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Introduction

The World Health Organization refers to mental health as a “state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community” (WHO, 2022). It is an integral part of health and is crucial in determining quality of life and productivity. In recent years, even prior to the pandemic, there has been a growing concern over mental health trends globally, particularly among the adolescents. It is estimated that one in seven adolescents (10–19-year-olds) experience adverse mental health conditions (WHO, 2021), with depression and anxiety as the two most common mental health concerns among young people.

In the Philippines, the mental health of adolescents is of great concern. The Global School-Based Student Health Survey 2019 Fact Sheet on the Philippines (WHO, n.d.) revealed that the percentage of adolescents (ages 13-17) who seriously considered attempting suicide increased from 11.6% in 2015 to 23.1% in 2019. Those who attempted suicide were about 16.8% in 2015 and in 2019 it rose to 24.3%. Results from the recently concluded Young Adult Fertility Survey (UPPI, 2021) likewise show increasing trends in suicide ideation and suicide attempts among Filipino adolescents in the last decade.

The COVID-19 pandemic, which started in 2020, has led to a significant increase in the prevalence of these mental health conditions globally (WHO, 2022), with younger people more affected psychologically than adults (Hechanova et al., 2022; Tee et al., 2020; Malolos et al., 2021). The imposed safety restrictions, i.e., community lockdowns, home confinements of vulnerable populations including children and adolescents, and limited social interactions may have fostered a sense of social isolation among the youth. These conditions contributed to higher psychological distress (Aknin et al., 2022) and mental health issues (Fancourt et al., 2021). Added to this, the curriculum shift to online learning may have also led to adverse mental health consequences (Alibudbud, 2021). Aside from being deprived of the usual interactions with classmates and teachers, students had to deal with technological demands and information overload on their own without much peer support (Magsambol, 2020; Adonis, 2021).

Goal 3 of the United Nations Sustainable Development Goals includes mental health which acknowledges its important role in achieving the targets for health and well-being. This chapter describes the mental health status of Filipino adolescents and their access to mental health care before and during the COVID-19 pandemic using data from the Longitudinal Cohort Study on the Filipino Child (LCSFC).

Measures

The Child Behavior Checklist (CBCL) and Youth Self Report (YSR), designed to be administered to parents and adolescents aged 11-18 respectively, were administered to assess mental health outcomes among the LCSFC cohort. These parallel instruments are part of the Achenbach System of Empirically Based Assessment (ASEBA) forms that measure competencies, adaptive functioning, and problem behaviors (Achenbach and Rescorla, 2001). This chapter focuses on CBCL and YSR items that constitute depressive

and anxiety problem scales as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM) (APA, 2013). The mental health status of the LCSFC cohort adolescents was measured starting at age 11 (Wave 2 conducted in 2018). In this wave the full CBCL questionnaire was administered to the cohort's mothers or primary caregivers. At age 13 (Wave 4 in Q1 2020), the YSR was administered to the cohort themselves. In the phone survey conducted in the early stage of the pandemic (Wave 4a in Q4 2020; cohort at age 14), with the mothers/caregivers as respondents, only specific CBCL items related to the DSM-oriented anxiety problem scales were asked. In the phone survey in the later part of the pandemic (Wave 5 in 2021; cohort at age 15), the YSR was again administered to the cohort adolescents. These measures capture the cohort's mental health status pre-pandemic (Waves 2 and 4) and during the pandemic (Waves 4a and 5).

Both the CBCL and YSR consist of 112 questionnaire items related to behavioral, emotional, social, and thought problems experienced by the adolescents within the past six months. The response categories and their numeric equivalents for each item range from "Not True" (scored as 0), "Somewhat/Sometimes True" (score:1), to "Very/Often True" (score: 2). When summed up, higher scores correspond to more severe mental health problems.

The DSM-oriented depression and anxiety problem scale items for YSR are listed in Table 6.1. Parallel items (from the perspective of mothers/caregivers) were used for CBCL. The items in these scales have been rated to be very consistent with DSM criteria for disorders (Achenbach, 2013). The numeric values for all responses in each scale were summed up to determine the respective depression and anxiety problem composite scores. These scores were further categorized into depression/anxiety severity levels: normal, borderline, and clinical range based on cut-off t-scores specific to age and sex defined by the Achenbach norming system.

Borderline range implies that scores are high enough to be of concern, signifying potential problematic behaviors, but not so high as to indicate clinical symptoms. While clinical range indicates the presence of clinical symptoms of the behavior. In the Achenbach scoring system, males have lower cut-off scores than females for severe categories in certain DSM scales, or that it takes a lower mean score for males to be classified as clinical or borderline compared to females.

Table 6.1. DSM-Oriented Problem Scale Items

Depressive Problems	Anxiety Problems
<i>There is very little that I enjoy</i>	<i>I'm too dependent on adults</i>
<i>I cry a lot</i>	<i>I am afraid of certain animals, situations, or places, other than school</i>
<i>I deliberately try to hurt or kill myself</i>	<i>I am afraid of going to school</i>
<i>I don't eat as well as I should</i>	<i>I am afraid I might think or do something bad</i>
<i>I feel worthless or inferior</i>	<i>I am nervous or tense</i>
<i>I feel too guilty</i>	<i>I have nightmares</i>
<i>I feel overtired without good reason</i>	<i>I am too fearful or anxious</i>
<i>I sleep less than most kids</i>	<i>I am self-conscious or easily embarrassed</i>
<i>I sleep more than most kids during day and/or night</i>	<i>I worry a lot</i>
<i>I think about killing myself</i>	
<i>I have trouble sleeping</i>	
<i>I don't have much energy</i>	
<i>I am unhappy, sad, or depressed</i>	

Results

This section presents the DSM-oriented depressive and anxiety problem scale results for all applicable waves, stratified by sex, island group (Luzon, Visayas and Mindanao), and urban/rural residence. Comparing CBCL against YSR results presents the limitation of comparing scores derived from different respondents. Studies have shown variations in cross-informant agreement between parents' and adolescents' reports (Rescorla et al., 2013; Wang et al., 2014; Mbekou et al., 2015). Assessments may also vary at different ages. Congruence analysis on ratings done by mothers/caregivers versus adolescents is currently being done by the LCSFC team.

Depressive Problem Scale

The depressive problem scale scores were obtained in Wave 2 (age 11), Wave 4 (age 13) and Wave 5 (age 15). Table 6.2 shows the summary of the scores across the three waves and stratifications. Mean scores significantly increased between Wave 2 and Wave 4; these plateaued between Wave 4 (immediate pre-pandemic period) and Wave 5 (later pandemic). This sharp increase in scores between Wave 2 and Wave 4 may be attributed to the following: a) differences in perspectives; in Wave 2, mothers/caregivers assessing adolescents to be less prone to depression compared to how the adolescents rated themselves in Waves 4, and b) true escalation of depressive symptoms due to the adolescents' transition into more mature pubertal stages (McGuire et al, 2019) starting in Wave 4 at age 13. This pubertal transition has been characterized as a period of volatile emotions as adolescents experience physiological and emotional changes.

Table 6.2. Depressive Problem Scale Scores*

Categories	Wave 2 (n=4,709)	Wave 4 (n=3,036)	Wave 5 (n=4,118)
Mean Score**	2.5 ± 0.1	4.5 ± 0.1	4.4 ± 0.1
By Sex			
Male	2.6± 0.1***	4.2±0.1****	3.9±0.1****
Female	2.4±0.1	4.8±0.2	4.9±0.1
By Island Group			
Luzon	2.4±0.1 ^a	4.5±0.2	4.2±0.1
Visayas	2.7±0.1	4.2±0.1	4.6±0.1
Mindanao	2.6±0.1	4.6±0.2	4.5±0.1
By Stratum			
Urban	2.6±0.1	4.5±0.2	4.7±0.1****
Rural	2.4±0.1	4.5±0.2	3.9±0.1

*Weighted results presented as mean ± standard error. Test for significant differences in means based on t-tests.

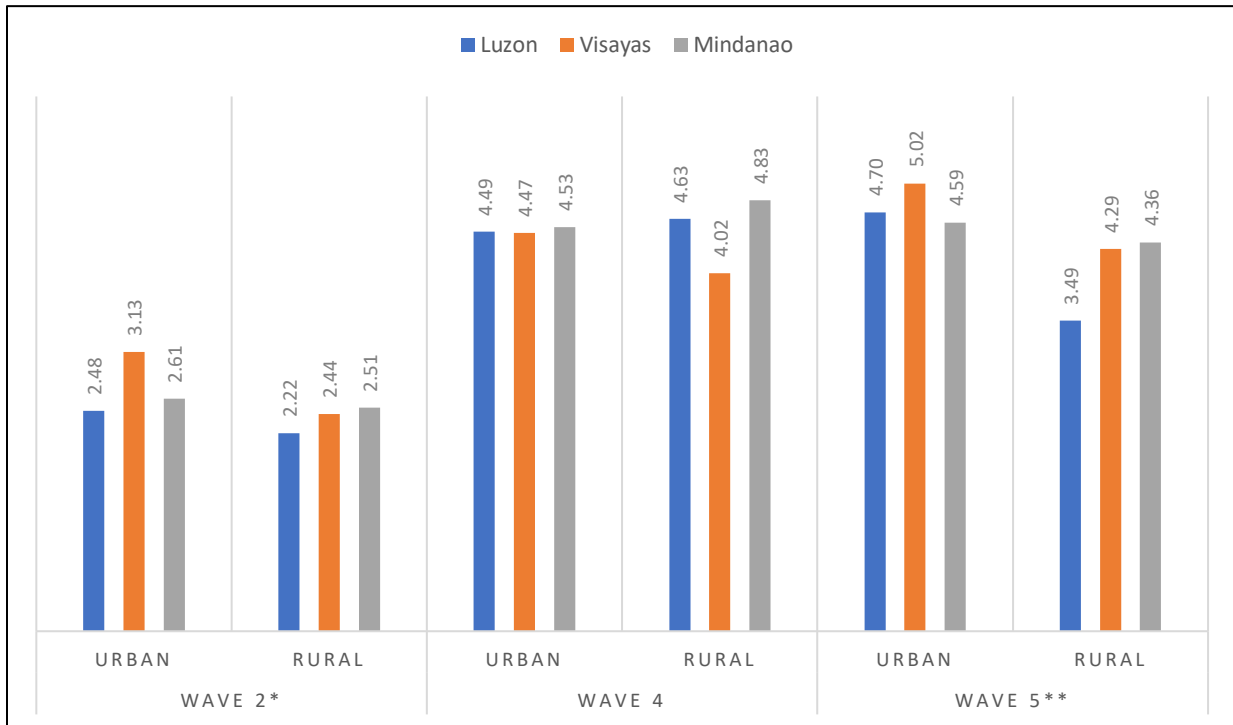
** Significant at: p<0.001 between Waves 2 and 4, and Waves 2 and 5 when means compared on a sample with complete data for all 3 waves (n=2,627); *** at p<0.05, **** at p<0.001, ^a at p<0.05 between Luzon and Visayas

Significant differences were also observed between males and females, with females having higher mean scores starting in Wave 4. This sex difference is consistent with reports from other studies (Campbell et al, 2021) and has been associated with differences in pubertal timing and experiences with females maturing earlier than males (Stumper and Alloy, 2021). Table 6.2 shows that in Wave 5, at age 15, the mean depressive problem score among the males decreased while this slightly increased among the females.

In terms of island groups, in Wave 2 the mean score in Luzon was lower than in Visayas and Mindanao but scores across island groups were not significantly different in later waves. The mean scores in the Visayas showed an increasing trend across waves unlike in Luzon and Mindanao where the mean scores slightly decreased by Wave 5. Urban adolescents had a significantly higher mean score than their rural peers at age 15. Mean scores among rural adolescents decreased to 3.94 in Wave 5 from 4.50 in Wave 4.

Figure 6.1 compares mean depressive problem scale scores between urban/rural adolescents within island groups. Results show that, except for Luzon and Mindanao in Wave 4, rural adolescents have lower mean scores than their urban counterparts. Across Luzon, Visayas and Mindanao, mean scores increased from Wave 2 to Wave 5 among urban adolescents while mean scores of those in the rural areas decreased in Wave 5 except in the Visayas.

Figure 6.1. Depressive Problem Scale Mean Scores by Urban/Rural Stratum and Island Group

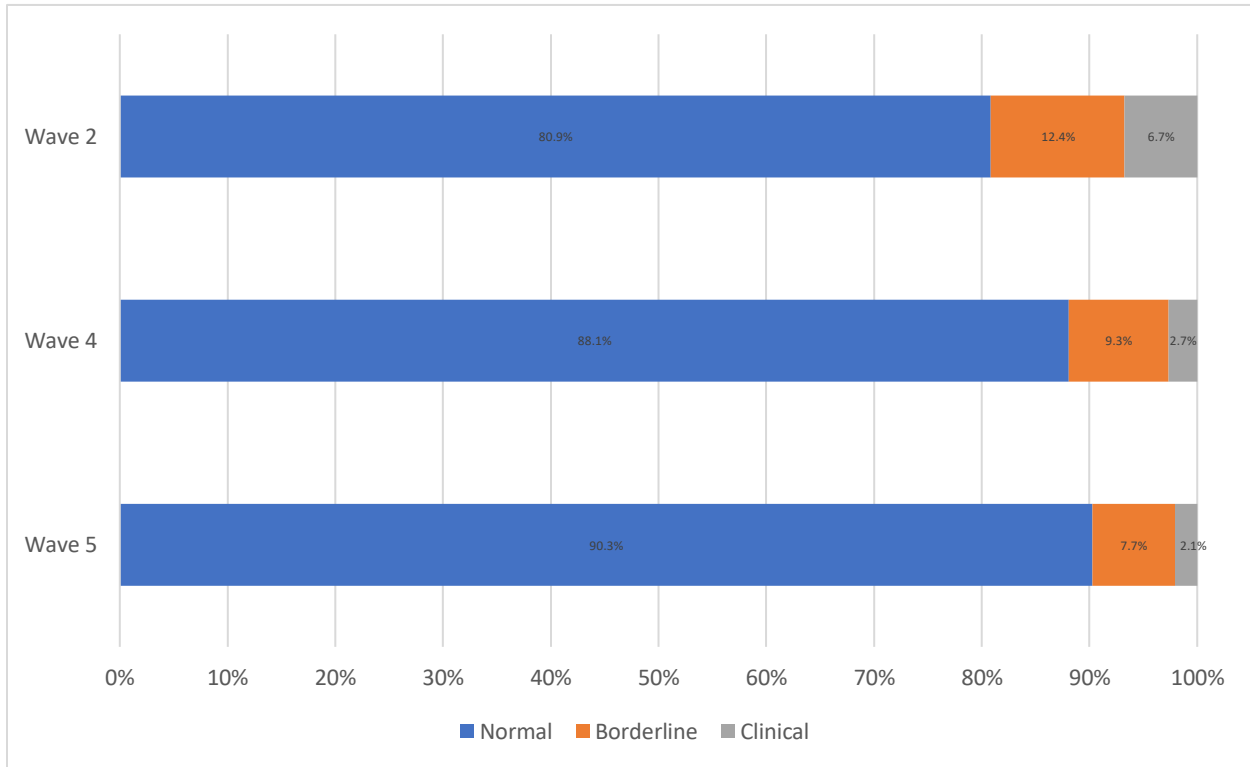


*Significant at $p < .000$ Visayas Urban/Rural

**Significant at $p < .000$ Luzon Urban/Rural, $p < .007$ Visayas Urban/Rural

Figure 6.2 shows the distribution across waves when scores are classified into three categories of severity in the depressive problem scale. This figure shows data on adolescents with complete data in all three waves and thus illustrates the true trend in levels of severity over time. The proportions classified as clinical or borderline significantly decreased between Waves 2 and 4, and those falling under normal range increased, reflective of the pattern seen in mean scores. The proportions classified as borderline or normal continued to significantly decrease between Waves 4 and 5. Thus, although there was an increase in mean scores as adolescents entered more mature pubertal stages (see Table 2), they were unlikely to be classified in the clinical range by ages 13 and 15.

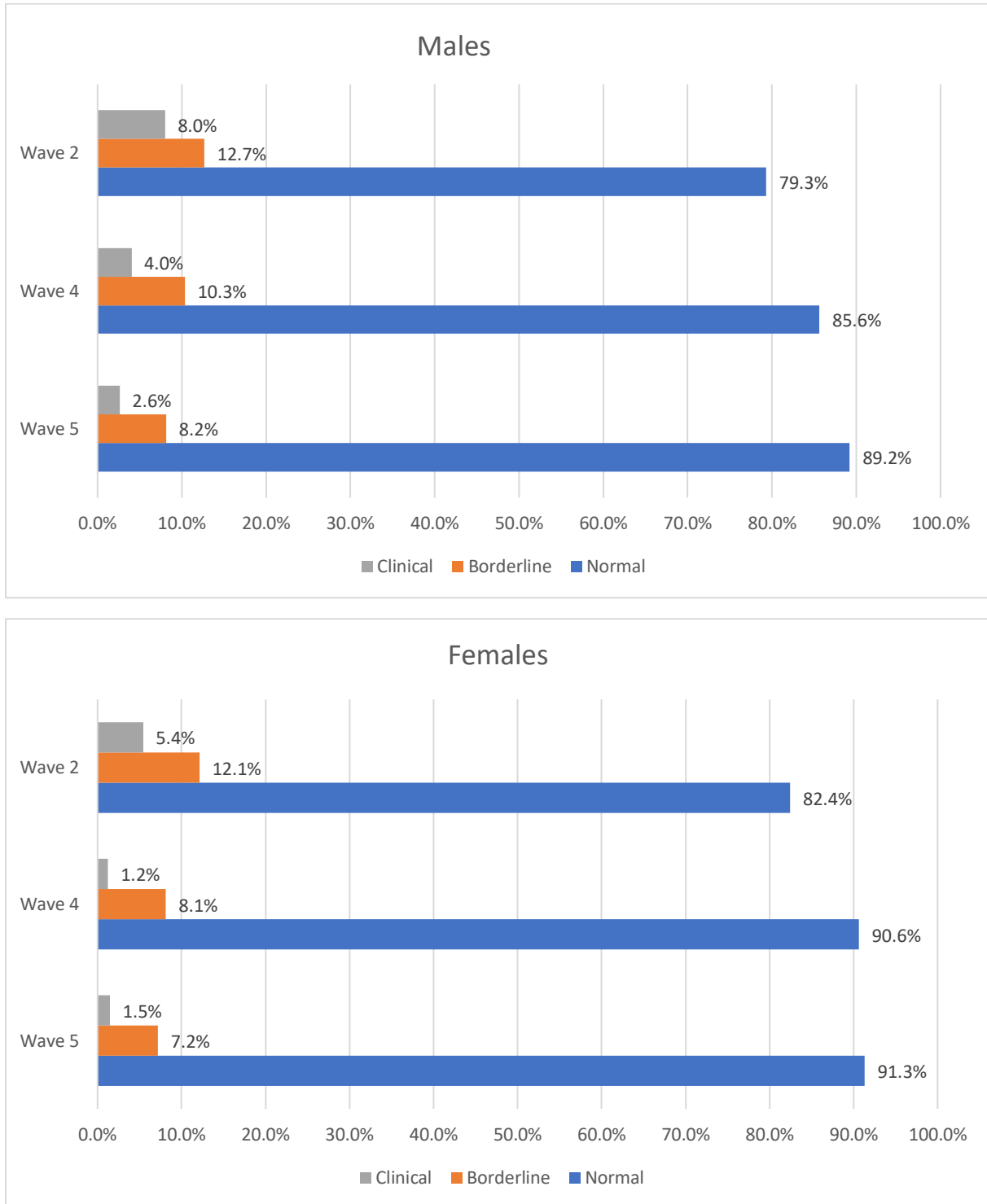
Figure 6.2. Depressive Problem Scale Categories by Wave (n=2,627)*



*Unweighted proportions across waves using sample with complete data. Except for the proportions in clinical range between Waves 4 and 5, the proportions in each category significantly changed over time (significant at $p < 0.05$ based on chi-square tests of independence).

In terms of distribution by sex (Figure 6.3), the same decreasing trend over time is seen in the clinical and borderline ranges, and increasing trend in the normal range. Noticeable though is the relative high proportion of males than females who were classified in the clinical range, despite the decreasing trend in mean scores shown in Table 6.2. This is partly explained by the fact that males have lower cut-off scores than females for both the clinical and borderline ranges particularly with YSR.

Figure 6.3. Depressive Problem Scale Categories Across Waves by Sex (n=2,627)*



*Unweighted proportions across waves stratified by sex using sample with complete data. Among females, the proportions in each category significantly changed between Waves 2 and 4 but not between Waves 4 and 5. Among males, except for proportions in borderline range between Waves 2 and 4, the proportions in each category significantly changed over time. Significant at $p < 0.05$ based on chi-square tests of independence.

Anxiety Problem Scale

The DSM-oriented anxiety scale items were administered in four waves: Wave 2 (age 11), Wave 4 (age 13), Wave 4a (age 14) and Wave 5 (age 15). Table 6.3 shows the mean scores across the waves and stratifications. Anxiety problem scale mean scores significantly increased between age 11 and age 15, particularly between the early (Wave 4a) and later (Wave 5) stages of the pandemic.

Looking at the distribution by sex, female adolescents' anxiety mean scores were higher than the males at age 13 (Wave 4) and age 15 (Wave 5). This is consistent with the literature pointing to adolescent females being prone to mental health problems as compared to males (Campbell et al., 2021) Among the island groups, mean scores generally increased during the pandemic except for Luzon which showed a slight decrease between Waves 4 and Wave 4a. Adolescents from Visayas and Mindanao had significantly higher mean scores than those from Luzon, with the values in Mindanao slightly higher than in the Visayas. No significant differences were detected between urban/rural residence. There was no change in mean scores in Wave 4 (immediate pre-pandemic) and Wave 4a (early pandemic). However, values were higher in the later stages of the pandemic (Wave 5).

Table 6.3. Anxiety Problem Scale Mean Scores*

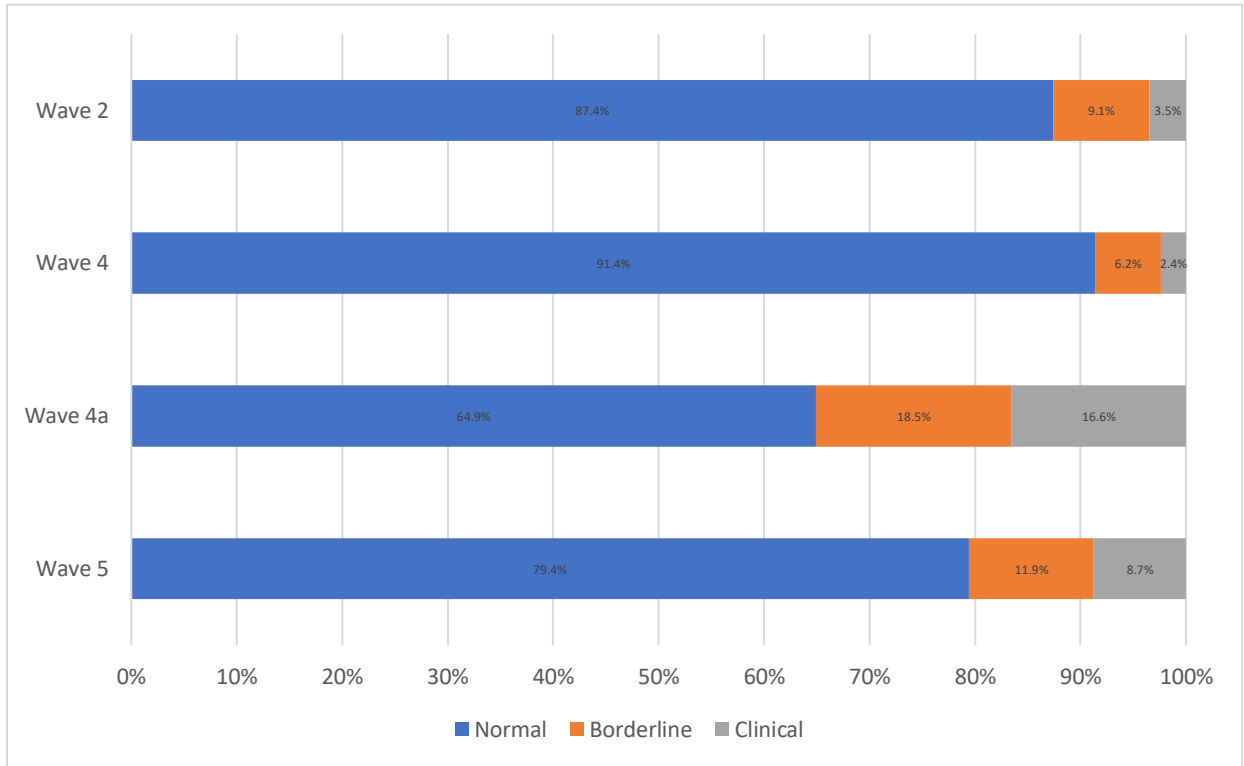
Categories	Wave 2 (n=4,714)	Wave 4 (n=3,036)	Wave 4a (n= 3,148)	Wave 5 (n=4,118)
Mean Score**	2.5 \pm 0.1	4.0 \pm 0.1	4.0 \pm 0.1	5.0 \pm 0.1
By Sex				
Male	2.6 \pm 0.1	3.7 \pm 0.1****	3.9 \pm 0.1	4.7 \pm 0.1****
Female	2.4 \pm 0.1	4.3 \pm 0.2	4.1 \pm 0.1	5.4 \pm 0.2
By Island Group				
Luzon	2.0 \pm 0.1 ^{a,b}	3.4 \pm 0.1 ^{a,b,c}	3.1 \pm 0.1 ^{a,b}	3.6 \pm 0.1 ^{a,b,c}
Visayas	2.9 \pm 0.1	4.4 \pm 0.1	4.9 \pm 0.1	6.4 \pm 0.2
Mindanao	3.0 \pm 0.2	5.1 \pm 0.3	5.3 \pm 0.2	6.9 \pm 0.2
By Stratum				
Urban	2.6 \pm 0.1	3.9 \pm 0.2	3.9 \pm 0.1	5.1 \pm 0.2
Rural	2.4 \pm 0.1	4.1 \pm 0.2	4.1 \pm 0.1	4.9 \pm 0.2

*Weighted results presented as mean \pm standard error. Test for significant differences in means based t-tests.

** Significant at: $p < 0.001$ between Waves 2 and 4, Waves 2 and 4a, Waves 2 and 5, and Waves 4a and 5 when means compared on a sample with complete data for all 3 waves (n=2,047); *** at $p < 0.05$, **** at $p < 0.001$, at $p < 0.05$ ^a between Luzon and Visayas, ^bLuzon and Mindanao, ^cVisayas and Mindanao

The anxiety problem scale scores were likewise categorized into normal, borderline, and clinical ranges. Figure 6.4 illustrates anxiety problem categories across the waves on a sample with complete data in all four waves, illustrating the true trend in levels of severity in this scale over time.

Figure 6.4. Anxiety Problem Scale Categories by Wave (n=2,047)

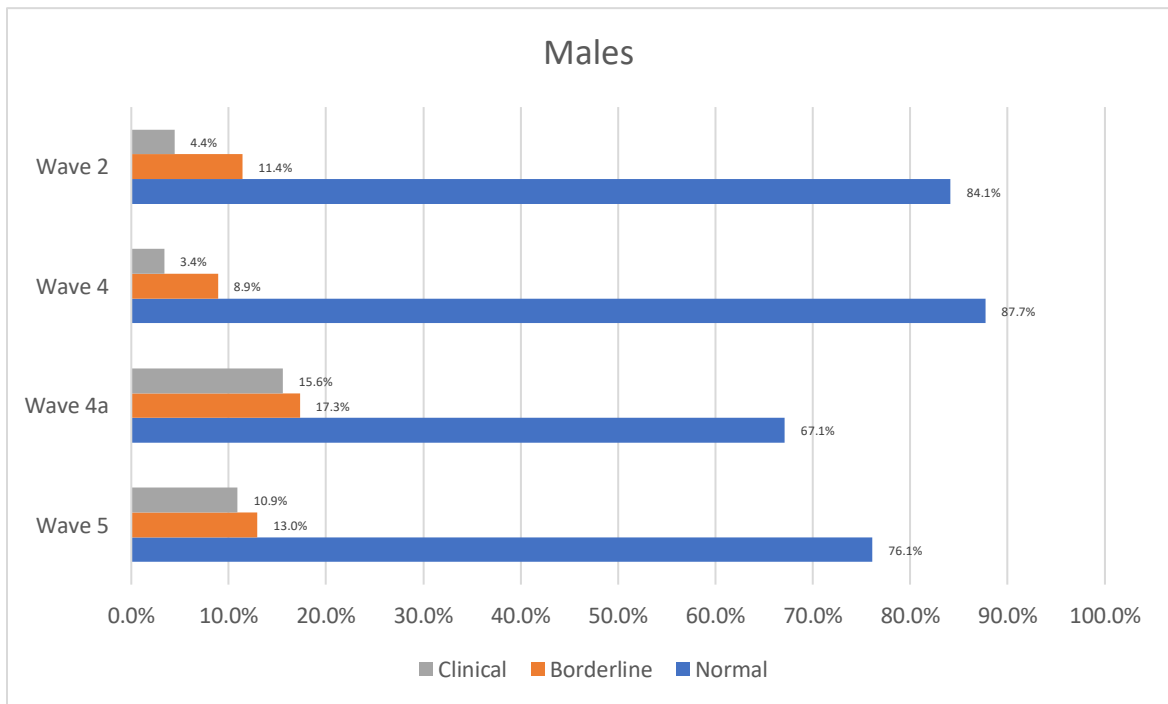
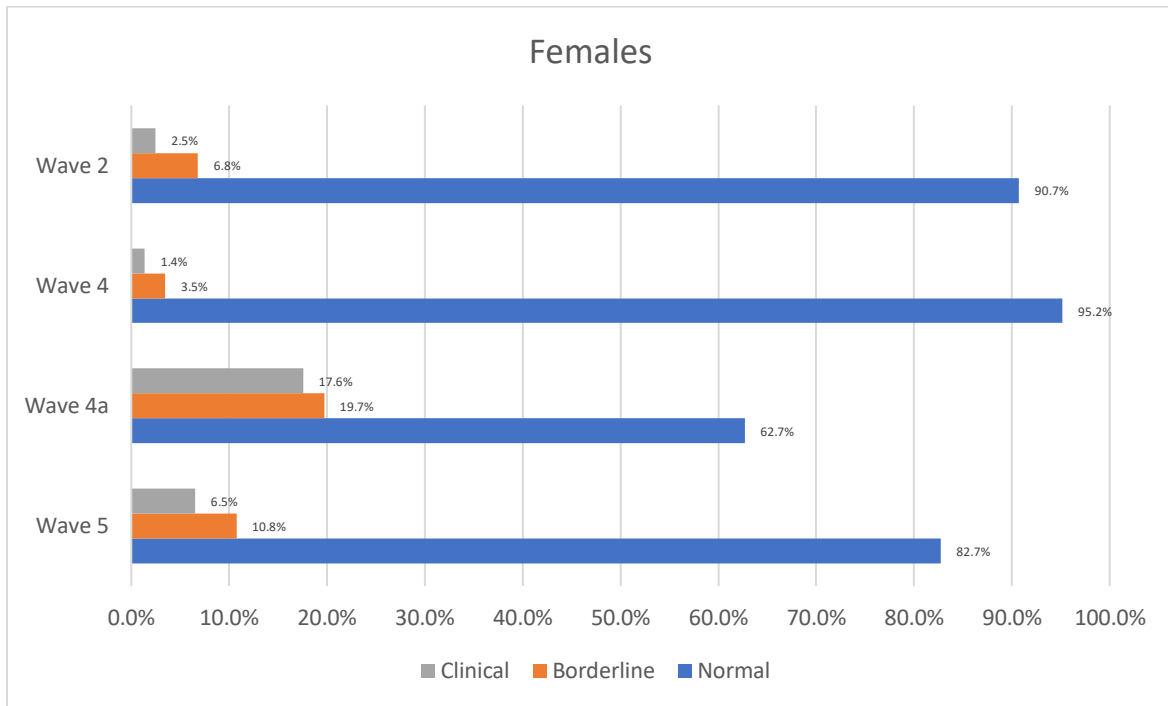


*Unweighted proportions across waves using sample with complete data. All the proportions in each category significantly changed over time (significant at $p < 0.05$ based on chi-square tests of independence).

In the pre-pandemic period, the proportion of adolescents classified in the clinical range decreased to 2.4% in Wave 4 from 3.5% in Wave 2. However, by the early pandemic survey (Wave 4a), the proportion falling under this range sharply increased to 16.6%. In the later stage of the pandemic (Wave 5), the proportion decreased to 8.7% but was nevertheless higher than pre-pandemic values. The same pattern was observed with the borderline group. The decline in Wave 5 could be due to the adolescents' adaptation to the situation after having been exposed to the pandemic for a year.

The same trend was observed when comparing the distribution by sex (see Figure 6.5). Similar to the depressive problem scale results, higher proportions of males than females were classified as either clinical or borderline during the later stage of the pandemic or at age 15 despite males having significantly lower mean scores than females as shown in Table 6.3. Once again, this is explained by the fact that males have lower cut-off scores than females for severe categories.

Figure 6.5. Anxiety Problem Scale Categories Across Waves by Sex (n=2,047)*



*Unweighted proportions across waves stratified by sex using sample with complete data. Among females, except for those within clinical range between Waves 2 and 4, the proportions in each category significantly changed over time. Among males, except for proportions in clinical or borderline range between Waves 2 and 4, the proportions in each category significantly changed over time. Significant at $p < 0.05$ based on chi-square tests of independence.

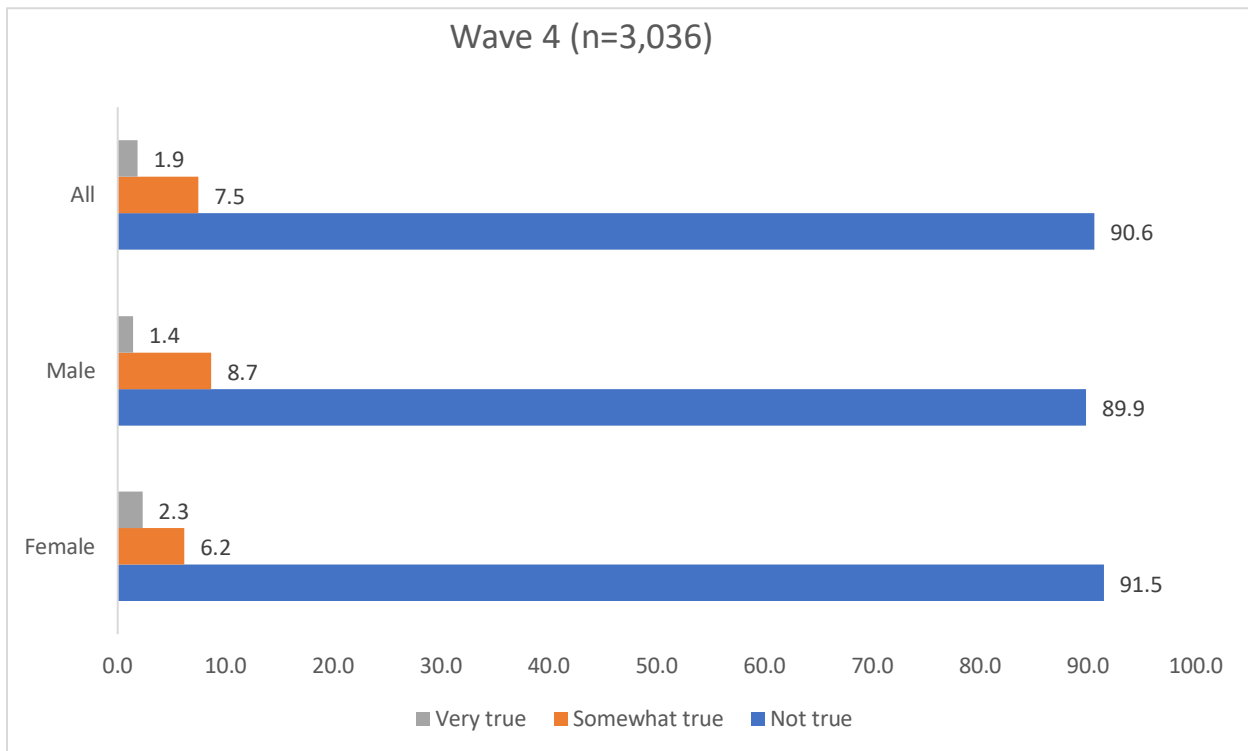
Suicide Attempt and Ideation

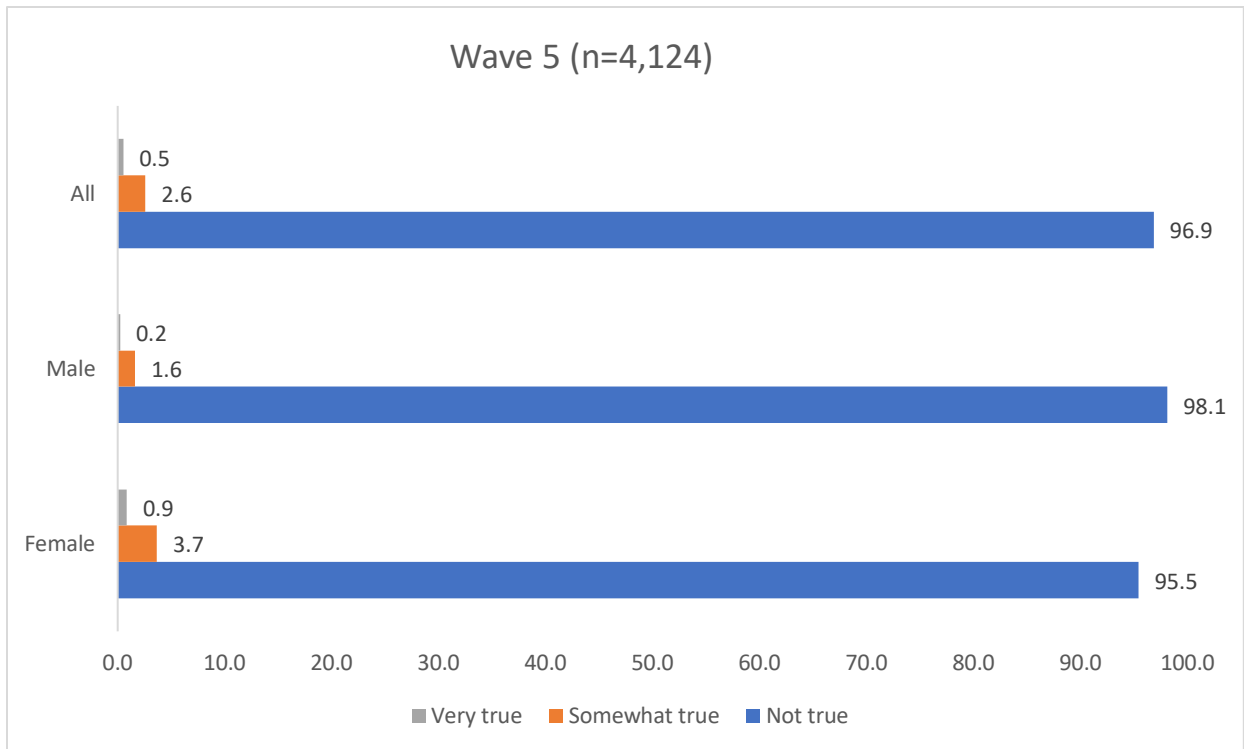
The adolescents' responses to the YSR item on suicide attempt (*I deliberately try to hurt or kill myself*) and suicide ideation (*I think about killing myself*) were also examined. Only YSR data were considered in this analysis to directly capture these constructs from the adolescents' perspectives rather than as perceived by mothers/caregivers using CBCL data.

Figure 6.6 shows how the adolescents responded to the suicide attempt question. At age 13 there were 60 adolescents (1.9%) who confirmed that this behavior was very true. At age 15, the corresponding number was narrowed down to 20 (0.5%). Of those with data in both waves, one persistently responded "Very true" in both waves.

The proportion of adolescents who responded as "Somewhat true" possibly indicating that they may have occasionally tried to hurt or kill themselves is higher in Wave 4 (age 13) at 7.5% than in Wave 5 (age 15), 2.6%. That is about 219 adolescents in Wave 4 versus 106 in Wave 5. For this question, significant differences in responses between males and females were only observed in Wave 5, with more females reporting greater inclinations to suicidal attempt. In contrast, in Wave 4 at age 13, there were more males than females who reported that they sometimes try to hurt or kill themselves although the sex difference was not significantly different in this wave.

Figure 6.6. Adolescent Responses to the Suicidal Attempt Question "*I deliberately try to hurt or kill myself*"*

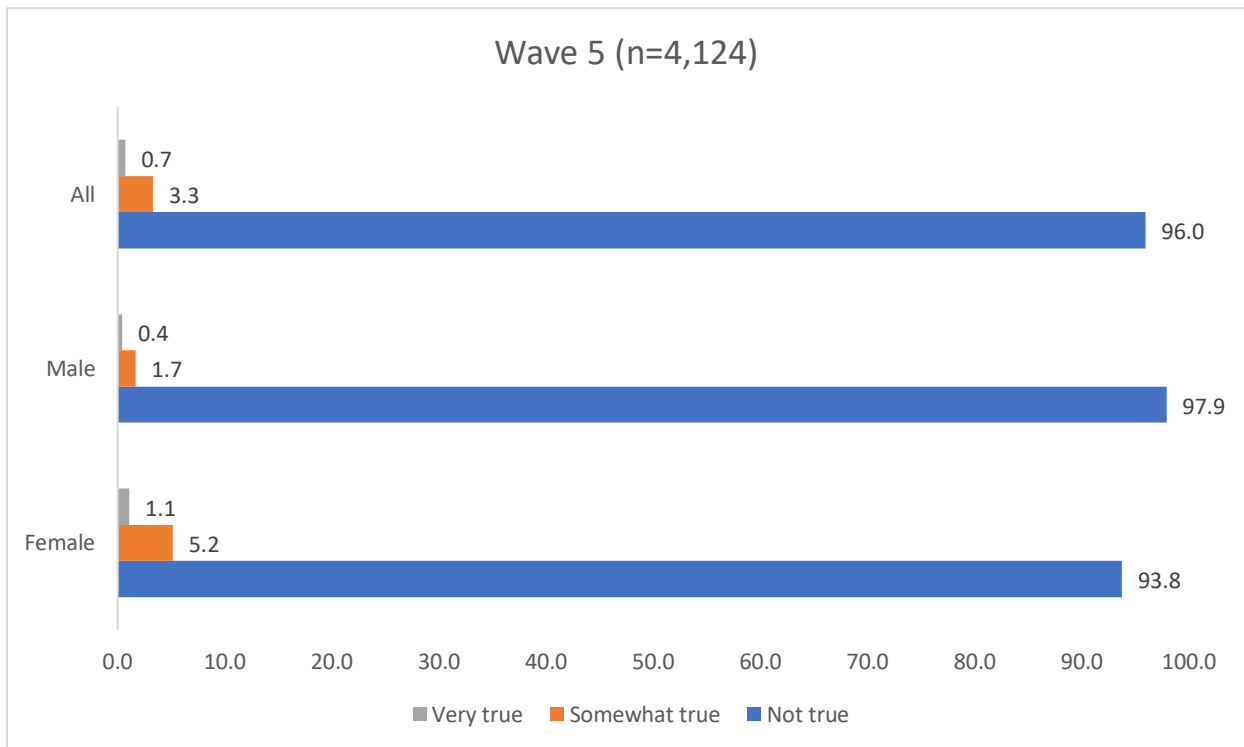
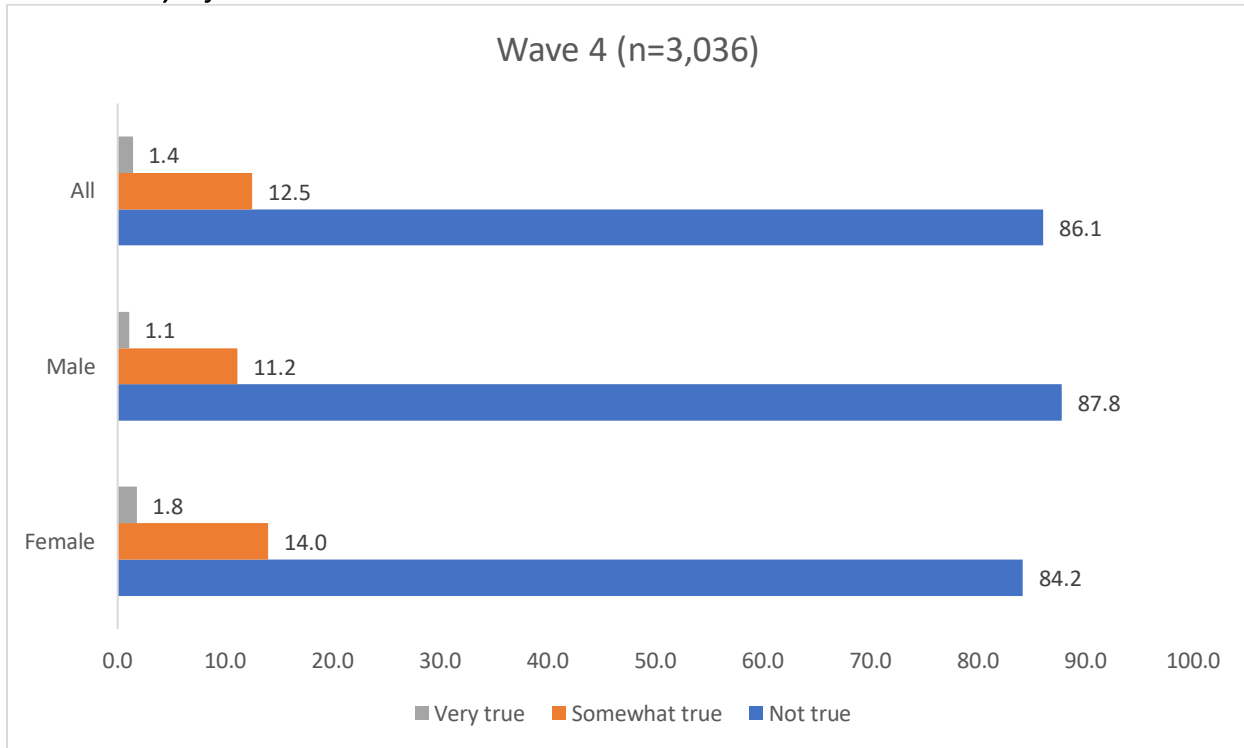




*Presented as weighted % stratified by sex in each wave; Significantly different by sex in Wave 5 at $p < 0.001$ based on chi-square test of independence. In a sample with complete data for both waves ($n=2,697$), the proportions in each category significantly changed over time.

A similar trend can be seen in the responses to the question on suicide ideation (Figure 6.7). A higher proportion of adolescents either confirmed thinking about suicide or admitted that they sometimes think about suicide in Wave 4 (at age 13) than in Wave 5 (at age 15). There were significantly more females than males who were inclined to suicidal ideation in Wave 5 as well as in Wave 4 (although not significantly different).

Figure 6.7. Adolescent Responses to the Suicidal Ideation Question "I think about killing myself"^{**}



*Presented as weighted % stratified by sex in each wave; Significantly different by sex in Wave 5 at $p < 0.001$ based on chi-square test of independence. In a sample with complete data for both waves ($n = 2,697$), the proportions in each category significantly changed over time.

Although overall, suicide ideation and suicide attempts decreased in Wave 5, it is still of great concern that this is being considered by adolescents as young as age 13. Female adolescents generally appear to be more at risk than their male counterparts in terms of suicide ideation and suicide attempt.

Availability and Access to Mental Health Related Services

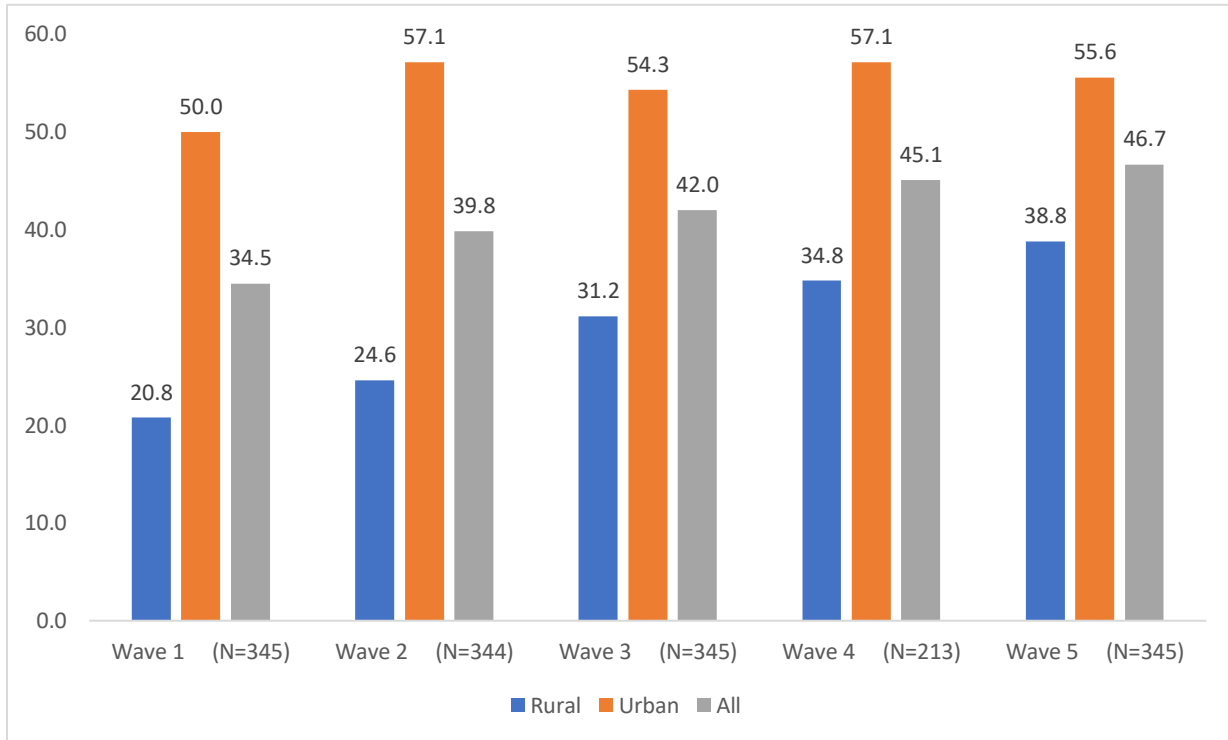
With the increasing concern regarding mental health problems, in 2018 the country signed to law the Mental Health Act (R.A. No. 11036). This promotes the delivery of mental health care services to the public especially at the local communities. The implementation of the law, however, is impeded by the limitations of the country in terms of resources (i.e., availability of trained mental health personnel and facilities, particularly at barangay levels).

The LCSFC collects community-level information at each wave and this section presents data on the availability of counseling services, adolescent clinics and mental health clinics in the barangays where cohort participants reside. Reported here are data from Waves 1 through 5 on the 345 barangays recruited at baseline. Due to the truncated data collection period for Wave 4 (as explained in the Introduction), only 213 barangays were visited for this wave and corresponding proportions may not be comparable to other waves. Data on new barangays where the cohort migrated to through the years are excluded.

Counseling Services

Figures 6.8 shows the proportion of barangays with facilities providing counseling services (for domestic violence, mental health and other concerns) from Waves 1-5 (2016-2021), stratified by urban/rural stratum. Availability of counseling service facilities in barangays significantly increased from 34.5% in 2017 (Wave 1) to 46.7% in 2021 (Wave 5). The most commonly mentioned facilities providing counseling were the barangay hall and the Violence Against Women and Children (VAWC) or Gender and Development (GAD) offices, implying that counseling are more likely sought for domestic violence. Having more of this type of service available in the barangay by 2021 is important. However, despite this development, these results also highlight the fact that in all the 345 barangays, there are still about more than half where these facilities are unavailable. For those who do not have such facilities in their barangay, the majority (about 80%) can access these services in neighboring barangays within the municipality. In terms of stratum (rural/urban) distribution, urban barangays have significantly more facilities for counseling services than rural barangays across all waves.

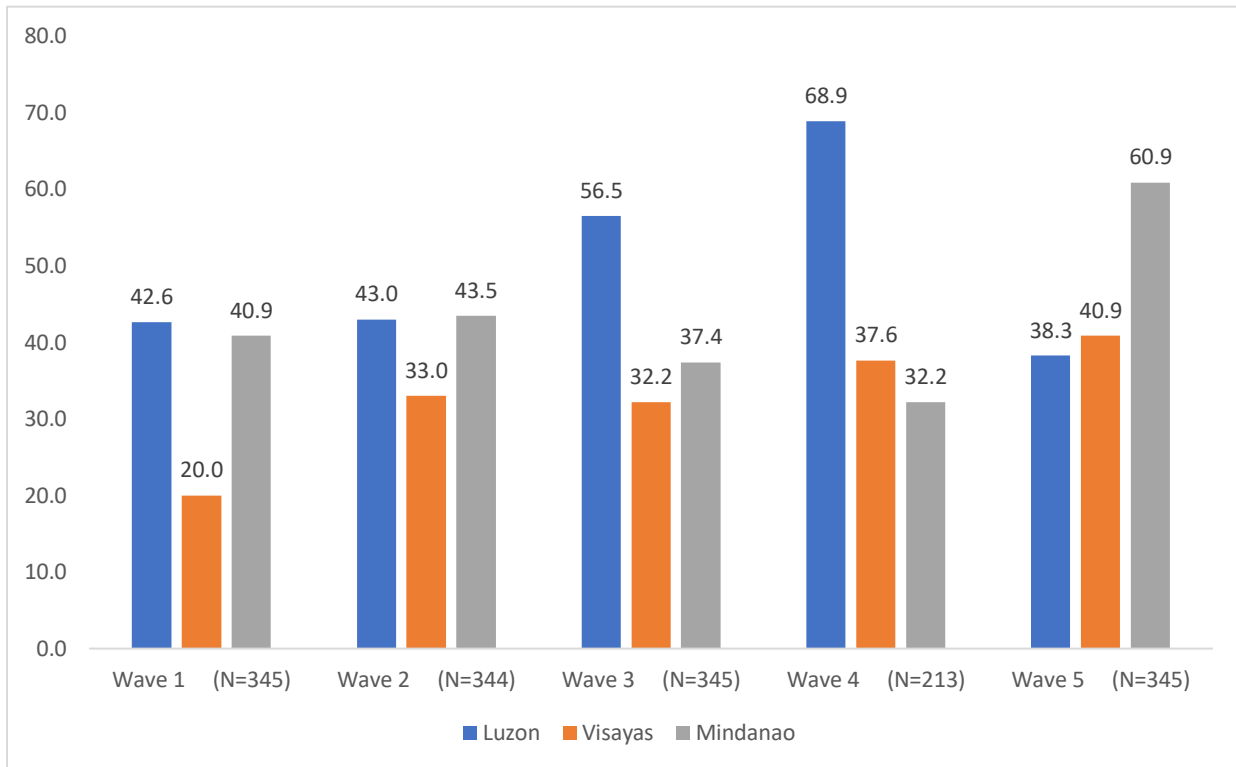
Figure 6.8. Percentage of Barangays with Counseling Services by Urban/Rural Stratum*



*Presented as %; significantly different at $p < 0.001$ between urban and rural barangays in all waves

When looking at the distribution of counseling services in barangays by island group (Figure 6.9), the proportions across Luzon, Visayas and Mindanao varied over time. In most waves, the Visayas barangays appear to have the lowest rates compared to those in Luzon and Mindanao. It is noticeable that the proportion of Luzon barangays confirming the presence of counseling services increased from Wave 1 (2017) up to Wave 3 (2019) (the increase in Wave 4 should be interpreted with caution given the smaller sample size), then sharply declined in Wave 5. The unavailability of services may have been caused by closures of offices and restrictions imposed by the government during the pandemic. This is ironic because the pandemic brought about a wide range of mental health concerns, yet available counseling services in barangays decreased during the pandemic. This, however, is not the case for the Mindanao region where the rate increased from 37.4% in Wave 3 to 60.9% in Wave 5. As discussed in the Chapter 9, among the island groups, Mindanao appeared to be the least exposed to severe COVID-19 cases. Thus, with less pandemic-related disruption in barangay services, this could partly explain the rise in facilities providing counseling. Another possible explanation to the higher rate in Wave 5 is the increasing need in such services.

Figure 6.9. Percentage of Barangays with Counseling Services by Island Group*

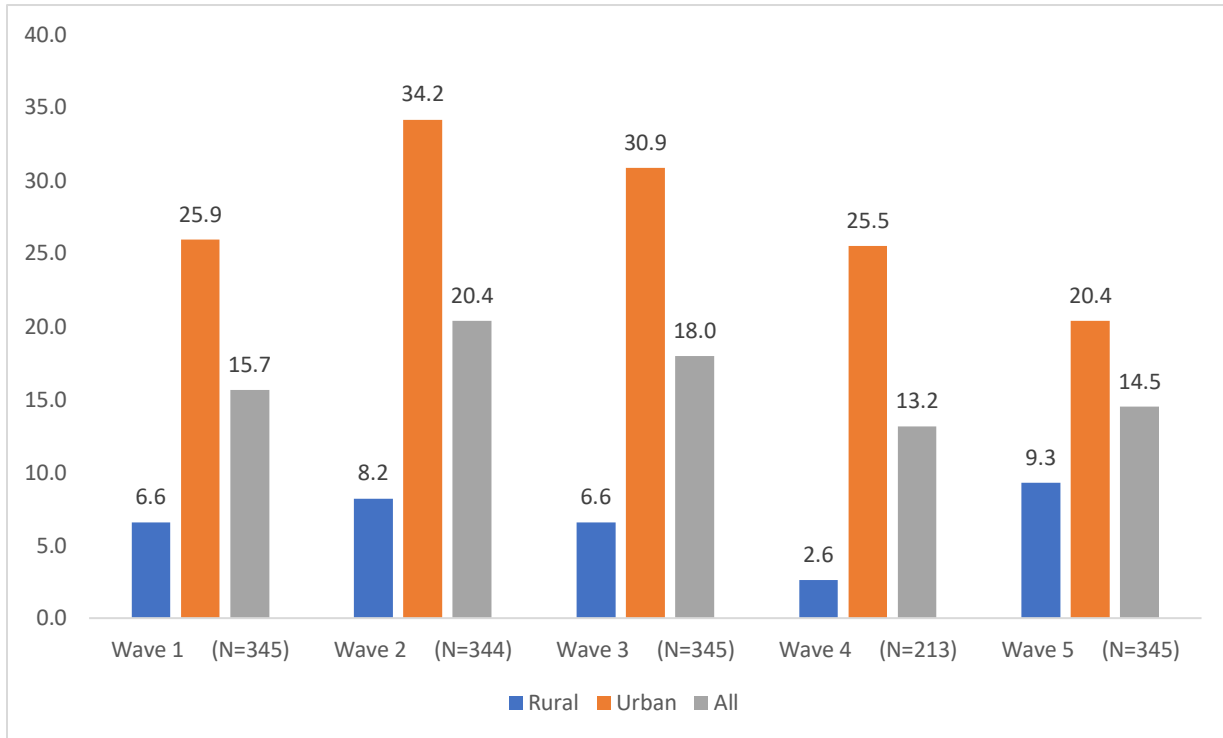


*Presented as %; significantly different at $p < 0.001$ across island groups in all waves except in Wave 2

Adolescent Clinics

In terms of the availability of adolescent clinics, health facilities specializing in adolescent health or catering to adolescents, Figure 6.10 reveals that less than 21% among the 345 barangays have these facilities. The most common facilities mentioned were the barangay health centers or lying-in clinics. For those without these facilities for adolescents, the majority (75%-79%) reported having such service in another barangay within the municipality. Figure 6.10 also shows the significant contrast between urban and rural barangays with the former having more adolescent facilities than the latter.

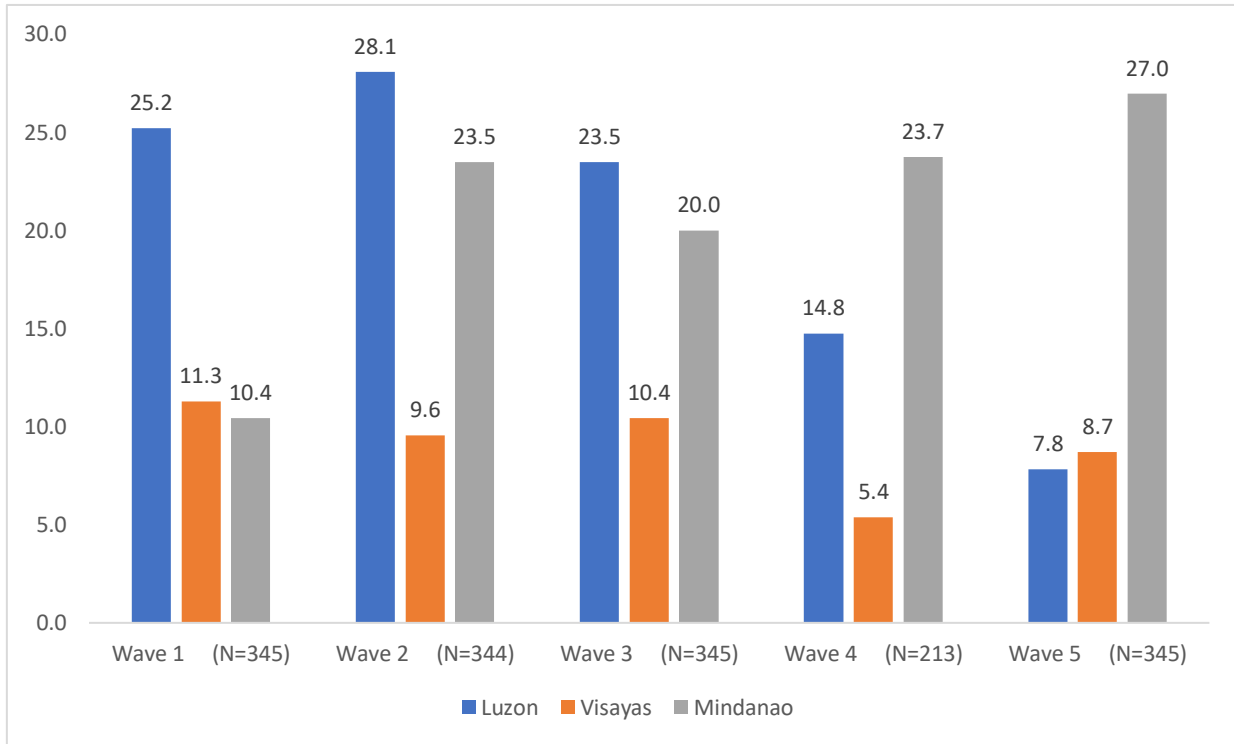
Figure 6.10. Percentage of Barangays with Adolescent Health Facilities by Urban/Rural Stratum*



*Presented as %; significantly different at $p < 0.01$ between urban and rural barangays in all waves

In comparing the percentage of barangays with adolescent facilities across island groups (Figure 6.11), the highest rates were in Luzon from Waves 1 to 3, with Mindanao taking the lead by Wave 5. The rates in the Visayas remained low over time unlike that of Mindanao which doubled its rates between Waves 1 and 2 and remained high over time. The proportions with adolescent facilities decreased between Waves 3 and 5 in both Luzon and the Visayas but the reverse was observed in Mindanao.

Figure 6.11. Percentage of Barangays with Adolescent Health Facilities by Island Group*



*Presented as %; significantly different at $p < 0.05$ across island groups in all waves.

Mental Health Clinics

In 2019 (Wave 3), after the Mental Health Act was signed into law, the LCSFC started to specifically ask about the availability of mental health clinics in barangays. From 2019 to 2021 there were only six to eight barangays reporting having such a facility through these years. Health centers and district hospitals were the facilities mentioned that provided mental health services. Most of these facilities were in urban areas and there were fewer in the Visayas than in Luzon or Mindanao. In Wave 5 (2021), Mindanao reported to have five barangays having a mental health clinic, The highest number so far since 2019.

As reflected in these LCSFC findings, the availability and accessibility of mental health care services remains a challenge despite the passing of the Mental Health Act into law in 2018. Although there is an increasing trend in the availability of counseling services in barangays, services specifically catering to adolescent health needs remain scarce, with less than 21% of the barangays in this study having such a facility. From these results, setting up of mental health clinics at the barangay level has yet to be fully implemented, particularly in rural areas.

Summary

As a developmental stage, adolescence has been characterized by rapid and dramatic changes physically, physiologically, socially, and emotionally. Behaviorally, it is associated with volatile emotions and sensitivity to social surroundings; which makes adolescents vulnerable to mental health issues (Stumper & Alloy, 2021; WHO, 2021).

This study was conducted at the time when adolescents were transitioning to the pubertal stage and when the COVID-19 pandemic happened. The aim of this chapter is to examine the impact of the COVID-19 pandemic on Filipino adolescents' mental health condition amidst their pubescence stage. Two mental outcomes were measured using the ASEBA DSM Oriented Scales, namely depression, and anxiety problems.

Results reveal that depressive problem symptoms significantly increased when adolescent respondents reached age 13, from Wave 2 to Wave 4. While a slight decrease in mean score was observed in the later stage of the pandemic (Wave 5) when adolescents were at age 15, this value is still higher than when they were age 11 (Wave 2). This may imply that depressive problem symptoms can be rather consequential to pubertal transition and less likely to be a response to the pandemic.

With regard to the anxiety problem symptoms, the scores increased from Wave 2 up to Wave 5, though this plateaued between Wave 4 and early pandemic (Wave 4a). However, the pandemic seems to exacerbate the levels of anxiety, as it significantly increased in Wave 5 (later pandemic); with adolescents in the Visayas and Mindanao having higher levels of anxiety compared to those in Luzon. Economic uncertainty, fear of contracting the COVID virus, concerns over when restrictions can be lifted, plus adapting to new learning environments that demand new technological skills, all or a combination of these factors may have contributed to the increasing levels of anxiety among adolescents.

The situation brought about by the pandemic (e.g., heightened restrictions and limited social interaction) appears to set off the prevalence of mental health concerns among Filipino adolescents. Amidst the demands of the adolescence period, the pandemic seems to exacerbate the already vulnerable state of young individuals undergoing pubertal transition. Not only were depressive and anxiety problem symptoms manifested, several of them have contemplated on committing suicide and a few actually attempted to do so.

Given how susceptible adolescents are to the changes happening to them during puberty, as well as to the uncertainties and fears caused by the pandemic, there is a need to intensify mental health programs directed at them not only at the national level but most especially in their local communities. Unfortunately, mental health services such as counselling facilities, adolescent, and mental health clinics, are not readily available within the barangay. There are substantial gaps in the delivery of mental health care services and a dearth of community-based mental health facilities (Lally et al., 2019). The number of available facilities is ill-equipped and so few to be able to cater to the mental health care needs of the adolescents. Compounding the problem is the severe shortage of mental health care specialists in the Philippines (WHO, 2020).

The following propositions are given. First, there is a need to set up gender- and age-sensitive mental health programs in schools given that males and females experience the various stages of adolescence quite differently; and more attention are likely needed by those undergoing pubertal transition when mental health needs may be wide-ranging. Second, it is important to establish community-based mental health care services to reach a wider mass of adolescents. Exploring available resources in the community

that may be tapped, such as empowering parents and other community members in administering psychological first-aid may be a more accessible way of filling in the gaps in government infrastructures. Third, exploring alternative modes of delivery of services, other than face to face counselling, may be more effective with adolescents. Services offered online or through digital messaging may appeal more to adolescents as these provide them a greater sense of privacy. Fourth, promoting mental health care education among adolescents is another way of increasing their awareness of everyone's vulnerability to mental health-related problems and conveying to them a more positive view on seeking help.

Mental health is an essential part of the overall health and well-being of individuals. It is an integral component in achieving Sustainable Goal 3 because mental state matters in promoting human potential for people to productively contribute to their communities (Dybdahl & Lien, 2018). As the pandemic disrupted people's life trajectories, especially so for the youth, it is timely to reflect on the World Health Organization's view on mental health – "...to cope with the stresses of life, realize abilities, ...work well, and contribute to their community." Indeed, these are the capabilities that the Filipino youth ought to have in order for the country to meet the SDG 3 targets by 2030.

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