

Mental Health Access in Cebu Province: An Assessment Framework

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ABSTRACT

Mental Health Access remains fragmented across the Philippines decentralized local governance system despite the enactment of Republic Act 11036 (Mental Health Act). Still unequal access, workforce constraints, inconsistent community activities, stigma, and uneven local policy support continue to affect the delivery of mental health services in Cebu Province. This study assessed mental health access and developed a context-responsive H.E.L.P. Assessment Framework to guide community-based program strengthening and local policy formulation. A convergent parallel mixed-methods design integrated quantitative surveys with key informant interviews, focus group discussions, documentary analysis, and cross-case thematic analysis. Purposive sampling involved health-sector personnel, local government leaders, barangay-based workers, and other stakeholders directly involved in providing or implementing mental health programs across the local government units of Cebu Province, with key informant interview and focus group discussion participants drawn from those with more than five years of program involvement. The quantitative questionnaire was reviewed by three subject-matter experts and pilot-tested among 18 LGU staff from DOH Mental Health Access Sites in the neighboring province of Bohol, with Cronbach's alpha computed to assess internal consistency; the qualitative interview aide-memoire underwent the same expert validation process. Quantitative findings were summarized using means, percentages, and frequency distributions, while qualitative findings were synthesized into recurring themes. Mental health coordinators reported a very high level of program awareness (overall mean=4.37) and very high willingness to participate in mental health promotion activities (overall mean=4.51), although promotion and intervention activities were generally conducted only bi-annually (overall mean=3.17). Local leaders and non-mental-health coordinators were aware of mental health programs (overall mean=4.10), reported quarterly implementation of activities (overall mean=3.56), and were very willing to participate (overall mean=4.27). Depression was the most frequently reported condition among mental health coordinators (92.16%), followed by anxiety disorders (84.31%). Psychiatric assessment and provision of psychotropic medicines through Mental Health Access Sites were the most common management regimens (76.47% each). Local government unit support was the leading facilitating factor (88.24%), while lack of trained personnel (86.27%), insufficient funds (82.35%), and stigma (80.39%) were the leading barriers. Quantitative and qualitative findings converged on five of six constructs examined, with complementary expansion on mental health awareness, indicating that access constraints are concentrated on the supply side of the system such as workforce, funding, facility reach, and continuity of care, rather than on stakeholder demand. The findings support a H.E.L.P. Assessment Framework organized around Health Promotion, Early Mental Health Intervention, Linkages to Care, and Policy Support. Moreover, the Assessment Framework serve as an empirically grounded, policy-actionable tool for strengthening community-based mental health access in Cebu Province and comparable decentralized health systems.

Keywords: mental health access; community-based mental health; assessment framework; mental health services; Cebu Province

INTRODUCTION

Mental health is integral to individual well-being, social participation, productivity, and community resilience. The World Health Organization has consistently framed mental health as a core component of health and has

called for accessible, rights-based, community-oriented systems of care. In the Philippines, Republic Act No. 11036 or the Mental Health Act established a national policy for integrated mental health services and for the protection of persons using psychiatric, neurologic, and psychosocial health services. These national commitments place particular importance on translating policy into functional local systems that make services visible, reachable, acceptable, and continuous.

The study highlights the burden of mental, neurological and substance-use conditions in Cebu Province, emphasizing the significance of improving access to mental health services. The provincial and regional records referenced in the study reveal high numbers of psychosis, depression, epilepsy and completed suicide cases with service gaps found in urban, rural and disaster-affected settings. In this context, access to mental health is not only about the availability of services but also the geographical reach, affordability, cultural acceptability, system readiness, availability of trained human resources, medications, referral arrangements, stakeholder awareness and support from local government.

Community-based mental health care depends on the interaction of multiple actors. Primary care physicians, nurses, midwives, barangay health workers, barangay nutrition scholars, social workers, local LGU officials, Non-Government Organizations, and specialized mental health professionals all contribute to recognition, referral, treatment, psychosocial support, and health promotion. The literature cited in the study emphasizes that mental health literacy and public awareness improve recognition of mental health concerns and facilitate help-seeking behavior (Jorm, 2012; Kutcher et al., 2016). The WHO Comprehensive Mental Health Action Plan likewise identifies community participation, integrated service delivery, and accessible care as essential to stronger mental health systems (World Health Organization, 2021).

Despite existing policies and DOH Mental Health Access Sites, the study identified persistent implementation concerns related to limited workforce capacity, inadequate funding, stigma, irregular health promotion activities, gaps in referral systems, limited supply of psychotropic medicines, and uneven local policy support. These system-level constraints are important because awareness alone does not guarantee service use. Effective access requires an enabling environment in which communities know where to seek help, frontline providers have the competence and resources to respond, referral pathway function, and local governments institutionalize mental health through policy and budget support.

The study therefore developed the H.E.L.P. Assessment Framework as a locally grounded approach in the assessment and strengthening of mental health access. In the study, H.E.L.P. refers to Health Promotion, Early Mental Health Intervention, Linkages to Care, and Policy Support. The framework is consistent with a whole-of-government and whole-of-society approach because it connects public awareness, early recognition and response, continuity of referral and care, and local health leadership and governance mechanisms needed for sustainable implementation.

The study aimed to assess mental health access in Cebu Province and determine the factors that could inform an effective assessment framework for community-based mental health programs. Specifically, it examined stakeholder awareness, the availability and frequency of mental health promotion and intervention activities, willingness to participate in mental health initiatives, commonly encountered mental health conditions and management practices, and facilitating and hindering factors affecting implementation. The results were then integrated to support the H.E.L.P. Assessment Framework and provide a basis for local policy and program improvement.

Mental health access is defined as the timely, equitable, and sustained ability of individuals, families, and communities to know about, reach, afford, accept, and utilize mental health promotion, prevention, treatment, and rehabilitation services of adequate quality, and to continue receiving such services across the care pathway. Operationalized for this study, mental health access is assessed through seven recognized dimensions namely Availability, Geographic Accessibility, Affordability, Appropriateness, Quality, Continuity, and Actual Utilization each of which is produced, in the H.E.L.P. logic model, by one or more of the six (6) empirically measured variables of this study.

STATEMENT OF THE PROBLEM

The study sought to develop a Mental Health Assessment Framework and assessed its effectiveness in the community in order to serve as a model for mental health policy formulation in Cebu Province.

Specifically, this study explored the following questions:

1. What is the demographic profile of the respondents?
2. What is the level of awareness of stakeholders regarding mental health programs?
3. What mental health promotion activities are available and at what frequency are they conducted?
4. What is the level of willingness of stakeholders to participate in mental health promotion activities?
5. What are the common mental health disorders and their management regimens as identified by stakeholders?
6. What facilitating and hindering factors affect the implementation of an ideal mental health assessment framework?
7. What available mental health assessment framework can be proposed to improve community-based mental health programs in Cebu Province?

METHODOLOGY

Research Design

The study employed a convergent parallel mixed-methods design. Quantitative and qualitative evidence was gathered during the same general phase, analyzed using appropriate methods, and integrated to produce a multidimensional assessment of mental health access. The design was selected to combine measurable patterns in awareness, program activity, willingness, MH service management practices, and implementation factors with stakeholder experiences and contextual explanations.

The research was conducted in Cebu Province, where the study identified 50 local government units, 62 Rural Health Units, and 42 DOH Mental Health Access Sites as the principal service environment for the study. The province was selected because of its large and diverse population, multi-level health system, active local government participation, and partnerships with national government agencies and NGOs.

Sources of Data

Non-probability, purposive sampling was used to recruit information-rich participants who had direct roles in mental health program implementation, local governance, primary care, or community health. Eligible participants were adults residing or working in Cebu Province and represented Department of Health regional and provincial personnel, Provincial Health Office personnel, city and municipal health workers, DOH Mental Health Access Site personnel, local government officials, Sangguniang Kabataan officials, barangay health workers, barangay nutrition scholars, social workers, NGO representatives, and other expanded Local Health Board members.

Respondents were purposively selected from personnel affiliated with Mental Health Access Sites who were shown to be directly involved in providing mental health services and who had experience or had five (5) years' experience, in one way or another, participated in the implementation of mental health programs in the different local government units of Cebu Province.

The study reported a quantitative sampling distribution of 250 participants. In the results chapter, quantitative findings were presented with a total of 250 respondents while for the qualitative component, the study specified 26 key informant interview participants and 50 focus group discussion participants from multiple health and governance sectors. Key informant interview and focus group discussion participants were purposively selected to gather insights from stakeholders who had been involved in the mental health program for more than five (5) years from the time of the conduct of the study, in order to draw on their extended programmatic experience and institutional insight.

Table 1. Distribution of Respondents and Stakeholder Roles

System Level	Designation of Stakeholders	Roles	Sample
National / Regional Policy	DOH Regional Program Managers	Sets national and regional policy direction and resource allocation that determine Availability and Affordability at lower levels.	10
Provincial Coordination	Cebu Provincial DOH Office Development Management Officers; Cebu PHO Program Coordinators	Translate national policy into provincial operations; monitor the 42 Access Sites; primary source of provincial-level Continuity data.	23
Health Facility/Frontline Service Delivery	City/Municipal Health Office Doctors, Nurses, Midwives specifically MH Coordinators; DOH Retained Hospital Coordinators; NGO Program Representatives; Social Workers	Deliver direct MH services and obtain first hand data on Quality, MH management regimens and referral mechanisms of service users	62
Local Governance	LGU Officials; Sangguniang Kabataan (SK) Officials	Control local ordinances, budget allocation, and youth engagement plus the Policy Support pillar and a key determinant of Affordability and Availability.	55
Community-Based Health Workers	Barangay Health Workers (BHWs) and Barangay Nutrition Scholars (BNS)	Front line of Geographic Accessibility and Appropriateness; closest point of contact with residents.	95
Special Sectors	Other expanded Local Health Board members (School Nurse, Indigenous People Representative, PhilHealth Liaison, Senior Citizen President)	Represent vulnerable populations and cross-sectoral linkages required by the Participatory Development Theory anchor.	5
TOTAL			250

Two hundred fifty (250) respondents were purposively drawn for the quantitative strand, with distribution weighted toward the categories carrying the largest underlying population and the most frequent community contact who were the Barangay Health Workers, Barangay Nutrition Scholars, and City/Municipal Health Office MH Coordinators. Since this population is finite and institutionally identifiable, the 250 respondents

are justified as a high-coverage, near-total enumeration of the accessible sampling frame within the study's resource and time constraints, rather than as a probability sample of an undefined larger population.

Moreover, the sample size ensures multi-level representation (national-regional-provincial-local levels), highlights multi-perspectives insights as cited in Table 1 and their representation provides direct alignment with the objectives of this study and contextual validity of findings. Hence, data gathered demonstrates authenticity and credibility in the field of public health specifically in the implementation of mental health programs in the community.

For the qualitative strand, 26 key informant interview (KII) and 50 focus group discussion (FGD) participants were purposively selected using a maximum-variation strategy that preserved the same six system levels, with data collection continuing per stakeholder tier until no new codes or themes emerged as per the principle of information power (Malterud, Siersma, & Guassora, 2016) rather than a fixed a priori count. This maximum-variation approach increases information power independent of raw participant count, since it is designed to surface the widest possible range of perspectives on facilitating and hindering factors with fewer total participants than a homogeneous sample would require.

Instrumentation and Data Collection

Researcher-developed questionnaires were used for the quantitative component. A general questionnaire measured demographic characteristics, awareness of mental health programs, availability and frequency of mental health promotion and intervention activities, willingness to participate in mental health initiatives, and perceived facilitating and hindering factors. A separate questionnaire for mental health coordinators only and additionally assessed common mental health conditions, management regimens, and cadres involved in care.

The instruments used five-point Likert-type response scales. Awareness ranged from 1 (Not Aware) to 5 (Very Aware), willingness ranged from 1 (Not Willing) to 5 (Very Willing), and frequency of mental health activities used categories from Not Known or Never to Monthly.

To ensure the quality of the quantitative aspect of the study, the researcher-made questionnaire was subjected to review by three subject-matter experts who are program managers from the Department of Health Central Visayas Center for Health Development, Philippine Mental Health Association – Cebu Chapter, and program implementers on the ground such as doctors and nurses who evaluated its effectiveness, accuracy, and appropriateness as to substance and form eventually serve as content and face validation.

Furthermore, to test its reliability and accuracy, a pilot testing was conducted among 18 purposively selected LGU staff in selected Mental Health Access Sites in the Province of Bohol, a neighboring province of the research locale, to check item clarity, response burden and feedback on the research tools.

Cronbach's alpha was computed from this pilot administration to assess the internal consistency of the researcher-made questionnaires. The reliability analysis revealed an overall Cronbach's Alpha coefficient of **0.774**, indicating **acceptable level of internal consistency**. These results confirm that the instrument is **sufficiently reliable** and **suitable** for data gathering and additional statistical analyses. This approach verified that the results of the instrument produced reliable, dependable and consistent results.

After its finalization, the questionnaire was translated into Visayan (Cebuano) to improve respondent comprehension. Moreover, data collection used a hybrid modality by online forms and face-to-face paper-and-pen administration in order to accommodate variation in respondents' connectivity and access across urban and rural LGUs.

In addition, triangulation across multiple data sources was applied originating from the Likert questionnaire, key informant interviews, focus group discussions, and documentary analysis of DOH, PHO and LGU records was applied to further establish the reliability and validity of findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014), consistent with the convergent parallel design's requirement that both strands independently measure the same underlying constructs.

For the qualitative component, an interview aide-memoire comprising open-ended questions was developed and went through the same process as the quantitative questionnaire with regard to review and validation by the subject-matter experts described above, prior to its use in the key informant interviews and focus group discussions.

Data collection used both online and face-to-face modalities. Qualitative data were obtained through key informant interviews, focus group discussions, documentary analysis, field observations, and interview guides. These data explored implementation experiences, barriers to service access, stakeholder roles, local practices, policy gaps, and recommendations for improving mental health services.

Data Analysis

Qualitative data were analyzed thematically and through cross-case analysis. Interview and focus group responses were reviewed for recurring patterns, clustered themes, common experiences, and differences across stakeholder groups. Triangulation across questionnaires, interviews, focus group discussions, documentary sources, and professional perspectives was used to strengthen interpretation.

Quantitative data were summarized using descriptive statistics, particularly frequencies, percentages, and weighted means. Mean scores were interpreted according to the study's five-point scales to describe awareness, frequency of activities, and willingness to participate. Responses were analyzed using simple percentage (for categorical/checklist items) and weighted mean (for Likert-scale items), interpreted against a standard five-point qualitative descriptor scale (1.00–1.99 = Not Aware/Not Willing; 2.00–2.99 = Slightly Aware/Willing; 3.00–3.99 = Moderately Aware/Willing; 4.00–4.99 = Aware/Willing; 5.00 = Very Aware/Willing, with parallel descriptors for frequency items).

Quantitative and qualitative findings were subsequently integrated in the development and appraisal of the H.E.L.P. Assessment Framework. The two strands were merged through an explicit joint display (Section 3.8), following Fetters, Curry, and Creswell's (2013) integration framework, in which each variable's quantitative result and qualitative theme were compared and classified as convergent (confirmation), convergent with expansion, or discordant.

Ethical Consideration

Formal permission was obtained from relevant health offices and participating institutions. Participants were informed of the study purpose, voluntary nature of participation, privacy safeguards, and their right to decline participation. Written informed consent was obtained in English or Visayan, and interview or recording procedures were explained before data collection in compliance with Data Privacy Act. The study includes an ethical clearance document and letters authorizing study implementation.

RESULTS

Demographic Profile

Fifty-one (51) Mental Health Coordinators and 217 local leaders/non-coordinator health workers comprised the two respondent groups of the quantitative strand (total N = 250 minus non-response, with 268 raw entries across both instruments as fielded). Respondents were predominantly in the 33 to 42 years of age range, suggesting a mid-career workforce with accumulated leadership and technical experience. Women comprised the majority of respondents, consistent with the female-dominated composition of the local health workforce (nursing, midwifery, BHW, and BNS roles) in the Philippines. Among general respondents, Barangay Health Workers (32.72%) and Barangay Nutrition Scholars (16.13%) were the largest single categories, followed by midwives (14.29%) and nurses (13.36%).

Level of Awareness, Activity Frequency, and Willingness to Participate in MH Activities

Mental health coordinators demonstrated high familiarity with the mental health program. Their overall awareness mean was 4.37, interpreted as Very Aware. Awareness was highest for the existence of a DOH

Mental Health Access Site (M=4.65) and mental health services provided in the community (M=4.59). Lower, although still favorable, scores were recorded for background or expertise in mental health programs (M=4.12), availability of information and education materials (M=4.16), and referral systems and procedures (M=4.20).

Mental health promotion and intervention activities among mental health coordinators were less frequent than awareness levels would suggest. The overall mean was 3.17, interpreted as Bi-Annual. Mental health awareness campaigns were the most regularly conducted activity (M=3.98; Quarterly), whereas Psychological First Aid, psychoeducation, stress management, school or workplace seminars, and most Mental Health Month activities were generally conducted bi-annually.

Willingness among mental health coordinators was consistently high. The overall mean was 4.51, interpreted as Very Willing. The strongest response was for attending mental health trainings or workshops (M=4.69), followed by participation in community mental health awareness campaigns (M=4.57), advocacy for improved mental health services (M=4.55), and collaboration with other stakeholders or support for local mental health policies (M=4.51 each). Local leaders and non-mental-health coordinators likewise demonstrated favorable perceptions. Their overall awareness mean was 4.10 (Aware), with highest scores for awareness of community mental health services (M=4.29) and the existence of Mental Health Access Sites (M=4.26). Their mental health promotion and intervention activities were generally reported as Quarterly (overall mean=3.56), and their willingness to participate was Very Willing (overall mean=4.27).

Table 2. Summary of key quantitative ratings by stakeholder group.

Indicator	MH Coordinators	Non-MH Coordinators	Interpretation
Awareness of MH program	4.37	4.10	Very Aware / Aware
Frequency of MH activities	3.17	3.56	Bi-Annual / Quarterly
Willingness to participate	4.51	4.27	Very Willing / Very Willing

Common Mental Health Conditions and its Management Regimen

Among the 51 mental health coordinators, depression was the most frequently reported mental health condition (92.16%), followed by anxiety disorders (84.31%), substance use disorders (76.47%), behavioral disorders (74.51%), psychosis or schizophrenia (70.59%), developmental disorders (66.67%), and epilepsy (60.78%). Self-harm was reported by 54.90% of respondents. Dementia (37.25%) and bipolar disorder (1.96%) were less frequently reported.

Psychiatric evaluation or assessment and provision of psychotropic medicines through DOH Mental Health Access Sites were the most frequently reported management regimens (76.47% each). Two-way referral and home visits were reported by 58.82% of mental health coordinators, followed by Psychological First Aid (45.10%), psychosocial support processing (31.37%), debriefing and hospitalization (27.45% each), community support groups (25.49%), and grief or crisis counselling (23.53%). Nurses (86.27%) and doctors (82.35%) were the cadres most frequently identified as managing mental health problems, followed by midwives and barangay health workers (68.63% each).

Table 3. Frequent Mental Health Conditions among Mental Health Coordinators

Mental Health Disorders	Frequency (n=51)	Percentage (%)
Depression	47	92.16%
Anxiety disorders	43	84.31%

Substance use disorders	39	76.47%
Behavioral disorders	38	74.51%
Psychosis/Schizophrenia	36	70.59%
Developmental disorders	34	66.67%
Epilepsy	31	60.78%
Self-harm	28	54.90%

Facilitating and Hindering Factors

Local government support emerged as the most consistent facilitating factor across both groups. Among mental health coordinators, 88.24% identified LGU support as a facilitator, followed by availability of mental health professionals (74.51%) and funds or resources (70.59%). Among local leaders and non-mental-health coordinators, 88.02% identified LGU support, 83.41% active community participation, 77.88% training opportunities, and 68.66% the presence of DOH Mental Health Access Sites as enabling factors.

Table 4. Facilitating and Hindering Factors reported by Stakeholders

Factors	MH Coordinators	Non-MH Coordinators
LGU support (facilitator)	88.24%	88.02%
Availability of MH professionals (facilitator)	74.51%	66.82%
Funds/resources available (facilitator)	70.59%	61.75%
Lack of trained personnel (barrier)	86.27%	59.45%
Insufficient funds/resources (barrier)	82.35%	63.13%
Stigma related to mental illness (barrier)	80.39%	55.76%
Training opportunities gap (barrier)	35.29%	77.88%

Barriers differed somewhat in ranking but reflected the same underlying system constraints. Mental health coordinators most frequently identified lack of trained personnel (86.27%), insufficient funds or resources (82.35%), and stigma related to mental illness (80.39%). Local leaders and non-mental-health coordinators most frequently identified a gap in training opportunities (77.88%), insufficient funds or resources (63.13%), lack of trained personnel (59.45%), low awareness among residents (58.06%), and stigma (55.76%). Weak monitoring systems, coordination gaps, and poor access to mental health facilities were also reported.

Qualitative Findings

Cross-case analysis of focus group discussions and key informant interviews reinforced the quantitative findings. Participants described existing practices such as mental health consultations, home visits, awareness campaigns, psychiatrist visits, psychosocial interventions, partnerships with mental health organizations, and referral to higher levels of care. These practices demonstrated that community mental health services were present but uneven in frequency and institutional support.

Recurring qualitative barriers included stigma, inadequate numbers of trained personnel, medicine stock-outs, insufficient facilities, limited health financing, weak referral arrangements, inconsistent local ordinances, and gaps in coordination. Participants also emphasized the need for safe spaces, continuous mental health training, reliable supply of psychotropic medicines and access to mental health specialists, sustainable government support, and stronger intersectoral collaboration.

Department of Health representatives highlighted the importance of implementing existing mental health laws and policies at the community level, strengthening workforce capacity, protecting the rights of service users, and improving coordination across national, regional, provincial, municipal, and barangay levels. The combined findings supported a more holistic and sustainable community-based mental health assessment framework.

Furthermore, cross-case thematic analysis of KII and FGD transcripts generated six recurring themes that paralleled the quantitative constructs: (1) moderate awareness with persistent stigma and limited services such as general awareness was present, but some local-governance representatives reported no awareness of a formal program; (2) limited but existing community mental health initiatives like programs exist but are irregular and often folded into other activities; (3) strong community willingness to support mental health programs, expressed uniformly across FGD groups; (4) the need for comprehensive and continuous mental health care management, extending beyond medicines to counseling, spiritual support, and coordination with family and community support groups; (5) resource and system challenges affecting program sustainability, including transportation difficulty, medicine stock-outs, and local political dynamics; and (6) enablers and barriers in program development, with training, facility readiness, inter-agency collaboration, and specific mechanisms such as Mental Health Gap Action Programme (MhGAP) training, PMHA Memoranda of Agreement (MOA), and PhilHealth Mental Health Outpatient packages identified as concrete facilitating levers.

Table 5. Summary of Quantitative and Qualitative Findings

Variables	Quantitative Result	Qualitative Result	Meta-Inference
Mental Health Awareness	MH Coordinators: overall “Very Aware/Aware”; highest item M = 4.65 (existence of Access Site); lowest item M = 4.12 (background/expertise on MH programs)	“Moderate Awareness with Persistent Stigma and Limited Services”; some LGU representatives reported no awareness of a formal program	Awareness is high among personnel with a designated MH role as coordinators but uneven among general local-governance actors; the qualitative strand explains the variance the quantitative mean alone cannot show, and surfaces stigma as a co-occurring, non-measured factor.
Program Availability & Frequency	Overall activity-frequency mean = 3.17 (“Bi-Annual”) for MH Coordinators; general respondents reported roughly quarterly	“Limited but Existing Community Mental Health Initiatives” —MH programs exist but are irregular and often folded into other activities	Both strands independently arrive at the same conclusion wherein programs exist but lack regularity so strengthening the credibility of the finding and directly supporting the H.E.L.P. specifically ‘Health Promotion’ pillar and its recommendation for a fixed, year-round activity calendar.
Willingness to Participate	Overall mean = 4.51 (“Very Willing”) across eight participation indicators, including training attendance (M = 4.69)	“Strong Community Willingness to Support Mental Health Programs” across all FGD groups	High confidence finding: Willingness is not a barrier to program scale-up; the constraint lies elsewhere in the system like funding, personnel, facilities), which the two strands jointly localize.

MH Problem Management Practices	Depression most common (92.16%); dominant regimens are psychiatric evaluation and psychotropic medicine provision (76.47% each), two-way referral and home visits (58.82% each)	KII theme (MH Coordinators): “Need for Comprehensive and Continuous Mental Health Care Management” — adds counselling, spiritual support, and coordination with family/support groups alongside medicines and follow-up	The clinical or pharmacological core of management is confirmed by both strands, while the qualitative strand expands the construct to include culturally embedded, family- and faith-based coping mechanisms not captured in the closed-ended checklist — suggesting that this evidence be added to future instrument revisions.
Perceived Hindering Factors	Lack of trained personnel (86.27%), insufficient funds (82.35%), stigma (80.39%), poor access to facilities (50.98%)	“Resource and System Challenges Affect Program Sustainability” — adds transportation difficulty, medicine stock-outs, local political dynamics, and caregiver burnout	The top three quantitative barriers are independently corroborated qualitatively; the qualitative strand additionally surfaces geographic/logistical (transport) and political-economy (local politics, stock-outs) barriers that the fixed-choice quantitative checklist did not explicitly list, pointing to Geographic Accessibility and Continuity gaps not fully captured numerically.
Perceived Facilitating Factors	LGU support (88.24%), MH-professional availability (74.51%), funds (70.59%), community participation and DOH Access Sites (60.78% each)	“Enablers and Barriers in Mental Health Program Development” corroborates on training, health facility readiness, inter-agency collaboration, and psychotropic medicines availability; DOH-level KII highlights specific initiatives such as MhGAP Training, PMHA MOA with LGUs, PhilHealth Mental Health Outpatient Packages)	Qualitative data names the concrete instruments such as MOAs, capacity building activities, health, financing mechanism through which the quantitatively ranked facilitators actually operate, giving the H.E.L.P. Framework implementable levers rather than abstract categories.

The above table highlighted a note-worthy meta-inference since it indicates that the researcher - made instruments and the KII and FGD guides, though independently administered, were measuring the same underlying phenomena with consistent direction leading to overall credibility to the dataset as a foundation for the H.E.L.P. Assessment Framework. Also, it depicts that the mental health access in Cebu Province is currently constrained less by demand-side factors such as awareness which is adequate among designated personnel and willingness is very high across all stakeholder groups.

On the other hand, more efforts will be taken into the supply-side and system-level factors like workforce availability, funding, health facility availability, geographic reach, and continuity of referral and monitoring mechanisms. This meta-inference, which neither strand could support as strongly alone, directly justifies

prioritizing the Linkages to Care and Policy Support pillars of the H.E.L.P. Framework as the primary levers for near-term improvement while sustaining the already-strong awareness and willingness base captured under Health Promotion.

Taken together, the quantitative and qualitative strands of this convergent parallel study converged on five of the six constructs examined such as program availability and frequency, willingness to participate, management practices, and both hindering and facilitating factors and thereby showed complementary expansion on the sixth construct (awareness), where qualitative data explained the variability that the quantitative mean alone could not.

No discordant findings were observed between strands, hence, this convergence strengthens the credibility of the dataset as an empirical foundation for the H.E.L.P. Assessment Framework indicates that the constraints on mental health access in Cebu Province are concentrated on the supply side of the system such as health workforce, program funding, facility reach, and continuity of care rather than on stakeholder awareness or willingness wherein both of which were already found to be strong.

Integration of the quantitative and qualitative findings supported the H.E.L.P. Assessment Framework. The four domains are: (H) Health Promotion, which emphasizes sustained awareness, psychoeducation, stigma reduction, school and workplace activities, and community engagement; (E) Early Mental Health Intervention, which focuses on early recognition, initial assessment, Psychological First Aid, psychosocial support, and timely clinical management; (L) Linkages to Care, which strengthens two-way referral, mental health specialist access, home and community follow-up, medicine availability, and coordinated care networks; and (P) Policy Support, which calls for local resolutions, executive orders, ordinances, financing, workforce development, monitoring and evaluation mechanisms, and formalized multisectoral partnerships.

DISCUSSION

The findings show an important contrast between high stakeholder readiness and incomplete program institutionalization. Both mental health coordinators and other local stakeholders demonstrated substantial awareness and strong willingness to participate, yet the regularity of activities and the consistency of system support remained variable. This pattern suggests that community motivation is not the principal limiting factor. Instead, the more consequential constraints lie in health workforce capacity, health financing, referral systems, availability of psychotropic medicines, mental health facility and local policy implementation.

The high awareness reported by mental health coordinators is consistent with the mental health literacy literature. Jorm (2012) conceptualized mental health literacy as knowledge and beliefs that facilitate recognition, management, and prevention of mental disorders. Kutcher et al. (2016) similarly emphasized that mental health literacy should improve recognition, reduce stigma, and increase effective help-seeking. In this study, awareness was strongest for the existence of access sites and community services, but relatively weaker for referral procedures, professional expertise, and Information, Education and Communication (IEC) materials. These lower-scoring domains are operationally important because awareness of a program does not automatically translate into competence to navigate or deliver mental health care.

The frequency results point to a second implementation gap. Mental health coordinators generally reported activities only twice a year, whereas non-mental-health stakeholders reported quarterly implementation. Mental Health awareness campaigns occurred more regularly than structured interventions such as Psychological First Aid, psychoeducation, stress management, and school or workplace health activities. A sustainable community mental health system requires these interventions to become routine components of primary care and community governance rather than activities concentrated around annual observances.

The prevalence of reported depression and anxiety reflects the need for frontline providers to be equipped for common mental health conditions while retaining pathways for severe and complex cases. The heavy reliance on nurses and doctors indicates that primary care remains central to service delivery. At the same time, the relatively lower identification of psychiatrists, psychologists, and psychometricians demonstrates limited

specialist reach. This reinforces the relevance of stepped care, task-sharing, referral networks, and collaborative arrangements between primary care, specialists, social services, schools, and NGOs.

Local government support was the strongest facilitating factor across stakeholder groups. This finding is particularly relevant in a devolved health system because local governments influence budget allocation, staffing, infrastructure, local legislation, program prioritization, and community mobilization. The results therefore frame mental health access as both a health-service and governance issue. Community participation and NGO partnerships can expand reach, but sustainable implementation requires local institutional ownership.

The most prominent barriers were closely interconnected. A shortage of trained mental health personnel limits early recognition, referral, psychosocial response, and continuity of care. Insufficient financing restricts medicine availability, health facilities, supervision, and regular mental health program activities. Stigma suppresses help-seeking and community participation. Weak monitoring and referral systems fragment services. These interacting constraints support a systems perspective in which no single intervention is sufficient. Health workforce training must be linked to functional referral mechanisms, medicine access, supportive policies, financing, and community education.

The H.E.L.P. framework responds directly to these findings. Health Promotion addresses high awareness while seeking to make education and stigma reduction continuous. Early Mental Health Intervention responds to the need for timely identification and first-line action. Linkages to Care address the fragmentation identified in referral, mental health specialist access, and continuity of care. Policy Support translates stakeholder willingness and LGU influence into ordinances, budgets, role delineation, health workforce plans, and monitoring and evaluation mechanism. The H.E.L.P. framework therefore functions both as an assessment lens and as a program improvement pathway.

From a development administration perspective, the H.E.L.P. framework underscores that mental health access depends on coordinated institutions, accountable local governance, participatory action, and equitable distribution of resources. Its value is not limited to measuring service availability and it also identifies where governance and system functions must be strengthened so that existing policies are converted into accessible community services.

First, local governments should institutionalize mental health as a routine component of primary care and local development planning. Dedicated budget lines, local ordinances or resolutions, defined referral pathways, and performance monitoring can reduce reliance on episodic mental health campaigns.

Second, workforce development should be continuous and competency-based. Training should extend beyond mental health coordinators to physicians, nurses, midwives, barangay health workers, barangay nutrition scholars, social workers, school personnel, and local leaders. Capacity-building should include mental health literacy, early identification of MH problems, Psychological First Aid, suicide risk recognition, referral, rights-based care, and community engagement.

Third, referral and continuity mechanisms should be formalized. DOH Mental Health Access Sites should have clear two-way referral pathways with mental health specialists, hospitals, social services, schools, and partner organizations such as PMHA Cebu Chapter and Americares. Availability of psychotropic medicines, scheduled mental health specialist consultation, case follow-up, and home visits should be monitored as MH service-access indicators.

Another community engagement should be sustained throughout the year. The very high willingness of stakeholders represents an implementation opportunity. Programs can leverage this readiness through peer support, psychoeducation, barangay-level activities, school and workplace interventions, and public-private partnerships.

Finally, findings justify the prioritization of the Linkages to Care and Policy Support pillars of the H.E.L.P. Framework as the primary near-term levers for improvement, since these pillars most directly address the

Continuity, Geographic Accessibility, and Affordability gaps identified, while the Health Promotion pillar's existing strength in generating awareness and willingness should be sustained rather than re-built. Concretely, this suggests: (a) institutionalizing a year-round, rather than October-concentrated, activity calendar to close the continuity gap; (b) expansion of the specialized mental health workforce and strengthening referral pathways to the Central Visayas Electronic Health Referral System to close the Geographic Accessibility and quality gaps; and (c) pursuing the PhilHealth Outpatient Mental Health Package accreditation at the LGU level to close the affordability gap through financial risk protection.

Study Limitations

The study used purposive, non-probability sampling design limits statistical generalizability beyond the stakeholder population. Also, self-reported frequency and management practice data are subject to social desirability and recall bias specifically among mental health program coordinators. In addition, mental health service users were not included as a principal respondent group due to ethical requirements. Future validation of the framework should incorporate MH service user experiences, service utilization indicators, geographic accessibility, and longitudinal program outcomes to obtain complete assessment of MH access.

CONCLUSION

Mental Health access in Cebu Province is supported by strong stakeholder awareness, high willingness to participate, existing Mental Health Access Sites, active community involvement, and substantial local government influence. However, service delivery remains constrained by workforce shortages, training gaps, insufficient resources, stigma, inconsistent referral and monitoring systems, limited mental health specialist access, limited psychotropic medicines, and mental health facility constraints, and uneven local policy support.

The H.E.L.P. Assessment Framework provides a practical structure for addressing these gaps through Health Promotion, Early Mental Health Intervention, Linkages to Care, and Policy Support. The framework is most useful when applied as an integrated local health-system approach rather than as a stand-alone checklist. Its implementation should be accompanied by sustained financing, continuous workforce development, formal referral networks, year-round community engagement, and locally institutionalized mental health policies.

Moreover, this study is developed and empirically grounded the H.E.L.P. Assessment Framework for mental health access in Cebu Province that demonstrates through a convergent parallel mixed-methods design that stakeholder awareness and willingness are strong assets on which community-based mental health programming can build, while workforce, funding, facility, and continuity gaps on the supply side remain the primary constraints to be addressed.

RECOMMENDATION

Based on the data and conclusions reached, the following recommendations are presented:

1. Strengthen Mental Health Human Service Providers or Health Workforce through mapping roles, creating job descriptions of psychometricians assigned in health facilities or even schools, and prevent brain drain of doctors and nurses through incentives, compensations and other benefits;
2. Timely conduct of MH capacity building activities such as Basic Mental Health and Psychosocial Support (MHPSS) Training, Suicide Prevention Seminar, and Mental Health Gap Action Programme (MhGAP) Training not only in October but scheduled whole year round in order to prevent gaps in training opportunities, advocate for improved mental health services, and collaborate with other partners stakeholders to support mental health initiatives;
3. Obtain buy-in from Local Government Units to invest on Mental Health Programs and pitch in to Local Chief Executives to invest more on Mental Health initiatives and actively support the implementation of the program at grassroots level through ordinances, executive orders and barangay resolutions;

4. Improve mental health policies through establishment of a coordinated MH Council in the LGUs in order to identify clear role delineation of stakeholders and push for the implementation of active multisectoral involvement of government, non-government organizations and civil society organizations towards implementation of the H.E.L.P. Assessment Framework;
5. Encourage active and strong community support towards mental health awareness by identification of Mental Health Champions for program sustainability, advocate for easy identification of “safe space” or mental health counselling rooms in the localities and push for more initiatives to obtain possible good practices in mental health;
6. Encourage LGUs to apply for accreditation in Outpatient Mental Health Packages in order to achieve financial risk protection through claims and ensure access to quality mental health services by sustainable program funding;
7. Ensure supply of psychotropic medicines timely inventory and updating of requisition issuance slip as part of the reportorial requirements of DOH Access Sites;
8. Expedite referral of MH service users from health centers up to the higher levels of care such as psychiatric facility and be part of the Central Visayas Electronic Health Referral System;
9. Advocate to health facilities to allocate a Mental Health Room so that clients with MH problems will be readily be identified, managed and provided psychosocial support without stigma and discrimination; and
10. For future research, extend data collection to mental health service users directly, and develop policy briefs to sustain multi-stakeholder buy-in.

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