

A Socio-ecological Framing of the Philippine Mental Health Act of 2017

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ABSTRACT

Filipinos experience numerous barriers to mental health care in their country, such as stigmatization of illness and behaviours, lack of mental health care services, and resource deficits. The Philippine Mental Health Act of 2017 was formed to resolve these issues and is in its early stages of implementation. Legislation and policy interventions of this nature are but one level of many interventions that can address health care at a population level. The influence of this legislation for different levels of society is analyzed in order to understand the different barriers and alternatives to its implementation. Solutions suggested in the legislation, such as addressing lack of accessibility in rural areas, creating liaisons between different levels of mental health care, and educating the population regarding mental health, are explored for their effects on different spheres, or levels, of influence. The comprehensiveness of the legislation to address the needs of mental health service users are highlighted, as are barriers to implementation that inhibit the realization of practical strategies. This policy case review and analysis informs program development by highlighting the strengths and weaknesses aligned to the legislative articles' target sphere of influence and the population.

Background: Evolving mental health legislation

Mental health care in the Philippines currently faces numerous challenges, including a lack of both trained personnel and financial resources, as well as a lack of formal legislation prior to 2017. The World Health Organization (WHO, 2014) reported that there were only 0.5 psychiatrists and 0.5 nurses per 100,000 people in the Philippines. The government's total health expenditure per

person in 2014 was US \$135, while normal hospital stays would cost US \$33 upon admission and US \$10 per day until discharge (WHO, 2014; National Center for Mental Health [NCMH], 2017). The public plays a role in creating an unsupportive environment for individuals with mental health needs which are beyond systemic burdens. Due to the stigma surrounding this topic, prejudices

are formed that lead to marginalization of this population (Ito, Setoya, & Suzuki, 2012). These barriers to accessible and appropriate service have serious impacts for patients and families suffering from the effects of mental illness, as well as professionals in health and social care in the country. The author's personal background as part of the Filipino diaspora based in Canada and as a graduate nurse interested in community mental health has provided insight and concern for those suffering, and for people who can shape policy and practice to promote health at multiple levels of intervention.

For about 15 years, the Philippine Psychiatric Association has advocated for a new law to be enacted to address the troubling inequities (Crisostomo, 2014). The Philippine Psychiatric Association instituted an online petition to reach the general population, aiming for the support of 200,000 signatures. Despite only receiving 34,627 supporters, they proceeded to submit their appeal to the Philippine legislators, demonstrating the lack of programs or policies to protect the mentally ill in the country (Philippine Psychiatric Association, 2014). This proposition to the Philippine government was, however, inaccurate. Earlier mental health policy had been instituted by, then Secretary of Health, Manuel Dayrit, in 2001 that outlined the standards for empowerment, equality, and mental health care (WHO, 2007). Before the Philippine Mental Health Act (MHA) of 2017 was passed, these standards of mental health care in the country were provided to health agencies as formal guidelines, for instance practice standards and care guidelines that were part of professional practice. Despite these standards, it was considered insufficient for making institutional or hospital-based policies. Also, a legislation had to be in place to ensure that the provision of mental health services is appropriately governed by law. The mental health policy was later reformed in 2005, with a focus on reorienting services to be more person-centered while simultaneously giving the senators the task to create

legislation that would protect the service users. As a response to this reform, multiple senators created drafts to support the cause. Both Senator (Sen.) Legarda and Sen. Cayetano of the Philippine Senate proposed plans for a mental health act, and representatives carried this on to various stakeholders, which allowed for restructuring of the bill. The drafts were based on the WHO's (2003) document *Mental Health Legislation and Human Rights*, which noted that legislation should go beyond the diagnosis and treatment of patients; rather, it should be focused on addressing inequities in the health care system. Sen. Sotto proposed another draft based on these past submissions to the Philippine Senate, and this ended up being passed as the Philippine MHA of 2017. Through this legislation, the government intends to provide high-quality and equal care to all service users, families, and workers (Philippine MHA, 2017). The purpose of the policy case review presented in this paper is to analyze the Philippine MHA of 2017, identifying its strengths, weaknesses and possible opportunities for implementation drawing on a socio-ecological framework.

An Ecological Frame of Analysis

Mental health promotion consists of strategies that intend to create a positive impact on mental health. Per Anderson and Jané-Llopis (2011), this strategy serves to create environmental conditions, such as reduced stigmatization of mental illness, that enable optimal psychological development while preserving one's dignity. This definition emphasizes the relationship between human behaviour and society. Thus, interventions for mental health are often targeted at different levels in society based on a socio-ecological model. Three domains of analysis in an ecological model of mental health promotion include micro, meso, and macro level.

At the micro level, the individual sphere, analysis focuses on individual characteristics, skills, and support systems with interventions such as those that allow individuals to gain control over their

own lives and care. For example, approaches that foster empowerment, where people are given freedom to choose the interventions, and are exposed to environments that best facilitate their development, may be implemented at this level (Rindner, 2004). Health professionals working at the micro level are also accountable for performing evidence-based practices that target intrapersonal issues and introduce problem-solving approaches. This could include “cognitive behavioural therapy” which allows harmful thoughts to be changed into behaviours that are beneficial to the client. In this way, micro-level approaches for mental health can be seen as a balancing act of problem-solving and individual empowerment (Jakubec, Mascaro, Nordstrom, Judd & Weimand, 2012).

The socio-ecological model’s community sphere, or meso level, consists of local communities, and requires the involvement of both the individual and the public. At this level, individual interventions, such as relaxation technique classes and leadership workshops, aim for the reintegration and inclusion of a patient into society with resources that preserve and strengthen skills for community engagement. The community is a crucial aspect of these interventions, such that communities bear responsibilities to provide safe spaces for those experiencing mental illness. Different barriers in the community are addressed by changing the culture of inclusion when public educational resources directly involve mental health service users (Jakubec et al., 2012).

The global sphere, or the macro level sphere of influence, provides the key site of exploration for the purposes of this paper – focusing on the mental health intervention of public policy and legislation. At this sphere, actions are aimed at public laws and advocacy that target the rights and freedoms of individuals. These strategies also aim to restructure culture by using liberation approaches, such that resources are accessible to those requiring mental health care. Protective approaches, which decrease disadvantages of

mental health service users, are also central to this level of intervention, particularly to address barriers and build resiliency within the broader public health system. Despite having more risks than protective factors, a community may still perceive itself as resilient. Although, risk factors, such as stigmatization and low socioeconomic status, can still decrease a community’s level of health. A community and its residents have their own advantages and disadvantages; environments that support community mental health are created by addressing inequities and aiming to facilitate the formation of protective factors (Campion & Nurse, 2007). Numerous organizations and government officials advocated for the Philippine MHA of 2017 drawing on a perspective of global and public health.

The purpose of the Philippine MHA of 2017 is to enhance mental health service delivery while protecting service users and workers, through formation of legislative policies. Indeed, in a socio-ecological model, this legislative intervention is used to create a supportive environment by protecting and liberating the population. This policy case review brings together the elements of the Philippine MHA of 2017 in order to understand its effects, connecting key areas of influence, strengths, limitations and barriers, to the different levels of health promotion: individual, community, and population.

Philippine Mental Health Act of 2017: A Policy Case

The Philippine MHA of 2017 is arranged in various articles and sections per the country’s current mental health system, its users, and its workers. The Act was explored in relation to population health principles and the socio-ecological model of mental health promotion, in order to gain knowledge of how the articles correspond to key mental health promotion approaches and spheres of influence. With an in-depth understanding of mental health concepts and the legislative contents, the articles

were categorized according to the different levels of the framework, as per Table 1. The basis for classification was the socio-ecological model with a focus on how an article's influence could affect a level of intervention in the framework. The analysis here is concerned mainly with the global sphere of influence, due to the political nature of the Philippine MHA of 2017. A global mental health policy evaluation, used across developed and developing country programs, is provided by the World Health Organization (2007). This tool has framed the analysis to follow. Facilitators and barriers within the tool are discussed, in order to consider the possible strengths and capacity for the law's implementation.

Table 1: Categorization of the Articles of the Philippine MHA of 2017 according to their influence in the socio-ecological framework

Micro Level Individual Sphere	Articles 2, 3, and 6
Meso Level Community Sphere	Articles 4, and 5
Macro Level Global Sphere	Articles 2, 4, 5, 7 and 8

Policy Case Discoveries

Macro Level Influence

The Philippine MHA of 2017 can be considered as a public health intervention that focuses on these spheres of influence. It is, however, specifically focused at the global sphere of influence for public mental health, since the general objective of the Philippine MHA of 2017 is to protect the rights of people with mental health needs by implementing related strategies and programs. As the macro level is its main target, specific solutions at the micro and meso level, for example, creation of workshops and individual psychotherapy, are not completely addressed in the legislation. Instead, the Philippine MHA of 2017 serves as a guide for the formation of evidence-based interventions in the individual and community

spheres. Intervening at the macro level aims, then, to restructure cultural norms in mental health care and increase protective factors for those who are marginalized. As proposed in the socio-ecological model, there are two key intervention strategies that can be analyzed at this level: interventions for liberation and protection (Jakubec et al, 2012).

Article 4 of the Philippine MHA of 2017 discusses mental health services at different levels of prevention and care and captures the essence of a liberation strategy. As such, local government units are expected to create programs that facilitate positive mental health development in their neighbourhood (Philippine MHA, 2017). Every district already has a pre-existing clinic to support their residents, and they will be tasked by law, as addressed in meso-level interventions, to provide assessment and support to those who are feeling symptoms of mental illness. This strategy addresses primary and secondary prevention for mental health care. Article 4 requires the allocation of resources to the smallest administrative divisions rather than just tertiary hospitals. Prior to the passing of the bill, the only area one could get appropriate mental health care was in the capital region of the Philippines (WHO, 2007). Therefore, having this increased accessibility to mental health care allows people from rural areas to have the same level of care as in major cities. The lack of resources is also addressed in Article 7, in which local government units are tasked to make sure that training programs are available to mental health care service providers, which are then followed-up by the Philippine Department of Health and Commission on Human Rights (Philippine MHA, 2017). This article also promotes de-institutionalization of mental health care as the Philippine Department of Health planning supports community-based recovery principles that support transition between all levels of public health care.

Governmental support for primary care also supports access as an element of public mental health improvement with referrals from

acute services (Philippine MHA, 2017). Acute management of mental health systems, in accordance with Article 4, serves to prevent the development of complications with ongoing care and treatment at the meso or community level. Regional hospitals that are not focused on mental care are required to have both short- and long-term stay units to increase accessibility in different parts of the Philippines (Philippine MHA, 2017). Following discharge, home care is proposed to follow up with mental health care patients in order to ensure proper use of medications prescribed. Tertiary prevention, the level of healthcare that tackles rehabilitation following an acute care experience, is then essential for patients who were hospitalized long term, addressing the recovery and resilience principles of mental health promotion.

Protection as an intervention strategy is also a consideration in the case of the Philippine MHA of 2017 being analyzed. As per Thompson et al. (2002), Filipinos perceive severe symptoms of mental illness as “softness” in one’s personal character or attributes (as cited in Tuliao, 2014). Public stigmatization of mental illness becomes internalized and thus results in reluctance to seek medical attention. Filipino people may then prefer to talk to their own social support first, further anchoring social stigmas, before consulting other medical professionals. These are just a few examples of the many factors that predispose the population to reduced access to comprehensive mental health care.

As a protective strategy, Article 2 of the Philippine MHA of 2017 affirms the equal rights of service users by protecting them from socio-economic discrimination. This article also emphasizes that those experiencing mental illness have the same access to care as any other individual in the country. Per Article 7, Section 23, “The Commission on Human Rights shall establish mechanisms to investigate, address, and act upon impropriety and abuse in the treatment and care received by service users, particularly when such treatment or

care is administered or implemented voluntarily” (Philippine MHA, 2017). The Commission of Human Rights can then recommend an administrative, civil, or criminal case to be filed according to the level and number of offenses following a discriminatory act against the population, especially in a professional setting (Philippine MHA, 2017). Protection strategies outlined in the Philippine MHA of 2017 increase resiliency through safeguarding: creating a non-judgemental environment allows individuals with mental health needs to express how they feel and become more open about who they are rather than what disease they have. These safeguards also decrease the likelihood that health care professionals will abuse their patients. In the Philippines, over 20% of patients are restrained, secluded, or abused in the mental health system (WHO, 2007). To prevent this, protection against discriminatory care is outlined in Article 4, Section 16, where it states, “Mental health facilities shall establish policies, and protocols for minimizing the use of restrictive care and involuntary treatment [of mental health service users]” (Philippine MHA, 2017).

Protection is also ensured through the education of students prior to professional designation and service, as well as those engaged in active employment. As mentioned in Article 5, mental health is to be integrated into all workplace and educational systems, regardless of industry (Philippine MHA, 2017). Article 5, Section 17, states, “The State shall ensure the integration of the mental health into the educational system, as follows: Age-appropriate content pertaining to mental health shall be integrated into the curriculum at all educational levels, and psychiatry and neurology shall be required subjects in all medical and allied health courses, including post-graduate courses in health” (Philippine MHA, 2017). In all school systems, curricula have been changed to include information for general elementary and high-school studies, and the integration of psychiatry and neurology courses in all allied health courses. Schools and workplaces are sites

where awareness, identification, and support can be facilitated for those at risk for mental illness. This protection strategy also increases the likelihood of people talking to their support networks, improving social support. As awareness and program building increases, people become more aware of what to do and how to intervene at certain points in another individual's life. Individuals become a liaison between their peers and the health care system, and this plays a role in crisis intervention. Articles 4, 2, 7, and 5 all provide inroads for restructuring the culture of mental health and illness across various areas of Filipino society. The strategies provide a framework for new policies to be developed at a community level. The Philippine MHA of 2017 establishes forms of intervention that may be related to other spheres of influence within the socio-ecological model.

Meso Level Influence

The recovery model provides a backbone for care planning in the mental health care system (Cleary, Lees, Molloy, Escott, & Sayers, 2017). Professionals must evaluate patients with a strengths-based approach to know what skills a person must possess to reintegrate themselves into the community (Philippine MHA, 2017). When patients lack skills to return into the community, Section 26 of Article 7 addresses the need for social workers to refer patients to livelihood training prior to their discharge. It states, "The Department of Social Welfare and Development shall provide or facilitate access to public or group housing facilities, counselling, therapy, and livelihood training and other available skill development programs" (Philippine MHA, 2017). Once patients are sent home, they can continue their training and further ease their integration through the help of local government units.

Community action is strengthened through education and awareness programs. As described previously, schools and workplaces are required to have program and curricular

changes to address the growing population of mental health care service users. The restructuring of culture also applies to the community sphere of influence as it greatly influences the thinking of the general public. These approaches to decrease stigma and increase acceptance at public places represent some possibilities for community level inclusion strategies.

Micro Level Influence

Health care workers make decisions based on evidence: as a diagnosis is presented to professionals, operating under the Philippine MHA of 2017, they must act with the best intention for the patient within their scope of practice. This is accomplished using a problem-solving strategy as per Article 2, Section 5, It is the patient's right to receive evidence-based treatment regardless of disadvantages with regards to their determinants of health (Philippine MHA, 2017). As stated in the article, "Service users shall enjoy, on an equal and non-discriminatory basis, all rights guaranteed by the constitution as well as those recognized under the United Nations Convention on the Rights of Persons with Disabilities and all other relevant international and regional human rights conventions and declarations" (Philippine MHA, 2017). In order to continuously provide safe and competent care, mental health care professionals are protected under Article 6, Section 20, which requires that they undergo reorientation and training to deliver evidenced-based and culturally-appropriate care. This section states, "(...)Mental health professionals, workers, and other service providers shall undergo capacity-building, reorientation, and training to develop their ability to deliver evidence-based, culturally-appropriate, and human rights-oriented mental health services" (Philippine MHA, 2017).

To facilitate patient empowerment at an interpersonal level of intervention, the Philippine MHA of 2017 emphasizes the need to use a recovery-based approach, in which patients are equal partners in their care and they are considered

masters of their own experiences (Philippine MHA, 2017). In Article 2 of the Philippine MHA of 2017, patients have the right to receive adequate information and participate in their own care process. Family-centered care is also taken into consideration in this part of the bill as mental health service users and their families are supposed to receive appropriate support from government bodies, as well as participate in their family member's plan of care. The idea of empowerment is reinforced in Article 3 which requires a patient to provide consent prior to undergoing treatment. If the patient is unable to make his or her own decision and there are no legal representatives, a planned intervention by an attending psychiatrist must go through the internal review board of the facility. Even then, the only interventions that can be implemented are ones that are necessary for the benefit of the patient. The Philippine MHA of 2017 outlines the goal that a patient will always have the right to their choice and involvement in decision-making for their mental health care - no matter the circumstance.

Discussion

This policy case review showed that with strong targets aimed at the sociopolitical environment, specific articles of the Philippine MHA of 2017 can be analyzed through a socio-ecological model. Looking at the different levels of prevention, individuals can be supported to ensure crisis intervention and rehabilitation in order to both serve and protect people experiencing mental illness in the Philippines. The WHO (2007) suggests that the country must advocate for the formation of programs to improve the experiences of mental health care service users in the Philippines. This case review has explored how the development of programs targets a specific sphere of influence with corresponding interventions. Although the Philippine MHA of 2017 alone lacks detail for specific solutions, and the political directions must be acted upon within a culture that also requires change in order to effectively work to both

liberate and protect people with mental illness. Various limitations, which will be discussed further in this paper, can be identified in the legislation, such as the insufficient funding for mental health programming extracted from tobacco and alcohol taxation, and the inattention to ingrained social and institutional stigmatization. The Philippine MHA of 2017 is also limited in that it does not task the Department of Health to display which components of health service are needed by the population. As per Gureje and Alem (2000), mental health policy must show where mental health fits in the whole to provide an accurate representation of budgeting every year. This information provides evidence to support overall funding and transparency between the government and the general public.

To support culture change, knowledge and education will also be important steps forward to advance the Philippine MHA of 2017 agenda (Semrau et al., 2018). There remains a lack of research in the area of interventions and effective implementation for the Philippine mental health care system and Filipino culture. Ethnographic and other qualitative accounts will be as valuable as statistical research in advancing the knowledge base. Despite numerous news reports regarding the stigmatization of mental health in the country, few qualitative studies support these statements (Tuliao, 2014). At this early stage of the Philippine MHA of 2017 and visibility of the issues within Philippine politics, there are no mental health programs that reflect the new changes being implemented into the country's mental health care system.

Barriers and Limitations to Implementation

Stigmatization of people with mental health problems is prevalent in the country and is deeply ingrained in Filipino culture. People tend to evade the topic of mental health or illness in social interactions (Tuliao, 2014). Because of this, recognition of the strengths of people with mental illnesses and the provision of opportunities

still proves to be a challenge in the Philippines. Therefore, even with the introduction of new legislation, a supportive environment will be a long-term endeavour (Ito et al., 2012). There is still a lack of research that connects formation of policy to decrease in mental health stigma; however, educational approaches, which were highlighted as a need in the Philippine MHA of 2017, may be beneficial for changes in perception about mental health. Educational strategies replace stereotypes with factual information through the use of books, flyers, and films (Corrigan, Kerr, Knudsen, 2005). These approaches, as well as the educational structures needed to inform the population about mental health, are not outlined in the Philippine MHA of 2017. The Philippine MHA of 2017 should also expand on the need for research for education in order to maintain the evidence-based training needed for service workers.

The Philippines has numerous university graduates in allied health fields; however, there is often little incentive to practice their profession in the country (WHO, 2007). Implementation of mental health programs is a challenge, with a lack of health care workers such as psychologists, nurses, and social workers. The inability of the government to match competitive offers results in numerous graduates leaving the country to work elsewhere (Ito et al., 2012). Gilbert, Patel, Farmer, & Lu (2015) suggest that in order for a program to be successful, further funding, staffing and research models are recommended. Potential funding derived from the proposed 5% of tobacco and alcohol excise taxes for mental health programs, as suggested in the Philippine MHA of 2017, is likely insufficient to support the models for resource allocation recommended by Gilbert et al., and consequently, realistic implementation and staffing is unlikely. Thus, a central task of the government is to motivate trained professionals to sustain involvement in the Philippine mental health care system. A study regarding retention strategies in Africa, which has a high migration rate for health workers, showed

that financial and non-financial incentives may be able to aide in discouraging citizens to work in other countries (Stilwell, Diallo, Zim, Vujcic, Adams, & Poz, 2004). Health care workers having access to constant training, study leaves, and feedback from supervisors motivate workers to do a good job. Providing housing, transport, and benefits also increase job satisfaction amongst workers (Stilwell et al., 2004). The Philippine MHA of 2017 only tasks the Department of Labour and Employment with ensuring that mental health is promoted in the workplace, and there is a lack of discussion of retention of workers (Philippine MHA, 2017). Government bodies can improve this by assessing the needs and wants of health care workers and providing appropriate programs that will allow employees to stay in the Philippines.

Conclusions

The new law explored in this review was designed to target different levels of the socio-ecological spectrum, especially at a broad societal sphere of influence. Protection and liberation strategies, such as implementation of mental health care programs in local government units, were used to restructure the culture of mental health care in the country. The discoveries in this policy case review serve to inform program development and emphasize strategic approaches to specific spheres of influence. Macro-level influences were found to serve as the main target of the Philippine MHA of 2017, while the legislation also supports the micro and meso levels. The Philippine MHA of 2017 serves as a guide for the government to shape mental health care strategies in all levels of prevention. Nonetheless, barriers such as stigmatization and lack of budget will continue to inhibit a strong policy implementation strategy, and it may be challenging given the longstanding stigma within Filipino culture. This critical case analysis from a socio-ecological perspective sheds understanding from which to track implementation, and change resulting from the new legislation. Future qualitative analyses may allow for a better

understanding of the roots of these barriers. Further research may also discuss programs and strategies that allow suppression of said barriers. understanding from which to track implementation, and change resulting from the new legislation. Future qualitative analyses may allow for a better understanding of the roots of these barriers. Further research may also discuss programs and strategies that allow suppression of said barriers.

Acknowledgments

I would like to thank my faculty supervisor, Dr. Sonya Jakubec, for guiding me in writing this review and pushing me to keep on going. I would like to thank my co-student Jean Garcia who supported initial proofreading and encouragement. I would also like to thank Frenz Del Rosario and John Borromeo for their endless support and encouragement in this publication.

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