ORIGINAL ARTICLE

Mental health and substance use services in schools and workplaces

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ABSTRACT

Background: In 2021, the World Health Organization (WHO) reported that about 3.6 million Filipinos suffer from mental health (MH) or substance use (SU) conditions [1]. However, there is a dearth of literature on the delivery of MH and SU services in Philippine schools and workplaces.

Objectives: This study aimed to describe the prevalence of MH and SU services in Philippine schools and workplaces. It also examined the level of institutional support, barriers, and stigma and discrimination for MH and SU.

Methodology: Data was gathered in October 2022 using an online survey. The survey generated 262 respondents from all regions of the country. Schools represented 55% of respondents whereas 45% were from government and private workplaces.

Results: Schools and workplaces report providing more services for MH compared to SU. They also have more budget for mental health compared to substance use. The most commonly provided services are prevention programs on stress with a greater percentage of schools providing this compared to workplaces. Majority of schools and workplaces do not have any screening or treatment programs for MH and SU. Barriers to service delivery include the lack of budget, personnel, and knowledge of what services to provide. Results showed moderate levels of stigma and discrimination, with attitudes towards substance users being more negative compared to those with MH issues.

Conclusion: Despite national policies requiring MH and SU services in schools and workplaces, gaps in service delivery and institutional support hinder implementation. To improve service delivery, there is a need to strengthen resources, policy, leadership support and address stigma and discrimination.

Introduction

The World Mental Health Report 2022 reveals that about 1 in 8 or 970 million people around the world live with a mental health disorder, 283 million have an alcohol use disorder, and 36 million have a drug use disorder [2]. Yet, despite its prevalence, the utilization of mental health (MH) and substance use (SU) services remains low. Worldwide, only a third of those with depression receive care and in low-income countries, this goes down to 3% [2]. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s 2020 National Drug Survey reports that only half of adults aged 18 years and above received either MH or SU treatment and only 6% received services [3]. Several factors impede help-seeking behavior such as poor MH literacy, stigma, and discrimination. The 2020 National Drug Survey revealed that 15% of people aged 12 years and above needed treatment but 98% did not believe they needed treatment [3]. Another barrier to help-seeking is perceived or internalized stigma [4]. In Asian cultures such as the Philippines, shame is a barrier because mental illness is viewed as a family illness [5]. Stigma, as well the fear of losing face or social position may prevent people from seeking help [6].

Another key barrier to delivery of MH services is the lack of access to resources. Countries dedicate less than 2% of their healthcare budget to MH and most resources go to inpatient facilities [1]. There is also a severe shortage of MH professionals globally with an average of one psychiatrist serving 200,000 patients [7]. As such, there is a need to take a public MH response specifically providing regular screening, prevention, and early treatment interventions as well as referral at the level of primary care and in schools and workplaces.

There is some evidence that MH care services provided in school-settings lead to greater utilization of services. A study on school-based health center (SBHC) utilization showed an increase in service usage during the COVID-19 pandemic suggesting that access to MH services particularly benefit disadvantaged communities [8].

Workplaces are another potent area for the promotion and protection of MH. The WHO guidelines emphasize the importance of organizational interventions, training for managers on MH, and interventions for workers [1]. A study on workplace health promotion and utilization of services reports that utilization of healthcare services and costs was higher for those receiving SU prevention interventions. However, employees who went through SU interventions experienced a decrease in heavy and binge drinking. The researchers suggested that prevention programs may increase health care utilization and cost in the short-term, but improved health behaviors lead to lower health care utilizations and costs in the long run [9].

MH and SU Services in the Philippines

In the Philippines, an estimated 3.6 million Filipinos suffer from a mental, neurological, or substance use disorder [1]. Major depressive disorders are the most prevalent (1.1%), followed by alcohol use disorders (0.9%), SU disorders (0.7%), and bipolar disorder (0.5%) [1].

From a policy level – there is support for the delivery of both MH and SU services. The Mental Health Act of 2018 mandates employers to "develop appropriate policies and programs on mental health issues, correct the stigma and discrimination associated with mental conditions, identify and provide support for individuals with MH conditions to treatment and psychosocial support." To fulfill this, the Department of Labor and Employment (DOLE) issued Department Order 2008-20 or the "Implementation of Mental Health Workplace Policies and Programs for the Private Sector," and the Civil Service Commission's guidance to the public sector was likewise issued

through CSC Resolution No. 1901265. It also emphasizes the integration of MH into the curriculum, providing services or referral to services for students identified as at risk, and ensuring a complement of MH professionals. On the other hand, the Republic Act 9165 or The Comprehensive Dangerous Drugs Act of 2002 mandates schools and workplaces to implement policies and programs for SU. In 2022, the Department of Health (DOH) and Department of Education (DepEd) launched the Health Learning Institutions initiative to highlight the importance of a whole-of-government and whole-of-society approach to promote healthy and health-seeking behaviors among learners across the life stage, which include substance use and mental health in the priority behavioral risk factors to be promoted in school-settings. In 2023, the DOH launched the Philippine Council for Mental Health's Strategic Framework and a key direction is the integration of mental, neurological and substance use (MNS) services in primary care. However, data suggests a lack of mental health professionals in the Philippines with only 0.52 psychiatrists [10] and 0.07 psychologists per 100,000 inhabitants, and 0.49 mental health nurses per 100 000 of the population [11].

Most research on MH comes from high-income countries and there is a dearth of data from low-income countries and on health services [2]. This study sought to address the lack of information by examining the level of stigma and discrimination, current practices, and barriers in the provision of services in Philippine schools and workplaces. Specifically, we ask:

1. What MH and SU services and programs are being delivered in schools and workplaces? Is there a difference between schools and workplaces in terms of MH and SU services?
2. What is the level of institutional support for MH and SU in schools and workplaces? Is there a difference between schools and workplaces in terms of institutional support for MH and SU?
3. What are the barriers to delivery of MH and SU in schools and workplaces?
4. What is the level of stigma and discrimination for MH and SU in schools and workplaces? Is there a difference between schools and workplaces in terms of level of stigma and discrimination for i MH and SU?

Methodology

This quantitative study utilized a cross-sectional survey design to evaluate the level of perceived stigma on PWUDs and the availability, perceived quality, and barriers to the delivery of MH and SU services.

Sample

Data was gathered through an online survey in October 2022 using convenience sampling. Invitations to participate in the study were sent through social media sites of government, educational institutions, and employer associations. Following the inclusion criteria, the respondents were either 1) school or workplaces employees in leadership roles; or 2) employees providing mental health and substance use services in schools and workplaces. The survey generated a total of 332 respondents. However, in instances where more than one person from an organization responded, the response of the person with the higher rank was retained. When there were multiple respondents of the same rank, only the first submission was included. The final sample analyzed was 300 respondents and organizations, 145 (48%) of which were respondents from schools and 155 (52%) were workplaces. Respondents came from all 17 regions in the Philippines with the majority coming from NCR (43%), Region 4A (8%), Region 3 (7%), Region 7 (5%), Region 1 (5%), Region 6 (4%) and Region 7 (4%). About three-fourths (74%) of respondents were female. A slight majority (n=167, 58%) were from private companies and 123 (41%) were from public institutions. Participants from educational institutions were principals, guidance counselors, human resource management staff, or faculty in charge of guidance. Respondents from workplaces were managers, HR practitioners, psychometricians, and nurses.

Measures

MH and SU services. The study adapted and modified the 12-item MH Organization Index developed by [12] Kessler, et al. (2014). Respondents were asked to indicate if they had prevention, screening, referral, and treatment for MH and SU using a 3-point scale. Responses of "yes, works well" received 2 points, a response of "yes, needs improvement" received 1 point, and a "no" response received 0 points. The reliability of the scale was α = .94.

Institutional Support. The survey measured the presence of institutional support in the form of policy, budget, and leadership support. Items used a 3-point scale with a response of "yes, works well" coded as 2, a response of "yes, needs improvement" coded as 1, and "none" as 0. For questions with only two options, "yes" responses received 2 points and "no," 0 points. The reliability of the scale was α = .82.

Barriers. A list of six barriers to the provision of mental health and substance use services were provided: personnel, budget, lack of knowledge, space, management support, and stigma and discrimination. Respondents were asked to rank them with 1 as the greatest barrier to 6.

Perceived stigma. This study used a modified version of Luoma and colleagues' (2010) perceived stigma of addiction scale (PSAS) that assesses the perceived stigma of both SU and MH conditions [15]. There were five items each for MH and SU using a 7-point Likert scale ranging from strongly disagree (1) to strongly agree (7). Some items were reverse scored with a higher score indicating greater stigma. The reliability of the scale was α = .77.

Procedure

The study received Ethics Approval from the Ateneo de Manila Institutional Review Board (AdMUREC_22_033CA). Before conducting the survey, the researchers sent out a letter of invitation to interested organizations. A poster was disseminated online to invite participants to answer the online survey in Google Form. The poster contains a link directing them to the survey and instructions for completing the survey. An informed consent form was included in the survey and collected from respondents.

Results

MH and SU Service Provision

Prevention. About three-fourths of the schools have a prevention program focusing on stress and two-thirds report providing prevention programs for depression and anxiety. About a fourth of workplaces have prevention programs for stress but only half report having prevention programs for depression and anxiety. In general, a greater proportion of schools are implementing prevention programs compared to workplaces. The most common prevention programs were talks on self-care. Results of Chi square test revealed differences in schools vs. workplaces on prevention of depression, anxiety, stress, substance use and smoking (see Table 1).

Screening. Similarly, screening for mental health and substance use is more prevalent in schools than workplaces. About 61% of schools have screening for stress compared to 41% in workplaces. Mental health screening was more common compared to screening for substance use in schools. A greater proportion of schools are conducting mental health screening compared to substance use screening. Schools that conduct screening report using tools such as: HEADSS (Home, Education/employment, Activities, Drugs, Sexuality, and Suicide), PHQ-9 (Patient Health Questionnaire), DASS-21 (Depression, Anxiety and Stress Scale), GAD-7 (General Anxiety Disorder), and Mini-MSE (mini-mental state examination).

However, the pattern in screening is reversed in workplaces. More workplaces are screening for substance use compared to mental health. The most common tools used were ASSIST (Alcohol, Smoking and Substance Involvement Screening Test), SRQ-25 (Self-Reporting Questionnaire), and PHQ-9.

Referral. More schools (63%) have referral protocols on MH compared to workplaces (40%). However, the majority of both schools and workplaces have no referral protocols for substance use.

Treatment. For both schools and workplaces, the most prevalent interventions are for stress. However more schools (64%) provide stress interventions compared to workplaces (50%). Majority of schools and workplaces have no treatment for SU. However, there appears to be more treatment on substances in workplaces. There were only two schools that reported that their programs are working well. In comparison, nine percent of workplaces (specifically those from local government units) report their SU treatment programs are working well.

Table 1. Services Provided by Schools and Workplaces

	Schools Freq (%)			Workplace Freq (%)			
	None	Yes, Needs Improvement	Yes, Works Well	None	Yes, Needs Improvement	Yes, Works Well	$X2$
PREVENTION							
Depression	34 (22%)	93 (60%)	27 (18%)	75 (503%)	53 (37%)	14 (10%)	30.66**
Anxiety	32 (21%)	93 (60%)	29 (19%)	75 (53%)	52 (36%)	15 (11%)	32.89**
Stress	24 (15%)	99 (64%)	30 (20%)	58 (41%)	57 (47%)	27 (12%)	22.43**
Substance use	73 (47%)	71 (46%)	10 (7%)	77 (54%)	48 (34%)	17 (12%)	5.89*
Alcohol	73 (47%)	71 (46%)	10 (7%)	82 (58%)	47 (33%)	13 (9%)	5.31
Smoking	77 (50%)	71 (46%)	6 (4%)	83 (58%)	46 (32%)	13 (9%)	7.67*
SCREENING							
Depression	68 (44%)	72 (47%)	14 (9%)	97 (68%)	36 (25%)	9 (6%)	17.73**
Anxiety	66 (43%)	71 (46%)	17 (11%)	96 (68%)	37 (26%)	9 (6%)	18.26**
Stress	61 (39%)	673 (48%)	20 (13%)	84 (59%)	46 (32%)	12 (9%)	11.31**
Substance use	93 (60%)	52 (34%)	9 (6%)	83 (59%)	37 (26%)	222 (15%)	8.08**
Alcohol	97 (63%)	50 (33%)	7 (4%)	99 (70%)	32 (22%)	11 (8%)	4.38
Smoking	96 (62%)	51 (33%)	7 (5%)	98 (69%)	34 (24%)	10 (7%)	3.46
REFERRAL							
Mental Health	57 (37%)	77 (50%)	20 (13%)	85 (60%)	39 (27%)	18 (13%)	17.62**
Substance use	87 (57%)	59 (38%)	8 (5%)	89 (63%)	37 (26%)	16 (11%)	7.26*
TREATMENT							
Depression	65 (42%)	81 (53%)	8 (5%)	81 (57%)	49 (35%)	12 (8%)	9.96**
Anxiety	64 (42%)	80 (52%)	10 (6%)	80 (56%)	39 (35%)	13 (9%)	9.15**
Stress	55 (36%)	83 (54%)	16 (10%)	71 (50%)	60 (42%)	11 (8%)	6.18*
Substance use	92 (60%)	60 (39%)	2 (1.3%)	88 (62%)	42 (30%)	142 (8%)	9.94**
Alcohol	93 (60%)	59 (38%)	2 (1.3%)	89 (63%)	43 (30%)	10 (7%)	7.45*
Smoking	92 (60%)	60 (39%)	2 (1.3%)	88 (62%)	45 (32%)	9 (6%)	6.21*

Note: ** $p<.01$, * $p.05$

Table 2. Institutional Support for MH and SU

	Schools Freq (%)			Workplace Freq (%)			
	None	Yes, Needs Improvement	Yes, Works Well or Is Sufficient	None	Yes, Needs Improvement	Yes, Works Well or Is Sufficient	
POLICIES							
MH	34 (22%)	94 (61%)	26 (17%)	57 (40%)	63 (44%)	22 (16%)	11.80**
SU	63 (41%)	76 (49%)	14 (10%)	52 (37%)	60 (42%)	30 (21%)	7.46*
BUDGET							
MH	31 (20%)	96 (62%)	27 (18%)	50 (35%)	71 (50%)	21 (15%)	8.48*
SU	87 (56%)	58 (38%)	9 (6%)	67 (47%)	58 (41%)	17 (12%)	4.58
LEADERSHIP SUPPORT							
MH	20 (13%)	109 (71%)	25 (16%)	23 (16%)	96 (68%)	23 (16%)	.63
SU	60 (39%)	83 (54%)	11 (7%)	37 (26%)	88 (62%)	17 (12%)	6.41*

Note: ** $p<.01$, * $p.05$

Institutional Support

Both workplaces and schools report high leadership support for MH. Despite this, there are still 22% of schools and 40% of workplaces that do not have a policy in place for MH. Conversely, workplaces report greater leadership support and policy on SU compared to schools. Schools and workplaces have more budget for mental health compared to substance use. However, more schools (39%) than workplaces (26%) reported no support for SU.

Barriers to Service Provision

School personnel ranked the lack of personnel as the top barrier to service delivery of MH and SU programs. This is followed by the lack of budget and knowledge about effective services. Workplaces, on the other hand, cited the lack of knowledge about effective services as their top barrier to service delivery of MH and SU programs. This is followed by the lack of personnel and budget (Table 3).

Table 3. Barriers to Service Delivery

	School	Workplace
	Rank	Rank
Lack of personnel	1	2
Lack of budget	2	3
Lack of knowledge about effective services	3	1
Lack of management support	4	4
Stigma and discrimination	5	5
Lack of space	6	6

Note: 1 is most important and 6 is least important

Table 4. Stigma and Discrimination Descriptive Statistics

	MH	SU
Total scores	Mean (SD)	Mean (SD)
MENTAL HEALTH	3.60 (1.16)	3.90 (1.07)
1. Most people in our school/workplace would willingly accept someone who has been treated for _____ disorder ®	3.57 (1.89)	4.09 (1.78)
2. Most people in our school/workplace believe that someone who has been treated for _____ disorder is just as trustworthy as the average person ®	3.66 (1.79)	4.05 (1.68)
3. Most people in our school/workplace think less of a person who has been in treatment for _____ disorder.	3.61 (1.76)	3.67 (1.64)
4. Most people in our school/workplace will be willing to hire someone who has been treated for _____ disorder as long as he or she is qualified ®	3.69 (1.81)	4.07 (1.74)
5. Most people in our school/workplace schools will pass over the application of a person who has been treated for _____ disorder in favor of another applicant.	3.67 (1.78)	3.68 (1.76)

Note: Higher scores indicate greater stigma and discrimination; ® Item was reverse coded

Perceived Stigma and Discrimination

Results reveal that respondents perceived a moderate level of stigma and discrimination in their settings. There was no significant difference between schools (M = 3.54, SD = 1.21) or workplace (M = 3.65, SD = 1.10) on their stigma and discrimination scores for mental health (t(294) = .877, p=.19) nor was there a significant difference between schools (M = 3.93, SD = 1.12) or workplace (M = 3.88, SD = 1.04) on their stigma and discrimination scores for mental health (t(294) = .443, p=.33). However, a paired sample t-test showed a significant difference between MH stigma scores and SU stigma scores (t(261) = -5.61, p < .001, d = -0.32) of respondents. Stigma and discrimination scores for SU (M = 3.91, SD = 1.09) was significantly higher compared to stigma and discrimination for those with MH concerns (M = 3.60, SD = 1.17). Persons who use substances are less likely to be accepted, less viewed as trustworthy, and less likely to be considered for employment compared to those with mental health concerns.

Discussion

This study surveyed personnel in schools and workplaces in the Philippines to examine the provision of MH and SU services and programs. Most schools have some form of prevention program for MH however, only half of schools reported offering prevention services for SU. In contrast, most workplaces do not have services or programs for MH and SU. Challenges in the delivery of MHSU services in both settings include lack of personnel, limited budget, and a lack of knowledge on appropriate services and programs to implement. These findings validate a report by the World Health Organization (WHO) that reports a significant service gap due to the lack of trained MH personnel in regions outside of the country's National Capital Region. The report also cited the difficulties in accessing MH services, the lack of health financing, and high out-of-pocket costs to avail of MH and SU services [1].

Historically, the implementation of programs on SU and MH have been led by the health sector and local government units. The direction of the DOH towards standardizing service packages for settings is an acknowledgment that individuals spend a significant amount of their time at work or in school, and services that can support them need to be in place in these settings [16].

However, the gap in services in schools and workplaces highlights the need to cascade existing guidelines, tools, and services, and develop financing packages specifically tailored for these settings. There also appears to be a need to provide guidance on what services and approaches can be used considering the varying resources in these settings.

Survey respondents also cited the lack of knowledge or trained personnel to deliver MH and SU services. This will require allocating human resources and strengthening capacity building to equip service providers with the appropriate knowledge and skills to deliver MH and SU services within these settings. These findings are not necessarily unique to the Philippines as the WHO reports similar barriers to access to health services globally [2]. The results validate the call of WHO for the need to strengthen MH promotion and prevention including school-based programs, developing peer support, health literacy, anti-bullying programs, embedding socio-emotional life skills in the curriculum, and providing resilience programs, especially for vulnerable groups [2].

A barrier cited was the lack of knowledge on what MH and SU services and programs can be provided. This can be addressed by disseminating information on and developing the capacity to deliver culturally-nuanced and evidence-based interventions. For example, the DOH and the USAID RenewHealth project created an integrated mental health and substance use program called Lusog-Isip Kabataan Education or LIKE. LIKE is a video-based program that consists of six modules that focus on stress, coping with stress, the effects of substances, refusal skills and well-being. It was pilot-tested as a school-based program facilitated by teachers of the Edukasyon sa Pagpapakatao course in junior high school. Using a cluster randomized trial (CRT) design, the program was implemented among 623 junior high school students. Grade 7 and 9 students served as treatment groups and Group 8 and 10 as control groups. Findings showed that controlling for age, those in the treatment group reported significant increases in knowledge and attitudes towards substances compared to the control group. Treatment group participants also reported improved use of adaptive coping skills particularly cognitive reappraisal, social support, problem-solving, and relaxation compared to the control group. LIKE was also tested as a peer-facilitated program with Psychology students implementing the program for public high school students. Results showed improvements in participants' knowledge, attitudes, refusal self-efficacy, and adaptive coping behaviors before and after the program [14].

Certain results showed that two-thirds of schools and a third of workplaces have no programs for SU, and 4 in 10 schools and workplaces do not have a program for mental health. A study on Filipino community-based drug rehabilitation clients revealed that 49% of clients are low risk and 36% are moderate risk suggesting that a large majority (85%) of clients can be treated in settings. The study reported that drug dependence is directly predicted by cigarette and alcohol use, recovery skills, and mental health problems and indirectly predicted by family support, life skills, and psychological well-being. Results imply the need for integrated mental health and substance use programs that develop recovery and life skills. The study also revealed differences in predictors by risk level with low-risk clients reporting less use of cigarettes and alcohol and greater recovery and life skills. This implies the need for differentiation in terms of length and content of programs [17].

A program that may be used especially for adults in colleges or workplaces is the General Intervention for Health and Wellbeing Awareness (GINHAWA) program. The program was created by DOH and USAID RenewHealth for low-risk adults and consists of three modules related to mental health and substance use. The first module focuses on stress and well-being and includes the effects of stress on well-being, ways to cope with stress, and living a healthier lifestyle. The second module focuses on substance use specifically, the effects of smoking, alcohol and drugs, signs of addiction, and identifying and managing triggers. The third module is a family module and clarifies myths about substance use, describes the influence of family on substance use, and develops family communication and social support. The program was tested in two phases. In the first phase, a randomized control trial revealed significant differences in recovery skills and quality of life of the treatment group compared to the control group. A larger field study found significant improvements in recovery skills, life skills, quality of life, perceived family support, well-being, and intent to use drugs [18].

Aside from treatment interventions for low and moderate risk users, the results also suggest a gap in referral mechanisms, especially for SU. This gap

may be addressed by mapping available services, resources, and facilities within the jurisdiction of schools and workplaces to help determine possible patient pathways and eventually establish a referral mechanism. One source of information is the *Lusog Isip* mobile app and website which contains a directory of providers created by MentalhealthPH.

A common and important barrier cited by both schools and workplaces is the lack of resources. This is not unique to the Philippines as the WHO [2] reports that two-thirds of low-income countries do not include MH in national health insurance schemes. It also reports that, in the Philippines, MH resources are focused on psychiatric care rather than public MH initiatives. A key advocacy of WHO is to integrate MH in primary care and scale up delivery in settings [2]. To help reduce out-of-pocket expenses and make MH services more accessible, the DOH and PhilHealth launched an outpatient benefit package for MH which includes a primary care package and an outpatient specialist care package [26]. These packages can be provided the resources to deliver mental health services. In addition, self-help materials or courses are available in the *Lusog-Isip* mobile app and *Lusog-Isip* Online website. A randomized control trial revealed that mobile app users reported improved psychological well-being and use of cognitive reappraisal and emotional release coping [19]. Digital platforms such as the *Lusog-Isip* mobile app may be used by schools and workplaces for prevention or as a complement to existing MH and SU programs in schools and workplaces.

Finally, the study reveals that four of 10 schools do not have leadership support nor policies related to SU. Researchers suggest the importance of engaging the entire school community including teaching and non-teaching staff, faculty, parents, and peers [20]. However, this requires commitment from leadership to prioritize the well-being of staff and students, establish a positive school culture, develop policies to support wellbeing, build partnerships for health, and invest in staff development. As such, advocacy for leaders and capacity building is required to enable schools and workplaces to create mentally healthy environments.

The results suggest that a possible barrier to help-seeking and the provision of services is the presence of stigma and discrimination towards persons with MH and SU conditions. The findings validate global literature that those with SU disorders experience higher levels of stigma than those with MH conditions [21]. A local study also suggests that stigma is a barrier towards help-seeking as well as the provision of care [22]. The relatively high stigma towards drug users may be attributed to the fact that drug use is a crime. The Philippine government's 'war on drugs' from 2016 to 2022 led to more than a million implicated for their drug use as well as thousands of victims of drug-related killings [23]. The positioning of drug users as criminals may have influenced the public perception of PWUDs as deserving of punitive treatment [24]. A study during this period highlighted how PWUDs experienced stigma from several interpersonal relations leading to hesitation in accessing treatment and impeding them from seeking further help [25]. Our findings highlight the need for advocacy and social behavior change communication materials for promotion and advocacy programs tailored for schools and workplaces to address stigma and discrimination. The Philippine government's proposed Anti-Drug Strategy now emphasizes the importance of Health, Social, and Developmental Services as a key pillar in the country's response to illegal drugs. Included in this policy direction is an emphasis on a comprehensive approach spanning various settings including schools and workplaces; informed and voluntary participation in treatment; respect for human rights and dignity, including confidentiality; and a proactive approach to stigma prevention [27].

A caveat in this study is that organization size and industry were not captured in the survey. Future studies may want to examine the extent to which organization size and industry affect the delivery of MH and SU programs in workplaces. In addition, the purpose of the study was to examine similarities and differences between schools and workplaces in terms of MH and SU programs and services. However, it may also be important to explore differences between public and private institutions given differences in their mandates, resources, and overall capacity. Finally, the study provides a snapshot of the MH and SU-related attitudes, programs, and barriers. Future research may consider measuring the effectiveness of these programs and services, as well as identifying best practices vis-a-vis resource capability of schools and workplaces. This can potentially provide models of MH and SU programs in the Philippines that schools and workplaces can adopt. Given that the delivery of MH and SU appears to be in its infancy in the Philippines, there is a need for increased resources, capacity building, and scalable interventions to reach under-served and vulnerable populations in the Philippines.

Acknowledgement and Disclaimer

References

1. World Health Organization. (2021) WHO Special Initiative for MH: Philippine Situational Assessment. World Health Organization: Metro Manila, Philippines. Retrieved from: https://www.who.int/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---philippines---2020.pdf?sfvrsn=4b4ec2ee_8
2. World Health Organization. (2022) World MH Report. https://www.who.int/teams/mental-health-and-substance-use/world-mental-health-report
3. Substance Abuse and MH Services Administration. (2020) Key SU and MH Indicators in the United States: Results from the 2020 National Survey on Drug. Use and Health. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf
4. Lally J, Tully J, Samaneigo R. (2019) MH Service in the Philippines. BJPsychInternational 16(3): 62-64.
5. Rivera AK, Antonio CA. (2017) MH stigma among Filipinos: Time for a paradigm shift. Philippine Journal of Health Research and Development 21(2): 20-24.
6. Hechanova MR, Waelde LC, Torres A. (2020) Cultural Implications for the Provision of Disaster MH and Psychosocial Support in Southeast Asia, Resistance, Resilience & Recovery from Disasters: Perspectives from Southeast Asia 21: 3-13.
7. World Health Organization (WHO) and Department of Health/ (2006) WHO-AIMS Report on MH System in The Philippines. World Health Organization. Retrieved from: https://cdn.who.int/media/docs/default-source/mental-health/who-aims-country-reports/philippines_who_aims_report.pdf?sfvrsn=479112f_3&download=true
8. Damian AJ, Oo M. (2022) Examining School Based Health Service Utilization Among Marginalized Youth in Connecticut During COVID. INQUIRY: The Journal of Health Care Organization, Provision, and Financing 59. doi:10.1177/00469580221105998
9. Dietz D, Cook R, Hersch R. (2005) Workplace Health Promotion and Utilization of Health Services. The Journal of Behavioral Health Services and Research 32(3): 306-319.
10. Isaac M, Ahmed HU, Chaturvedi SK, *et al.* (2018) Postgraduate training in psychiatry in Asia. Current Opinion in Psychiatry, 31, 396–402.
11. World Health Organization (WHO). (2014) Global Health Observatory Data Repository: Human Resources Data by country. World Health Organization.
12. Kessler R, Miller BF, Kelly M, *et al.* (2014) Mental health, substance abuse, and health behavior services in patient-centered medical homes. The Journal of the American Board of Family Medicine, 27(5):637–644. https://doi.org/10.3122/jabfm.2014.05.140021
13. Luoma JB, O'Hair AK, Kohlenberg BS, Hayes SC, Fletcher L. (2010) The development and psychometric properties of a new measure of perceived stigma toward substance users. Substance use & misuse, 45(1-2):47-57.
14. Department of Health. (2022) Omnibus Health Guidelines for Managers of Various Settings. Retrieved from:

https://doh.gov.ph/sites/default/files/basic-page/OMNIBUS-HEALTH-GUIDELINES-FOR-ADULTS-2022.pdf

15. Hechanova MR, Co TC, Guevara AM, Soliman JA, Tuliao A, Botor NJ, Felipe MV (in press). Evaluation of an integrated mental health and substance use video-based prevention program for Filipino youth. Drugs, Habits and Social Policy.

16. Tamayo MC, Filart K & Hechanova MR (n.d.) Feasibility of a peer-facilitated video-based mental health and substance use service learning program. Unpublished manuscript. Ateneo de Manila University.

17. Hechanova MR, Manaois J, Co T, Escartin I. (2023) Biopsychosocial predictors of drug dependence among Filipino drug uses in community-based drug rehabilitation", Journal of Ethnicity in Substance Abuse, DOI: 10.1080/15332640.2023.2217417 (2023)

18. Baloloy JRR, Hechanova MR, Co TAC, Angeles PLB. (2023) Pilot of an early intervention programme for low-risk persons who use drugs in the Philippines. Health Education Journal, 82(8: 892-906. https://doi.org/10.1177/00178969231203973

19. Hechanova-Alampay MR, Angeles PL, Tuliao A, Hilario E, Pagente AF, Narra CV. (2022) "The development and pilot evaluation of a mental health mobile app in the Philippines", Mental Health and Social Inclusion, Vol. ahead-of-print No. ahead-of-print. https://doi.org/10.1108/MHSI-04-2022-0024

20. Glazzard J. (2019) A whole-school approach to supporting children and young people's MH. Journal of Public Mental Health 18 (4);256-265. https://doi.org/10.1108/JPMH-10-2018-0074.

21. Gutierrez D, Crowe A, Mullen, PR, Pignato L, Fan S. (2020) Stigma, Help Seeking, and SU. Professional Counselor 10(2): 220-234.

22. Del Castillo R. (2015) A Qualitative Evaluation of Mental Healthcare Service Delivery in the Western Visayas, Philippines. Philippine Journal of Health Research and Development, 19(3):10-19.

23. Pangilinan MKA, Fernandez MC, Quijano N, Dizon Jr W. (2021) Examining the Effects of Drug-Related Killings on Philippine Conditional Cash Transfer Beneficiaries in Metro Manila 2016–2017. Journal of Illicit Economies and Development 2(2):110-126.

24. Lasco G, Yarcia LE. (2022) The politics of drug rehabilitation in the Philippines. Health and Human Rights, 24(1), 147.

25. Cunanan ALP, Yabut HJ. (2019) Lived Experiences of Stigma Among Filipino Former Drug Dependents: An Interpretative Phenomenological Analysis. Philippine Journal of Psychology 52(1): 127-154.

26. Philhealth Circular. (2023) Outpatient Benefits Package for Mental Health https://www.philhealth.gov.ph/circulars/2023/PC2023-0018.pdf

27. Saavedra EP. (2024) Philippine Anti-Drug Strategy Presentation. [PowerPoint Slides] Dangerous Drugs Board. https://www.facebook.com/uplawofficial/videos/795137885832774