A SURVEY ON THE ATTITUDES OF LEGISLATIVE OFFICIALS IN RIZAL PROVINCE TOWARDS MENTAL ILLNESS

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ABSTRACT

OBJECTIVE: This research aimed to gain information on the attitudes of legislators to mental illness in relation to demographic and political factors that impact mental health policy implementation. **METHODOLOGY:** This was a cross-sectional study conducted using a semi-structured three-part questionnaire to collect data on demographic and political variables. Attitudes toward mental illness i.e. perceived need for services, legislation, local capability with their plans concerning mental health was measured using Attitudes to Mental Illness Questionnaire (AMIQ). Purposive sampling included all elected legislators and self-completion questionnaires were distributed personally to provincial, city and municipal LGUs of Rizal province, the area of study chosen for its demographic diversity, apart from it belonging to the Southern Tagalog Region, which has the highest prevalence rate of mental illness in the Philippines[1,2]. Data analyses used descriptive statistics, Multiple Logistic Regression and Spearman Correlation studies. **RESULTS:** Response rate was 54%; most of the respondents were males, aged 51 to 60, college graduates, >30 years residence, >9 years government service, 1st term legislator and political Conservatives. Mean scores on AMIQ were generally negative; more negative scores toward the Heroin addict (-3.49) and diagnosed Schizophrenic (-2.86). multiple logistic regression revealed grouped variables on 'age', 'years of residence' and 'term in office' as influencing factors. Significant correlations were noted between attitudes and perceived need for services, legislation, local capability and future plans concerning mental health at the level of significance, $p<0.05$). **CONCLUSION:** In this study, legislators had negative attitudes towards mental illness, with age, years of residence and term in office appearing as influencing factors. Correlations between variables showed that more negative attitude scores led to better scores in perceived needs and plans for mental health service delivery.

KEYWORDS: *Attitudes, Mental Illness, Legislative officials, Rizal Province*

INTRODUCTION

Mental health is essential to successfully deal with poverty, fundamental to social equality and economic progress[2], yet, we fall short when it comes to legislation and provisions for mental health services.

In the absence of a comprehensive mental health legislation in the Philippines, the delivery of mental health services has been indirectly provided through laws such as the: Penal Code, Magna Carta for Disabled Person (R.A.7277), Family Code and Dangerous Drug Act[3]. Legislation for equal work opportunities, social benefits and against discrimination has provided for differently-abled persons through R.A.7277[4]. Mentally ill patients could access some of its provisions only if or when classified as a person with disability (PWD), which is still far from covering the scope of mental health.

For years, mental health advocates have lobbied for a comprehensive legislation. Several mental health bills from 2009 to 2016 were filed but never decreed. Most recently, Senate Bill No. 1354 was passed that stipulated Local Government Units (LGUs) to develop regulations and guidelines necessary for the implementation of mental health care and wellness policies within their jurisdiction[5]. Hence, it is expected that LGUs should respond in terms of legislation and services.

How responsive will they be? Legislative officials of LGUs decide on local policies and implementation. Therefore, they have the power to decide on the course of local mental health action.

Researches by several authors have mentioned the central role of legislators in providing social services through their decisions in allocating public resources[6,7]. Decisions on resource outlay for mental health services would be influenced by their attitudes towards the mentally ill[8].

An individual's attitude towards those with mental illness determines their 'choice' on given response options and in deciding on a particular course of action[9]. However, a negative attitude towards that option may lead to a biased reaction[10]. Stigma could result from these negative attitudes causing fear, avoidance, rejection and discrimination against people with mental illnesses[11].

Social marketing approaches have presented ways on how to defeat stigma by creating understanding through targeting respondents' attitudes and reactions[12,13,14]. Systematically reducing negative attitudes would require an instrument to measure stigma[15].

Most insights assessing decisions in health policies measured values, personality, cognitive style, group dynamics, affiliations and individual demographics[16,17]. A study in

the United States and other countries identified variables affecting voting behavior in legislation as: represented district of the legislator, type of constituency, personal characteristics (age, gender, socioeconomic background) or political party affiliations[18, 19, 20, 21].

In 2014, a Croatian study revealed that demographic factors like age, gender and educational attainment matter in decision making while job tenure did not show any significant influence[22]. Although in another research study these relationships were said to often be unpredictable, interconnected and mediated by other factors[23]. A meta-analysis revealed mixed empirical evidence for gender differences in decision styles[24].

The area of implementation also influenced decision making in the health system[18]. In most program deliberations, rural areas were evaluated differently compared to urban areas, considering population profile, skills requirements and workforce capabilities[24]. The devolution of authority and responsibility from the national government gave LGUs direct charge on sectors that impacted health such as social services, environment, housing and public health[25,26,27].

The Province of Rizal is considered a high-level LGU[27,28,] with 1 provincial, 1 city and 13 municipal level legislative bodies. The demographic diversity i.e. rural, suburban, urban[29,30], apart from the mixed populace and broad geography of the province resonated various factors (from literature) influencing legislation[26,27,30]. Remarkably, Rizal is in the Southern Tagalog Region, which has the highest prevalence rate of mental illness at 132.9 cases/100,000 population[2,29].

This study aimed to gain information on the legislators' attitudes towards mental illness, its relation to demographic and political factors and their perception on the state of mental health care in their locality. Specifically with the following objectives:

1. Assess the attitudes of the legislative officials in Rizal Province towards mental illness and mental health services through a questionnaire survey.
   - 1.1 Determine the attitudes of legislators toward mental illness in relation to the demographic factors of respondents: age, sex, civil status, educational attainment and years of residence in their locality,
   - 1.2 Describe the attitudes of legislators toward mental illness in relation to the political profile of respondents: LGU or Locality served, term in office, number of years in government service and political party affiliation
2. Establish possible significant difference in the respondents' attitudes when grouped according to the demographic factors and political profiles.
3. Gauge the level of legislators' perceived need for mental health services and local legislation to provide mental health services in their area
4. Assess the respondents' opinions on the readiness of their LGU to provide mental health services based on their local capability scoring.
5. Measure the participants' degree of prioritization through their graded plans and likelihood to provide specific mental health programs in their locality.
6. Measure the correlation between the attitudes of legislators with their scores on the perceived needs, capabilities and plans in terms of mental health legislation and services in their locality.

METHODOLOGY

Study Design

The research was a cross-sectional study conducted through survey using self-completion questionnaires. This type of study design was used since the authors intended to describe the prevailing 'attitude' of a particular population, that of Legislative officials of Rizal province at a given point in time.

Participants

The study covered all 161 members of the legislative bodies of Rizal Province that included the ff:

a. *Sangguniang Panlalawigan* ng Rizal (13 respondents); presided by the Vice-Governor, composed elected officials known as '*Bokalng Lalawigan*' or Provinicial Board, included 2 sectoral representatives (from the Provincial League of Municipal/ City Councilors and Provincial League of Barangay Captains)
b. *Sangguniang Bayan* of each of the 13 municipalities of Rizal (130 respondents); presided by the Vice-Mayor of each municipality, composed of 8 elected officials known as '*Konsehal ng Bayan*' or municipal councillors; included a representative from L*iga Ng mga Barangay*' (LNB) from each municipality.
c. *Sangguniang Panlungsod* of the component city (18 respondents); presided by the Vice –Mayor of the city, composed of elected officials also known as '*Konsehal*' or city councillors from the two districts; included a representative from the city LNB

Sampling Technique

The study used a type of Purposive Sampling technique known as total population sampling[31,32,] where the whole population of interest was studied that included all legislative officials of Rizal province. This technique was selected to emphasize on the legislative officials of the province and the interests of the research. The sample frame included all the 161 elected legislators from the municipal, city and provincial legislative bodies of Rizal.

Research Instrument

The questionnaire used was a semi-structured, self-

completion type, uniformly written in English since the respondents were elected legislative officials under the DILG and proficient in English since it was the language used for office communications. It consisted of three parts: (Appendix 1)

a. Part I - collected basic information, the demographic factors i.e. age, sex, civil status, educational attainment, years in residence and political profile i.e. LGU served, term in office, political affiliation, length/years in government service. Based on related literature, these items of demographic and political profiles were the influential factors in making legislative decisions[26,28,30].

b. Part II - consisted of the Attitudes to Mental Illness Questionnaire (AMIQ) developed by Cunningham, Sobell & Chow (1993)[16] and considered to have good psychometric properties, satisfactory structural validity, good stability and test-retest reliability[17]. The AMIQ used in this study comprised of 7 case vignettes, describing a person with Diabetes, a convicted Criminal, a religious Christian, a diagnosed Schizophrenic, case of Depression, an Alcoholic undergoing treatment and a Heroin addict followed by questions with 5 Likert type responses i.e. -2 strongly disagree, -1 disagree, 0 neutral, +1 agree, +2 strongly agree[31,33].

For this research, permission was secured (through email correspondence) to use similar case vignettes adapted from the questionnaire validated by the group of Drs. Luty, Fakuda and Umho in 2006[17]. All 7 case vignettes were from the said study by Luty et al including the 3 case vignettes purposely chosen to elicit strongly negative or strongly positive responses (items II.A, II.D & II.E). These cases related Mental Health with Chronic Illness (Diabetes), with Crime (Convicted Criminal) and with a completely contrasting character (religious Christian).

In this study however, the last statement of case vignette II.F, "He has been detained under the Mental Health Act 1983 in the past"was replaced by "He has been detained in the past", to fit the local research setting. The questions were printed in a different format from their questionnaire i.e. using tables for the scales; and the case vignettes created by Luty et al[17] were adapted to validate the AMIQ, which was developed by Cunnigham et al[16].

After reading the vignettes, participants responded to questions on a 5-point Likert scale. The range of scores from each vignette was between -10 to +10. A score of 0 or anything < 1.00 or more than > -1.00, meant 'neutral'[33].

c. Part III - consisted of questions developed to assess the respondents perceived state of mental health care in their locality, structured in context with Sec. 27 of Senate Bill 1354, which specified the duties and responsibilities of LGUs[24,26,27,28]. The 4 sets of part III questionnaire were composed of inquiries on the following:

III.A - The NEED for Mental Health Services in their respective locality

III.B - The Legislators' Assessment regarding the READINESS OR CAPABILITY of their locality to provide Mental Health services

III.C - The Legislators' views on the need for creating LOCAL POLICIES to provide Mental Health Services

III.D - The Legislators' FUTURE PLANS in relation to providing Mental Health Services

A Certified Assessment Psychologist validated contents of Part III items. Other forms of validation for Part III was not done due to time and resource constraints of the researcher. Participants responded to questions on a 5-point Likert scale, as in Part II.

A Consent Form was attached to the letter of Request sent ahead of the questionnaire. A 2nd copy of the Consent Form along with the information sheet was on the last page of the questionnaire. Both forms had the same content, which provided contact information of the researcher should there be a need for further inquiries.

Area of Study

The province of Rizal is the second most densely populated area of Region 4A. Each of the nine municipalities of Rizal registered that their urban population was more than 85% and included the City of Antipolo. Based on LGU income classification, the 1st class municipalities that were predominantly urban-suburban localities included Angono, Binangonan, Cainta, Rodriguez, Pililla, San Mateo and Tanay. The admixture of suburban-rural municipalities of Morong and Teresa were 2nd class, along with Cardona, considered as 3rd class. The municipalities of Baras and Jala-jala were categorized as 4th class as for the most part remained rural[1, 24, 28].

The province covers a land area of 1,191.94 square kilometers, about 16-18 kilometers East of Manila, bordered by Metro Manila (west), Bulacan (north), Quezon (east) and Laguna (south). Geographically, it has significant development of urban-rural fringes; provincial terrains in general were hilly and mountainous with several municipalities in the shoreline of Laguna de Bay, including Talim Island situated within the lake[30]. (Appendix 1)

Procedure

Setting-up the Survey

Prior to survey proper, email inquiries for authorizing research were sent to each LGUs of Rizal Province.

Permission to use the validated AMIQ as part of the survey instrument was obtained through email correspondence with the respective author.

Approval to commence the survey was granted by the NCMH Medical Training Office who deemed it unnecessary to subject this study for an Ethics Board review for as long as a written informed consent was given by the responders and anonymity was strictly maintained. Letters asking permission to conduct research accompanied with a sample of the 3-part questionnaire to be used in the survey were sent to designated offices of the LGUs via courier. Following approval to conduct research, appointments were set with each LGU (settings differ depending on convenience), some during council or board assemblies while others preferred separate office visits.

The appointed data gatherer provided a brief research introduction, instructions on answering the questionnaires, signing the consent form and the process retrieving the survey forms. Packets of documents (addressed to prospective respondents) were then distributed; each contained an invitation to participate in the research survey, a consent form and the 3-part questionnaire.

To avoid bias, solicitation-appearance and unnecessary queries that may affect research outcome, the researcher did not have any personal contact with respondents aside from accommodating queries coursed through the contact information provided.

Data Gathering

The survey was designed to take about 10-15 minutes of a respondent's time. The data gatherer verified submission using a distribution checklist and conferred with researcher. The envelopes should be returned sealed with respondents' signature; contrary to these conditions were not accepted.

Guidelines followed for consistency and accuracy were: 1) respondent should be a qualified participant, 2) consent form should show name and signature of respondent, 3) the item for 'NAME' in part I must be filled and match the signed consent form, 4) at least 5 of 7 items in part II and 3 of 4 items in part III were accomplished.

From the 96 returned envelopes, only 87 survey questionnaires were acceptable and included in the study. Prior to data encoding, the names and contact information of the respondents were blotted out by the undersigned; names of LGUs and political parties were assigned alphanumeric codes to ensure confidentiality while a master list of the corresponding codes were kept by the author as reference. (Appendix 2)

The mode of collection varied with each LGU, some submitted right after answering the questionnaire, others requested scheduled dates of submissions, while several requested deadline extensions.

The survey proper began on June 26, 2017 and deadline for data gathering was extended thrice until October 11, 2017 so as to provide more time for the responders to accomplish the questionnaire and for collating the forms, which in turn would provide for better yield of data. Copies of the endorsement given by the Rizal Provincial Council in conducting the survey were also furnished for each city/ municipality.

Data Analysis

Data processing and statistical analyses were conducted using Microsoft Excel Version 14.5.5, with the aid of a qualified research statistics specialist.

Descriptive statistics were used in summarizing demographic and political variables. Mean scores and standard deviations were obtained for analysis of variables and attitude scores. Multiple Logistic Regression was done to examine possible relationships between variables in Part I (demographic variables) and Part II (AMIQ scores).

Spearman Correlation Coefficient was used to explore the relationships between the outcome variables on Part II (AMIQ scores) and Part III (needs perception and plans). The level of significance was set $p < 0.05$.

RESULTS

From the questionnaires gathered, it appeared that LGU A, a 4th Class municipality had the highest percentage of respondents, and that LGU G and LGU X, both 1st class municipalities, did not submit any questionnaires at all. (Appendix 2)

Comparing the actual number of respondents with the expected number of respondents who were the elected legislative officials at the time study was conducted. (Table 1)

Overall, the response rate was 54% (87/161). Table 2 shows the mean scores and standard deviations (SD) of case vignettes. As stated previously, three case vignettes were deliberately selected to elicit strongly positive and negative responses. These were described in vignettes II A describing a person with Diabetes (Chronic medical illness), II D describing a convicted criminal and II E describing a religious Christian. Cases obtaining negative scores from -5 to -10 were marked with "neg" indicating a negative attitude.

All of the mean scores were within -5 and +5. Attitude scores were 'positive' towards a person with Diabetes and religious

Christian. A 'neutral' score (- 0.01 to + 0.90) was given to the case of an Alcoholic undergoing treatment. The most negative attitude score was towards the convicted Criminal.

Notably, respondents showed more negative attitude scores towards case vignettes related to mental health II C (Heroin addict), II F (diagnosed Schizophrenic) and II G (Depression). As mentioned, earlier three case vignettes were deliberately selected to elicit strong attitude scores for the purpose of finding analogies pertaining to cases related to mental health. (Table 2)

TABLE 1. Participating Legislators from LGUs of Rizal Province

LGU		Actual #	Expected #[ii]	% Participation
Income Classification[i]	LGU CODE			
4th	A	10	10	100
3rd	C	9	10	90
1st	I	8	10	80
2nd	R	8	10	80
1st	K	10	13	77
1st	T	7	10	70
4th	B	6	10	60
1st	Y	6	10	60
1st	O	9	18	50
1st	L	4	10	40
1st	N	4	10	40
1st	S	4	10	40
2nd	E	2	10	20
1st	G	0	10	0
1st	X	0	10	0
TOTAL		87	161	54

Source:

[i] Department of Interior and Local Government, as of 2016;
[ii] Records & Statistics Divisions, Commission on Elections (COMELEC) as of May 2013

Of the 87 respondents, 80.46 % were male and 16.09% were female, mean age was 48.986 and 22.99% within the age range 51-60; 74.71% were married, 67.8% graduated college and 40.2% resided in their locality >30 years.

Majority (56.3%) of the respondents had spent more than 9 years in government service, 41.4% were 1st term legislators and 49.4% had political party affiliation with NPC (Nationalist People's Coalition).

Tables 3–10 show the grouped variables with corresponding mean scores. For vignettes II B, II C, IIF and IIG, mean scores that were Negative, ranging from -5.00 to -1.00 (Disagree) and ranging from -5.01 to -10.00 (Strongly Disagree) were shaded in gray; mean scores ranging from – 0.01 to + 0.90 (Neutral / Don't Know) were in white background; mean scores from that were Positive, with ranges from +1.00 to +5.00 (Agree) and from +5.01 to +10.00 (Strongly Agree) were printed in bold characters.

TABLE 2. Mean Scores of Respondents on AMIQ Part II

CASE VIGNETTE		MEAN	SD
II A	Peter has diabetes. He needs to inject insulin every day and has a special diet	3.034	0.76
II B	Steve has been drinking heavily for 5 years. He is now going for treatment & has started attending Alcoholics Anonymous meetings.	-0.023	2.26
II C *neg*	John has been injecting heroin daily for 1 year	-3.49	2.38
II D *neg*	Robert is a convicted criminal. He has spent time in prison for several convictions for theft & shoplifting. He is currently on bail for fraud & burglary	-3.64	1.09
II E	Steve is a practicing Christian. He attends church every Sunday & attempts to lead a Christian life.	4.89	2.87
II F *neg*	Michael has schizophrenia. He needs an injection of medication every 2 weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the Devil & thought that he had the power to cause earthquakes. He has been detained in the past.	-2.86	2.07
II G neg	Tim is depressed & took a paracetamol overdose last month to try & hurt himself.	-1.32	1.36

Respondents grouped according to SEX showed a more negative attitude from FEMALE respondents notably towards diagnosed schizophrenic case (II F), depression case (II G) and alcoholic undergoing treatment (II B), compared to mean scores from MALE respondents. Though, it is also important to take note that there was a predominance of MALE respondents (80.46%) in the survey whose more negative attitude scores were towards heroin addict case (IIC) rather than towards the criminal (II D).The males were also less negativistic towards the schizophrenic patient (II F) compared to the females. (Table 3)

Variables according to AGE GROUP, respondents from ages 21-30 was the only group to have a negative attitude mean score towards the alcoholic undergoing treatment (II B) and a neutral score towards diagnosed schizophrenic (II F). For respondents ages 31-40, the most negative attitude was towards the heroin addict (II C) and showed a neutral attitude mean score towards the depressed patient (IIG). However, the 51-60 age group, which was about 22.99% of the respondents showed the most negative attitude scores on the heroin addict (IIC), the diagnosed schizophrenic (IIF)

and the depressed patient (IIG). (Table 4)

Majority (74.7%) of the respondents grouped according to CIVIL STATUS were Married and their most negative attitude mean score was towards the heroin addict (IIC), followed by towards the convicted criminal (IID), then by the diagnosed schizophrenic (IIF). They had a less negative attitude mean score for the depressed case (II G) and neutral score towards the alcoholic undergoing treatment (IIB). The least number of respondents, grouped as 'Separated' showed negative attitude scores only towards IID (convicted Criminal), and the only group that gave a neutral attitude to score to II C. Most negative attitude scores were obtained from the Widow/Widower group toward the schizophrenic case (IIF). (Table 5)

TABLE 3. AMIQ Mean Scores of Respondents grouped according to SEX (N=87)

SEX	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
MALE	70	80.46	**3.014**	0.343	-3.457	-3.257	**4.629**	-2.643	-1.157
FEMALE	14	16.09	**3.071**	-1.500	-2.786	-5.000	**6.286**	-4.071	-2.143
No Reply	3	3.45	x	x	x	x	x	x	X

TABLE 4. AMIQ Mean Scores of Respondents According to AGE GROUP (N= 87)

AGE	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
21 – 30	5	5.75	**4.600**	-1.000	-2.800	-5.000	**4.800**	-0.200	-1.400
31 -40	14	16.09	**4.214**	0.571	-3.286	-2.286	**5.571**	-3.714	-0.571
41 – 50	17	19.54	**2.851**	0.259	-2.185	-2.519	**5.000**	-1.481	-1.037
51 – 60	20	22.99	**3.600**	0.100	-4.800	-4.850	**5.200**	-4.700	-2.500
≥61	14	16.09	**3.143**	0.071	-3.214	-3.642	**4.500**	-3.571	-1.571
No Reply	17	19.54	x	x	X	x	x	x	x

Table 5. AMIQ Mean Scores of Respondents According to CIVIL STATUS(N=87)

CIVIL STATUS	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
Single	8	9.19	**3.375**	-0.250	-1.250	-4.875	**6.75**	-1.75	-0.375
Married	65	74.71	**3.138**	0.092	-3.831	-3.630	**4.662**	-3.031	-1.385
Separated	4	4.6	**1.750**	0.750	-0.750	-1.500	**4.500**	0.250	-0.250
Widow/ Widower	5	5.75	**1.200**	0.000	-3.800	-3.200	**6.200**	-4.200	-1.600
Annulled/ Divorced	0	0.00	x	x	x	x	x	x	x
No Response	5	5.75	x	x	x	x	x	x	x

The attitude mean scores grouped according to EDUCATIONAL ATTAINTMENT revealed that 67.82% of respondents were College graduates who had the most negative attitude mean scores towards the heroin addict (IIC) and towards the diagnosed schizophrenic (IIF); while giving the second most negative score on the depression case (II G). Respondents in the Vocational and Post Graduate groups were nearly as negative as the college graduates. Neutral attitude scores towards diagnosed schizophrenic (IIF) and depressed patient (IIG) were observed by those who had reached grade school and high school. (Table 6)

Most respondents grouped according to YEARS of RESIDENCE were from the 31-40 years range, at 17.24%. This group gave negative attitude scores on the heroin addict (II C), the diagnosed schizophrenic (II F) and the depression cases (II G). The most negative attitude scores were obtained from the 1-10 years range. Of the two items on substance use, the heroin addict case (II C) had far more negative scores. Most attitude scores of the grouped variables towards the alcoholic undergoing treatment (IIB) were neutral except for the negative mean scores from respondents who had 11-20 and 31-40 years of residence. Notably, the 31.03% 'No Response' rate was higher than the group with the most respondents in this variable. It seems that the most negative scores were towards the Heroin addict (IIC) and schizophrenic patient (IIF) amongst those who had only 1-10 years of residence. Those who had 11-20 years of residence also had a very similar negative attitude towards the heroin addict (IIC) yet had a positive score towards the depressed patient (IIG). Those who had more than 61 years of residence had a very positive attitude towards the alcoholic undergoing treatment (II B). (Table 7)

TABLE 6. AMIQ Mean Scores of Respondents According to EDUCATIONAL ATTAINMENT (N= 87)

EDUCATIONAL ATTAINMENT	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
Grade School	1	1.15	0.000	0.000	0.000	0.000	**2.000**	0.000	0.000
High School	6	6.89	**2.833**	-0.167	-2.500	-2.000	**5.333**	-0.833	-0.667
Vocational	4	4.6	**3.034**	-0.030	-3.483	-3.643	**4.885**	-2.862	-1.322
College	59	67.82	**3.200**	-0.350	-3.967	-4.233	**5.333**	-3.100	-1.483
Post Graduate	11	12.64	**3.727**	0.545	-3.000	-2.636	**5.818**	-3.273	-1.091
No Response	6	6.89	X	x	x	X	x	x	x

TABLE 7. AMIQ Mean Scores According to YEARS OF RESIDENCE in their locality (N= 87)

# Years	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
1 – 10	5	5.75	**3.6**	0.833	-7.000	-6.800	**10.000**	-7.000	0.200
11 – 20	5	5.75	**4.6**	-1.333	-7.200	-7.400	**3.800**	-3.000	**1.400**
21 – 30	8	9.2	**5.286**	0.000	-3.429	-4.571	**3.000**	-3.000	-3.000
31 – 40	15	17.24	**3.733**	-3.000	-3.933	-2.600	**5.733**	-3.400	0.400
41 – 50	10	11.49	**1.889**	0.667	-1.100	-2.200	**4.800**	-2.300	-1.200
51 – 60	10	11.49	**3.400**	**1.000**	-5.100	-4.600	**5.200**	-4.700	-3.400
≥61	7	8.05	**3.000**	**4.38**	-2.857	-6.800	**5.714**	-4.286	-3.143
No Reply	27	31.03	x	X	x	x	X	x	x

LGUs, 'K' and 'A' showed the most respondents. Attitude scores on the alcoholic undergoing treatment (II B) were neutral or positive (LGU I, L, N) but LGU T, S and A had a negative attitude scores. Only LGU Y showed a neutral mean score towards case vignette of the heroin addict (II C) while the rest of the LGUs had negative scores, with LGU O, S and E having stronger negative attitude scores. Strikingly, LGUs O and E showed the strongest negative attitudes towards diagnosed schizophrenic case (II F), while LGU B had a neutral score towards the same case. LGU I, T, R and

B scored neutral attitude towards the depression case (II G) while the rest of the LGUs had negative scores. (Table 8)

Majority (56.32%) of the respondents had more than 9 years of GOVERNMENT SERVICE and negative attitude scores on the heroin addict case (II C), diagnosed schizophrenic (II F) and depression case (II G). Neutral attitude scores were given to the depression case (II G) by those with a short number of years in government service i.e. 3 years or less and those with 6-9 years in service. The most negative attitude scores were for the heroin addict case (II C) from those with 1-3 years of government service. (Table 9)

TABLE 8. AMIQ Mean Scores of Respondents distributed according to LGU (N=87)

Income Classification	LGU	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
1st	K	10	11.49	**1.800**	0.400	-5.000	-5.400	**5.800**	-2.800	-1.700
1st	I	8	9.2	**5.750**	**1.375**	-4.000	-2.250	**6.625**	-2.250	0.250
1st	T	7	8.05	**3.285**	-1.286	-1.714	-1.714	**6.000**	-2.571	-0.714
1st	Y	6	6.9	**5.000**	0.000	0.000	-4.000	**3.500**	-3.000	-1.167
1st	O	9	10.34	**3.556**	0.444	-5.222	-6.556	**5.444**	-6.000	-2.000
1st	L	4	4.6	**1.750**	**1.750**	-3.500	-1.750	**5.250**	-1.250	-2.250
1st	N	4	4.6	**1.750**	**1.000**	-2.750	-3.000	**3.500**	-1.750	-1.000
1st	S	4	4.6	0.800	-1.200	-6.200	-6.800	**2.800**	-4.400	-3.400
2nd	R	8	9.2	**1.572**	0.286	-2.429	-1.571	**2.286**	-1.571	-0.857
2nd	E	2	2.29	**4.500**	-0.500	-5.500	-5.500	**4.500**	-5.500	-2.000
3rd	C	9	10.34	**2.111**	-1.667	-4.111	-4.111	**5.444**	-3.444	-1.000
4th	A	10	11.49	**2.600**	0.100	-1.300	-1.000	**4.500**	-2.300	-1.600
4th	B	6	6.9	**2.667**	0.333	-4.000	-4.500	**6.333**	-0.667	-0.833

TABLE 9. AMIQ Mean Scores According to YEARS IN GOVERNMENT SERVICE (N=87)

# Years	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
< 1	5	5.75	**2.800**	-2.400	-3.000	-2.600	**4.400**	-0.600	-0.800
1-3	7	8.05	**4.428**	-1.571	-5.143	-4.714	**3.714**	-3.571	-0.428
3-6	9	10.34	**3.000**	**2.333**	-3.111	-2.667	**2.111**	-2.111	-1.444
6-9	13	14.94	**3.071**	**0.643**	-2.143	-2.928	**5.285**	-1.285	-0.214
> 9	49	56.32	**2.714**	-0.367	-4.224	-4.347	**5.571**	-4.061	-1.898
No Reply	4	4.6	x	x	x	x	x	x	x

Respondents from all grouped items according to TERM in OFFICE showed negative attitudes towards the heroin addict case (II C) and schizophrenic case (II F). The most negative attitude scores towards the heroin addict (II C) were from the 1st Term group who comprised 43.68% of the respondents. Respondents from the 2nd Term and 3rd Term groups also showed negative attitude scores towards the heroin addict (II C) and schizophrenic case (II F) but had neutral scores towards the depressed case (II G). Those on their 4th term or more had a positive score towards the alcoholic undergoing treatment (II B). (Table 10)

All respondents grouped according to POLITICAL PARTY AFFILIATION scored the heroin addict case (II C) and schizophrenic (II F) negatively. Most respondents affiliated with political parties including NPC, NUP, UNA and LP showed neutral attitude scores towards the alcoholic undergoing treatment (II B) while the PDP and Independent had negative scores towards this case (II B). Notably, respondents grouped under NUP political affiliation showed the strongest negative attitude scores towards the diagnosed schizophrenic (II F). The UNA, LP and INDEPENDENT political parties revealed neutral mean scores towards the depression case (II G). (Table 11)

Multiple logistic regression showed that amongst all grouped variables, those grouped according to YEARS OF RESIDENCE influenced AMIQ scores given by respondents in all case vignettes. It also showed that variables grouped according to AGE affected the attitude scores towards the diagnosed schizophrenic case vignettes (II F) and towards the depression case (II G). The grouped variables according to their TERM in OFFICE had an effect on the attitude scores given to the Alcoholic undergoing treatment (II B), however this grouped item did not influence the attitude scores toward the other cases.

Correlation studies done between the mean AMIQ attitude scores on Part II cases and response scores from the 4 sets of questions in Part III (A, B, C, D), showed low correlation. Keeping in mind the mean attitude scores obtained from case vignettes related to mental health: IIB were neutral at -0.023 (Alcoholic undergoing treatment), II C were negative at -3.49 (Heroin Addict), IIF were negative at -2.86 (diagnosed Schizophrenic), IIG were negative at -1.32 (Depression).A positive correlation would mean an increase in the Part II scores increases response scores in Part III i.e., more positive attitude score, the higher response score or vice versa. On the other hand, a negative correlation would mean that a decrease in Part II scores would increase response scores in Part III i.e., the more negative attitude score, the higher response score, or the higher attitude scores, the lower the response scores.

Part IIIA, response scores on questions pertaining to the NEED for Mental Health Services in their respective locality showed negative correlation with attitude scores of case vignettes IIB (Alcoholic undergoing treatment), IIC (Heroin addict), II F (diagnosed Schizophrenic). Hence, the more negative attitude, the greater the perceived need, otherwise, the more positive attitude score, the lesser the perceived need. Nonetheless, results also revealed positive correlation of attitude scores in case IIG (Depression) to response scores in Part III A, hence the higher attitude scores, the greater the perceived need. Results then indicated that the low or negative attitude scores on cases II C (Heroin addict) and II F (diagnosed Schizophrenic) meant greater recognition of their need for local health service to address these, while the low or negative attitude scores towards II G (Depression) denoted that respondents perceived it as a less concern for health service provision.

Part IIIB consisted of questions regarding the READINESS

OR CAPABILITY of their locality to provide Mental Health services. Results showed negative correlations with attitude scores on cases IIF (diagnosed Schizophrenic) and IIG (Depression) to response score of Part III B, which meant that lower attitude (more negative) scores translated to greater local readiness or capability to provide services. Attitude scores of case vignettes IIB (Alcoholic undergoing treatment) and IIC (Heroin addict) revealed positive correlations with response scores on Part III B. Thus, in this case, the low or negative attitude scores obtained from II C, the Heroin Addict entailed unreadiness or incapability of their locality to provide needed health services.

Part IIIC were questions regarding the need for creating LOCAL POLICIES to provide Mental Health Services. Response scores showed negative correlations with attitude scores on cases IIB (Alcoholic undergoing treatment) and II C (Heroin addict), thus, a decrease in attitudes scores meant an increase in their perceived need to create local policies. Attitude scores from cases IIF (diagnosed Schizophrenic) and IIG (Depression) showed positive correlations with response scores of Part IIIC, therefore, the lower attitude scores, the less is their perceived need for local policies.

Table 10. AMIQ Mean Scores According to TERM in OFFICE as Legislator (N=87)

POLITICAL PARTYAFFILIATION	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
NPC(Nationalist People's Coalition)	43	49.42	**3.446**	-0.107	-4.143	-4.232	5.214	-3.178	-1.410
NUP (National Unity Party)	4	4.6	**3.250**	0.250	-2.750	-7.250	1.750	-7.000	-1.250
UNA(United Nationalist Alliance)	8	9.2	**1.625**	0.500	-2.500	-2.625	3.750	-1.000	-0.125
LP (Liberal Party)	16	18.39	**2.312**	0.625	-2.250	-1.500	4.687	-2.812	-0.437
PDP-*LABAN* (*Partido Demokratiko Pilipino-Lakasng Bayan*)	5	5.75	**3.000**	-1.400	-3.800	-5.200	7.800	-2.800	-2.000
INDEPENDENT	4	4.6	**5.000**	-3.500	-6.500	-5.000	7.500	-4.500	0.500
No Response	7	8.05	X	x	x	x	x	x	x

Table 11.AMIQ Mean Scores of Respondents According to their POLITICAL PARTY AFFILIATION (N=87)

POLITICAL PARTYAFFILIATION	#	%	II.A*	II.B	II.C	II.D*	II.E*	II.F	II.G
NPC(Nationalist People's Coalition)	43	49.42	**3.446**	-0.107	-4.143	-4.232	5.214	-3.178	-1.410
NUP (National Unity Party)	4	4.6	**3.250**	0.250	-2.750	-7.250	1.750	-7.000	-1.250
UNA(United Nationalist Alliance)	8	9.2	**1.625**	0.500	-2.500	-2.625	3.750	-1.000	-0.125
LP (Liberal Party)	16	18.39	**2.312**	0.625	-2.250	-1.500	4.687	-2.812	-0.437
PDP-*LABAN* (*Partido Demokratiko Pilipino-Lakasng Bayan*)	5	5.75	**3.000**	-1.400	-3.800	-5.200	7.800	-2.800	-2.000
INDEPENDENT	4	4.6	**5.000**	-3.500	-6.500	-5.000	7.500	-4.500	0.500
No Response	7	8.05	X	x	x	x	x	x	x

With regards the scores for items of Part IIID, concerning the Legislators' FUTURE PLANS to providing local Mental Health Services, findings showed negative correlations with IIB (Alcoholic undergoing treatment) and II G (Depression). Consequently, the negative attitude scores would likely generate prospects for service provisions. Findings also included positive correlations with case IIC(Heroin addict) attitude scores and Part III D scores, which meant higher attitude scores entailed better prospects, however negative or lower scores entailed lesser chances of mental health provisions being included in the future legislation. No correlation was seen between attitude scores of case II F (diagnosed Schizophrenic) and response scores of Part III D.

Based on respondents' views, attitude scores given to the Alcoholic undergoing treatment turned out as 'neutral', hence correlations were more evident on other case vignettes. Nonetheless, it showed negative correlations with response scores on parts III A, III C and III D; with positive correlation with part III B. The negative attitudes of respondents towards the Heroin addict revealed their recognition of the need for mental health services and legislation in their locality as they had low capability to handle such cases, yet prospects would be low regarding provision of these services in the future.

Correlation studies on attitudes scores on the diagnosed Schizophrenic translated to legislators' recognizing the need for providing mental health services, however they did not consider the need for local legislation. The respondents' negative attitudes towards Depression paralleled the perceived need for local mental health services and legislation. Nevertheless, in their assessment, although they were locally capable of providing these services, the likelihood for future mental health provisions were low.

DISCUSSION

This study was conceptualized in the advent of the recently passed Senate Bill 1354, at the backdraft of a decentralized health system in our country[34]. The survey had a response rate of 54%, almost satisfactory to the suggested standard for an organizational study[35], albeit low considering efforts to avoid non response bias, increase yield in data collection, the target population and timely issues. Notably, it could be an indicator on the level of interest (of potential respondents) in taking part of a survey concerning mental health.

Most survey respondents were from lower income municipalities despite the preponderance of 1st Class LGUs in the province, showing another facet on their level of concern for mental health provisions in their locality. Apart from it being a reflection of disinterest, a low response rate could indicate non-response bias that impacted survey findings. It could be that results would only show preferential views of respondents as they may substantially differ from that of

non-responders. As the sample size obtained was only 54% of the target population that may have led to higher variance of results. If the 'non-response' in the survey was to resonate attitudes of the target population towards mental illness, that was one important issue duly taken note of in the study.

The attitude scores of legislators towards the case vignette pertaining to substance abusers or drug addicts (II C) were nearly as negative as their scores towards the convicted criminal (II D). In the context of the government's declared war against drugs, strong reactions towards drug addiction and its association with criminality have been anticipated. Though, divergent from the medical/disease model of addiction, it seemed inevitable since mental health involves social concerns entailing multi-sectoral solutions.

The attitude scores towards the Alcoholic undergoing treatment were neutral (-0.023), the mean scores implied another direction on attitudes of respondents when it came to a person with substance use disorders manifesting health seeking behaviors. As it appeared, it was a case of substance use disorder with neither positive or negative attitude scores that could have been tempered by the phrase 'undergoing treatment', which would point to the influence of health seeking behaviors or willingness to undergo treatment. These findings were consistent with US studies of authors Jorm AF et al[36], MojtabaiR[37] and that of Hedden & Gfroerer[38].

The attitude scores between that of case vignettes for Schizophrenia and Depression appeared congruent with the Labelling Theory[39]; the legislators' attitude towards an individual officially diagnosed with Schizophrenia or labelled as mentally ill were more negative, consistent with studies conducted abroad by authors Link et al[40] at the Center of Prevention and Evaluation (COPE) in New York, USA; Angermeyer & Matschinger[41] in Germany; Link & Phelan[42] at the Columbia University, New York, USA; Yang et al[43] also at COPE in New York, USA; Berkelmann[44] at the University Of Massachusetts, USA; and Yang et al[45] in China.

Statistically significant relationships noted between attitudes to mental illness and 'age' as an influence corroborated research findings of Goll & Rasheed[21], Bulog[24] and Frederick[46]. Notably, age as an influencing variable could also be associated by factors such as the level of knowledge and amount of experience acquired by the respondent as reflected on their attitude scores. There was no increasing trend or pattern seen longitudinally with attitude scores and age. Given the findings, attitude scores differed from each age bracket, therefore, whether with a more negative or positive score, the differing type of generation, on which a respondent belonged was also taken into account.

Respondents grouped according to 'Years in residence' appeared as an influencing factor however 31.03% of the grouped variable belonged to the 'no response' group. This was even greater than those in the 31-40 years range who comprised 17.24 % of the respondents i.e. the group with the most number of respondents next to the non responders. As mentioned above, a possible non response bias that could have affected this finding, thus making it questionable as an influencing factor of attitude scores obtained.

Correlation studies between variables (Part II with Part III) showed how attitude reactions fared with scores on questions regarding perceived needs and plans for mental health service delivery.

Results indicated that the more negative the attitude scores toward individuals with Substance Use Disorders (-3.49 attitude score on the Heroin Addict) translated to a greater perceived need (higher or more positive part III A scores) for mental health services; lesser capability / unreadiness of each locality to provide mental health services (lower part III B scores) for these cases; greater need for local policies (part III C scores). However, the more negative the attitude scores for this case, the lower the response scores for part III D, which meant lesser prospects or future plans to address this concern.

Negative or lower attitude scores on Schizophrenia (-2.86) translated to greater perceived need (higher or more positive part III A scores) for mental health services; increase or more positive capability of the locality to provide mental health services; however, attitude scores on Schizophrenia have nothing to do with respondents' scores on future plans for service provision.

On the contrary, a survey on health workers done in Cambodia by Alfredsson M. et al[47] found that the more positive the attitude towards mental health, the greater the recognition for the need to integrate of mental health services. The said study was conducted amongst health workers whereas this survey covered an entirely different study population. The positive attitudes of the survey respondents may have resulted from their level of knowledge on mental health. Hence, educating the target population to promote mental health action could facilitate a change in attitude.

The positive correlation between the attitude scores on Depression and response scores on III A entailed that the low or negative attitude score (-1.32) meant less perceived need in terms of providing mental health services.

On the other end, how the respondents viewed Depression would be a consideration. If the negative attitude score given to the case of Depression resonated the respondents' views entailed the opposite, then the issue could be, whether the

respondents saw it as a real mental health problem in need of medical services or a non-medical, less important concern not requiring health provisions. As were the findings of a study survey in Brazil by Peluso and Blay[48], wherein public views Depression more as a psychosocial concern rather than a medical or health care concern.

The negative correlation found in most items of Part II to Part III A, suggested that the more negative attitude entailed an increased need for segregated treatment services that would isolate mentally ill patients (i.e. institutionalization). These findings were consistent with previous researches of Corrigan and Watson[7,8], since mental health has long been regarded as financially draining and linked with danger or violence. Conversely, this view opposed WHO's aim to present mental health as a social capital not solely as resource outlays but as productive assets[49,50].

Part III B questions showed that the more negative attitude scores toward Schizophrenia and Depression indicated an increase in the capability or readiness to provide local mental health services; on the other hand the more negative attitude scores towards Substance Use Disorders meant that respondents considered their localities less capable for providing health services. A more negative attitude score seemed to increase the gap on their perceived capability (of their respective locality) to provide mental health services.

The negative attitude scores on Schizophrenia and Depression decreased the respondents' perceived need for creating local policies to provide Mental Health Services (IIIC); while with the case vignettes on Substance Use Disorders, response scores to create local policies increased. Though, such findings would not be enough to assume that the respondents thought of Substance Use as a more pressing problem hence, needed to be addressed. How the respondents viewed it as a problem may be reflected in the mean attitude score -3.49 given the heroin addict which, was nearly the same as the mean attitude score -3.64 given to the convicted criminal. Such findings may be evidence that the respondents associated addiction more with criminality rather than as a mental health problem needing health service provision.

On the other hand III D results showed response scores on future plans for mental health provisions diminished as attitude scores on Heroin addiction became more negative. Looking at the negative attitude scores vetted with previous response scores on this case, findings showed the recognized need for mental health services (III A) albeit the low capability of providing them (III B) and the need to generate local policies were acknowledged by the participants. In the end however, legislative officials or the respondents' negative attitude scores did not lead to prospects on mental health provisions or plan of action (III D). Nevertheless, such findings cannot just assume that legislators tend to avoid acting on the issue.

Of the case vignettes, the legislators' attitude scores toward mental health disorders such as Schizophrenia reflected awareness of the need for providing mental health services (III A) but not in their locality. Findings suggest that legislators did not see providing mental health services as their responsibility at the local level. They only recognized the need to address such cases then probably, instead of their LGU, it is for the national government to create the mental health services needed. And in a way discounting the decentralized structure of health care delivery system wherein the control and responsibility of delivering public health service would be in the hands of each LGU[28,29].

They may have recognized mental health concerns but their negative attitude led them to divert the responsibility to others; viewing it as another obstacle and endorsing it to the central government rather than implementing mental health programs necessary to determine themselves at their local government units. It might then be whether the approach of mental health advocacies be directed nationally or channelled locally, to create an impact; involving the legislators aside from health personnel as with the mhGAP[2,51].

In mental health advocacy, promotional direction is vital and must be strategically positioned given the influencing factors, such as the findings of Barcellano & Bordado[52] on the significant shift on the knowledge, attitude, care and management of mental health disorders after educating primary health care workers.

Conclusion

In general, this study showed that the legislators of Rizal Province had negative attitude towards mental illness. Legislative officials had more negative attitudes or were more repulsive towards drug abuse and towards those diagnosed or labelled as having mental illness.

In this study, 'age', 'years of residence' and 'term in office' appeared to be influencing factors affecting attitudes of legislators. Respondents who were older, resided longer and served longer as legislators in Rizal province, generally showed more negative attitude scores. These influencing factors may need to be taken into consideration when manoeuvring a more favorable attitude change towards mental health.

The research suggested that the negative attitude of legislators could also mean they perceived a need for legislation and provision of mental health services. Correlations between variables showed that stronger negative attitude reactions led to higher scores in perceived needs for mental health service

delivery that could push legislators in proposing mental health program implementation.

The question might then be whether mental health advocacies should impact nationally or approached locally with multi-sectorial participation. Whether or not it is feasible to utilize negative or stigmatizing attitudes as a pivot in advocating for mental health action, such as citing how untreated patients can be a danger to others and himself and therefore the need for providing mental health services. On the other hand, advocacies could be channelled to changing mindsets of stakeholders thru vigorous education directed to favorable attitudes on mental health programs.

It was said that there is no health without mental health[50]; and there would not be services for mental health without legislation thus the need to rally for passage of the Mental Health Act and its full implementation.

Limitations

The time interval between the distribution and collection of survey questionnaires was not uniform and spanned up to 4 months. That length of time may have exposed them to other influences that could have changed their attitudes or perceptions. A survey conducted at the same point in time and nearly similar setting for all groups would have been ideal.

Consent from each participant was collected together with the survey form. To have an idea of the size of the sample population or ensure the number of participants, consent from participants should have been gathered initially, prior to the conduct of survey.

Timely issues (like the 'War in Marawi' and 'Resorts World Tragedy') at the time of the research were not mentioned during the conduct of the survey nor were they included in the vignettes. Such relatable issues could have had an impact on the response rates and attitudes of legislators.

The response rate of 54% was rather low and frequency of non-responders to several items in the questionnaires have rendered some of the findings inconclusive especially regarding the grouped variables according to years in residence and LGU classification, wherein non-response rate was greater than the proportion of biggest number of respondents.

The over representation of male respondents may have also rendered 'gender' factor as an inconclusive influence. It would have be ideal to conduct the survey from a well distributed groupings of variables.

Part III of the questionnaire had only undergone face validation under advice and content validation by one qualified psychometrician. The questions would still need further construct and concrete validation with reliability tests. These may have greatly affected conflicting inferences in the correlation studies.

Social desirability bias may have affected some of the respondents' answers given the type of survey population. There may have been survey participants that responded based on popular values and not necessarily as a reflection of their own true personal choices. Respondents may have chosen 'safe zone' options avoiding the more extreme responses of 'strongly agree' or 'strongly disagree'; choosing either 'neutral' or 'don't know' responses instead, possibly at the thought of being incriminated, despite assuring anonymity.

The cross-sectional study design of this research allowed examination of measures, analysis of variance and correlation studies but causal relationships could not be drawn between variables.

Recommendations

Further research on attitudes of stakeholders and decision-makers in the local setting could contribute additional insights and aid in mental health advocacy efforts; perhaps including in the survey a larger and a more heterogeneous population would provide a more reliable view of attitudes towards mental health.

The conduct of survey should be conducted during a specified time with only a brief interval between questionnaire distribution and data gathering for nearly simultaneous measurements.

Further validation and reliability testing on survey questions of Part III would be needed for better research inferences. It is also recommended that other individual characteristics like occupation, family history of mental illness or personal encounters with mentally ill patients are influential factors on legislators that are worth analyzing.

The use of other validated scales measuring attitudes and stigma could also be used on different groups of stakeholders on mental health.

To lessen social desirability bias, the use of Marlowe- Crowne Scale[53] to control for response bias in research using self-completion questionnaires could be used in future studies.

It is recommended that mental health advocates and strategists coordinate between and within government agencies -national and local, administrative and legislative, regional health offices or Center for Health Development

(CHD)- aside from emphasizing that mental health is a social concern that requires multi-sectoral collaboration.

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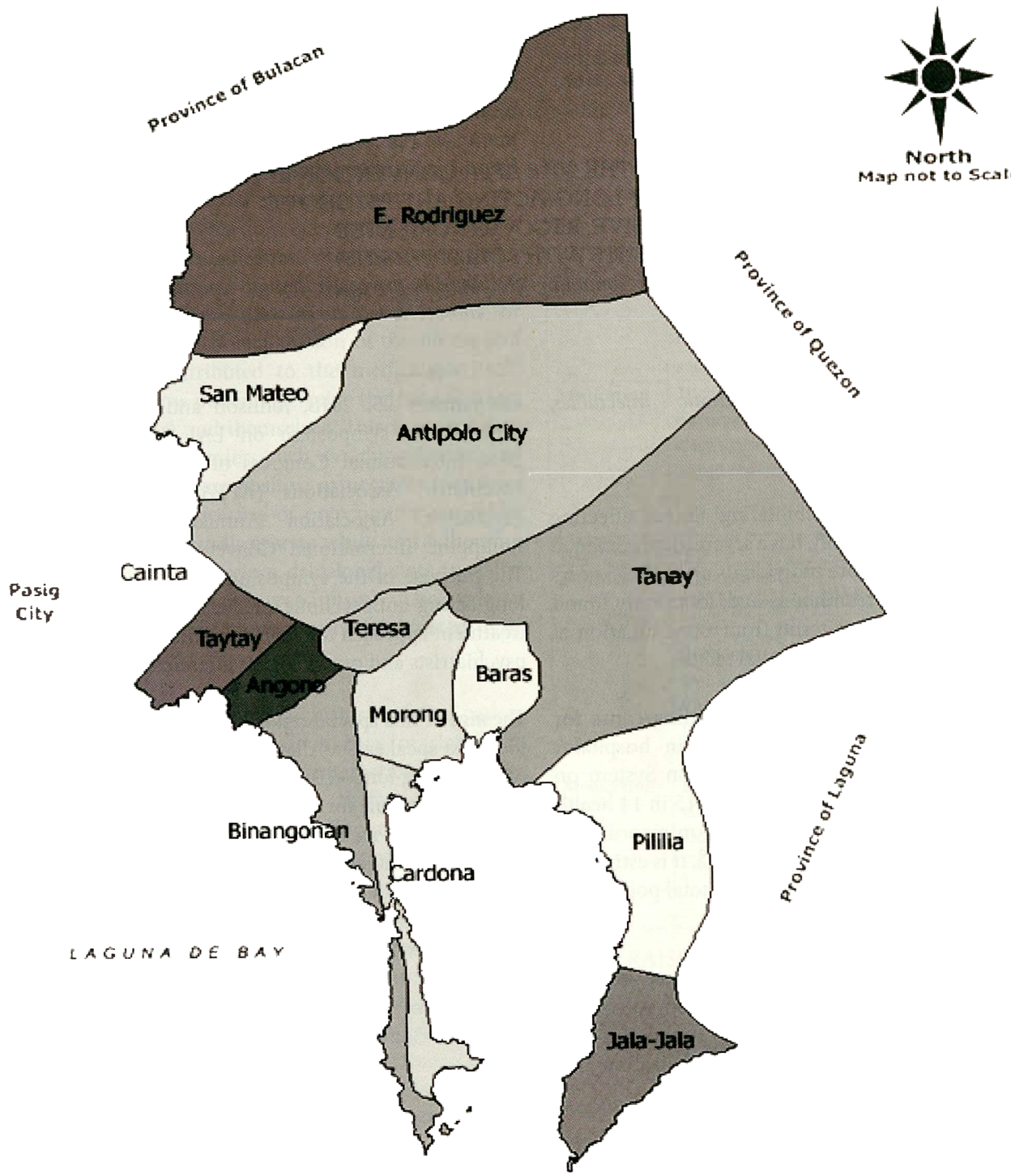
APPENDIX 1. Political Map of Rizal Province



APPENDIX 2. LGU Legislative Bodies

Codes	LGU	Codes	LGU
A	Jala-jala	O	Antipolo City
C	Cardona	L	Pililla
I	Binangonan	N	Angono
R	Morong	S	San Mateo
K	Provincial Capitol	E	Teresa
T	Tanay	G	Rodriguez
B	Baras	X	Cainta
Y	Taytay		