60 child pyschiatrists.[48]

Limited integration of child and adolescent mental health into primary-level and community-based facilities also contributes to poor accessibility of services. According to a 2016 ASEAN report, only one of the 81 provinces has the capacity to provide mental health services in primary health clinics.[50] Additionally, non-physician health care workers, including nurses and community health workers, are not permitted to prescribe psychotropic medications, which further limits the accessibility of basic mental health care.[51] Among physician-based clinics, only a minority have access to any psychotropic medications. Stakeholders noted that the COVID-19 pandemic has not only increased the demand for mental health services but also has had a significant impact on the availability of mental health care. Redirection of personnel to COVID-related care (contact tracing and clinical care), redistribution of funding to the pandemic response and limited service availability due to stay-at-home orders and facility closures due to outbreaks have resulted in limited availability of mental health services.

The **social welfare** sector also provides MHPSS, particularly for children and adolescents engaged in the child protection sector and during humanitarian emergencies. DSWD social workers, psychologists and child protection officers provide psychological first aid, counselling and critical incident stress management. Most of these services are provided in institutional settings, such as residential care or facilities, for children who are the victims of trafficking, exploitation or sexual abuse. The sector also works collaboratively with the health sector in the implementation of child protection units. The Philippine General Hospital Child Protection Unit and Child Protection Network (with 84 units across 48 provinces) provide psychosocial support and services (in addition to physical health and legal services) through multidisciplinary teams of health professionals, social workers, lawyers and also teachers and community members to support children who are victims of violence, abuse, neglect or exploitation.[47]

The DSWD also provides technical assistance and guidelines to LGUs to support MHPSS activities. It provides training and capacity development for social workers on MHPSS and child-friendly counselling and has a role in coordinating with other sectors in the delivery of MHPSS to children at risk. Supporting children in need of special protection is largely the responsibility of LGUs, with technical assistance and capacity-building provided by DSWD to the local Social Welfare and Development officers responsible for these programmes. In humanitarian settings, the DSWD also provides psychosocial interventions for children.[52] For example, after a landslide in Cebu Province in 2018, the DSWD was involved in establishing child-friendly spaces. These facilities provided play, art therapy and counselling to children with mental health needs. The government-run Women's and Children Protection Center provides therapy sessions to women and children who have been victims of abuse.[31] A rehabilitation centre for child victims of online sexual abuse is run by the CURE Foundation in Cebu. Through collaboration with the University of Philippines Manila and the International Justice Mission, social workers and psychologists deliver multiple sessions to each of the victim-survivors to help them deal with abuse and trauma, the mental health consequences and reintegration into society.[31]

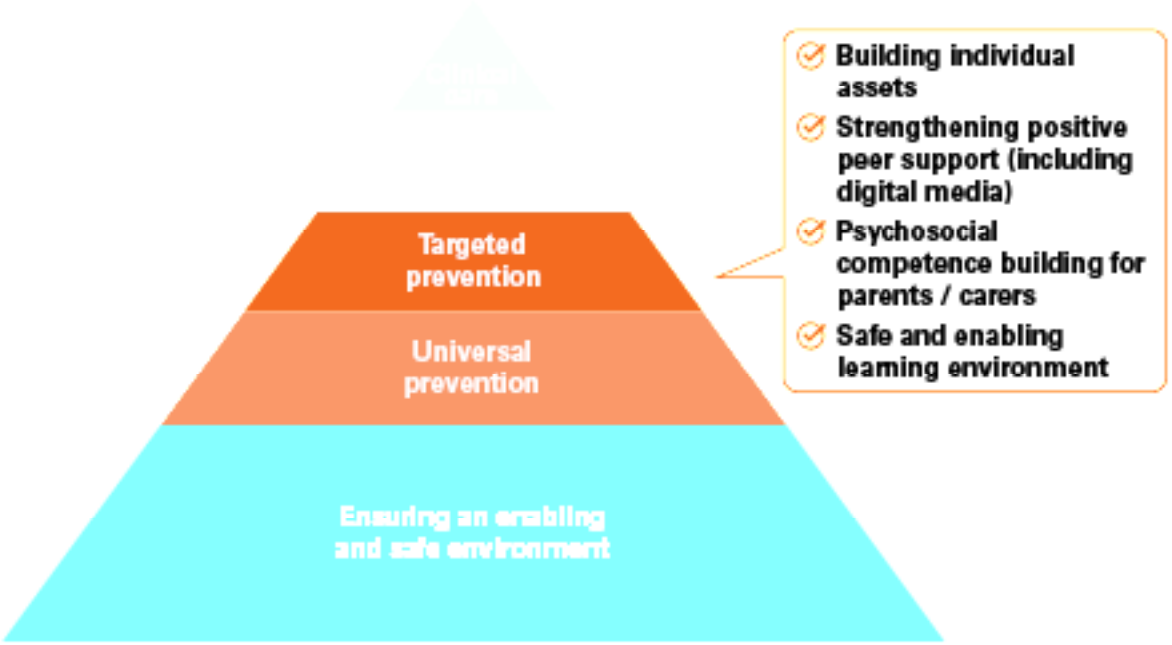
Within the **justice** settings, the DSWD and the DOJ, through the local Social Welfare Development officers, are tasked with providing multidisciplinary care, including for mental health, to children in conflict with the law. This includes institutional care through Bahay Pag-asa, which is funded and managed by the LGUs or licenced and/or accredited NGOs. Services include intensive interventions, such as counselling, that are provided by social workers, psychologists and an educational guidance counsellor. Other mental health support is provided through community-based programmes for children in conflict with the law.[53] The DOJ's 2012–2016 strategy document acknowledges a systemic failure to support children in the justice system with their psychosocial needs. The strategy committed to implementing psychosocial intervention programmes.[54] Stakeholders from both the DSWD and the justice sector emphasized the insufficient numbers of psychologists and other trained personnel in mental health to support the delivery of responsive services, including in institutional and rehabilitation settings.

Within the **education** sector, there have been efforts to deliver aspects of mental health care in school settings, in collaboration with the DOH and NGOs. According to a 2006 WHO and DOH report, 60 per cent of primary and secondary schools had a part-time or full-time mental health professional in-house.[51] No recent data are available.

Schools provide some services to students with mental health conditions, such as psychological first aid, and there are some examples of education initiatives to support children with mental health conditions, particularly in the context of the COVID-19 pandemic. Stakeholders pointed out the limited number of trained guidance counsellors, most of whom are only available in secondary schools and may have a dual teaching–counsellor role. Guidance counsellors provide psychological first aid but have limited training and support to provide behavioural modification and other MHPSS in school settings. The lack of psychologists in schools was a noted barrier to improving delivery of care in schools. In response to the COVID-19 crisis and school closures, the DepEd initiated a programme to support students learning by distance due to the lockdowns.[55] The overall theme for primary school students was 'remote psychosocial support through play', and for secondary school students it was 'remote psychological first aid'. The programme, called Kakaiba-yanihan, included targeted TV programmes on these themes that were developed and broadcast for primary students, secondary students, teaching staff, parents and learners with disabilities. Teachers' guides for Remote Psychosocial Support through Play for Elementary Learners were developed, with accompanying educational activity sheets, books, comics and online modules for children and adolescents to learn about mental health. A critical challenge for the education sector is the lack of trained staff in education settings. Stakeholders highlighted the lack of guidance counsellors or psychologists in all levels of education and a reliance on homeroom teachers and advisors to deliver MHPSS. These teachers are generally not trained to perform these roles, and so MHPSS, from early identification to initial care and support, is often not provided.

There are examples of **digital or online delivery of responsive care**, particularly in response to the COVID-19 pandemic. The National Center for Mental Health provides a range of online or telehealth services, including for children and adolescents. The DSWD has developed online programmes to support mental health couselling and psychosocial support for children and their families (such as WiSupport). Several psychosocial interventions have been implemented by NGOs. For example, the Positive Youth Development Network, the Council for the Welfare of Children, UNICEF Philippines and more than 40 youth organizations created a support group to develop mental health services. In 2020, this group recorded more than 20,500 youth participants.[56] The Philippine Red Cross and UNICEF Philippines established nationwide helplines that provided mental health support for more than 9,500 callers in 2020. Many of these calls were children and adolescents receiving counselling or child survivors of violence receiving case management services. The DSWD has also piloted online provision of psychosocial support for children at increased risk of poor mental health.

Figure 15. Prevention of mental health conditions in the immediate social context



Actions to prevent poor mental health by addressing risk factors and enhancing protective factors are critical for ensuring mental health and well-being. For children and adolescents, this requires a focus on factors related to where they live, grow, learn and socialize, with parents and caregivers, peers and learning environments a high priority. The health, education, social welfare and justice sectors, along with NGOs and youth organizations all have important roles in supporting mental health prevention programmes targeting the general population, school children, teachers, parents and at-risk children and adolescents.

Building individual assets

A 2006 WHO report found that 21–50 per cent of schools conducted activities to promote mental health and prevent mental disorders.[51] The DepEd recently prioritized mental health education and prevention for children. The *K to 12 Health Curriculum Guide 2016* includes mental health content delivered through health classes.[57] In grade 5 and grade 7, children receive three months of specific teaching on the importance of mental and emotional health; problems such as unhealthy relationships, cyberbullying and child abuse; and skills to cope with stress and how to recognize and seek help for mental disorders, such as depression or schizophrenia. Stakeholders from the education sector noted that in addition to needing to strengthen the content of the curriculum with respect to social and emotional learning, there is also a need to improve delivery. The focus, they explained, should not solely be on teacher-led instruction to address knowledge gaps, but it should include approaches that support skills and create enabling environments for well-being.

> *Now, when it comes to the curriculum, what we are currently doing is strengthening the referral system and the integration of the social emotional learning. Actually, the topics are already integrated, those that could help with the mental health of the children in the K–12 curriculum. However, I think what is needed there is to be more conscious about these topics, that whenever these are delivered, the delivery, pedagogy and everything should have the consciousness of mental health…. Before, when teaching about these topics, you just teach as is. But the mental health [aspect] needs to be brought to the consciousness of the children, that is what needs to be deepened.* – Education sector representative

In addition to the standard curriculum, the DepEd, in partnership with UNESCO, developed a teachers' manual (*Supporting, Enabling and Empowering Students (SEES)*) to support students generally and students in disaster or emergency settings. The manual has nine modules that serve as curriculum-support materials to facilitate secondary students' recovery from a disaster and prepare them for returning to the classroom. Modules 1–4 focus on the delivery of psychological first aid in groups, delivered during the emergency phase (two weeks to six months after a disaster). Modules 5–9 aim at strengthening or developing resiliency of students, delivered within or after six months to three years.

The NGO UNILAB Foundation has partnered with the DepEd to develop and deliver programmes to support the mental health and well-being of learners, including through EDUC+, which is a positive education programme to support social and emotional learning. It includes module-based training for schools, families and communities and has been implemented in five schools, reaching more than 300 educators and nearly 1,000 students (although no evaluation of the programme is available).[58]

> *We also have a programme, Positive Education. In this programme, we want to increase the resilience of children. This is only what we can do for now. We Filipinos are known to be resilient, but these children need training. This is modular, so we trained teachers on how to implement these modules and backed them up by research. This programme is very effective. Now, [the DepEd] wants to integrate this programme into its curriculum. It is the first time that the socioemotional skills were acknowledged through the Positive Education program. All of these are in partnerships as we are not experts. Our approach is Bayanihan [helping one another]. We formed a coalition of seven mental health professional organizations in the Philippines, then we created interventions. In the mechanism that the experts will conceptualize and will deliver, it will not work. In our coalition, we have the experts that will conceptualize and the community will deliver through our organization.* – Education sector representative

In response to the COVID-19 pandemic, the DepEd introduced online programmes to support social and emotional learning and coping skills. These include:

- TALA (Tuklasin, Alamin, Likhain at Alalahanin), an educational, child-friendly programme that offers learners' informative segments, storytelling and art activities. It was introduced through DepEd TV in March 2021. It also can be viewed on the DepEd Facebook page and YouTube channel.
- OKKK! Tambayan (Online Kahusayan at Katatagan ng Kabataan) is an online programme series that talks about mental health concerns of secondary learners with student panellists and experts on mental health and psychosocial support. It is broadcast live every Saturday (at 9 am) on the DepEd Facebook and YouTube channel. It can also be viewed on DepEd TV.
- In 2021, the Disaster Risk Reduction and Management Service of the DepEd spearheaded a new virtual series to support personnel's mental health by providing proactive MHPSS to its personnel and stakeholders. It is called the TAYO Naman! (Tulong, Alaga, Yakap, at Oras para sa mga Tagapagtaguyod ng Edukasyon). TAYO Naman! is a continuation of the DepEd initiative, the Wellness Check Series, to have discussions on coping mechanisms to combat stress and other challenges to a person's mental health especially during the pandemic.

The DepEd recently formed a technical working group on mental health (Order OO-OSEC-2021–005) to strengthen the MHPSS programme for learners. This includes actions to strengthen referral, integrate social and emotional learning and support the development of skills that will contribute to overall well-being. The Council for the Welfare of Children has approved a resolution to create an adolescent MHPSS training manual for service providers to use during emergencies and the pandemic.

On a smaller scale, there are also examples of pilot programmes or initiatives in school and community settings, including for children and adolescents at increased risk of poor mental health. In 2020, the DOH worked with NGOs, such as the Council for the Welfare of Children, the Philippine Red Cross and UNICEF to deliver several one-day mental health and wellness camps for vulnerable children and adolescents. This included child survivors of online sexual abuse and exploitation, children affected by armed conflict and adolescents living with HIV or AIDS.[56] In 2019, UNICEF Philippines and the Positive Youth Development Network helped to develop the Kabatan: Youth for Community Care initiative for children in Datu Odin Sinsuat, Maguindanao for children and families affected by conflict.[56] Teachers were trained to help children to express their emotions, respond to students' needs and establish safety networks in and outside of schools. More than 2,000 students in three primary schools were engaged.[56]

Strengthening positive peer support

Despite the importance of promoting healthy peer relationships, addressing bullying and violence and supporting positive peer networks, few examples of programmes to strengthen peer support were found. The Anti-Bullying Act (2013) directs all primary and secondary schools to enact policies prohibiting bullying and cyberbullying, investigating reports of bullying, implementing punitive actions, providing rehabilitation programmes for bullies (and encouraging their parents to attend) and providing counselling for bullies and victims.[45] Education stakeholders noted the current efforts to address cyberbullying by strengthening teacher training and skills, and the integration of interpersonal skills training, anti-bullying programmes and digital literacy into DepEd programmes.

In 2021, the DOH and the Department of Interior and Local Government (DILG) issued a joint memorandum Order (No. 2021–002) endorsing implementation of the National Policy Framework on the Promotion and Recognition of Healthy Communities. It aims to: (i) set guiding principles to guide decision-making for LGUs in the development, implementation and monitoring of their policies, plans and programmes for health and development; (ii) provide the framework and strategies to operationalize the promotion and recognition of healthy communities; and (iii) delineate roles and responsibilities of actors in the DOH, the DILG and LGUs to collectively contribute to the promotion of healthy communities.[59] Within this, the DOH developed the MHPSS Peer Support Playbook, which was piloted in 2021.

Psychosocial competence-building for parents and caregivers

Both the DepEd and the DSWD have initiated programmes to support positive parenting. As one of its responses to the COVID-19 pandemic, the education sector launched the Online Parental Support Intervention on Effective Parenting, or Gabay Bahay: An Online Parenting Series for Parents and Caregivers of Learners. The programme provides guidance to parents and caregivers to support children's learning in the context of the COVID-19 pandemic. The DSWD has similarly provided an online parenting programme, in addition to integrating programmes to improve parenting skills into child protection programmes targeting families at risk.

The Parenting of Lifelong Health for Young Children programme,[60] developed by Oxford University, the WHO and UNICEF, is being adapted and piloted in the Philippines. The programme focuses on supporting behaviour change among caregivers (focusing on a range of techniques, such as child-led play, social and emotional communication, responsiveness, positive instruction, praise, problem-solving and mindfulness) and delivered through home visits, group sessions, phone calls, messages and a parent handbook. Funded by UNICEF and the UBS Optimus Foundation, the DSWD and the Child Protection Network are conducting a three-phased trial of the programme, locally known as Masayang Pamilya, or MaPa. The programme is two-tiered, with one tier targeting caregivers of children and the other one for adolescents. The goal of the MaPa is to reduce the risk of violence against children and improving positive parenting behaviour in the Filipino context.

At the LGU level, the National Mental Health Strategic Plan states that the Philippine Council for Mental Health may choose to advocate for policies related to positive discipline, but no specific guidance is provided. Local Social Welfare and Development officers are also integrating parenting support into programmes for children in need of special protection. This includes services to support parents, such as identifying and supporting parents' mental health needs.

Safe and enabling learning environments

While there are a number of initiatives to improve MHPSS in school settings, there is no national whole-of-education approach to support mental health promotion. In 2021, the DepEd began piloting the School Mental Health Program, with support from the Southeast Asian Ministers of Education Organization's Tropical Medicine and Public Health Network. It includes a number of MHPSS programmes (described previously) to support children and adolescents in the context of the COVID-19 pandemic, with a focus on improving skills, self-care and access to mental health support for learners, including persons living with a disability and their caregivers. The DepEd is also developing a School Mental Health Program policy to improve mental health promotion, screening and early identification, provision of basic services and referrals. School-based guidance counsellors

provide counselling and support to students, with a potential role in supporting broader mental health promotion in school settings. Stakeholders noted that not enough counsellors are employed in the system to reach all students.

In addition to government programmes, the Philippine Mental Health Association has implemented the Youth Life Enrichment Program to improve mental health and well-being, including in school settings. The programme covers mental health education delivered through lectures on social and emotional learning, interpersonal skills training and leadership training. It has established mental health clubs (LINK) through which lectures, training and other support are provided. A limited evaluation of the programme in 2013–2014 found that it had had a positive impact on self-reported student well-being, increased awareness of mental health and improved positive peer and student support.[61]

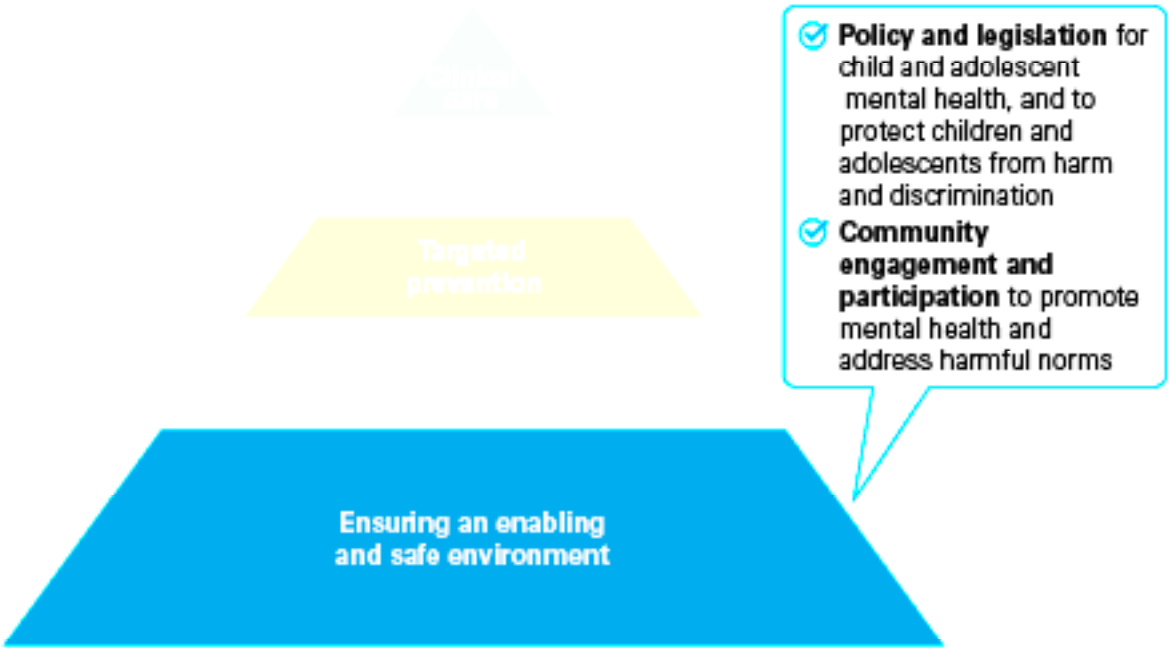
Targeted interventions for children and adolescents at high risk

There are several examples of programmes targeting children and adolescents who are at increased risk for poor mental health due to risky behaviours or high-risk exposure. A major focus cited are the programmes to **prevent and respond to child abuse, violence, exploitation and neglect** because it is these children and adolescents who are at excess risk of poor mental health. Primary responsibility lies with the DSWD and the DOJ, including for investigation of child abuse, providing support for at-risk families and coordinating multidisciplinary care and intensive intervention for children in institutional settings or in the community. The DWSD manages the logistics of adoption and fostering of children and support of foster families. Additionally, the DSWD Recovery and Reintegration Program for Trafficked Persons provides employment, lodging, documentation and medical assistance for victims of trafficking.[52] As described in the section on responsive care, child protection units, including the Philippine General Hospital Child Protection Unit and the Child Protection Network, provide multidisciplinary services and support to children at risk, including provision of preventive services to address mental health risks.

For **children in conflict for the law**, the DSWD and the DOJ, through the local Social Welfare Development officer, are tasked with providing multidisciplinary support and preventing interventions. This includes institutional-based care through Bahay Pag-asa, which is funded and managed by LGU or licenced and/or accredited NGOs. Emphasis is on diversion programmes that not only address psychological needs but also focus on re-engaging with education, life skills programmes, counselling and emotional skills. Similar interventions are also provided through community-based programmes.[53]

There are examples of targeted programmes to address risk factors other than violence against children. For instance, the DSWD delivers programmes to support people who have experienced **harmful use of substances**.[62] Although this programme is not specifically adolescent or youth focused, it is recognized that young people are a major target group. Services include social worker engagement, financial assistance, medical assistance and skills training for employment. There are also examples of programmes to **build skills or support children and young people who are marginalized or disadvantaged**. The DepEd provides an alternative learning system for out-of-school youth and adults who have not completed 10 years of basic education, as mandated by the Philippine Constitution. Through this programme, out-of-school youth are able to complete elementary and secondary education outside the formal system. Although the programme does not focus on MHPSS, the policy document states that a post-programme support system will help address academic, psychological and social issues affecting learning and will prepare learners for their options after undergoing alternative learning, specifically their transition to employment, self-employment, entrepreneurship and/or continuing education or post-secondary training.

Ensuring a safe and enabling environment to promote mental health



The Mental Health Act outlines a national policy of mental health promotion, with the Mental Health Strategic Plan focusing on promoting well-being, supporting resilience and addressing stigma and health literacy. A priority is improving mental health literacy by engaging multisectoral stakeholders to develop a national mental health promotion and communication plan, including a national multimedia campaign.

In addition to policies and legislation for MHPSS and to protect children from harm (described previously), there have been programmes to improve mental health awareness and address stigma. For example, in 2020, the Council for the Welfare of Children and Optimum Media Minds Production developed short advocacy films for widespread distribution, including three short films aimed at increasing community awareness of adolescent mental health, cyberbullying and peer violence and to reduce stigma against HIV and AIDS.[56] The country observes World Suicide Prevention Day, National Mental Health Week and Mental Health Fairs. These include virtual and local activities to promote mental health awareness. Stakeholders noted that the health, social welfare and educations sectors have engaged in community-based activities to raise awareness about mental health and address harmful norms and stigma.

A priority package of MHPSS actions for children and adolescents

A package of priority MHPSS actions was defined during the development of the Regional Conceptual Framework in the initial phase of this project. As described previously, these actions were determined through a review of existing frameworks, guidance, evidence and expert consensus. As part of the application of the regional framework to the four national contexts, the package was then reviewed, refined and prioritized in the Philippines during consultation workshops, an online prioritization tool and through the informant interviews. *Table 3* outlines the final package of actions prioritized for the Philippines.

Table 3. Package of priority MHPSS actions for children and adolescents

Accessible and responsive services for mental health conditions	
Screening and early identification of needs	
DOMAIN	**ACTION**
Early identification of mental health conditions and risks	Train and sensitize providers engaged in child and adolescent development, education and welfare to identify, support and refer children and adolescents with mental health needs (for example, nutrition specialists, teachers, school-based counsellors, social welfare workers, justice sector workers)
	Train and sensitize primary health care providers to identify, support and refer children and adolescents with mental health needs
Screening children and adolescents at higher risk for poor mental health	Strengthen screening of children and adolescents with high-risk behaviours (such as substance use) in clinical, school, child protection and justice settings
	Strengthen screening of children and adolescents with high-risk exposure (such as family violence) in clinical, school, child protection and justice settings
	Strengthen screening of pregnant and postpartum adolescent girls through antenatal and postnatal services
Strong referral pathways	Strengthen referral criteria, protocols and mechanisms within the health system and from other sectors or settings (schools, social welfare, child protection and justice)
	Strengthen self-referral through helplines, hotlines and online
	Integrate mental health into primary health care and physical health services
Management of clinical and subclinical mental health conditions	
DOMAIN	**ACTION**
Accessible and inclusive mental health services	Establish child, adolescent and family-friendly services that are inclusive
	Deliver community-based, online and mobile services for underserved children and adolescents (and their families)
Responsive care for subclinical conditions	Establish child and adolescent specialist support, case management and therapy provided by multidisciplinary team
	Establish specialized services and support to families of children with complex behaviours and needs in social welfare, child protection and justice settings

Responsive care for mental disorders	Establish specialist clinical child and adolescent mental health treatment and care (including hospital-based care)
	Provide child and adolescent mental health residential rehabilitation services
Continuing care	
DOMAIN	**ACTION**
Continuing care for those with mental health conditions	Provide person-centred care that includes social support, peer support and mental health professionals to support recovery and rehabilitation
	Ensure ongoing participation in education for those with mental health conditions
	Provide education and support for parents of children and adolescents with mental health conditions
Prevention of mental health conditions in the immediate social context	
Build individual assets of children and adolescents	
DOMAIN	**ACTION**
Social and emotional learning, resilience and problem-solving skills	Implement universal interventions and approaches in schools and out-of-school settings that focus on social and emotional learning; positive behaviours; social connectedness; violence and effective problem-solving; help-seeking behaviour; and common risk factors for poor mental health
Targeted interventions for children and adolescents at risk	Deliver selective, intensive programmes in clinical, school, community, residential care and justice settings for children and adolescents with high-risk behaviour (such as substance use) or exposure (including as part of emergency response in humanitarian or disaster settings). Interventions can be packaged with counselling and referral to services for screening and further care
	Provide guidance and support to schools on effective interventions following a crisis (such as a suicide in the community)
Build up psychosocial competence of parents and caregivers	
DOMAIN	**ACTION**
Safe, stable parenting and attachment	Implement programmes to raise awareness about nurturing and responsive care, positive parenting, non-violent discipline, social and emotional learning and good mental health of children and adolescents
	Increase coverage of parenting programmes (such as Parenting For Life and MaPa) focused on building up skills in nurturing and responsive care, positive parenting practices and non-violent discipline across early childhood, childhood and adolescence, including targeted support for parents and caregivers of children with disabilities or at high risk of poor mental health
	Implement programmes to raise awareness and build capacity in positive and non-violent caregiving for providers of alternative care (including residential care)
	Identify and address mental health needs of parents, guardians or other caregivers, including through improved early identification and screening

Strengthen positive peer support, including online	
DOMAIN	**ACTION**
Positive peer relationships	Establish and support peer-to-peer groups and youth clubs in school and community settings
	Develop or strengthen online social networks that promote mental health literacy among children and adolescents
Address peer victimization	Implement programmes to promote online and digital civility and digital literacy among children, adolescents, parents and teachers. Integrate education on digital civility and literacy into the school curricula
	Implement school policies and curricula that promote healthy and respectful peer relationships and address peer-to-peer violence and harassment as part of wider skills development
Ensure safe and enabling learning environments	
DOMAIN	**ACTION**
Optimal school environment for mental health and well-being	Implement a whole-of-education approach to mental health promotion (in early education and at primary and secondary levels). In addition to curriculum-based and other approaches to support social and emotional learning and positive peer relationships, include strategies and policies to ensure a safe, respectful and inclusive environment with a focus on well-being; positive approach to behaviour management; violence prevention; and participation and partnerships with students, parents, community and service providers.
	Promote teacher–parent communication on the safety and well-being of children and adolescents
Teacher and education staff capacity to support student mental health	Provide training and resources to teachers, school counsellors and other education-based workers to build up mental health literacy and skills to support mental health and social and emotional learning of children and adolescents
	Implement programmes to support the mental health and well-being of teachers and education-based workers
Mental health promotion: Ensuring an enabling and safe environment	
Community engagement and participation	
DOMAIN	**ACTION**
Community-based mental health promotion	Implement campaigns to raise awareness about mental health; address mental health-related stigma, discrimination and abuse; and promote help-seeking behaviour
	Train community-based workers, volunteers, young people, religious and community leaders and educators to raise awareness about mental health, promote mental health literacy and address harmful social and gender norms
	Build capacity of adolescents and provide opportunities for them to participate in planning, design and evaluation of MHPSS policy and programmes and mental health advocacy (including adolescents with lived experience of mental health)

Supportive mental health-related policies and legislation at the national and subnational levels	
DOMAIN	**ACTION**
Policies, strategies and plans for child and adolescent mental health	Assess and address the barriers for children and adolescents in accessing mental health care, particularly for marginalized groups
	Adopt a national mental health strategy or policy that details the multitiered and multisectoral vision and plan for mental health and develop and adopt a multisectoral (costed) implementation plan with specific goals, actions and performance indicators for child and adolescent mental health
	Ensure sufficient allocation of public resources to implement the national policy, through detailed costing, defined budget lines, allocation and expenditure tracking across all allied sectors
	Adopt a multisectoral national suicide-prevention plan and integrate prevention of suicide and self-harm across child and adolescent health, development and welfare programmes
	Integrate mental health into child and adolescent health, primary health care, nutrition and maternal and child health policies and plans
	Integrate mental health into the education sector policies and plans, including a whole-of-education policy for mental health promotion
	Strengthen the integration of mental health into policies and plans on early childhood development, child protection, ending violence, social welfare and social protection, with clear roles and actions in relation to MHPSS
	Strengthen the integration of the mental health of children and adolescents into juvenile justice and justice health policies and plans, with clear roles and actions in relation to MHPSS
Legislation and actions required for effective mental health services	Adopt national standards that define high-quality mental health care for children and adolescents (minimum standards of care) and that include relevant sectors and government, non-government and private providers
	Adopt legislation and develop implementation guidance that ensures children's and adolescents' right to access mental health services in accordance with their evolving capacities and in a manner that protects confidentiality, including effective implementation of legislation and policies that support the right of adolescents to access care without mandatory parental consent
	Implement legislation that mandates access to mental health care for children and adolescents who are deprived of liberty, in conflict with the law or in out-of-home placements
	Address legislation that denies access to mental health care for migrant, displaced or other marginalized children and adolescents

Legislation to protect children and adolescents within the mental health system	Prohibit physical restraint of children and adolescents with acute mental conditions in home, school, health care or other settings that provide services or care
	Adopt protections (legislation, regulation, monitoring and complaints mechanisms) to ensure that deprivation of liberty, including detention for mental health purposes, is a last resort, for the shortest appropriate period and subject to periodic review
Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Prohibit all forms of violence (physical, sexual, emotional) against children and adolescents in all settings, including home, school, online and in places of alternative care and detention, including use of corporal punishment
	Prohibit early marriage of children who are younger than 18 years
	Prevent and eliminate child labour (defined as work that deprives children of their childhood, their potential and their dignity and is harmful to their physical health or mental development)
	Prohibit the association and recruitment of children and adolescents with armed forces or groups
	Legislate a minimum age to purchase substances (alcohol and other drugs), and introduce alternatives to criminalization of possession and use of substances by adolescents younger than 18 years
	Adopt legislation that restricts access to lethal means (firearms, poisons, drugs)
	Ensure the minimum age of criminal responsibility is at least 14 years (as per the Convention on the Rights of the Child recommendation)
	Adopt legislation to protect children and adolescents from discrimination on the basis of gender identity or sexual orientation and decriminalize consensual sexual acts
	Adopt legislation to prohibit discrimination on the basis of gender, race, ethnicity, religion, disability, nationality, political affiliation or geographic location
	Implement social protection programmes (social insurance, social protection schemes and other means) with a focus on families and caregivers of children and adolescents

All actions proposed in the Regional Conceptual Framework were considered a high priority for inclusion in an MHPSS package for the Philippines. While progress has been made to introduce some of these actions, stakeholders across sectors noted significant challenges impacting on implementation, particularly at scale, and a need to strengthen coordination and delivery.

Responsive care for children and adolescents with mental health conditions

Stakeholders cited actions related to responsive care as the highest priority. Establishing and strengthening mechanisms to enable **early identification and screening** in multiple settings (primary and community-based health care, schools and other education settings, child protection and justice settings) are critical needs in the short term. Developing a **strong referral system** for mental health services and supports is another high priority, with stakeholders noting that screening in the absence of available and accessible services is likely to be stigmatizing. Other priority actions within this tier include strengthening the availability and accessibility of **specialist and multidisciplinary services** that are child- and adolescent-friendly and improving the integration of mental health services into primary-level and community-based facilities.

Prevention of mental health conditions in the immediate social context

The next highest priority that stakeholders cited are actions related to prevention. Among them, **school-based actions** (from early education through secondary education and higher) were considered central to preventing poor mental health and enhancing protective factors. High priority actions include programmes to address violence, bullying and substance use; strengthening a national standard curriculum for mental health with a focus on mental health literacy and supporting social and emotional learning; improving mental health training and support for teachers; and investing in approaches to create mental health-promoting schools. Similarly, high importance was placed on strengthening the quality and coverage of **parenting programmes** to support positive parenting and improve mental health literacy and care-seeking. Supporting **positive peer networks** through online platforms and peer and youth groups and addressing digital literacy and civility were also high priority actions within this tier.

Ensuring a safe and enabling environment to promote mental health

Among actions related to ensuring a safe and enabling environment, stakeholders cited campaigns and programmes to address **stigma, discrimination and harmful norms**, noting that stigma remains a significant barrier to seeking services and support. Stakeholders across the allied sectors also noted the need to explicitly integrate mental health into sectoral policies, with clear descriptions of roles, responsibilities and accountabilities. Greater **protection of children from harm** remains a priority, through strengthening legislation and/or improving enforcement and implementation. Stakeholders added that increasing the legal age of criminal responsibility and strengthening specific protections for children within the mental health system are also priorities.

BOX 4. ACTIONS THAT STAKEHOLDERS CITED AS HIGHEST PRIORITY IN THE NEXT TWO YEARS

Responsive care

- Strengthening early **identification and screening** in health and non-health settings
- Improving **referral mechanisms** within the health sector and between sectors
- Ensuring access to and quality of **child-, adolescent- and family-friendly mental health services**
- Establishing **specialized and multidisciplinary mental health services** and support

Prevention

- Implementing **whole-of-school-based programmes** to promote well-being, support healthy peer relationships and address violence and bullying, and strengthening the national curricula to support social and emotional learning and mental health literacy
- Implementing **parenting programmes** focused on nurturing, responsive care and non-violent discipline
- Improving **online networks** for mental health support, literacy and referral, and providing education to address digital civility

Mental health promotion

- **Integrating mental health into other sectoral policies** and plans (education, social welfare, child protection and justice)
- **Increasing protections** against violence, harm and discrimination, including protections within the mental health system
- Implementing programmes to address **stigma, discrimination and harmful norms**

Recommended sectoral roles and responsibilities

Table 4 gives an overview of the recommended roles of the health, education, social welfare and justice sectors in implementing the priority package of MHPSS actions. Actions in **bold** indicate where a sector is recommended to have a leading role or primary responsibility for implementation.

Table 4. Sectoral roles in implementing MHPSS actions

Accessible and responsive services for mental health conditions			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Screening for persons at risk, including parents or caregivers with mental health conditions	Early identification of persons with mental health conditions or risks	Screening for children and adolescents (and parents or caregivers) with high-risk exposure	Screening for high-risk behaviours and exposure
Referral systems and mechanisms Self-referral hotlines	Referral links and mechanisms	Referral links and mechanisms Self-referral hotlines	Referral links and mechanisms
Multidisciplinary case management and support	Ongoing education participation for persons with mental health conditions Targeted education and support for parents of children with mental health conditions and complex behaviours	Multidisciplinary case management Targeted education and support for parents of children with mental health conditions and complex behaviours	Specialized services and support, including provision of mental health services in detention settings
Community-based, online and outreach services	Community-based, online and outreach services	Community-based, online and outreach services, particularly for children and families at risk	Community-based, outreach services for children and families engaged in the justice system
Establishing specialized and clinical services		**Establishing specialized and services and case management for families**	
Establishing residential services		Supporting residential mental health services	

Prevention of mental health conditions in the immediate social context			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Support to mental health approaches in education, including teachers' well-being	**School and education-based programmes and approaches** • whole-of-education mental health promotion, including a focus on creating safe, respectful and inclusive learning environments, supporting social and emotional learning, violence prevention and supporting positive peer and peer–teacher relationships • teacher–parent communication • staff and teachers' well-being	Support to mental health approaches in education	Support to mental health approaches in education, particularly around substance use
	Establishing youth and peer support groups	Establishing youth and peer support groups	
Digital literacy, **online networks for mental health**	**Digital literacy and civility education**	Digital literacy, **online networks** for mental health	
Intensive interventions to address risk factors Support to schools following a crisis (such as a suicide in community)	**Intensive interventions to address risk factors** **School-based interventions following a crisis in the community (such as suicide)**	**Intensive interventions to address risk factors**	Intensive interventions to address risk factors (including substance use)
Identify and address mental health needs of parents or caregivers	Raise awareness about positive parenting	**Parenting programmes** to build skills in nurturing and responsive care and non-violent discipline	Raise awareness about positive parenting

Mental health promotion: Ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
National, multisectoral mental health plans and strategies, including suicide prevention **Integration of mental health into maternal and child health, adolescent health, nutrition and HIV policies and strategies**	**Integrating mental health into education policies**	**Integrating mental health into early childhood development, child protection, ending violence, social welfare and social protection policies and plans**	**Integrating mental health of children and adolescents into health policy and plans for the juvenile justice and justice sectors**
Policy and standards for high-quality mental health care		Identifying barriers to access of mental health services for marginalized groups	
Legislation mandating access to mental health care, including removing mandatory parental consent requirements		**Legislation mandating access to mental health care**, including removing mandatory parental consent requirements	**Legislation mandating access to mental health care for children and adolescents deprived of liberty an in out-of-home placements**
Protections for children and adolescents in the mental health system		**Support to legislation and policies to protect children and adolescents from violence and harm** Social protection programmes for families	**Legislation and policies to prohibit violence, harm, discrimination** • end all forms of violence • end child marriage • end discrimination • control substance use • restrict access to lethal means • end child labour • end recruitment to armed forces • reconsider minimum age criminal responsibility

Training and community-based programmes to address stigma and discrimination		**Training and community-based programmes to address stigma and discrimination**
Capacity-building for adolescents to support participation in the planning and design of MHPSS, including those with lived experience of mental health needs	**Capacity-building for adolescents to support participation in the planning and design of MHPSS, including those with lived experience of mental health needs**	**Capacity-building for adolescents to support participation in the planning and design of MHPSS, including those with lived experience of mental health needs**

Health sector

Stakeholders singled out the health sector, through the DOH and Philippine Council for Mental Health, as having an overarching leadership role for setting national policy, planning and oversight and monitoring MHPSS services. The DOH was also cited as the lead for developing technical guidance, quality assurance for clinical care, accreditation of mental health facilities and capacity development of the mental health workforce.

In addition to an overall leadership role for MHPSS, stakeholders considered the health sector as having primary responsibility for the implementation of actions related to responsive care. While this reflects the sector's role and mandate with respect to the delivery of clinical services, stakeholders emphasized that the health sector should have a much greater role in prevention and promotion, including supporting mental health advocacy and addressing stigma. Stakeholders recommended that the health sector take a greater role in supporting mental health programmes in schools and other non-health settings. Specifically, the health sector should be an important technical partner to support school and whole-of-education approaches to promote good mental health, increase mental health literacy, address risk factors with targeted interventions and work with schools to support screening and referral. Although parenting programmes were cited as being the primary responsibility of the social welfare sector, stakeholders considered the health sector as an important technical partner in identifying and supporting families at risk and assessing parenting relationships.

Education sector

The education sector, through the DepEd, was singled out by the education stakeholders to have the leading role in coordination and implementation of preventive actions needed to optimize learning environments, build individual assets and support healthy peer relationships. Broadly, the education sector was identified as having responsibility for developing and implementing a whole-of education approach to mental health promotion, with consideration not only of the individual programmes to address specific risk factors (such as peer victimization) but also actions to recognize and address the impacts of the school culture, environment and teaching approaches on mental health and then to develop approaches to create safe and enabling learning environments. Stakeholders recommended that the education sector lead more focused efforts to strengthen the national curricula to support social and emotional learning, promote positive and respectful peer relationships, address risks (bullying and substance use) and improve mental health literacy.

Stakeholders recommended that the education sector take a greater role in early identification and screening of children and adolescents with mental health conditions through improved training and support for teachers and school-based counsellors and with greater links to health services.

They noted that teachers are often the first to identify children and adolescents with mental health conditions (or at risk) and the first link between families and other mental health services. They added that the provision of special education programmes for children with development disorders and ensuring ongoing education for those with other mental disorders are important responsibilities for the sector. Although stakeholders recognized the primary responsibility for parenting programmes remains with the social welfare sector, they recommended that the education sector share a role in raising awareness on positive parenting (including guidance for parents of children living with a disability) and facilitating the delivery of parenting programmes to parents in the school community. Given the leadership role of schools in communities, the education sector was also noted as having responsibility for supporting general mental health awareness and addressing stigma.

Social welfare sector

Stakeholders recommended the social welfare sector, through the DSWD, take the leading role in planning, coordinating, developing and monitoring actions related to child and youth welfare.

Stakeholders said the sector is a critical link between families and communities and the health, education and justice sectors due to the focus on and engagement with children and adolescents at increased risk of poor mental health. They noted that the social welfare sector has a critical role in identifying and supporting children within child protection agencies, residential or institutional care, justice settings and foster care facilities. This not only includes a link for service delivery but also for strengthening the identification and monitoring of children most at risk. Stakeholders also recommended the sector take a role with the health sector in the early identification and screening of children and adolescents with high-risk behaviours or exposure (including in community, education, alternative care and justice settings), supporting a strong and efficient referral system and being part of a multidisciplinary team to provide acute and continuing care. Additionally, the social welfare sector was identified as having primary responsibility for implementing parenting programmes and community-based actions to improve mental health literacy, address stigma and discrimination and advocate for children's rights and well-being.

Justice sector

Although stakeholders from the justice sector did not identify a sectoral role in supporting responsive care, other recommendations emerged from the consultation workshops and interviews that positioned the justice sector with a role in supporting early identification, screening and referral for children and adolescents at risk of mental health disorders. In addition to screening and referral in the acute setting for children who are victims of violence or those in conflict with the law, the justice sector was also identified as having a role in supporting continuing care. This includes follow-up services for families who have been in conflict with the law or have had contact with the justice system by way of a multidisciplinary team supporting diversion and other interventions. Stakeholders cited the justice sector as central to improving and enforcing legislation to protect children and adolescents from harm, including Indigenous children and other marginalized populations and investigating complaints regarding the treatment of children and adolescents within the mental health system. Stakeholders also noted a significant role for the sector in addressing harmful use of substances.

In addition to sectors having responsibility for implementing different MHPSS actions within each tier, there are **several critical areas of convergence** where effective implementation of specific actions requires strong collaboration across the sectors. These include actions to:

- improve early identification, screening and referral to multidisciplinary care;
- ensure continuing care and support for children, adolescents and their families experiencing mental health conditions or at increased risk;
- implement targeted, intensive interventions for children and adolescents at increased risk of poor mental health (particularly in relation to high-risk exposure, such as violence and conflict with the law);

- implement school-based approaches to prevent poor mental health and promote well-being; and
- support positive parenting and provide services and support to parents and caregivers of children with mental health needs or for their own mental health needs.

Non-government organizations

Not-for-profit NGOs were characterized for their important role in implementation of MHPSS, particularly in humanitarian settings, where many agencies are mobilized and coordinated to provide psychological first aid and other MHPSS interventions. In other contexts, stakeholders cited other critical roles for NGOs: advocacy (at the government and community levels); mental health literacy (including through use of multimedia and digital technology); provision of capacity-building and training in mental health for service providers as well as community members; and provision of services to fill gaps in public MHPSS.

Private sector

Stakeholders considered the private sector as having an important role in providing funding for MHPSS initiatives, for example, through foundations that could fund community-based projects. They cited professional associations for a role in providing support and guidance, particularly technical resources to improve the quality and accessibility of programmes for children and adolescents. Some stakeholders also noted that private sector providers, such as psychologists, could help fill service-delivery gaps, although the high fees were described as a barrier.

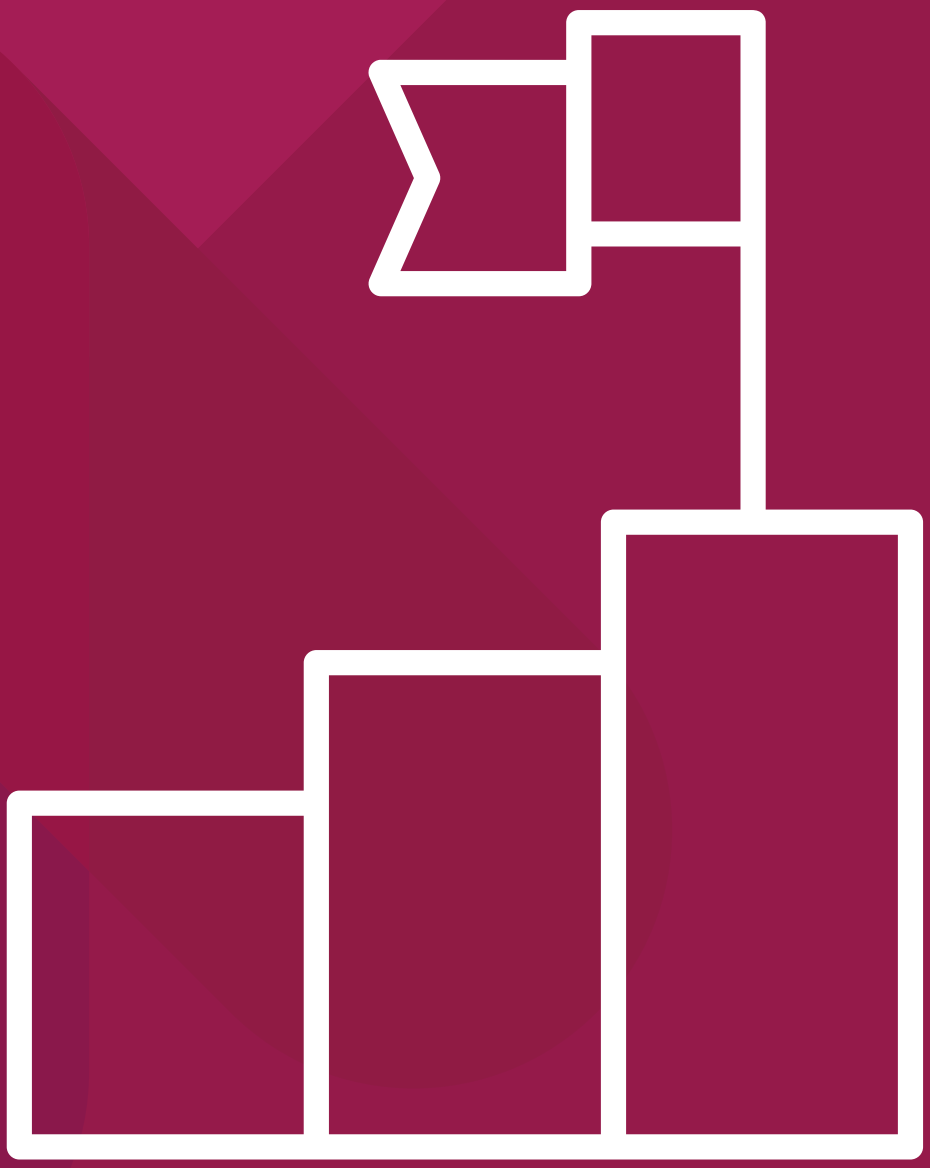
United Nations agencies

UNICEF was noted for its critical role in supporting MHPSS, particularly regarding technical assistance to policy and programme development and advocating for child and adolescent mental health and well-being. Stakeholders considered UNICEF as having expertise in supporting capacity development of other organizations, community groups, parents and adolescents and that could support the development and dissemination of MHPSS guidelines and toolkits. They recommended that UNICEF support knowledge and evidence-generation by conducting needs assessments, research and monitoring and evaluation. Stakeholders also highlighted the potential for UNICEF to provide funding to support new initiatives, pilot projects and other innovations to test new ways of implementing MHPSS for children and adolescents. Stakeholders noted a potential role for UNICEF in supporting LGUs to implement and identify innovations and good practice that could be shared nationally. The WHO was cited as having an important role in supporting the DOH in developing technical guidance and systems strengthening, particularly for responsive care. Given the already extensive engagement in the WHO, stakeholders recommended that the WHO be a technical resource for other United Nations agencies and development partners engaging in MHPSS.

Through consultation with UNICEF representatives in the region, UNICEF was described as having an important role and comparative advantage in:

- leading advocacy efforts;
- crucial convening role, including capacity to facilitate links between sectors (such as health, social welfare, child protection and education) and support for cross-sectoral dialogue, planning and resource allocation;
- integrating MHPSS into existing UNICEF programmes and platforms (including primary health care, education, parenting programmes and child protection);
- supporting and delivering programmes to address mental health-related stigma and improve mental health literacy through national-level advocacy and community-based programming; and
- integrating MHPSS into emergency settings.

Challenges and recommendations for strengthening the multisectoral mental health system



Legislation, policy and strategy

The Philippines legislative and policy framework for MHPSS provides a good foundation for ensuring mental health and well-being support for children and adolescents. The **Mental Health Act** and the **Mental Health Strategic Plan** broadly outline actions needed for good child and adolescent health, particularly in promoting well-being through the education sector and establishing a national suicide prevention programme that includes youth. Yet, neither contains a focus on children and adolescents, nor do they provide detailed guidance around service delivery, quality assurance, special considerations, or performance indicators for this age group. Both are lacking guidance on reaching out-of-school, marginalized and other children at high risk of poor mental health. An additional gap in the Mental Health Act is the lack of articulation of the need for social and fiscal protection for children and families.

Importantly, the Mental Health Act recognizes the rights of children to express their opinions and have their views considered regarding mental health. It includes a presumption of legal capacity to provide consent for 'minors', although no definition of 'minor' is provided to guide implementation. The law includes general protection of rights of persons within the mental health system in relation to physical restraint, deprivation of liberty, involuntary treatment and appeal, but there are no specific protections or additional considerations for children and adolescents. Such protections could include:

- right to least restrictive assessment and treatment possible, including specific consideration of the use of physical restraint, involuntary seclusion and deprivation of liberty for persons younger than 18 years;
- right to have contact with family or other support persons; and
- right to recreational activities, education and other support that responds to individual needs.

The Mental Health Act and the Strategic Plan recognize the importance of multisectoral collaboration and partnership to promote well-being, prevent poor mental health, provide responsive services and protect the rights of children and adolescents. It also provides some guidance on the roles and responsibilities of allied sectors, although primarily for agencies that lie within the health sector. It identifies actions required of the education, social welfare and justice sectors and includes performance indicators for these sectors (for example, mental health training provided to teachers and police officers; provision of MHPSS in schools; and mental health services provided in justice settings. It does not, however, provide clear guidance on the mechanisms needed to enable cross-sectoral collaboration and accountability.

Additionally, mental health and MHPSS are only included to a limited extent within **other sectoral policies and plans**. While there is a suite of laws and departmental Orders that are relevant to MHPSS (such as child protection legislation, inclusion of mental health in the provision of care to children in conflict with the law), there is a lack of explicit integration of mental health into strategic plans and policies of the education, social welfare and justice sectors. A priority action that stakeholders cited for the National Mental Health Strategic Plan is the development of guidelines on mainstreaming mental health into the education sector, with the DepEd taking responsibility in collaboration with the DOH.

Across sectors, stakeholders noted that in addition to addressing these gaps, there was need for implementation strategies, plans and frameworks that more clearly define the roles and responsibilities of agencies, particularly the LGUs. Limited dissemination of policies, plans and legislation at the local level was cited as a significant barrier to implementation, with many LGUs not aware of relevant policies, their specific roles or available guidance around implementation. This was seen as particularly critical, given that LGUs have responsibility for implementation and resource allocation but may not prioritize mental health due to limited awareness.

KEY RECOMMENDATIONS – LEGISLATION AND POLICY:

- Integrate mental health in all policies with more explicit recognition and actions to address mental health in non-health sector policies.
- Strengthen the Mental Health Act to include specific protections and provisions for children and adolescents within the mental health system.
- Develop a specific policy or strategy for child and adolescent mental health that details a multisectoral implementation plan and offers guidance, with clear roles, responsibilities and accountabilities at all levels (including performance indicators related to multisectoral coordination).
- Develop multisectoral mental health plans at the LGU level to support coordination and implementation.
- Review legislative and regulatory barriers to access (for undocumented migrants) and to greater coordination between sectors.
- Develop policies and strategies to reach out-of-school children and adolescents and other marginalized groups.
- Strengthen child protection and criminal legislation to better respond to risks related to online harms, and integrate MHPSS into the forthcoming National Child Protection Strategy.
- Improve dissemination of MHPSS-related policies and plans across sectors and to administrative and implementation agencies.

Leadership and governance

National level

As described in the National Mental Health Strategic Plan and the Mental Health Act, the Philippine Council for Mental Health, within the DOH, has overall leadership for policymaking, planning, coordination and advice to oversee implementation. This includes responsibility for developing national multisectoral strategic plans (for service delivery, human resources, information systems, budget and investment case), monitoring implementation, coordination with government agencies, LGUs and NGOs and coordinating joint planning and budgeting with relevant agencies. The Council members include representatives from the DOH, the DepEd, the DILG, the Department of Labor and Employment, the Commission on Higher Education, the Commission on Human Rights and representatives from academic institutions, health professionals and NGOs. Participation by representatives from the DSWD, the DOJ, government units with a focus on children and youth, youth organizations or young people themselves is not specific within the law. The law also requires the creation of a Mental Health Division with the DOH, under the Disease Prevention and Control Bureau, with responsibility for implementation of the national programme.

> *Actually, it's in the Philippine Council for Mental Health and in the Mental Health Act, in which, mental health is in the [hands of the] Philippine Council for Mental Health and in the LGU. They have specific roles. However, how to harmonize this and how to integrate it well?*
> – Health sector representative

Stakeholders described the limited coordination between sectors and MHPSS programmes as contributing to duplication, fragmented services and delivery gaps.

> *Maybe the platform really is the one that could harmonize all the mental health initiatives, mental health and psychosocial interventions, because we don't have that right now. Duplication, that's what being done by other organizations, instead of complementing. So, the effort is wasted or others are not addressed because there is no one particular platform where you can check where all those services can be implemented. So, if we have a platform on harmonizing interventions, then that would be helpful not only for those who are doing the implementation of the project but also for those who seek assistance.* – Education sector representative)

To facilitate better collaboration and coordination at the national level, stakeholders recommended the creation of a multisectoral unit for child and adolescent mental health, under the DOH, with accountability to the monitoring body for health systems. In addition, they recommended that a special planning body be established with representation from all allied sectors to co-develop implementation plans, guidelines, targets and indicators to track progress in child and adolescent mental health. Such a body should also include representation from United Nations agencies (UNICEF and the WHO in particular), NGOs and the private sector to provide technical support.

Additionally, representatives from the health sector recommended drafting a Joint Administrative Order that specifies mental health services to be made available in schools, communities and workplaces, with emphasis on the needs of children and adolescents. This would be drafted with allied agencies to support coordination.

Administrative and implementation levels

At the local level, LGUs have responsibility for financing and implementation of the mental health programme, although with a focus on actions in relation to responsive care. Under the Mental Health Act, LGUs are required to develop policies, regulations and guidelines (including local ordinances) that are consistent with the national guidance. They are to establish training programmes to build up the capacity of providers and to integrate mental health into basic health services. They are also required to ensure social protection and other supports for those with mental health conditions and to establish a multisectoral network for early identification, referral, management and prevention. Stakeholders noted the lack of awareness or prioritization of mental health by LGU authorities and poor coordination across sectors as barriers impacting implementation at the local level.

To overcome these challenges, stakeholders recommended that a special coordinating body be established to build awareness, capacity and support for LGUs to formulate mental health ordinances. The National Mental Health Strategy requires regional mental health councils to be established in all 16 regions by 2023 to support local planning and implementation, and these could provide this function. It was also recommended that each LGU be required to allocate a nominated amount in each budget to support the mental health programme, similar to the Gender and Development programme that requires a 5 per cent share of the total budget allocation.

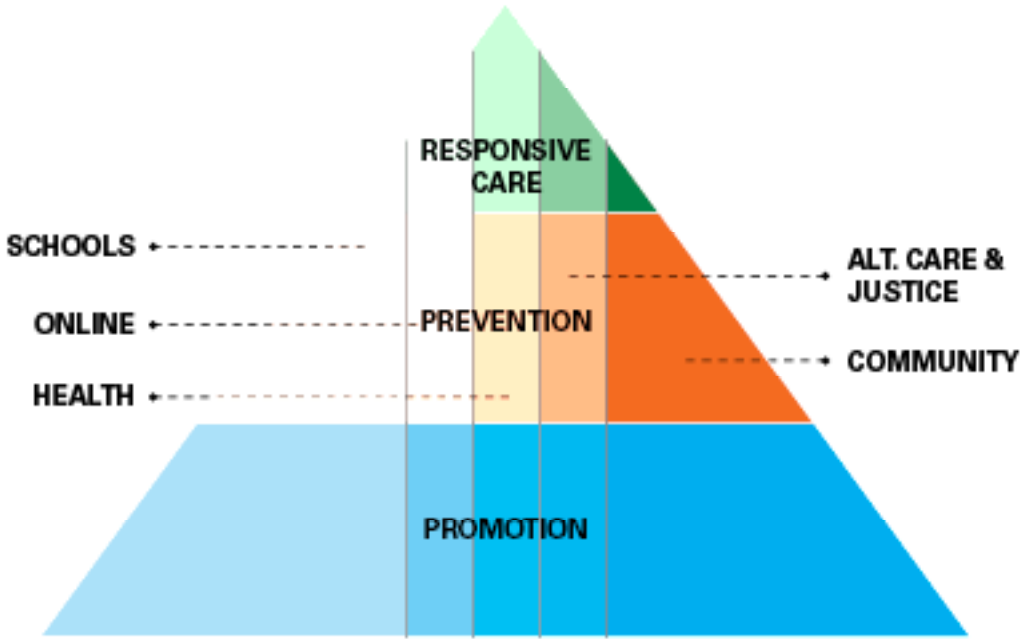
KEY RECOMMENDATIONS – LEADERSHIP AND GOVERNANCE:

- Expand the Philippine Council for Mental Health to include membership from the justice sector and DSWD. Consider establishing a high-level multisectoral national coordinating body for child and adolescent mental health, with representation from all allied sectors and with authority and resources to drive action.
- The DOH should draft a Joint Administrative Order, together with allied sectors, that defines the mental health services to be provided in key settings for children and adolescents (including schools and communities) and that support coordination.
- Build up the capacity of the LGUs to support local planning, coordination and resource allocation for MHPSS.
- Establish or strengthen local multisectoral committees to support coordination and implementation of the priority MHPSS package.
- Develop subnational implementation plans for MHPSS that clearly articulate sectoral roles. and responsibilities and are aligned with national goals and strategies for mental health

Service delivery

Multiple platforms exist to support the delivery of MHPSS actions (*see Figure 14*). For responsive care, **health facilities** (primary, secondary and tertiary levels) remain an important setting to deliver screening and specialized care. While the Philippines has a network of hospitals, units and outpatient services for mental health, availability is constrained in rural areas, and there are limited services specific to children and adolescents. Within existing health care settings, further attention is needed to develop child- and adolescent-centred and friendly care models that build on existing service-delivery standards set out in the National Adolescent Health and Development Program. Integrating mental health into basic health and social services is a priority within the National Mental Health Strategic Plan and the Mental Health Act and a primary responsibility of the LGUs. The law also states that the DOH will fund the establishment and assist in the operation of **community-based services**, including community facilities staffed with trained professionals and volunteers (including barangay health workers) to provide responsive care.

FIGURE 17. PLATFORMS FOR DELIVERY OF MHPSS



Note: The figure illustrates how existing platforms cut across the three tiers of MHPSS actions.

There have been efforts to expand the services provided through the DSWD, from institutional to community-based delivery. Currently, DSWD shelters work with community-based social workers and local Social Welfare and Development officers to provide community or home-based services to support rehabilitation and recovery of children who have survived trafficking (medical, educational, financial and other services). Many NGOs engaged in social welfare also provide services and support at the community-level, including psychological first aid during humanitarian emergencies.

Schools and other learning environments are a critical platform for reaching large numbers of children and adolescents with MHPSS. All sector stakeholders nominated school-based delivery as essential to the effective implementation of MHPSS, with a focus on improving early identification and screening, contributing to multidisciplinary and continuing care and, most significantly, actions to build individual assets, promote positive peer relationships and create safe learning environments. Schools are not only a platform for delivering interventions – learning environments have profound influence on mental health and well-being from early childhood to adolescence. There is a need to consider the impact of the school and learning culture, the academic pressures and inclusiveness on well-being. And there is a need for a more comprehensive whole-of-education approach to mental health promotion that would support a more holistic and coordinated programme in schools and other learning settings.

The potential of **online and digital platforms** has received increasing recognition, particularly in the context of the COVID-19 pandemic. Several hotlines, websites, online programmes and telehealth platforms provide information and education, mental health literacy, self-referral and services (such as counselling). While stakeholders agreed online platforms have the potential to increase accessibility of MHPSS, particularly for adolescents who are regular users of technology, there is a need to address equity in access. Poorer households and families in rural areas were described as having less access to technology and reliable internet. Some stakeholders noted that service providers and facilities in many areas do not have sufficient equipment and skills in digital delivery to support online service delivery and that greater investment is needed to improve the quality and accessibility of online services.

Justice settings are also important for the delivery of screening, referrals, targeted interventions to address risk factors and continuing care for children who are victims or witnesses of a crime and juvenile offenders. Some existing models of collaborative care were cited, including the Bahay Pag-asa and regional rehabilitation centres for children in conflict with the law. These centres provide mental health and psychosocial support, including intensive interventions and counselling, through social workers, psychologists and educational guidance counsellors.

All sector stakeholders noted significant **barriers** impacting on equitable access to MHPSS. They recognized rural and remote communities and ethnic minorities as having limited access to facilities, services and skilled providers, with both government and NGO services concentrated in more urban settings. Children and adolescents not engaged in formal education were also noted as an underserved group, primarily because most national policies and programmes focus on school-based delivery**.** Stakeholders recommended further research to understand the barriers and service-delivery preferences. They also recommended improved coordination with community-based organizations to better serve marginalized groups.

KEY RECOMMENDATIONS – SERVICE DELIVERY:

- Develop models and standards of child and adolescent-centred health services for mental health.
- Transition to integrated community-based services that span the three tiers of MHPSS.
- Integrate MHPSS into other health services at the community level, including maternal and child health, nutrition, adolescent health and general medical or physical health.
- Build on existing school-based models to strengthen responsive care and preventive actions.
- Develop and evaluate online and digital service delivery models that link mental health promotion, positive peer relationships, parenting programmes and responsive care (self-referral and counselling).
- Identify barriers and service delivery preferences for marginalized and underserved communities, and develop strategies to reach out-of-school children and adolescents and especially those living with a disability.

Standards and oversight

Several recommendations were made to strengthen the quality of MHPSS and support oversight. At the national level, the Philippine Mental Health Council was identified has having overarching responsibility for the development of technical guidelines, service standards, performance indicators and quality assurance processes. This role is more clearly defined in terms of responsive care and delivery of mental health services through the health sector, but oversight in relation to other MHPSS actions delivered through other sectors is less clear.

A high priority is the development of a national protocol for early identification and screening of children and adolescents to identify those with mental health conditions and those at increased risk (including through Child Protection Units). This would include developing locally validated and age-appropriate screening tools and detailed protocols for administering these within the different settings (health, education, child welfare and justice). Standardized protocols and procedures for the referral of children and adolescents with mental health needs are also critical, not only for efficient referral within the health system but to support referral between sectors (for example from schools or child protection settings to health services). A noted barrier for children within the child protection system is the lack of clarity around interagency referral processes. While some protocols exist for

case management, training of front-line providers (including social workers) appears limited. Providers are unclear of these processes even when a protocol exists.[47]

To support responsive care, the national standards of adolescent-friendly health service delivery could be expanded to provide more specific service standards in relation to mental health. Similarly, standards of care provided in other settings are also needed, for example, protocols and service standards for the provision of psychological first aid or initial management of behavioural problems in schools and the provision of MHPSS in the social welfare and justice settings. For the justice sector specifically, stakeholders recommended protocols be developed to provide greater guidance on the management (health and legal) of children in conflict with the law who have a mental health condition and protocols to minimize harmful impacts on the mental health of juvenile offenders, child victims and child witnesses.

The National Mental Health Strategic Plan highlights the need for policies and guidelines to support a suicide prevention programme, including guidelines for suicide prevention hotlines, emergency response and care for suicide (for health professionals, non-health providers and first responders) and suicide surveillance. It also articulates a plan for developing standardized guidelines and a manual or procedures for facility standards, service standards, human resources standards (including task-sharing) and process flow, from identification and referral to treatment and follow-up.

Stakeholders noted the need for harmonized indicators across sectors to monitor performance and track progress. They highlighted that currently there are limited mechanisms of accountability and reporting for MHPSS in relation to mental health workforce. They recommended national accreditation of mental health providers for non-health workers who are trained to provide some MHPSS services (such as psychosocial first aid).

KEY RECOMMENDATIONS – STANDARDS AND OVERSIGHT:

- Define clear multisectoral indicators to monitor MHPSS performance.
- Strengthen the guidance, protocols and procedures for the delivery of child- and adolescent-friendly mental health services, including clarity around parental consent.
- Develop clear guidance and protocols for early identification, screening and referral (within sectors and between), with defined roles and accountability for each actor.
- Establish standard operating procedures across agencies to support the coordinated care of children and adolescents engaged in child protection or justice settings.
- Strengthen the justice-related protocols to minimize harm to children and adolescents who come into contact with the justice sector.

Multisectoral mental health and psychosocial support workforce

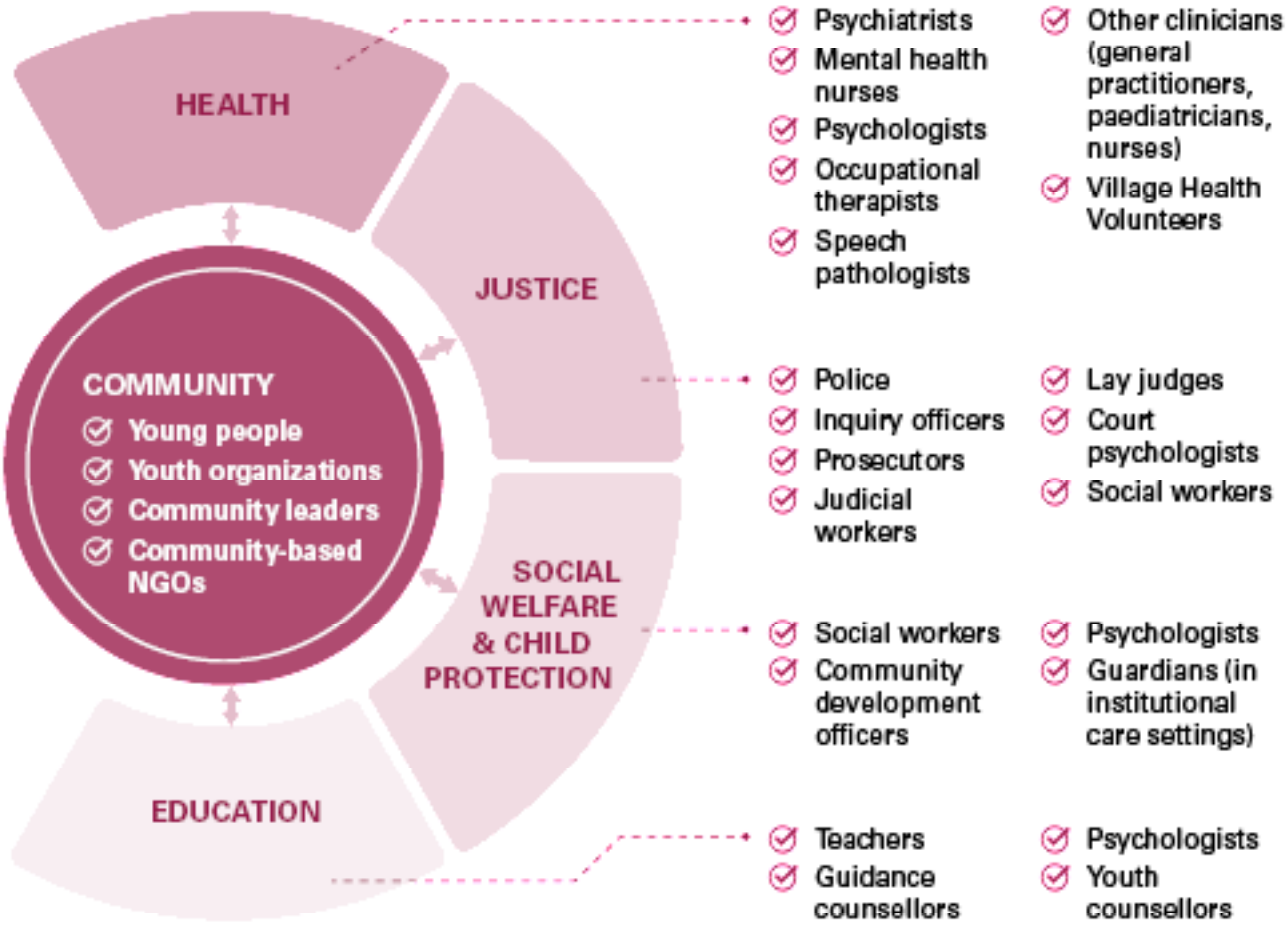
The multisectoral mental health and psychosocial support workforce is challenging to define because it is diverse and dynamic. It incorporates specialist providers whose primary roles relate to mental health, along with providers and volunteers who may be required to deliver some aspect of MHPSS but for whom this is not a primary responsibility. The three tiers of MHPSS action (responsive care, prevention and mental health promotion) can be coarsely mapped against the corresponding multisectoral mental health workforce, as shown in *Figure 18*.

FIGURE 18. TIERS OF WORKFORCE REQUIRED TO ENSURE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The current workforce

In the Philippines, the mental health and psychosocial support workforce includes government, non-government and private sector actors across health, education, social welfare, justice and community sectors (*see Figure 19*).

FIGURE 19. MULTISECTORAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE



All sector stakeholders identified workforce shortages as a major challenge impacting the implementation of the National Mental Health Strategic Plan and other MHPSS programmes. Limited numbers of professionals trained to deliver components of MHPSS (health professionals, teachers, school counsellors, educational area psychologists, social workers and court psychologists) contribute to constraints on service delivery. It results in heavy caseloads and overreliance on institutional and specialized services and leads to referral bottlenecks and delayed access to care. To address inequity in access to MHPSS, stakeholders said it is necessary to consider the skills mix and distribution of the workforce, noting the need for collaborative and multidisciplinary teams. In addition to increasing the number of skilled providers in rural areas, stakeholders also emphasized the need for providers with diverse gender, ethnic and cultural backgrounds so that communities have access to an appropriate and trusted provider. To support a strengthened workforce, stakeholders recommended forming a national **mental health workforce taskforce** that comprises all relevant sectors and that could have an overarching role in defining the required workforce (roles, competencies, qualifications and settings of practice), making recommendations for training and supportive supervision and to support workforce planning and development.

The current mental health and psychosocial support workforce and recommended MHPSS roles

Many priority MHPSS actions are already integrated into existing workforce roles, although providers' capacity to carry out these roles is hampered by the challenges previously noted. *Table 5* outlines recommended roles by sector.

Within the **health** sector, specialist mental health professionals (psychiatrists, medical doctors, nurses, psychologists, social workers, occupational therapists and speech therapists) have primary responsibility for the delivery of responsive care, in addition to non-specialist providers trained through the WHO mh-GAP programme. However, the limited numbers of these professionals, particularly those with training and expertise in child and adolescent mental health, is a major bottleneck. There are an estimated 2,051 professionals working in government and non-government settings. Of the 567 registered psychiatrists, 60 are child psychiatrists.[48] For the entire population there are around two mental health professionals for every 100,000 people. Many are concentrated in urban areas and tertiary hospital facilities. Thus, there is limited access to specialists in rural areas. Stakeholders also described specialists working within the private sector because of low remuneration in government service.

Stakeholders also noted challenges referring children and adolescents for specialist clinical care because of the limited accessibility of trained mental health professionals.

> *…the lack of psychologists or psychiatrists, the difficulty to access them. We do not have sufficient psychiatrists and psychologists, you know, mental health practitioners… suppose you look at the child psychiatrists available in the Philippines. In that case, I think there are just 60 all over the country, and most of them are practising in Metro Manila in the National Capital Region.* – Justice sector representative

> *One thing that we lack is a neurodevelopmental and behavioural paediatrician. Very few applied [because] the income earned outside the country is very high. In fact, we've been offering new doctors that will come to us and send for training, but still no applicants.* – Health sector representative

To address these constraints, stakeholders recommended improving the training of primary health care providers to deliver mental health care, noting that many children and adolescents can be effectively managed at the primary care level without requiring highly specialized tertiary-level care. Barangay health workers have a role in the delivery of some mental health services. The Mental Health Act and the National Mental Health Strategic Plan define a role for trained barangay health workers in supporting community-based delivery of responsive care as part of a team of mental health professionals. However, stakeholders noted that these workers are generally facility-based and older, with limited training on mental health (including to address attitudes and misconceptions) and so are not accessible to children and adolescents. Additionally, they have heavy workloads with other health conditions in the community and may not prioritize mental health. To address these concerns, stakeholders suggested to improve training and supervision of barangay health workers as well as additional community-based cadre who are developed specially to support child and adolescent mental health and well-being. This could involve more junior health workers with a primary focus on children and adolescents, for whom MHPSS could be better integrated into their role.

The **education sector** arguably comprises the biggest mental health and psychosocial support workforce, although the education workforce roles in MHPSS are not as well defined as they are for the health sector. Current roles defined by the National Mental Health Strategic Plan are largely limited to delivery of mental health-related curriculum by teachers in schools, although the Mental Health Act also includes a role for educational facilities (including schools) in improving mental health awareness, identifying and providing support and services for those at risk and facilitating referral for additional treatment and support as needed (including through networks with health professionals). There are limited numbers of guidance counsellors or psychologists based in schools, with no budget allocation for hiring counsellors in public schools. Therefore, schools rely on homeroom teachers to identify students with mental health needs or behavioural problems, but they have limited guidance on how to provide support and referral. Stakeholders prioritized ensuring that all schools have a dedicated

guidance counsellor and a school nurse (there is currently only one per district). A school mental health committee could provide additional coordination and guidance on mental health promotion.

> *First and foremost, if I may add, I think DepEd should place in schools [should hire] not just guidance designates…we need guidance counsellors in schools. Also, additional human resources in establishing a committee in every school that will focus on mental health and psychosocial support is needed, not only a guidance counsellor and a nurse. But let us remind you also that we have no nurse in every school. There is only one nurse for every district. So, this is the scenario in DepEd. We need guidance counsellors. We need nurses.* – Education sector representative

The **social service workforce**, including social workers and psychologists, encompasses a broad professional workforce in the Philippines working across government, non-government, institutional and community settings. Although the exact number of social service workers is not known, in 2018 the DSWD estimated there were 5,423 registered social workers (the majority of whom were government employed) and 13.8 social workers per 100,000 children).[47] This does not include social workers working in health, education or justice settings or employed by NGOs. The social work profession is defined by the Social Work Act, the Magna Carta for Public Social Workers and the Act Regulating Sundry Provisions Relative to the Practice of Social Work, including setting ethical standards for practice and minimum requirements for registration (including university degree).[47] Current roles in relation to MHPSS include case management, the provision of counselling and services in relation to child protection (identification, referral, support for children experiencing family violence, neglect, child labour, those in conflict with the law, victims of sexual exploitation and trafficking and children with disabilities). Social workers also have a significant role in disaster relief and recovery and have received additional training in response to the COVID-19 pandemic:

> *So last year, in the pandemic, we had a seminar on basic social work counselling for local government units, also in other organizations focusing on children. Social workers were able to undergo how to do team counselling, counselling for children and counselling for children with special needs. It's a series of trainings for maybe about five to six weeks. Aside from direct services for children, we also capacitate other stakeholders so they can also accompany us with what we are doing.* – Social welfare sector representative

Stakeholders described heavy workloads and limited resources, particularly in times of disaster or crisis, as major challenges. Insufficient numbers of social workers and psychologists were also noted. Limited numbers of social workers employed in the government sector and few psychologists to support MHPSS in institutional settings (rehabilitation, care facilities and shelters) contribute to the heavy workloads and inability to provide services. This is compounded by insufficient budget allocation for staff salaries and low salary levels for these cadres, despite requiring undergraduate or postgraduate qualifications.

> *Social workers are professionals and they know how to handle these children. But the main problem is the fact that we lack social workers in the Philippines who work for the Government. Rehabilitation and care facilities for abandoned children and those in conflict with the law, these facilities do not have sufficient social workers to work with the children under their care… we are not even talking about trainings yet. But more of the availability of social workers.* – Justice sector representative

Within the **justice** sector, the National Mental Health Strategic Plan identifies a role for police, jail officers and other justice sector workers in supporting MHPSS, particularly for the children in conflict with the law and child victims. The Juvenile Justice and Welfare Council, working under the DSWD, provides early identification, screening and some mental health services as part of multidisciplinary teams. However, the DOJ has a limited role in MHPSS, other than referral of children in conflict with the law for mental health assessment and care. The Philippine National Police, under the DILG, provide some services (such as identification and referral) through the Women and Children's Desk for child victims of crime and child offenders. The specific roles of justice workers are not clearly defined, nor are the competencies required to support MHPSS in these settings.

Table 5. Overview of MHPSS roles, by sector

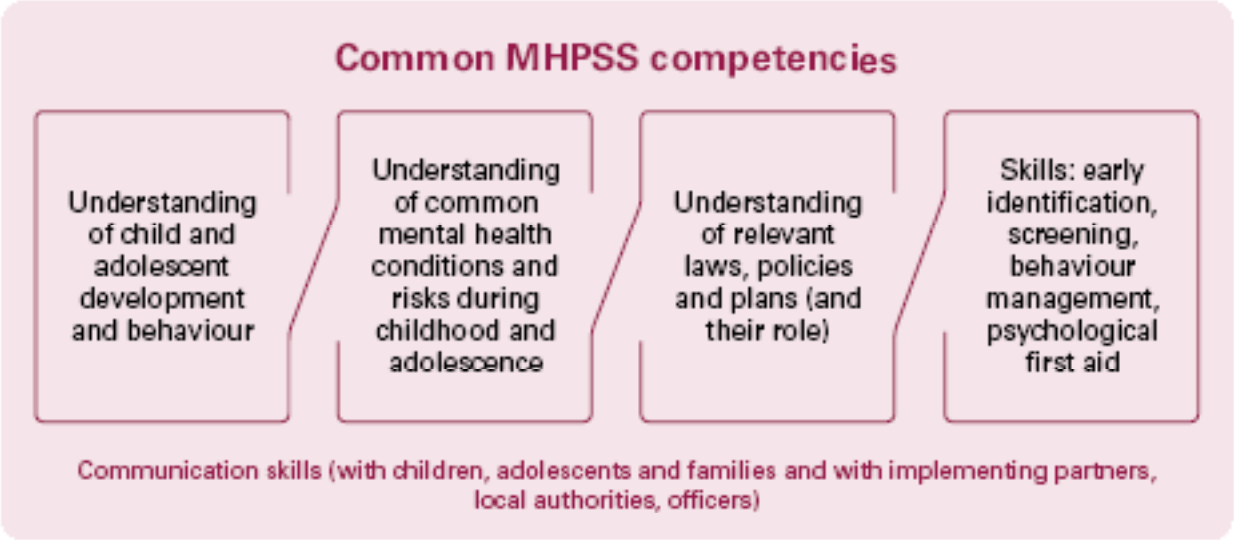
Sector	Provider	Responsive care	Prevention	Promotion
Health	Specialist mental health clinicians	Screening, diagnosis and management as part of a multidisciplinary team	Targeted interventions to address risks (such as harmful substance use) Support to school-based approaches	Support mental health literacy
	Other clinicians and allied health professionals	Screening, diagnosis and management as part of a team and supported by specialists as needed	Support positive parenting and targeted interventions to identify and support children and families at risk Support to school-based approaches	Support mental health literacy
	Barangay health workers	Community-based early identification and screening, referral, supporting community-based care	Support universal prevention actions (such as promotion of positive parenting)	Mental health literacy, addressing stigma and discrimination
	New cadre of junior health workers (similar to barangay health workers)	Community-based early identification and screening, referral, supporting community-based care	Support universal prevention actions (such as positive peer relationships and building up the skills of children and adolescents)	Mental health literacy, addressing stigma and discrimination
Education	Teachers	Early identification, screening and referral Behaviour modification for uncomplicated cases Support continuity of care and ongoing education	Support social and emotional learning, skills and resilience, promote positive peer relationship (with curriculum-based and participation in whole-of-school approaches)	Support mental health literacy and anti-stigma through greater engagement with families and school communities

Sector	Provider	Responsive care	Prevention	Promotion
	Guidance counsellors	Screening and referral, provision of counselling and initial management of mental health conditions	Support school-based interventions to increase mental health literacy and social and emotional skills	Support mental health literacy and anti-stigma through greater engagement with families and school communities
	School nurses	Training and support to teachers and guidance counsellors for screening, referral and management		
Social welfare and child protection	Social workers, community development workers, psychologists	Early identification, screening and referral of children and adolescents at increased risk Case management as part of a multidisciplinary team (facility, residential and community-based)	Parenting programmes (universal) and support to families in need (targeted) Other targeted interventions to address risks	Mental health literacy and programmes to address stigma and discrimination Social protection programmes for children and families
Justice	Police, court psychologists, judges, social workers, special investigators, lawyers and other front-line justice workers	Early identification and referral for screening, diagnosis and management as part of a multidisciplinary team	Targeted intervention and follow-up of children, adolescents and families at risk	
Community	Youth leaders, community leaders, community-based organizations	Early identification and mental health first aid	Promote positive peer relationships, positive parenting and support to community-based interventions	Mental health literacy and programmes to address stigma and discrimination

Competencies, training and support

Stakeholders identified common competencies required of the multisectoral mental health workforce (*see Figure 20*). They particularly emphasized improving understanding of child and adolescent mental health and related behaviours as well as specific skills for screening, managing difficult behaviour and dealing with crisis (including psychological first aid).

FIGURE 20. COMMON CROSS-SECTORAL MHPSS COMPETENCIES



The National Mental Health Strategic Plan prioritizes mental health training and education to support a multisectoral mental health and psychosocial support workforce. This includes specialist training for psychiatrists and other medical professionals as well as the development of evidence-based standardized training modules for non-health professionals (teachers, barangay health workers, justice workers and community members). However, no further details are provided on the specific competencies, training modalities or delivery (pre- or in-service). There is also lack of clarity around accreditation of training, outside of medical specialists. The responsibility for training the mental health workforce is primarily with the DOH, although LGUs have responsibility to establish training programmes to support community-based delivery, as per the Mental Health Act.

Across the sectors, stakeholders emphasized training that aims to build skills and competencies, noting that many provides engaged in MHPSS have some basic understanding of mental health but lack the skills to implement their knowledge. Additionally, stakeholders, particularly in the education sector, highlighted the importance of continuing education and support to maintain and build skills.

A primary barrier to strengthening the mental health and psychosocial support workforce is budget allocation to support staff salaries. Stakeholders acknowledged the significant difficulty attracting skilled personnel to mental health positions (psychiatrists and psychologists) and challenges retaining staff because the salaries offered are low. Registration and employment, even at the entry level, require a high educational qualification (including a master's degree for psychologists) but offer a low entry-level salary.

> *Yes, there are only a few takers…very high educational qualifications yet, the salary grade of the entry position is very low. It is just salary grade 15. The educational qualification required does not match the salary for the position. It is unreasonable to demand a masters' degree as a qualification to be hired for the Psychologist 1 position.* – Social welfare representative

KEY RECOMMENDATIONS – MENTAL HEALTH WORKFORCE:

- Establish a multisectoral taskforce or working group for the development and planning of the mental health workforce.
- Undertake further detailed mapping of the multisectoral mental health workforce and existing mental health competencies to identify gaps (numbers, skills and distribution).
- Integrate and strengthen pre-service mental health training for health, education, social welfare and justice sector providers, coordinated by the Department of Health.
- Strengthen job aids, tools and protocols to support MHPSS roles (screening, referral, behaviour management and mental health first aid).
- More explicitly integrate MHPSS actions into the defined roles and performance indicators of cadres (teachers, counsellors, social workers and justice officers).
- Address the discrepancy between entry-level qualifications and salary grade for psychologists and other mental health professionals.

Budget and financing

Government expenditure on mental health is estimated at nearly 2.7 per cent of the total health budget (around US$0.47 per capita).[63] Most of the current health funding for mental health is directed to mental health hospitals, and there is no specific mental health line in the budget. Significantly, mental health care (other than hospital inpatient care for acute psychosis or drug dependence) is not included in the Universal Health Care Act. Outpatient psychotherapy and counselling are specifically excluded from the National Health Insurance Program. Therefore, most mental health care, including for child and adolescent mental health services, is paid for out of pocket by service users. There is limited data available from other sectors in relation to spending on MHPSS programmes, although all sector stakeholders noted that insufficient budgeting and financial resources for mental health were major barriers to implementation of MHPSS. This is particularly exacerbated in the context of the COVID-19 pandemic, with stakeholders noting that demand for MHPSS had increased, and sectors are required to prioritize mental health without an increase in budget. For example, education stakeholders described schools being asked to prioritize mental health activities, but with operational budgets having already been set, the funding for these new activities had to be drawn from school maintenance and other operating expenses. There is no education budget for mental health programmes.

At the **national level**, the major source of budget for government agencies and units is through the General Appropriations Act implemented by the Department of Budget and Management. Through this process, government units submit specific, itemized budgets against programmes and activities for approval. For national programmes, such as the DOH mental health programme, the process for budget request and allocation includes: (i) individual agencies prepare their estimates of expenditures or proposed budgets for the succeeding year and submit these estimates or proposals contained in required budget forms to the Department of Budget and Management following baseline figures, guidelines and the set timetable; (ii) agencies justify details of their proposed budgets before the Department of Budget and Management technical review panels; (iii) the Department of Budget and Management reviews and consolidates proposed budgets of all agencies for inclusion in the President's proposed budget for submission to Congress; (iv) agencies explain the details of their proposed budgets in separate hearings called by the House of Representatives and the Senate for inclusion in the General Appropriations Bill; and (v) the President signs the General Appropriations Bill into law, or what is known as the General Appropriations Act.*

* See Basic Concepts in Budgeting, www.dbm.gov.ph/wp-content/uploads/2012/03/PGB-B1.pdf.

The National Mental Health Strategic Plan includes actions to cover outpatient and inpatient mental health services with the National Health Insurance Program. It proposes the establishment of programme convergence budgeting to the Department of Budget and Management, monitor appropriations for mental health in the General Appropriations Act and advocates for the inclusion of mental health in the Gender and Development guidelines. The Strategic Plan also sets out a budget for elements (health promotion, governance and leadership, mental health services and information and research), totalling around US$80 million over the next four years. While the Strategic Plan includes specific costings (and funding source) for some actions, they primarily relate to health sector actions, with limited costing or guidance related to actions implemented by other sectors.

Stakeholders recommended elevating mental health and MHPSS to a primary programme of the DOH so that it can be included in the health budget plan. Because MHPSS is under the general mental health programme of the DOH, there is no specific cross-sectoral committee working for MHPSS budget planning.

At the **local level**, LGUs, since devolution, are responsible for financing mental health programmes. Each LGU has a 40 per cent internal revenue allotment, from which officials are tasked with determining budget allocation across programmes and activities. There is no specific budget for mental health or MHPSS programmes at the LGU level, with prioritization and allocation highly dependent on the awareness and support of each local chief executive. As noted previously, stakeholders recommended that local-level authorities be provided with greater training and support to identify and respond to mental health as a priority issue, including by establishing local coordinating bodies for mental health (with representation from schools, social welfare and youth organizations) to guide coordination and prioritization. They also recommended that each LGU be required to allocate a nominated amount in each budget to support the mental health programme, similar to the Gender and Development Program that requires a 5 per cent share of the total budget allocation. They also recommended a greater focus on child and adolescent development at the LGU level, noting that increasing budget for preventive programmes to support children and adolescents would also contribute to delivering MHPSS actions. Stakeholders further recommended that budgeting (and monitoring) be outcome-focused so that local authorities have flexibility to allocate budget to different programmes and activities aiming to improve mental health, rather than be restricted to funding activities that may not respond to local needs.

While government was identified as the main source of funding for MHPSS, private, NGO and United Nations agencies cited as contributing to funding for MHPSS-related activities. This includes direct programme assistance to NGOs and other non-government actors to provide child welfare services and funding for research and innovation.

KEY RECOMMENDATIONS – BUDGET AND FINANCIAL RESOURCES:

- Include mental health (and out-patient services) within universal health care and the National Health Insurance Programme.
- Fully cost a comprehensive minimum services package for child and adolescent mental health (based on the tiered framework of actions) addressing responsive care, prevention and promotion that can be costed.
- Include mental health as a primary programme within the DOH, with a specific budget line.
- Establish a programme convergence or cross-sectoral mental health budget committee to support efficient and coordinated budget requests in relation to MHPSS.
- Increase support and guidance to LGUs to improve budget allocation and coordination for MHPSS at the local level.

Participation

Mental health-related stigma, discrimination and lack of mental health literacy are major barriers to seeking support and services. Mental health stigma contributes to a lack of care-seeking by parents (including withholding consent for referral), with a preference for keeping mental health conditions and symptoms secret and addressed within the family. Misunderstandings and misconceptions about mental health and behaviours are also common, with teachers and parents reportedly dismissing signs of poor mental health as attention-seeking or bad behaviour. Limited mental health literacy among children, adolescents and their parents or caregivers also contributes to delays in seeking care and a lack of awareness of available support and services.

Engaging communities and strengthening the participation of children, adolescents and families are central to ensuring that policies, programmes and services respond to needs and address barriers. The National Mental Health Strategic Plan recognizes stigma and low mental health literacy as a major challenge and emphasizes the need for community engagement to support mental health promotion. However, the role of children, adolescents and families (particularly those with lived experience of mental health conditions) in supporting the design, implementation and monitoring of MHPSS programmes is not clearly defined. Stakeholders emphasized the central importance of engaging children, adolescents and families in strengthening the mental health system and noted that they should be engaged at all stages of policymaking, planning, implementation and evaluation.

Adolescents and young people were also described as being critical partners in supporting implementation of MHPSS programmes and services. They were characterized as being a 'bridge' between government sectors and services to improve accessibility for adolescents who are poorly served by existing services.

> *I am thinking if we can provide the youth, because they are very energetic, they have the solution in their minds on how to solve mental health issues that they are also affected [by]. Yet, the Government does not understand it. If there is a programme that can focus on them, creating programmes, implementing programmes, with minimum funding, they can create good models. Our chat line in Ilo Ilo was created by young people. During the pandemic, they served hundreds of thousands of their peers that the DOH was not able to reach. Mental health is the next killer. We need innovation, we need speed and efficiency. Our programme should be anchored on those things. Of course, not abandoning the work of our experts – they can be mentors. We should complement each other and acknowledge the strength and weaknesses of the other. When we conduct meetings, it is always the question of 'who is the best among us?' Is it the psychologists? Or the psychiatrists? Or doctors? We are not in the point on who should be the best. Our point is, we should build programmes, and they are still in this kind of phase. If we want to make a change, we focus on areas that we can control.* – Education sector representative

To support greater participation, stakeholders recommended that further research and consultation be undertaken with communities to better understand mental health needs and service delivery barriers and preferences. For the policy and planning levels, including locally, they recommended that representatives from youth and parenting groups be included in mental health coordinating bodies or committees.

Strengthening mechanisms for community feedback and monitoring is also important. Stakeholders recommended that communities be more closely engaged to develop indicators to monitor progress and evaluate the responsiveness of MHPSS to local needs. The National Mental Health Strategic Plan intends to improve the internal review board process for individuals within the mental health system. The National Center for Mental Health provides a system (hotline, online, email, SMS or through its Facebook page) to provide feedback (positive or negative) on government mental health services, although there are no similar processes for non-health sector MHPSS services.

KEY RECOMMENDATIONS – PARTICIPATION:

- Build up the capacity and increase opportunities for young people and youth organizations to participate in MHPSS policy and planning.
- Strengthen engagement between government agencies, communities and youth groups to ensure that MHPSS approaches meet local needs and support implementation.
- Include youth representatives in local-level mental health subcommittees and/or establish an adolescent task force to guide planning and implementation.
- Strengthen the national system (including online platform) for providing feedback and handling complaints in relation to mental health care to support a more child- and adolescent-friendly platform.

Data, health information and research

Several data and information needs were identified. At the national level, timely and reliable statistics (disaggregated by location, age and sex) related to the prevalence of common mental health conditions and risks are needed to inform policies, support prioritization and implementation plans and support budgeting. These include estimates of common mental disorders (depression, anxiety, developmental disorders and psychosis), suicide rates, psychological distress, behavioural problems, risk factors (substance use, bullying, violence and adolescent pregnancy) and population and service delivery data (such as the number of families requiring social welfare). Up-to-date data concerning the number and coverage of mental health facilities, services and the multisectoral workforce are needed to support better planning. Some data could be collected through routine health information and surveillance systems and reported by the DOH. Other indicators are included in school and household surveys (such as the Global School-based Student Health Survey and the Multiple Indicator Cluster Survey), although they are more suited to monitoring longer-term trends and progress because they are not conducted annually. There is no national surveillance system for suicide or self-harm. The National Mental Health Strategic Plan also calls for improving epidemiological data for priority mental health conditions, including data for children and adolescents.

Several stakeholders highlighted the need to include mental health indicators in the routine data collection of other sectors outside of health and improved sharing of data through linkage within sectors and between sectors to support planning and implementation (with consideration of confidentiality and privacy). For example, better sharing of data collected through the education, social welfare and justice sectors with multidisciplinary teams and data linkage would improve the identification, planning and follow-up of children and families at risk. This was particularly emphasized by the justice sector stakeholders, noting that strengthened information systems and sharing of data across agencies would improve the ongoing support and follow-up of children and families at risk or those who have been engaged in the justice system.

Improved access to data describing the multisectoral system was also a noted priority, including up-to-date information on the multisectoral workforce, MHPSS service availability and distribution, coverage and use of services and data on non-government actors in MHPSS. To support this, stakeholders recommended that a multisectoral information system be established that links to other government agency systems to improve sharing and coordination of data related to mental health.

In addition to data to inform policy and programming and monitor progress, better use and availability of data are important to support front-line mental health workers and communities to improve the efficiency and flexibility and contribute to workforce motivation. Strengthening information systems at a local level was identified as important for supporting planning and implementation by LGUs, with data in relation to mental health burden and risks, service availability and workforce coverage

needed to support local service delivery. Improved data concerning the burden of mental health and increased budget to address these and likely benefits to the community were cited as critically important at the local level to advocate with LGU authorities for greater investment in mental health.

The DOJ representatives noted the need for a situation analysis of children in conflict with the law and those at risk to inform a comprehensive juvenile intervention programme. This is proposed for 2023, with MHPSS included as a priority intervention.

The National Mental Health Strategic Plan also calls for the establishment of a national repository of mental health research and the setting of a national mental health research agenda. Data and research needs identified by stakeholders included improved data on availability and coverage of MHPSS programmes and services (including health services), better understanding of mental health needs of children and adolescents (including outcomes, risks and experiences accessing care), specific needs of children living with a disability or poverty and mental health needs of learners, particularly exploring the impacts of the COVID-19 pandemic.

KEY RECOMMENDATIONS – DATA, INFORMATION AND RESEARCH:

- Integrate child and adolescent mental health indicators into the routine information systems for education, social welfare and justice.
- Improve mechanisms for the timely analysis, reporting and sharing of data within and across sectors to support implementation of MHPSS and continuity of care for those at risk.
- Improve the availability of data at the LGU level to support local resource allocation and planning.
- Invest in further research to understand demand-side needs, barriers and service-delivery preferences and build the evidence for specific actions and effective implementation models.

Recommendations and conclusions

Children and adolescents aged 0–18 years in the Philippines experience a high burden of poor mental health. They have considerable unmet needs for services and support that respond to their mental health conditions, prevents poor mental health and ensures safe and enabling environments for psychosocial well-being. Recognize this need, the Philippines has made important efforts to address child and adolescent mental health. National policy and legislative frameworks are broadly supportive, recognizing at least in part the specific needs and considerations for this age group with a national multisectoral approach to mental health care, prevention and promotion. While a significant focus of the current response has been on the clinical management of mental health conditions through the health sector, there are also many examples of programmes delivered through the education, social welfare and justice settings to improve early identification and assessment, multidisciplinary management and programmes in schools, child protection and justice settings to address risk factors. This has been particularly the case in the context of the COVID-19 pandemic, with several new initiatives (including online programmes) to support children and their families.

Despite this progress, this analysis has identified some important gaps in the current MHPSS response. These include the accessibility and availability of child- and adolescent-friendly and multidisciplinary care for mental health conditions (particularly outside specialized tertiary and institutional settings), comprehensive and coordinated whole-of-education approaches to mental health promotion, a national (and targeted) approach to support nurturing and responsive care provided by parents and carers and coordinated programmes to support healthy peer relationships and address peer victimization. There are also important gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents, including coordinated programmes and protocols across agencies to support children engaged in the child protection or justice systems.

There are critical cross-cutting challenges impacting on implementation of MHPSS. While mental health and well-being are integrated to some degree into the sectoral plans of education, social welfare and justice, they generally focus narrowly on specific actions (such as screening, or provision of counselling) rather than encompassing a more holistic vision for mental health and well-being and articulation of the sector's role and response. At the LGU level, the lack of plans, guidance and structures to support implementation and multisectoral collaboration have contributed to limited coordination across sectors. Across all sectors insufficient numbers and inappropriate distribution of skilled personnel were noted as major barriers to implementation, contributing to heavy workloads, long delays in access to care and fragmented implementation of preventive programmes. Limited availability of services responsive to the needs of children and adolescents, particularly at the community level, and overreliance on tertiary and institutional-based care also contributes to the high unmet needs and delays in access to services through health and social welfare sectors and time-consuming referral from other sectors, such as education and justice sectors. Insufficient budget for MHPSS-related programmes and budgeting processes that do not support agenda-based and cross-sectoral budget planning are also challenges.

Overarching recommendations

In addition to specific recommendations to strengthen the multisectoral mental health system, this analysis led to overarching recommendations to improve the implementation of MHPSS for children and adolescents in the Philippines.

1. At the national level, strengthen the Mental Health Act to articulate protections for children and adolescents. Consideration should be given to developing a multisectoral child and adolescent mental health strategy that articulates MHPSS actions and details a multisectoral plan (and coordination structure) for implementation.
2. The Government should strengthen or expand the Philippine Council for Mental Health to include the DSWD and the justice sectors. The Government should consider establishing a multisectoral coordinating body for child and adolescent mental health, with responsibility for coordinating the planning and implementation of MHPSS for this age group. As per the National Mental Health Strategic Plan, regional mental health councils should be established and should include a multisectoral focus on child and adolescent mental health. These should be supported by national counterparts to provide capacity-building of LGU officials to improve their awareness of mental health issues and support the development of their multisectoral implementation plans, resource allocation and coordination.

3. The DOH, in consultation with other sectors and technical partners, should strengthen the national standardized protocols for child and adolescent mental health across agencies, including:
   - validated screening tools for this age group and detailed guidance on use in different settings, such as Child Protection Units (including consideration of potential harms of screening);
   - referral procedures across sectors;
   - non-specialist management;
   - case-management of children and adolescents engaged in the child protection and justice sectors;
   - greater protection for children in conflict with the law and child victims within the justice system; and
   - national quality service standards for child and adolescent mental health services across sectors.
4. The Government should include mental health services (including outpatient services) within the national health insurance programme and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, consideration should be given to including mental health as a primary programme. A minimum-services package (based on the Regional Conceptual Framework) should be defined and costed, with budget allocation and responsibility defined across the allied sectors. The Government could also consider establishing a national cross-sectoral body or cross-sectoral committee on MHPSS within the Department of Budget and Management to support coordinated and comprehensive budget requests that align with national MHPSS goals.
5. The DOH and the DSWD should prioritize the integration of MHPSS into primary health care and community-level services for children, adolescents and their families, including through primary health care and community-based approaches to child protection and support for families.
6. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisectoral mental health and psychosocial support workforce through:
   - in-depth mapping to identify roles across sectors against the MHPSS priority actions and the required competencies and intersectoral training needs to support these roles;
   - development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for providers across sectors;
   - integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector officers, teachers and other school-based staff that aligns with roles and responsibilities with respect to MHPSS;
   - strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, justice sector officers, teachers and education staff that is competency-based and aligned with expected MHPSS roles;
   - training provided to relevant department staff within the health, education, social welfare and justice sectors to support planning and development of the workforce and broader MHPSS programmes;
   - expansion of the number of posts at the national and subnational levels; and
   - improved supervision and support for MHPSS providers across sectors, including establishing provider-support networks and multidisciplinary teams, improved remuneration, job security and career pathways and attention to the mental health needs of providers themselves.

7. The DOH, in consultation with the DSWD, the DepEd, the DOJ and academic and development partners, should improve the collection, use and accessibility of data at the national and subnational levels. This should include data and mechanisms to identify mental health needs, support planning and implementation and track the progress. It also should strengthen data linkages and sharing across agencies, in conjunction with privacy laws to protect children and adolescents. In addition to greater investment in mental health research, national information systems (health, education, child protection and justice) should be strengthened to include a minimum set of child and adolescent MHPSS-related indicators that are harmonized across sectors. A national suicide surveillance system should be established.
8. The Government, development partners and non-government organizations should increase opportunities for children and adolescents (and parents and caregivers) to participate in MHPSS policy and programming, including establishing more formal roles for young people (such as representation on mental health committees and other bodies at the national and subnational levels) and improved child- and adolescent-friendly mechanisms for providing feedback and complaints on MHPSS programmes and mental health services.
9. The Government, with support from development partners and non-government organizations, should expand national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents, parents and other caregivers).

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Appendix A:

Workshop agenda and interview guide

COUNTRY-LEVEL CONSULTATION WORKSHOP ON THE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES IN EAST ASIA AND THE PACIFIC REGION

Day one

Time	Activity	Facilitator
Session A: Introduction		
9:00–9:15	Welcome remarks and introductions	UNICEF and Philippines Technical Advisory Group chair
9:15–9:30	Overview and objectives of the project and workshop	Burnet
Session B: Overview the conceptual framework for MHPSS		
9:30–10:15	The conceptual framework for MHPSS *Presentation of the framework* *Questions and discussion*	Burnet to provide overview Country partner and UNICEF to help facilitate discussion
Session C: Prioritize actions and sectoral roles		
10:15–10:30	Introduction to the proposed actions of the conceptual framework *Presentation of the actions against each tier* *Introduction to potential sectoral roles*	Burnet to provide overview
10:30–10:45	Overview of the prioritization tool and tasks *Introduction to the online tool and tasks to be completed before the next meeting*	Burnet to provide overview
10:45–11:00	Questions and next steps	UNICEF and Philippines Technical Advisory Group

Day two

Time	Activity	Facilitator
Session A: Introduction and recap		
9:00–9:15	Welcome and recap	UNICEF and Philippines Technical Advisory Group chair
Session B: Defining a minimum-services package for MHPSS		
9:15–9:30	Presentation of the findings from the online tool *Outline of the actions prioritized for the minimum-services package*	Burnet
9:30–10:30	Discussion and agreement on the minimum-services package *Break out rooms by sector to discuss:* • Agreement on actions included • Any actions missing or need modification • Agreement on timeframe *Each group feedback*	Country partner, UNICEF and Philippines Technical Advisory Group chair
10:30–10:45	Break	
Session C: Identifying sectoral roles		
10:45–11:00	Presentation of the findings from the online tool *Recommendations for sectoral roles for actions*	Burnet
11:00–12:00	Discussion and agreement on sectoral roles Break-out rooms by sector to discuss: • Agreement on lead sector • Recommended roles for other supporting sectors *Each group feedback*	Country partner, UNICEF and Philippines Technical Advisory Group chair
12:00–12:15	Questions and next steps	UNICEF and Philippines Technical Advisory Group

Participants to complete the online tool in preparation for the second workshop.

Example of the online prioritization tool

MHPSS Prioritisation Tool

Thank you for participating in this online consultation.

In brief, this prioritisation tool seeks your feedback on a series of actions to strengthen mental health and psychosocial support services (MHPSS) for children and adolescents in your country. We will collate all responses and discuss these at our workshop to define a key package of actions (a minimum-services package). You can find more information on the aim of the project and the framework of actions here:
https://www.dropbox.com/sh/vp3odcso41p7r20/AADXuS7HzXWqlzuy1ykVSAV1a?dl=

This tool will present you with a series of actions in three groups: actions to ensure an enabling and safe environment for mental health promotion; actions for prevention of mental health problems in the immediate social context ; and actions to ensure accessible and responsive services for mental health problems.

For each action, please indicate what priority you believe it is for your country. For actions that are rated as high and medium priority, we will then ask some brief questions about sectoral roles and timing of implementation. We will also ask for any additional actions that should be included.

Your responses will be anonymous and confidential. You can save and return to this tool at any time, but please complete it by the end of today so that your responses can be included in the key findings presented at the next workshop.

** If possible, please complete this form in one sitting. You can also save and return to it but clicking the button 'save and return' at the bottom of the page. It will ask for your email address- this will only be used to send you a link and will not be saved with your responses.

For any further info or clarification please contact A/Professor Peter Azzopardi on Peter.azzopardi@burnet.edu.au

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Demographics

Which country do you work in?
* must provide value

- ○ Malaysia
- ○ Papua New Guinea
- ○ Philippines
- ○ Thailand

reset

What sector do you mainly work in?
* must provide value

- ○ Health
- ○ Education
- ○ Social Welfare
- ○ Justice
- ○ Other (specify)

reset

What organisation do you represent?
* must provide value

- ○ Government
- ○ Non-government and civil society organisations
- ○ UN agency
- ○ Private sector
- ○ Professional associations (such as psychiatry, social work)
- ○ Youth-focused organisations
- ○ Other (please specify)

reset

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Domain	Subdomain	Recommendation
Accessible and responsive services for mental health problems (clinical and sub clinical disorders)	Screening and early identification of needs	Screening for those at risk of poor mental health

Specific action required

Routine mental health screening of children and adolescents with high-risk behaviours (e.g. harmful use of alcohol and other substances, sexual risk behaviours)

Priority for including this action in minimum package for MHPSS in your country:
* must provide value

- (●) High
- ( ) Medium
- ( ) Low

reset

Who should be the lead sector?

- ( ) Health
- ( ) Education
- ( ) Social Welfare
- ( ) Justice
- ( ) Other

reset

What other sectors should play a role in this action?

- [ ] Health
- [ ] Education
- [ ] Social Welfare
- [ ] Justice
- [ ] Other

Is this action already being implemented?

- ( ) Yes
- ( ) No

reset

What is your suggested timeline for implementation?

- ( ) Next 2 years
- ( ) 2-5 years
- ( ) 5 years plus

reset

Any challenges or considerations in implementing this action?

Expand

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Implementing the mental health and psychosocial support services in East Asia and the Pacific

Key informant interview

*Note that sector-specific question guides were also developed and are available on request

Interviewer ID:		Date (dd/mm/yy):	
Start time:		End time:	
Participant ID:		Sector / organization:	
Current designation / role of participant:			
How is this role related to MHPSS?			
Has the participant had a previous role related to MHPSS? Please describe			
Age of participant		Gender of participant:	
Consent obtained?	YES / NO		

Thank you very much for agreeing to participate in this interview.

Today we will be asking for your views and opinions about how to improve mental health and psychosocial support services (MHPSS) for children and adolescents. This includes your thoughts about the mental health needs of children and adolescents, what role your sector currently plays in delivery of support services and the challenges and opportunities to improve the delivery of MHPSS.

The session today will take approximately 60–90 minutes.

Participating in this project is voluntary. You do not have to answer any question that I ask you, and we can stop the interview at any time. If you don't want to answer a question or would like to stop the interview you do not have to give a reason. If you wish to withdraw from the project after our discussion, please contact the study team and the information that you shared will be destroyed.

With your permission I will be taking notes and recording today's interview using the video recording function, or an audio-recorder, to make sure we gather all your ideas. Everything you say will remain confidential. Your responses will not be shared with your manager or employer and they will not affect your role or employment.

What we learn from this interview will be compiled with the responses from other interviews. A summary of the findings will be shared with government representatives and United Nations agencies in this country and in East Asia and the Pacific region. They will also be used to develop recommendations to improve the delivery of mental health support services in your country and the region. No personal information identifying you or your organization or employer will be included in any reports or other documents.

Please confirm the participant's consent to continue the interview and consent to have the interview recorded.

Question guide:

Theme	Questions
Mental health needs of children and adolescents	**I would like to start by asking what you think the main mental health needs or problems are of children and adolescents in [YOUR COUNTRY]?** • Children (younger than 10 years) • Adolescents (10–18 years) Are there particular groups of children or adolescents who have worse mental health than others, or are at increased risk? Why? **What do you think are the main factors that contribute to poor mental health or well-being of children and adolescents?** • Individual-level • Family-level • Peer • Community • Society **What factors promote good mental health and well-being?** **What impact do you think COVID-19 has had on the mental health and well-being of children and adolescents?**
MHPSS policies and national plans	**I would like to ask you about what is currently being done by your sector or organization to address mental health and well-being of children and adolescents.** **Are you aware of any government policies, plans or initiatives that relate to mental health of children and adolescents?** • Can you briefly describe these – what sectors do they relate to, what plans or actions do they include for child or adolescent mental health? • To what extent do you think these sectoral plans or policies are being implemented? **What national standards, guidelines, or other tools currently exist to support the delivery of mental health services or programmes?** *If the participant identifies specific policies, please ask them if they would be happy to be contacted by the research team at a later date to help us access these documents for the desk review.*

Theme	Questions
Current role in providing MHPSS	**I would like to ask you about the different mental health and psychosocial support services that are provided by your sector or organization. I will refer to this as 'MHPSS', which broadly includes services, support and programmes to respond to children and adolescents with mental health problems, to prevent mental health problems (addressing risk factors) and to promote good mental health.** **Could you talk me through what specific MHPSS for children and adolescents your sector or organization currently provides? We are interested in understanding what services or programmes are provided, who they are for and how they are delivered** **Which groups of children and adolescents are these MHPSS for? Are any programmes targeted and, if so, to who?** **To what extent are these initiated or led by the government** • Which ministries? • By non-government organizations? • By private sector? • Where they are led by non-government or private sector agencies, what role has the Government had? **Were there any MHPSS that had been implemented your sector or organization previously but are no longer provided? Why?** **Are there any new MHPSS that are being planned or developed?** *Additional prompts:* **Services** • What MHPSS does your sector or organization provide for children or adolescents who have mental health problems (**responsive care)**? • What MHPSS does your sector or organization provide that address specific risk factors to prevent mental health problems (**prevention**) • What MHPSS does your sector or organization provide to promote good mental health and well-being **(enabling environment)** – For example, programmes to address harmful norms or attitudes towards mental health, stigma or discrimination related to mental health, to protect children and adolescents from harm (violence, exploitation, abuse, neglect etc) **Delivery** • Through what mechanisms, systems or platforms are these MHPSS provided: – community-based – facility-based (health, education, residential care, other) – Online or digital – *[explore what services are provided through which platforms]*

Theme	Questions
	• Who provides MHPSS within your sector or organization and what roles do they have in supporting MHPSS? – Who (professional, paraprofessional, volunteer) and what role or tasks do they have in delivering MHPSS? – What training and other supports do they receive with respect to mental health of children and adolescents? » pre-service or in-service » accredited (diploma, degree, etc.) or informal – who provides this training – Who is responsible for supervision of these MHPSS roles? – Are these MHPSS workers supported by a professional association? – How are these roles licenced, accredited or regulated? Is there specific regulation with respect to MHPSS roles? **Linkages** • Is there any current engagement between your sector or organization and communities to address norms and attitudes related to mental health, stigma, care-seeking behaviour or other factors that influence mental health? • What links are there with other supports provided in other sectors (health, social welfare, education, justice)? – What linkages exist with NGOs? The private sector? – How are these linkages coordinated? – For children and adolescents who are identified as having mental health problems, how are referrals coordinated to » health services » social welfare » or other community-based supports » Are there regulations, guidelines to support these referral systems? • To what extent have adolescents, children and parents and caregivers been involved in designing, delivering or evaluating mental health supports or services in your sector or organization? Is there a process for children, adolescents and parents and caregivers to provide feedback?
Barriers and enablers providing current MHPSS	• **I would like to ask now about what has been working well and what some of the challenges have been delivering MHPSS for children and adolescents** • What do you think is currently being done well to address the mental health of children and adolescents by your sector or organization? • What could be improved or strengthened? • What are the gaps (what specific areas of mental health and well-being aren't being addressed)?

Theme	Questions
	• What are the main challenges currently impacting on the delivery of MHPSS through your sector or organization? For example: – Lack of understanding or prioritization of mental health – Community and parent attitudes and norms and social taboos – Funding and other resources for MHPSS – Existence of nationally mandated programmes that include MHPSS – Mental health worker training and education – Links and coordination with other sectors (social welfare, education, health services, NGOs, etc.) – Information sharing within your sector or organization and across sectors and organizations
What role *should* the social welfare sector have in implementing MHPSS and minimum-services package	• **I would like to ask you now about what roles and responsibilities your sector or organization *should* have in MHPSS for children and adolescents** • Broadly speaking, what do you think the role of your sector or organization should be in implementing MHPSS? How is this different to the current roles we have already discussed? • Reflecting on the different 'tiers' of MHPSS what role should your sector or organization have in: – Responsive care for children and adolescents with mental health problems – Prevention of mental health problems – Creating an enabling environment to promote good mental health *You can refer to figure A1 and table A1 in the conceptual framework* **I would like to ask you now about the specific MHPSS actions or services that your sector or organization should have responsibility for. This minimum-services package for MHPSS has been proposed by stakeholders across different sectors in [YOUR COUNTRY]** • Are there any actions that you think are missing? • What actions do you think your sector/organization should have primary responsibility for and why? • Which of these would be feasible for your sector/organization to deliver and why? • How could they be delivered? – What mechanisms currently exist to support implementation of these MHPSS actions? (what existing programmes or services could MHPSS be integrated with, what existing workforce could deliver MHPSS actions) – Do new delivery mechanisms or systems need to be developed? • What actions do you think your sector or organization could contribute to (if not primary responsibility) and how (links with other sectors, etc.)?

Theme	Questions
Challenges and considerations for implementation of a minimum-services package and strengthening a multisector mental health system	**I would like to ask you about how the MHPSS actions proposed in the minimum-services package could be effectively implemented. In particular I would like to ask about what frameworks, structures, resources or supports your sector or organization would need to strengthen implementation** **Legislation and policy** • What additional policies are needed to support the delivery of MHPSS? • What legislation or regulation changes are needed? • *[consider: sector-specific policies to enable delivery of MHPSS, multisectoral mental health policies that clearly define sectoral roles]* **Governance and leadership** • What government or non-government agencies should have primary responsibility for implementation of MHPSS? – Planning – Implementation – Monitoring • What role in leadership or governance do you think your sector or organization should have, why? • How could coordination be improved within your sector or organization (planning, implementation, monitoring)? • How could coordination with other sectors (health, education, justice, social welfare) and with NGOs and private sector be improved? • What role should other sectors have in implementation of MHPSS? • What role should UNICEF have in supporting MHPSS? • What role should the private sector have in supporting or delivering MHPSS • What role should NGOs have in supporting or delivering MHPSS **Services** • How could MHPSS be integrated with existing services or programmes for children and adolescents? • What new services or programmes might be needed? • Are there systems or structure changes needed within this sector or organization to take on these roles and implementation of MHPSS? • What tools, resources or supports would be needed? • Is there an opportunity for online or digital delivery of MHPSS? • What actions are needed to ensure that children, adolescents and parents and caregivers have access to these services and support? What actions are needed to reach the most underserved children and adolescents?

Theme	Questions
	Standards and oversight • What national standards, guidelines, or other tools currently exist to support the delivery of MHPSS? How could these be improved? What additional guidance is needed? [Consider: new procedures, SOPs, programmes, referral mechanisms, etc.] • What further actions are needed with respect to accreditation or certification of workers who are engaged in delivering MHPSS? • How should quality of MHPSS be monitored and assessed? By whom? **Resources** *Financial* • How are current (or planned) MHPSS delivered by your sector or organization currently funded? – If government organization: » Are national policies or programmes that relate to MHPSS costed? » What is the source of the budget (through a specific programme, specific budget line, etc.) » To what extent does the budget include contributions from user fees, sponsor contributions, in-kind contributions, private sector or local business support? » Are MHPSS funded through national or district and local government? » How are the staff who deliver MHPSS funded? » How is infrastructure for MHPSS funded? – If non-government, private sector or United Nations » Are MHPSS plans or programmes costed? » What is the source of budget for these » To what extent does it include user fees, private sector support, government funding, other? • What additional financial resources would be required to support MHPSS? Where should these come from? *Workforce* • What additional human resources are required for MHPSS? • What 'types' of MHPSS providers are needed in your sector or organization? With what competencies? • Can MHPSS be integrated into existing roles and/or are new roles needed? • What additional training is needed? For whom? Who should provide this?

Theme	Questions
	• What supportive supervision is needed? • What job aids or other resources are needed? • What requirement or role might there be for professional associations for MHPSS workers in your sector or organization? • How could linkages with other MHPSS providers (health workers, teachers, social workers) be improved to support delivery of MHPSS? **Participation** • What role should children, adolescents and parents and caregivers have in designing or developing MHPSS policy, programmes and services? • What role should they and the community have in monitoring and evaluating MHPSS? What mechanisms are needed to enable feedback? • What mechanisms are there or could be developed to support the participation and engagement of young people? **Data and information** • What data or information do you think is needed to support the implementation of MHPSS? – For design and delivery of services or support programmes – For monitoring and quality assurance – For evaluating outcomes and impact – For financing MHPSS • Are there existing systems (routine data collection, population or household surveys, etc) that do, or could, include mental health? How? • What systems are needed (or could be strengthened) to improve reporting, use and communication of mental health data? How is or could this information be shared (within your sector or organization, across different sectors, with NGOs and the private sector)? • What do you think are some important knowledge and evidence gaps with respect to child and adolescent mental health? For example, what further research would help support MHPSS?
Any other issues?	Any other comments or suggestions you would like to raise that we have not yet covered today? I will go over a summary of what we have discussed, if you would like to add or change anything you have said please let me know.

Appendix B:
Development of the regional MHPSS conceptual framework

The approach to development of the project on the Regional Conceptual Framework was consultative and iterative and included the following.

Synthesis of the available evidence

An important foundation to this work is the framing of mental health and well-being in UNICEF's *The State of the World's Children 2021* report.[2] A core recommendation is to consider the 'spheres of influence' that shape mental health and well-being from an early age, with spheres encompassing 'the world of the child' (mothers, fathers and caregivers), 'the world around the child' (schools and communities) and 'the world at large' (the social determinants). In a related commentary co-authored by UNICEF, opportunities to intervene were broadly mapped against these spheres of influence:[64] Mental health promotion largely targets the social determinants of health that impacts on the world of the child, with preventive and treatment services more targeted towards the world of and around the child. The following additional documents and resources were reviewed in drafting the conceptual framework: UNICEF reports focusing on MHPSS; [65–68] WHO guidelines related to mental health;[15,69–72] the Lancet Commissions on Global Mental Health and Sustainable Development and on Adolescent Health and Wellbeing;[73,74] United Nations guidance on social and emotional learning;[75,76] and available country-level operational guidance on implementation of MHPSS from high-income settings[77–79] and available guidance from focal countries for this project (Thailand and the Philippines).[80–84] The draft framework considered the context of the region and in particular the experience and capacity of allied sectors to implement MHPSS.

Review by the regional Technical Advisory Group

The regional Technical Advisory Group was assembled specifically for this project by UNICEF with membership including experts in child and adolescent mental health and well-being, UNICEF regional focal points related to child and adolescent mental health, as well as UNICEF representatives from each of the four countries where focal research was undertaken. The conceptual framework was first presented during a virtual meeting, with the framework then circulated for written feedback in April 2021. All members of the Technical Advisory Group provided feedback and subsequently endorsed the conceptual framework.

Additional review by content experts

Further to input from the Technical Advisory Group, written input was sought from content experts in social and emotional learning; interventions to address the social determinants of mental health; and the role and responsibilities of the social welfare sector in mental health. Input was also sought from programming and implementing partners in each focal country, as well as the technical lead for MHPSS at UNICEF headquarters, with consideration of the forthcoming Minimum Services Package for MHPSS (in development) in refining the conceptual framework and actions.

Finally, extensive feedback was sought from country-level stakeholders during an online two-day workshop in each focal country

Each online workshop (in Thailand, Philippines, Papua New Guinea and Malaysia) was organized with stakeholders and implementing partners across the health, education and social welfare sectors and youth advocacy representing government, non-government, the private sector and United Nations agencies. Feedback was gathered through facilitated discussion and an online prioritization tool completed by individuals. The feedback from across all countries was collated to inform a cross-cutting regional framework, in addition to identifying specific priorities within each country.

Appendix C:
National data on mental health outcomes and risks

Mental health outcomes

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of depressive disorders (%)	Female	5–9	0.05	0.05	0.05	Global Burden of Disease	2019
	Male	5–9	0.04	0.04	0.04		
	Both	5–9	0.04	0.04	0.04		
	Female	10–14	0.85	0.85	0.85		
	Male	10–14	0.58	0.58	0.58		
	Both	10–14	0.71	0.71	0.71		
	Female	15–19	2.34	2.34	2.34		
	Male	15–19	1.75	1.75	1.75		
	Both	15–19	2.04	2.04	2.04		
Prevalence of bipolar disorder (%)	Female	10–14	0.09	0.09	0.09	Global Burden of Disease	2019
	Male	10–14	0.09	0.09	0.09		
	Both	10–14	0.09	0.09	0.09		
	Female	15–19	0.33	0.33	0.33		
	Male	15–19	0.33	0.33	0.33		
	Both	15–19	0.33	0.33	0.33		
Prevalence of inability to sleep due to worry so much most of the time or always in the previous 12 months (%)	Female	13–17	12.6	14.2	11.2	Global School-based Student Health Survey	2015
	Male	13–17	9.4	11.0	8.1		
	Both	13–17	11.0	12.2	9.9		
Prevalence of anxiety disorders (%)	Female	1–4	0.17	0.17	0.17	Global Burden of Disease	2019
	Male	1–4	0.10	0.10	0.10		
	Both	1–4	0.13	0.13	0.13		
	Female	5–9	1.96	1.96	1.96		
	Male	5–9	1.15	1.15	1.15		
	Both	5–9	1.55	1.55	1.55		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
	Female	10–14	4.86	4.86	4.86		
	Male	10–14	2.92	2.92	2.92		
	Both	10–14	3.88	3.88	3.88		
	Female	15–19	6.38	6.38	6.38		
	Male	15–19	3.77	3.77	3.77		
	Both	15–19	5.06	5.06	5.06		
Prevalence of conduct disorder (%)	Female	5–9	0.88	0.88	0.88	Global Burden of Disease	2019
	Male	5–9	1.53	1.53	1.53		
	Both	5–9	1.21	1.21	1.21		
	Female	10–14	2.96	2.96	2.96		
	Male	10–14	4.56	4.56	4.56		
	Both	10–14	3.77	3.77	3.77		
	Female	15–19	1.48	1.48	1.48		
	Male	15–19	2.80	2.80	2.80		
	Both	15–19	2.14	2.14	2.14		
Prevalence of idiopathic developmental intellectual disability (%)	Female	1–4	1.51	1.51	1.51	Global Burden of Disease	2019
	Male	1–4	1.01	1.01	1.01		
	Both	1–4	1.25	1.25	1.25		
	Female	5–9	1.65	1.65	1.65		
	Male	5–9	1.16	1.16	1.16		
	Both	5–9	1.40	1.40	1.40		
	Female	10–14	1.51	1.51	1.51		
	Male	10–14	1.09	1.09	1.09		
	Both	10–14	1.29	1.29	1.29		
	Female	15–19	1.36	1.36	1.36		
	Male	15–19	0.97	0.97	0.97		
	Both	15–19	1.16	1.16	1.16		
Prevalence of schizophrenia (%)	Female	10–14	0.01	0.01	0.01	Global Burden of Disease	2019
	Male	10–14	0.01	0.01	0.01		
	Both	10–14	0.01	0.01	0.01		
	Female	15–19	0.08	0.08	0.08		
	Male	15–19	0.09	0.09	0.09		
	Both	15–19	0.09	0.09	0.09		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of autism spectrum disorders (%)	Female	1–4	0.20	0.20	0.20	Global Burden of Disease	2019
	Male	1–4	0.66	0.66	0.66		
	Both	1–4	0.44	0.44	0.44		
	Female	5–9	0.19	0.19	0.19		
	Male	5–9	0.63	0.63	0.63		
	Both	5–9	0.42	0.42	0.42		
	Female	10–14	0.18	0.18	0.18		
	Male	10–14	0.60	0.60	0.60		
	Both	10–14	0.39	0.39	0.39		
	Female	15–19	0.17	0.17	0.17		
	Male	15–19	0.55	0.55	0.55		
	Both	15–19	0.36	0.36	0.36		
Prevalence of attention-deficit/ hyperactivity disorder (%)	Female	1–4	0.13	0.13	0.13	Global Burden of Disease	2019
	Male	1–4	0.36	0.36	0.36		
	Both	1–4	0.25	0.25	0.25		
	Female	5–9	1.13	1.13	1.13		
	Male	5–9	3.01	3.01	3.01		
	Both	5–9	2.10	2.10	2.10		
	Female	10–14	1.48	1.48	1.48		
	Male	10–14	3.99	3.99	3.99		
	Both	10–14	2.75	2.75	2.75		
	Female	15–19	1.15	1.15	1.15		
	Male	15–19	3.03	3.03	3.03		
	Both	15–19	2.10	2.10	2.10		
Prevalence of suicidal attempt one or more times in the previous 12 months (%)	Female	13–17	28.4	30.9	26.0	Global School-based Student Health Survey	2019
	Male	13–17	19.9	21.9	18.1		
	Both	13–17	24.3	25.9	22.1		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Mortality rate due to self-harm (deaths per 100,000 population)	Female	10–14	0.44	0.53	0.35	Global Burden of Disease	2019
	Male	10–14	0.65	0.84	0.35		
	Both	10–14	0.55	0.67	0.39		
	Female	15–19	2.22	2.72	1.82		
	Male	15–19	4.94	6.55	2.91		
	Both	15–19	3.62	4.45	2.56		

Mental health risks

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of lifetime marijuana use (%)	Female	13–17	3.0	4.2	2.2	Global School-based Student Health Survey	2019
	Male	13–17	11.2	13.4	9.3		
	Both	13–17	7.0	8.4	5.9		
Prevalence of lifetime amphetamines or methamphetamines use (%)	Female	13–17	3.5	9.0	1.3	Global School-based Student Health Survey	2015
	Male	13–17	6.1	9.5	3.9		
	Both	13–17	4.8	8.7	2.6		
Prevalence of having been bullied at school on at least one day in the previous 12 month (%)	Female	13–17	40.9	43.1	38.6	Global School-based Student Health Survey	2019
	Male	13–17	40.4	42.9	37.9		
	Both	13–17	40.6	42.6	38.7		
Prevalence of being physically attacked one or more times in the previous 12 months (%)	Female	13–17	23.9	26.3	21.7	Global School-based Student Health Survey	2019
	Male	13–17	38.0	40.3	35.8		
	Both	13–17	31.0	32.9	29.1		
Prevalence of loneliness most of the time or always in the previous 12 months (%)	Female	13–17	19.7	22.1	17.5	Global School-based Student Health Survey	2015
	Male	13–17	12.4	13.9	11.0		
	Both	13–17	16.1	17.8	14.5		
Prevalence of suicidal ideation in the previous 12 months (%)	Female	13–17	27.1	29.1	25.1	Global School-based Student Health Survey	2019
	Male	13–17	18.8	20.9	17.0		
	Both	13–17	23.1	24.7	21.5		

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for every child

UNICEF East Asia and Pacific Regional Office (EAPRO)
19 Phra Athit Road
Pranakorn, Bangkok 10200

Tel: +66 2 356 9499
Fax: +66 2 280 3563
Email: eapro@unicef.org

Facebook: www.facebook.com/unicefeap/
Twitter: @UNICEF_EAPRO
Website: www.unicef.org/eap/

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