STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES for children and adolescents in East Asia and Pacific Region - SYNOPSIS - Philippines Country Profile 2022

​​<https://www.unicef.org/eap/media/13026/file/Philippines%20Country%20report.pdf>

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.

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 fourthleading 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.

Reference 1. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019. 2019.

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 wellbeing 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.

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.

Reference: 1. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019. 2019. 2. United Nations Children’s Fund, The State of the World’s Children 2021: On My Mind – Promoting, protecting and caring for children’s mental health, UNICEF, New York, 2021.

Children and adolescents aged 0–18 years in the Philippines experience a substantial burden of poor mental health. Modeled 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)

Reference: 1. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019. 2019. 2.

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) .(12) The Philippine Department of Health (DOH) is undertaking the first national survey to establish the prevalence of mental health conditions.(17)

Reference: 12. Philippine Department of Health, Global School-based Student Health Survey, World Health Organization, Department of Health, Centres for Disease Control, Department of Education, Manila, 2015.

16. Cagande, C., ‘Child Mental Health in the Philippines’, Adolescent Psychiatry (Netherlands), vol. 3, no. 1, 2013, pp. 11–13.

17. Estrada, C.A., et al., ‘Current Situation and Challenges for Mental Health Focused On Treatment and Care in Japan and the Philippines: Highlights of the training program by the National Center for Global Health and Medicine’, BMC Proceedings, vol. 14, Supplement 11, 2020, p. 11.

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.(12,13)

Reference: 12. Philippine Department of Health, Global School-based Student Health Survey, World Health Organization, Department of Health, Centres for Disease Control, Department of Education, Manila, 2015. 13. Philippine Department of Health. Global School-based Student Health Survey, World Health Organization, Department of Heatlth, Centres for Disease Control, Department of Education, 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 agedisaggregated 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 . 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)

Reference: 1. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019. 2019. 2.

18. Philippine Statistics Authority, ‘PSA OpenSTAT’, 2022, https://psa.gov.ph/ (accessed 7 March 2022. 19. Evaluation IfHMa, Global Burden of Disease Data Tool, IHME, Washington, D.C., 2019.

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.

Reference: 14. Council for the Welfare of Children and UNICEF Philippines, National Baseline Study on Violence Against Children: Philippines, UNICEF, Manila, 2016

22. Ethier, L., J. Lemelin, and C. Lacharite, ‘A Longitudinal Study of the Effects of Chronic Maltreatment on Children’s Behavioral and Emotional Problems’, Child Abuse & Neglect, vol. 28, 2014, pp. 1265–1278. 23. World Health Organization, ‘Fact Sheet No. 150: Child maltreatment’, WHO, Geneva, 2010

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)

Reference: 12. Philippine Department of Health, Global School-based Student Health Survey, World Health Organization, Department of Health, Centres for Disease Control, Department of Education, Manila, 2015.

Exposure to bullying 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)

Reference: 12. Philippine Department of Health, Global School-based Student Health Survey, World Health Organization, Department of Health, Centres for Disease Control, Department of Education, Manila, 2015.

13. Philippine Department of Health. Global School-based Student Health Survey, World Health Organization, Department of Heatlth, Centres for Disease Control, Department of Education, Manila, 2019.

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)

Reference: 14. Council for the Welfare of Children and UNICEF Philippines, National Baseline Study on Violence Against Children: Philippines, UNICEF, Manila, 2016.

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)

Reference: 14. Council for the Welfare of Children and UNICEF Philippines, National Baseline Study on Violence Against Children: Philippines, UNICEF, Manila, 2016.

​​28. United Nations Population Fund, My Body Is My Body, My Life Is My Life: Sexual and reproductive health and rights of young people in Asia and the Pacific, UNFPA Asia Pacific Regional Office, Bangkok, 2021. 32. ECPAT, INTERPOL, and UNICEF, Disrupting Harm in Philippines: Evidence on online child sexual exploitation and abuse, Global Partnership to End Violence against Children, Manila, 2022.

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)

Reference: 33. Anti-Slavery International, Child Domestic Work, ASI, London, 2010. 34. Hesketh, T.M., et al., ‘The Psychosocial Impact of Child Domestic Work: A study from India and the Philippines’, Archives of Disease in Childhood, vol. 97, no. 9, 2012, pp. 773–778.

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)

Reference: 35. Ritchie, H., and M. Roser, Natural Disasters 2017, Centre for Research into the Epidemiology of Disasters, Brussels, 2018.

36. Edwards, B., M. Gray, and J. Borja, ‘The Influence of Natural Disasters on Violence, Mental Health, Food Insecurity and Stunting in the Philippines: Findings from a nationally representative cohort’, SSM – Population Health, vol. 15, Edwards, Gray, Australian National University, Australia(Borja) Office of Population Studies Foundation, Inc., University of San Carlos, Australia, p. 100825.

The pandemic has significantly affected mental health and well-being.(38,39) 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)

Reference: 38. Fegert, J.M., et al., ‘Challenges and Burden of the Coronavirus 2019 (COVID-19) Pandemic for Child and Adolescent Mental Health: A narrative review to highlight clinical and research needs in the acute phase and the long return to normality’, Child and Adolescent Psychiatry and Mental Health, vol. 14, 2020, p. 20. 39. Sharma, V., M. Reina Ortiz, and N. Sharma, ‘Risk and Protective Factors for Adolescent and Young Adult Mental Health Within the Context of COVID-19: A perspective from Nepal’, Journal of Adolescent Health, vol. 67, no. 1, pp. 135–137. 41. Tatum, M. ‘The Impact of a Year Indoors for Filipino Children’, Lancet Child and Adolescent Health, vol. 5, no. 6, 2021, pp. 393–394. 42. Tee ML, Tee CA, Anlacan JP, et al., ‘Psychological Impact of COVID-19 Pandemic in the Philippines’, Journal of Affective Disorders, vol. 277, 2020; ((Tee) Department of Physiology, College of Medicine, University of the Philippines Manila, Taft Avenue, Manila 1000, Philippines, Philippine One Health University Network, Department of Pediatrics, College of Medicine, University of the Philippine, pp. 379–391. 43. Loperfido, L., and M. Burgess, The Hidden Impact of COVID-19 on Child Poverty, Save the Children International, London, 2020.

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 suicide 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).

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.

Reference: 57. Department of Education, K to 12 Health Curriculum Guide, Government of the Philippines, Manila, 2016

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 curriculumsupport 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)

Reference:58. Foundation U, ‘EDUC+ (Empower. Develop. Understand. Cultivate)’, 2022, www.unilabfoundation. org/programmes/99/educ-empower-develop-understand-cultivate.

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.

Reference: 63. World Health Organization, Philippines WHO Special Initiative for Mental Health: Situational assessment, WHO, Geneva, 2020.

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.

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).