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Philippines mental health country profile

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Summary

The Philippines is one of the world's most heavily populated countries. Even though democracy was restored in 1986 after years of occupation and dictatorship, a high level of poverty still exists and malnutrition and communicable diseases continue to be the main cause of morbidity. For almost 50 years people with mental disorders have been treated in a mental hospital setting. The National Mental Health Program aims to establish psychiatric wards in university and private hospitals and encourage community-based mental health care.

Societal organization, culture and context

Topography

In the past, The Philippines was referred to as the Pearl of the Orient. It is an archipelago of 7100 islands in South Asia bounded by the China Sea in the west and the Pacific Ocean in the east. It has an extensive coastline of fine white sandy beaches, the sea is rich with marine life and a variety of fauna and flora abound the valleys and tropical forests that occupy an area of approximately 300,000 square kilometers. The climate is tropical, with the weather shifting only between a wet and dry season due to the regular occurrence of monsoon rains from June to October.

However changes to the topography followed rapid urbanization and industrialization. In the last three decades, massive denudation has destroyed the forest cover. Astride the typhoon belt, the Philippines is struck by an average of 10–20 strong typhoons and five cyclones a year. The destruction of the forest cover, in addition to the rains, causes heavy flooding (at disastrous levels) and loss of agricultural crops. Thousands of people living alongside the rivers and in the low areas need to be evacuated. In November 1991, a flood on one of the southern islands caused the death of at least 3000 people overnight.

A major fault line traverses the entire length of the Philippines from its northernmost point to its southernmost tip. This fault has recently become destabilized and earthquakes occur on a regular basis. In July 1990, an earthquake measuring 8.5 on the Richter scale caused death and injury numbered in the thousands, destroyed buildings and devastated the agricultural region of north and central Luzon. A mental health task force specializing in disaster was organized by the President of the Philippines to address the psychosocial consequences.

The Philippines is also situated within the volcanic 'Ring of Fire' and has many active volcanoes. In the last decade there have been at least three disastrous eruptions, the most devastating of these being the eruption of Mount Pinatubo (which had been dormant for over 600 years). This eruption in 1991 caused massive destruction and devastation of agricultural land, buried entire communities, killed thousands, and displaced at least three to five million people. The eruption of Mount Pinatubo happened only a year after the devastating earthquake of 1990, aggravating the sufferings of the people. Ten years on, volcanic debris continues to be emitted regularly during the typhoon season, clogging rivers and causing further destructive flooding. The psychosocial consequences of this disaster continue to affect the people in these communities and continue to drain the economic resources of the country, including those needed for health care and mental health services.

Population

As of 2001, the population of the Philippines was 77.9 million, with an almost unchecked population growth rate of 2.3%. It is one of the world's most

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populous countries having a population density of 249 people per square kilometer. Thirty-eight percent (38%) of the population is under the age of 15, while 3.5% are aged 65 or over. Adults in their productive years still comprise the majority. Indigenous people make up 18% of the population.

Education is highly valued among the Filipino people and literacy levels are in the region of 94.8%. Parents would go to great lengths and sacrifice in order for their children to finish a college education. Despite this however, folk beliefs and practices that are sometimes detrimental to health are still prevalent and they pose socio-cultural barriers to health care in most rural communities, where the majority of the population reside.

The Philippines is the only predominantly Christian country in Asia, with Roman Catholics comprising 83% and Muslims only 5% of the population. Catholicism is pervasive in the ways of life of the majority of Filipinos. The Catholic stance regarding contraception for example is considered as one of the major factors responsible for the high population growth rate and of course there is no divorce. The influence of the Church is very much felt by the government—despite the Church and state being separated in the Constitution, the Church spearheaded the historic 'People Power' non-violent revolution (and subsequent overthrow of the dictatorship) in 1986 and featured heavily in the impeachment of another President in 2000.

The strong influence of religion on the Filipino people has however, generated a strong and positive sense of spirituality, which is considered a source of strength in the individual. Since this spirituality is actively acknowledged and practiced in communities, it is recognized as a major coping mechanism in times of social deprivation and disadvantage, crises, political upheavals, and natural and man-made disasters. In fact psychosocial intervention programs during these times often integrate a psycho-spiritual approach. It is thought that the rate of successful suicide is low because taking one's life is considered a sin.

The family is the basic unit of society. It is still considered to be very important and there is active consciousness in the majority of Filipinos to preserve this despite the many social conditions that threaten its structure and the roles within it. While the nuclear family is evolving in the rapidly expanding urban areas, extended families are still prevalent. It is not unusual to find a variety of multigenerational family members and other relatives residing in one household and having a palpable influence on the affairs of an individual and family as a whole. Families are close-knit and influenced by tradition (even when one or other of the parents work overseas). Major decisions are not made unless parents are consulted and have given their approval. Family support is crucial as a basis of community support in times of need. Where this is absent, as in time of disaster, armed conflict and evacuations causing displacements and separation, an informal definition of 'family' among neighbors would be sought for help and support. Since the country is composed of islands, it is understandable that the people have acquired an 'island orientation' based mainly on the distribution of families as a social unit by regions, and conducted in a clan-like fashion (e.g., Ilongos, Cebuanos and Ilocanos etc.,).

More than half of the Filipinos (56%) live on the island of Luzon, with the greatest concentration (11 million) being based in the capital city, Metro Manila. The population density in the metropolis is 16,051 people per square kilometer. The rapidly expanding urbanized areas like Manila and other cities, with their wide range of economic, educational, and recreational opportunities encourage rural-to-urban migration. This migration however has resulted in urban slums, which puts a strain on the provision of basic social services like health care, shelter, sanitation and education. The congestion, pollution, lack of clean water and other basic necessities are among the many resultant health and mental health risks. A university study of health centers in the high-density urban slums of Manila showed that 17% of the adults seeking treatment have psychiatric disorders, 34% of which are as a result of their social circumstances.

Governance

After struggling through 400 years of Spanish colonization, two decades of American occupation, four years of Japanese occupation during World War II, the post-war rehabilitation after the declaration of independence from the USA in 1946, and a dictatorship ruled by martial law from 1972–1986, the Philippines is once again an independent democratic republic.

In 1986, the Philippines restored its democracy through the historic 'People Power Revolution', a non-violent mass demonstration that ended a 14-year dictatorship. Three years later, the military treaty with the USA was terminated and the US military bases formally closed and the land returned to the country.

At present, the country continues to struggle for political and economic stability. Although democracy, individual freedom and peace are values held by almost all Filipinos, there continues to be armed conflict with the Communist guerillas occupying several areas in the north and Moslems in the south. This unrest continues to drain the economic resources of the country. One area—Mindanao—has experienced decades of continuous conflict and the people bear the scars of the trauma of war, the constant search for peaceful areas to resettle, the search for sustainable livelihoods and for some stability in their lives. The mental health

consequences are well recognized and there is now a program for psychosocial intervention in the transition from conflict to peace run by non-government organizations (NGOs) working in collaboration with the Department of Social Welfare and Development. In 2001, 40% of the population was estimated to be living below the poverty line. This situation has actually not changed over the last three decades; in fact the situation is more a case of increasing economic inequality between the increasingly deprived 40% and the rising economic wealth and power amongst the affluent 8–10% of the population. Unemployment is estimated to be around 12–15% and is projected to rise as political instability fosters low investor confidence in the country as well as poor productivity in the industrial and agricultural sectors. This has led to a massive outflow of skilled and semi-skilled Filipinos overseas, a number now estimated to be in the region of five million and increasing.

Employment overseas a major concern in the Philippines. Overseas Filipino workers (OFWs) are regarded by the government as modern day heroes because their dollar remittances to their families are a major source of revenue (enough to prop up the dollar reserves of the country) and contribute to the nation's economic stability. On the macro level, in terms of the country's economy, this is encouraging, however the psychosocial stresses and strains on the individual families are very real and its mental health implications have been recognized and documented. These include the effects on child rearing and personal development when one or both parents are absent, and the socio-cultural stresses experienced by the OFWs because of the adverse or harsh social and cultural conditions in the country that they find work and the resultant homesickness, detachment from the family and breakdown of marital ties that often result. Many Filipinos working as overseas contract workers find refuge and strong social support in their spirituality, and in the thought that the sacrifices they are making in being separated from their families are matched by the improvements in their socio-economic conditions.

The present government struggles to pursue its economic reforms to help the Philippines match the pace of development among other newly industrialized countries of East Asia. The strategy includes improving the infrastructure, overhauling the tax system to bolster government revenues, further deregulation and privatization of the economy, increasing trade integration within the region and fighting corruption.

The current health situation

A decreasing death rate, increasing life expectancy and changing disease patterns since the turn of the century have indicated that the state of health of the Filipino people has improved. The crude birth rate is 26.2/1000, while the death rate is 5.9/1000. Infant mortality has fallen to 49/1000 live births in 1885 to 45/1000 in 1998. The average life expectancy is 69.25 with a lot more people reaching 'old age', however the country's health system has not developed enough provision to respond to the emerging needs of this aging population.

Only 2–3% of the national budget is allocated to health care—this is below the World Health Organization's (WHO) recommendations for developing countries. The total health expenditure of 3.6% of GDP and the per capita expenditure on health of US$32 are among the lowest in the region. Approximately 46% of health care cost is paid out of pocket. Health spending is still biased towards hospital or curative care and the biggest budget share is given to the large tertiary government hospitals in Manila, to the detriment of regional hospitals at the local level. Local governments are responsible for allocating budgets to the provincial hospitals. Funding for health promotions and preventative work is still very limited.

The impact of poverty on the health of the Filipino people is reflected in the malnutrition and communicable diseases that continue to be a leading cause of morbidity. Malnutrition among children is one of the main mental health concerns, given the intellectual impairment it can cause in the growing child. Public health interventions such as health education, vector control, provision of clean water and toilet facilities and mass immunization have, in the last few years, resulted in some changes in the mortality pattern. Non-communicable diseases like cardiovascular disease and cancer are emerging as the leading causes of mortality. These two conditions are known to often be co-morbid with anxiety and depression, but the latter are not included in the health information system of the country.

Health care delivery

The Philippine health care policy is implemented at the national level through the Department of Health and locally through the local government units at the provincial and municipal levels. The latter covers all the primary care units.

Health care delivery relies heavily on the private sector, despite the fact that the government has a mandate to provide health care services to the people. The private sector service is generally considered to be of better quality than that provided by the government. Even though the public health care services are extensive, access to medical care for the majority of the population is still limited because of this reliance on costly private medical services (which is generally situated in urbanized areas).

Although a medical care insurance system was established in the 1960s by the government, its benefits are available only to the employed, hence its coverage is limited to those who are employed and who can afford the cost of such a private scheme. The insurance specifically excludes cover for the treatment of mental disorders.

Human resources

The human resources for health are enormous but unevenly distributed, with the highest concentration in Metro Manila and other urban centers. In 1990–1995, there were 82,494 doctors, 259,629 nurses and 102,878 midwives. The ratio of government health workers to the population in 1997 was one doctor per 9727 people, one dentist per 36,481 people, one nurse per 7,361 people and one midwife per 4503 people. These numbers are gradually dwindling due to the increasing number of health professionals seeking employment overseas for economic reasons.

As of 1997, there are 1812 hospitals with a total bed capacity of 81,905 (or one bed per 873 people). Of these hospitals, only 36% (644) are public hospitals contributing 42,070 beds or 52% of the overall bed capacity (Table 1). There are 2405 rural health units (RHUs) and 13,556 barangay health stations (BHSs). Each RHU comprises a physician, nurse, dentist and midwife and serves approximately 29,746 people, while each BHS is manned by a midwife and a volunteer and serves approximately 5277 people.

The mental health situation

A historical perspective

The strong belief that spirits are a cause of physical and mental illness is prevalent throughout the Western Pacific Region, including the Philippines.

The first known organized care for the mentally ill was established in the late 19th century at the Hospicio de San Jose, for sailors of the Spanish naval fleet. The arrival of the Americans in the 1900s gradually transformed the treatment of mental illness from the use of traditional indigenous medicines to a more scientific approach. Two American physicians opened a clinic for mental disorders, using somatic treatments, such as fever therapy, insulin shock therapy, Lock's sol, barbiturates and electro-convulsive treatment. By 1904 the first 'Insane Department' was opened in a government hospital, and by 1918 the City sanitarium was built. In 1928 the mentally ill were transferred to the National Psychopathic Hospital in Mandaluyong, where it remains to this day, as the National Center for Mental Health.

For almost five decades, the mental health program has largely been centered on the treatment of those with mental disorders in a mental hospital setting. There are now efforts to establish psychiatric wards in university and private hospitals; however, these small units are unable to respond to the needs of the growing number of patients with mental disorders. In 1950 a non-government civic association, the Philippine Mental Health Association was organized, but its programs, although envisioned to be community-directed, have remained isolated.

The first real effort to comprehensively address the growing mental health problems in the country, including the need to reform the mental health care delivery system, happened in 1986. This was in line with the general demand for reforms following the change in government as a result of the 'People Power' Revolution and the overthrow of the dictatorship. The newly appointed Secretary of Health in his trips around the country to assess the health care delivery system, having seen the deplorable conditions of one particular hospital in the provinces of Mindanao, where half naked

Table 1. *Review of the facilities for mental health by the government*

DOH Regional facilities	Name of hospital	Number of inpatient beds
CAR	Baguio General Hospital and Medical Center	50
I	Ilocos Regional Hospital	None
II	Cagayan Valley Regional Hospital	200
III	Jose B. Memorial and General Hospital and the Paolino J. Garcia Research and Medical Center	None
IV	Batangas Regional Hospital	None
V	Bicol Regional Hospital	500
VI	Western Visayas medical Center	15
VII	Vicente Sotto Medical Hospital	30
VIII	Eastern Visayas Regional Medical Center	20
IX	Zamboangas Medical Center	20
X	Northern Mindana Regional Training Center	None
XI	Davao Regional Hospital	None
	Davao General Hospital and Medical Center	200
XII	Cotabato Regional Hospital	None
ARMM		None

patients were allowed to roam the grounds or were left immobilized in corridors, created a project team for mental health composed primarily of faculty members from university psychiatric departments. This team worked closely with the staff of the National Mental Hospital.

In 1988–1990, a multi-sectoral consultation led to the organization of the National Program for Mental Health (NPMH) at the Department of Health. The NPMH in recognition of the prevailing social conditions and their mental health implications identified five priority areas of concern. These were: patients with mental disorders, victims of disasters and violence, street children and victims of child abuse, substance abusers and overseas workers.

The Department of Health organized a Task Force on Mental Health to implement the National Program for Mental Health. The Task Force proceeded to organize mental health coordinators in all the regions of the country. These are composed of psychiatrists other mental health professionals working at the regional offices or medical centers and tasked with implementing the programs for the identified mental health priority areas. They work in collaboration with the regional and provincial health authorities.

The initial multi-sectoral consultation facilitated the presentation by the Task Force of its mental health priority areas of concern to the relevant agencies in the government and other sectors of society. Consultations were organized with the Department of Labor and Employment concerning programs for overseas workers; the Department of Social Welfare and Development in relation to their programs for family, women and child welfare and the protection; with the National Defense Department regarding disaster management through its National Disaster Coordinating Council; and finally with local government departments in implementing their own programs as well as in initiating community mental health programs especially the integration of mental health care in primary health care.

The Presidential Drug Enforcement Agency collaborates with the NPMH regarding the country's substance abuse programs. The Department of Health (through the NPMH) supervises and monitors the drug treatment and rehabilitation facilities as well as the laboratories where drug testing takes place.

In addition, the NPMH, in collaboration with the University of the Philippines Psychiatrists Foundation Inc (UPPFI), a non-governmental organization, composed of the faculty of Psychiatry from the University of the Philippines, organized a Mental Health Task Force in Disaster, which conceptualized and implements the psychosocial intervention program for victims of the series of disasters that have effected the country since 1990.

The NPMH has however not been provided with a specific budget from the Department of Health. Initially, primarily because it was a favorite with the then Secretary of Health, the NPMH enjoyed a strong position when it came to the allocation of resources. However subsequent political changes have resulted in the support for the structure, organization and activities of the NPMH to dwindle. In 2000, another administration implemented a re-engineering of the Department of Health and the NPMH was reduced to a point of dissolution, however it has since been revived (in 2002) and renamed the National Mental Health Program (NMHP).

Upon the reevaluation of its current programs in April 2002, the NMHP has found that:

- The land on which the National Center for Mental Health is located is urgently needed for other city programs. This means that 3500 patients will have to be relocated or discharged. It is expected that the plan will be implemented within the next year, but it has transpired that there are no community mental health programs in place and no provision for them in the general healthcare system.
- Although the situation in the Department of Health is such that the NMHP cannot pursue its programs in a sustained way (because of the inability of the Department to provide the Mental Health Program with definite organizational and financial support), mental health programs in other sectors of the government, in addition to those of non-governmental organizations and the private sector have been undertaken and sustained. These agencies had participated in the multisectoral consultation prior to the creation of the NMHP and had benefited from the initial assistance and training provided by the NPMH. They have allocated monies for their own mental health agendas from their own budgets, for example, the Department of Labor and Employment has integrated in its policy on overseas employment, mental health concepts and interventions at promotive, preventive and curative levels in order to address the needs for mental health care amongst the overseas workers.
- Although the Mental Health Program suffered some severe setbacks in 1999–2001 at a national level (when the Department of Health implemented its re-engineering) regional mental health coordinators, supported by the regional and provincial health authorities, managed to continue their work in mental health promotion, treatment of mental disorders and various other specialized programs such as the disaster programs and child protection units.
- Non-governmental organizations and university groups engaged in mental health programs have continued their work, and tend to fill the gaps that the government programs have been unable

Table 2. *Study data regarding the prevalence of mental illness in the Philippines*

Lubao study (1970s)	10.8%–17.2% of adults and 18.6%–29% of children consulting a health center were found to have psychiatric problems 75% of mental illnesses presenting at health centers were not recognized by the health workers
Sapang palay study	Results showed a prevalence of mental illness in 12 per 1000 people (the internationally recognized rate is 1/1000)

If the above data were extrapolated (taking into account that the Philippines has a population of over 60 million), then the figures of mentally ill people according to the Lubao data would exceed 2,460,00 and 720,000 according to the Sapang Palay data. The differences between these two rates is that the Lubao study included mild cases of mental illness whereas the Sapang Palay study restricted its data to those with moderate to severe mental illness. The above data only pertains to those who are identified as having a psychiatric illness and not those who may have psychosocial or minor psychiatric problems.

to fill. The Philippine Mental Health Association and its chapters nationwide have been conducting mental health promotions, education and public awareness programs. The University of the Philippines' Department of Psychiatry has conducted prevalence studies and continues to research mental health care in primary health care, as well as disaster mental health and provides training in these areas for other health professionals. The resultant work (and publications) have proved invaluable when formulating various mental health programs, both on a national level as well as locally.

Mental health research

A recent review of mental health research in the Philippines has shown that in the last four decades, studies have evolved from case studies and literature reviews to intervention research (such as mental health in primary health care and disaster mental health studies), to surveys involving larger populations. At present one see a mix of clinical case studies and drug trials, epidemiological surveys using population surveys and key informant interviews, to the utilization of social science research methods for victims of child abuse and violence, as well as those internally displaced following disasters or armed conflict.

Academic institutions with departments of psychiatry and/or the related behavioral and social sciences like psychology, sociology or anthropology have generally conducted these studies.

As part of the WHO seven-nation collaborative study, the Philippine study conducted in three primary health centers situated in an urban slum in Manila, showed that 17% of adults and 16% of children had mental disorders. This is similar to the findings of a study performed in 1989 by the University of the Philippines' Department of Psychiatry, conducted in a rural area 45km from Manila where 34% of those with mental disorders had social problems. A study in 1988–1989 in a barrio in San Jose Del Monte Bulacan, showed the prevalence of adult schizophrenia to be 12 cases per 1000 persons.

In 1993–1994, a population survey for mental disorders was conducted by the University of the Philippines Psychiatrists Foundation Inc, in collaboration with the Regional Health Office. The study areas covered both urban and rural settings in three provinces (Region VI). The prevalence of mental disorders was 35%. The three most frequent diagnoses among the adults were: psychosis (4.3%), anxiety (14.3%) and panic (5.6%). For children and adolescents, the top five most prevalent psychiatric conditions were: enuresis (9.3%), speech and language disorder (3.9%), mental sub-normality (3.7%), adaptation reaction (2.4%) and neurotic disorder (1.1%). (See Table 2 for more data).

Mental health legislation and policy

There is no mental health law in the Philippines. The laws that govern the provision of mental health services are contained in various parts of the Administrative and Penal Code promulgated in 1917.

The prevention, treatment and rehabilitation from substance abuse are covered in the Dangerous Drugs Act (which was revised in 2001). A Dangerous Drugs Board is responsible for the policy; a Presidential Drug Enforcement Agency implements the policy and the Department of Health supervises and monitors the laboratories where drug testing, treatment and rehabilitation take place.

In April 2001, the Secretary of Health signed the National Mental Health Policy, which is now known as Administrative Order No.5, Series 2001. The document contains generic goals and strategies for the Mental Health Program. Although signed in April 2001, the policy has still to be presented and implemented by the various stakeholders in mental health.

The National Mental Health Program

The current National Mental Health Program (NMHP) reactivated in 2002 has been placed under the administrative authority of the Undersecretary of Health for Operations. A Program Manager, three

executive assistants and 10 technical staff have been appointed. Regional mental health coordinators have been identified. In November 2002, the NMHP conducted a workshop with these and other mental health leaders representing the various stakeholders in mental health in the country. A status review of the program in relation to earlier programs has since been presented.

The NMHP has identified six areas of concern in which it needs to give priority, namely: mental disorders; substance abuse; disaster and crisis management; women, children and other vulnerable groups; epilepsy; and overseas Filipino workers. With the exception of epilepsy, the other five areas of priority were already provided for in the previous National Mental Health Program.

In the treatment of mental disorders, the NMHP has articulated its support for the policy shift from mental hospital-based psychiatric treatment to community-based mental health care. This integration of mental health care in general health services proposes, as a first step, the opening up of acute psychiatric units and outpatient clinics in all 72 government hospitals and the provision of psychiatric drugs. So far, primarily because of budgetary constraints, only 10 hospitals have opened an outpatient clinic. For those hospitals that have opened clinics, the NMHP has provided guidelines and recommendations as to the standards of psychiatric care.

The role of the NMHP in the current situation where land currently occupied by the National Center for Mental Health is being acquisitioned for city developments is not clear. This development could be an opportunity for the NMHP to participate in redirecting the budget allocated to the Center for the development of a variety of appropriate and alternative community-based mental health programs and the reorientation of mental health professionals. In doing this, the NMHP may be able to realize its goal to fully integrate mental health care into general health services in the community.

The NMHP is also involved in the development of a demonstration project in collaboration with the Regional Health Office III, under the supervision of the Regional Health Director. This project involves the development of a 'collaborating center for mental health'. It is proposed that a mental hospital in one of the provinces (Mariveles, Bataan) be redirected and transformed into a center for comprehensive mental health care catering for the six provinces in the region. The aim of this development is to shift mental health care out of the hospitals to a variety of community-based services ranging from acute psychiatric units and outpatient clinics in the provincial hospitals, home treatment care, mental health care and psychosocial rehabilitation in primary health care. The implementation of this project was due to start in the latter months of 2003.

The NMHP has sustained its Lusug Isip (Mental Health) Program and considers this its flagship program because the Department of health has integrated it into some of its programs, especially its Healthy Lifestyle Theme. This is one NMHP achievement that has survived the various administrative changes.

Lusug Isip is an annual advocacy and mental health promotion program directed at mental health concerns other than mental disorders. A 'life course' approach has been adopted and its yearly promotions have ranged from mental health in children and adolescents to stress in the workplace. Stress management programs for health workers and government employees have been positively received and have given the NMHP further credit.

Mental health service delivery

Although the ill effects of long term confinement in a mental hospital and the advantages of community-based mental health services (especially at the primary level of care) are well known, large overcrowded mental hospitals are still in use. The NMHP has categorically articulated that a major objective should be the integration of mental health within the general health services. However this has not been achieved despite the efforts of the NMHP to train primary health workers. Attempts to downsize the larger hospitals (which cope with as many as 3500 patients) and other regional hospitals by establishing acute psychiatric wards in regional medical centers and provincial hospitals has to date failed. It has been suggested that the Department of Health has not shown the necessary political will in order to instigate these changes, and so the large hospitals remain, the community-based programs not developed and monies allocated elsewhere.

The National Center for Mental Health, formerly the National Mental Hospital, provides 67% of the psychiatric beds in the country. The remainder are distributed among the eight mental health units based in the regional medical centers. However these facilities are effectively 'closed' and their services are generally inaccessible due to the severe limitations in manpower and resources. Medication, although provided for in the Department of Health's essential drug list are not available, with psychiatric drugs being neglected in favor of other life-saving medications needed by the other medical specialties. These eight units house between 25–100 beds but are nearly always overcrowded. There is psychosocial rehabilitation for the chronic patients but this remains hospital-based.

There are 10 government general hospitals, designated as the pilot areas for the development of acute psychiatric units and outpatient mental health clinics. However, only the outpatient clinics are operational since the wards (expected to cater for

10-15 beds) have not opened due to budgetary constraints. These hospitals remain isolated from the community. They have remained custodial in orientation and have not been able to develop alternative community-based programs. Lately, however, family education programs have been initiated in some areas.

There are university and private hospitals with psychiatry department that provide inpatient and outpatient services. These are generally situated in the urban centers, primarily Manila. Because of the imminent relocation of the National Mental Hospital, demand for home care services for the chronic patients have increased, and these services are only known to exist in Manila. In truth there development has not been monitored, so the exact numbers are not known.

Although there have been significant research in the Philippines that has shown the feasibility of mental health care in primary health care, its integration has to date remained within the confines of a demonstration project.

Other mental health programs

Although the Department of Health has fallen short of providing the necessary organizational structure and budgetary support to the NMHP at central office, relevant mental health programs that address the special concerns of other government agencies have been sustained and budgetary support has been forthcoming.

The Department of Labor and Employment (DOLE)

The department, through its Overseas Workers Welfare Assistance (OWWA) has recognized the importance of a mental health component in its policies.

Pre-departure policy. Prior to departure, overseas workers must undergo neuropsychiatric screening and those found with symptoms of mental distress and symptoms are not certified to leave for overseas employment. Any reapplication must be accompanied by psychiatric clearance. A pre-departure seminar is compulsory. This prepares the overseas candidates for life abroad. Lectures on the culture of the country of employment, their expected stresses, including coping strategies are discussed. These coping strategies are given high priority since the mental and emotional distress inherent with overseas working has transpired to be a major cause for concern. This policy addresses the need to minimize, if not totally prevent mental distress and possible disorders among overseas workers.

Provision of mental health services. A memorandum of agreement has been signed between the Department of Health (DOH), the DOLE and the Department of Social Welfare and Development to appoint social welfare officers in Philippine Consulates who can provide counseling and social welfare assistance. Physicians in several consulates have been trained by the NMHP (DOH) to identify and manage disorders among the overseas workers.