

Implementation and Operational Viability of the LGU Malay Mental Health Ordinance

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Abstract. This study evaluated the implementation and operational viability of the LGU Malay Mental Health Ordinance using the seven-component Project EMBRACE framework. The study addressed a local evidence gap by examining not only whether ordinance activities were implemented but also whether the workforce, referral, infrastructure, monitoring, and partnership conditions required for sustained delivery were present. A convergent parallel mixed-methods design was used. Quantitative data were obtained from 50 program implementers through a validated researcher-developed questionnaire (Cronbach's alpha = 0.962), while qualitative data were collected through Focus Group Discussions with 10 adult mental health service clients from Mainland Malay and Boracay Island. Means and standard deviations summarized five-point viability ratings, and qualitative transcripts were thematically analyzed; the two strands were integrated by comparing convergent, complementary, and divergent findings. The ordinance obtained an overall viable assessment, but component results were uneven. Wellness of Daily Living (M = 3.75), Mental Disorder (M = 3.65), Substance Abuse and Other Forms of Addiction (M = 3.72), and Provision of Services for Mental, Neurologic, and Substance Disorders (M = 3.45) were rated Viable. Extreme Life Experience (M = 3.11), Neurologic Disorders (M = 3.37), and Enhancement of Mental Health Facilities and Partnerships (M = 3.29) were Moderately Viable. Service-user accounts generally supported these patterns and highlighted limited specialist access, psychosocial workforce gaps, dependence on external referrals, and infrastructure constraints. The findings indicate that Malay has established a functional community mental health foundation, but long-term viability requires prioritized investment in crisis-response personnel, neurologic referral capacity, facilities, formal partnerships, continuity-of-care mechanisms, and integrated monitoring.

Keywords: Community Mental Health; Local Governance; Mental Health Ordinance; Mixed Methods; Operational Viability

Introduction

Mental health is a core public-health concern because it shapes individual well-being, productivity, family functioning, and community resilience. In the Philippines, Republic Act No. 11036 (Mental Health Act of 2018) established a national framework for accessible, affordable, rights-based, and community-oriented mental health care and directed local government units (LGUs) to integrate promotive, preventive, curative, and rehabilitative services into primary health care (Lally et al., 2019). Yet national policy does not automatically produce uniform local delivery: funding, workforce availability, governance capacity, referral systems, and institutional readiness vary substantially across LGUs (Alibudbud, 2023).

This implementation gap is especially important at the municipal level, where policy intent must be translated into routine services. In this study, implementation refers to the extent to which the ordinance's prescribed programs and activities are actually delivered, whereas operational viability refers to whether those services can be maintained through sufficient personnel, financing, infrastructure, referral arrangements, monitoring, partnerships, and community participation. Distinguishing the two concepts makes it possible to identify programs that are present but remain vulnerable to discontinuity or system constraints.

The Municipality of Malay, Aklan institutionalized a local response through Project EMBRACE (Educate Mental Health and Become Resilient and Alert Through Community Enablement), a multisectoral framework covering Wellness of Daily Living, Extreme Life Experience, Mental Disorder, Neurologic Disorders, Substance Abuse and Other Forms of Addiction, Provision of Services for Mental, Neurologic, and Substance (MNS) Disorders, and Enhancement of Mental Health Facilities and Partnerships (Panay News,

2021). The framework is particularly relevant in a tourism-driven municipality encompassing Mainland Malay and Boracay Island, where population mobility, service demand, and access to specialized care create distinct implementation pressures.

Although Philippine studies have discussed national mental-health policy, resource limitations, community-based care, and selected LGU initiatives, the available literature provides little component-level evidence on whether the Malay ordinance is both implemented and operationally sustainable across the full Project EMBRACE framework. Previous work has generally examined policy adoption or broad implementation barriers rather than combining implementer ratings with service-user experiences to identify where local systems converge, complement, or contradict one another. This specific evidence gap provides the rationale for the present mixed-method evaluation.

Therefore, this study evaluated the implementation and operational viability of the LGU Malay Mental Health Ordinance using the seven Project EMBRACE components and developed evidence-based policy recommendations from the identified strengths and constraints. The findings are intended to support local decision-making on workforce, infrastructure, referral systems, monitoring, partnerships, and continuity of care and to provide context-specific evidence for other LGUs implementing community-based mental health policies.

Research Questions

This study aims to evaluate the implementation and operational viability of the Mental Health Ordinance of the Local Government Unit of Malay using the Project EMBRACE framework. Specifically, it seeks to answer the following questions:

1. What is the level of implementation and operational viability of the LGU Malay Mental Health Ordinance based on the Project EMBRACE components in terms of:
 - 1.1 Wellness of Daily Living;
 - 1.2 Extreme Life Experience;
 - 1.3 Mental Disorder;
 - 1.4 Neurologic Disorders;
 - 1.5 Substance Abuse and Other Forms of Addiction;
 - 1.6 Provision of Services for Mental, Neurologic, and Substance (MNS) Disorders; and
 - 1.7 Enhancement of Mental Health Facilities and Partnerships?
2. What policy recommendations can be proposed to enhance the implementation and operational viability of the LGU Malay Mental Health Ordinance?

Scope and Delimitation of the Study

This study evaluated the implementation and operational viability of the Mental Health Ordinance of the Local Government Unit of Malay using the Project EMBRACE framework. It focused on the seven implementation components: Wellness of Daily Living, Extreme Life Experience, Mental Disorder, Neurologic Disorders, Substance Abuse and Other Forms of Addiction, Provision of Services for Mental, Neurologic, and Substance (MNS) Disorders, and Enhancement of Mental Health Facilities and Partnerships. The study was conducted in the Municipality of Malay, Aklan, from November 2025 to February 2026. It involved fifty (50) program implementers and ten (10) mental health service clients who participated in Focus Group Discussions. A convergent mixed-methods design was employed using a structured questionnaire and qualitative interviews. The study was limited to evaluating the implementation and operational viability of the ordinance based on the perspectives of the identified respondents. It did not assess clinical outcomes or long-term treatment effectiveness, and the findings are limited to the context of the Municipality of Malay, Aklan.

Literature Review

Local mental health ordinances operationalize Republic Act No. 11036 by converting national rights and service obligations into community-level programs, referral arrangements, and partnerships. Across the literature, the same enabling conditions recur: adequate financing, trained personnel, primary-care integration, governance accountability, and multisectoral coordination. Where these conditions are weak, implementation becomes uneven even when the policy framework itself is comprehensive (Alibudbud, 2023; Lally et al., 2019; van Ginneken et al., 2013). Thus, the central issue is not merely whether an ordinance exists, but whether the local system has the capacity to sustain its intended services.

Operational viability extends this concern from policy execution to durability. Evidence from community mental-health systems indicates that dedicated resources, reliable referral pathways, medicine availability, institutionalized monitoring, and formal partnerships support continuity, whereas staffing shortages, fragmented governance, and short-term funding arrangements undermine sustainability (Baum &

Friel, 2017; WHO, 2020). These findings suggest that implementation and viability are related but analytically distinct: a service may be delivered at present while remaining vulnerable if the supporting workforce, infrastructure, or financing is unstable.

The seven Project EMBRACE components represent different points in this local service system. Wellness and preventive programs can improve mental-health literacy and reduce risk when they are embedded in schools, workplaces, families, and community settings (Durlak et al., 2011; WHO, 2013). Crisis and extreme-life-experience interventions similarly benefit from psychological first aid, emergency coordination, and trained responders, but their continuity depends on refresher training and functional referral systems (Inter-Agency Standing Committee [IASC], 2007). These preventive and crisis components therefore test whether community-facing services are routinely available before and during periods of heightened need.

For clinical and continuing care, research supports task sharing, primary-care integration, referral coordination, and follow-up for mental, neurologic, and substance-use conditions (van Ginneken et al., 2013; WHO, 2016). However, specialist scarcity, inconsistent medication supply, and limited rehabilitation or aftercare remain recurrent barriers in lower-resource settings (Lally et al., 2019; van Ginneken et al., 2013). The literature therefore anticipates that a municipality may demonstrate stronger viability in basic assessment, awareness, and referral than in specialist-dependent neurologic services, long-term rehabilitation, or continuity mechanisms.

Facilities and partnerships connect the seven components at system level. Infrastructure investment, formal agreements with government and non-government partners, shared referral protocols, and routine monitoring can reduce fragmentation and distribute scarce expertise across institutions (Baum & Friel, 2017). This systems perspective is especially relevant to Malay because specialized services may need to be accessed outside the municipality; local viability therefore depends not only on services physically located within Malay but also on the reliability of referral and inter-agency arrangements.

The study is informed by complementary policy-implementation perspectives. Top-Down Theory highlights the role of formal mandates, administrative authority, financing, and accountability in translating the ordinance into standard programs, whereas Bottom-Up Theory emphasizes the role of frontline implementers and local actors in adapting policy to operational realities (Sabatier, 1986). Systems Theory links these perspectives by treating governance, workforce, financing, infrastructure, partnerships, and evaluation as interdependent elements rather than isolated inputs (von Bertalanffy, 1968). Together, these perspectives support the mixed-method assessment: implementer ratings provide evidence on system performance, while service-user narratives identify how those arrangements are experienced in practice.

The literature therefore establishes broad determinants of local mental-health implementation, but it does not provide a component-by-component mixed-method assessment of Project EMBRACE in Malay. In particular, prior studies have not jointly examined the seven ordinance components from both implementer and service-user perspectives and then used areas of convergence and divergence to prioritize local policy action. Addressing this gap, the present study evaluates not only whether services are being implemented but whether the operational conditions needed to sustain them are sufficiently established.

Methodology

Research Design

This study used a convergent mixed-methods design (Creswell & Plano Clark, 2018). The quantitative and qualitative strands addressed the same evaluation problem and were analyzed independently before integration. Field administration was logistically sequenced, with the implementer survey conducted before the service-user FGDs; however, the qualitative strand was not used to build a new instrument or test a separate hypothesis. Integration occurred during interpretation by comparing convergence, complementarity, and divergence across the two strands, consistent with mixed-method integration principles (Fetters et al., 2013). This terminology is used consistently throughout the manuscript to distinguish the design from a purely sequential explanatory study.

Research Locale

The study was conducted in the Municipality of Malay, Aklan, including Mainland Malay and Boracay Island, from November 2025 to February 2026. Project EMBRACE is implemented through local government, health, education, barangay, and partner institutions. Malay was selected because the ordinance is operational in a tourism-driven municipality where population mobility, service demand, and dependence on referral linkages create distinctive conditions for community-based mental health delivery.

Research Participants

The study involved 60 participants: 50 program implementers and 10 mental health service clients. The implementer group comprised 20 Barangay Health Workers, 7 Municipal Health Office personnel, 8 high school representatives, and 15 LGU/program implementers who met the stated eligibility criteria and were selected within their respective functional strata. The service-client group consisted of adults from Mainland Malay and Boracay Island who had previously received at least one Project EMBRACE-related mental health service. The 10 FGD participants were purposively selected because their direct service experience made them information-rich participants for examining how ordinance implementation was experienced in practice. Their island-mainland composition introduced relevant geographic variation while keeping the discussion group small enough to support interaction and meaningful participation by each service user. These qualitative findings are interpreted as contextual, explanatory evidence rather than statistically representative evidence or a claim of exhaustive thematic saturation.

Research Instrument

Two researcher-developed instruments were used. The structured questionnaire measured perceived implementation and operational viability across the seven Project EMBRACE components using a five-point Likert scale. Content validity was established through expert evaluation by three specialists in public administration, health policy, and mental health services, who assessed clarity, relevance, and alignment with the study objectives. Revisions were incorporated before administration. Internal consistency was very high (Cronbach's alpha = .962). The FGD guide, organized around the same seven components, underwent expert review and pilot testing before use with service clients.

Data Gathering Procedure

After validation of the instruments, administrative permissions and written informed consent were obtained. The 35-item questionnaire was then administered to the 50 program implementers selected through the documented stratified procedure, with field administration conducted first in the Boracay Island barangays and then in Mainland Malay. Focus Group Discussions (FGDs) were conducted separately with the 10 purposively selected adult mental health service clients at the designated primary-care facilities; with participants' consent, the discussions were audio-recorded and subsequently transcribed verbatim for qualitative analysis.

Results and Discussions

Research Question 1: What is the level of implementation and operational viability of the LGU Malay Mental Health Ordinance based on the Project EMBRACE components in terms of Wellness of Daily Living; Extreme Life Experience; Mental Disorder; Neurologic Disorders; Substance Abuse and Other Forms of Addiction; Provision of Services for Mental, Neurologic, and Substance (MNS) Disorders; and Enhancement of Mental Health Facilities and Partnerships?

Table 1. Level of Implementation and Operational Viability in terms of Wellness of Daily Living

Wellness of Daily Living	Mean	SD	Interpretation
1. The LGU can sustain programs that promote healthy lifestyles (nutrition, exercise, stress management).	3.72	1.07	Viable
2. Disease prevention and control initiatives (e.g., vaccination, community health drives) can be sustained over the long term.	4.26	.922	Highly Viable
3. Family wellness programs (early family intervention, parenting support, counseling) are feasible and supported.	3.80	.948	Viable
4. School-based health and wellness programs can be consistently implemented with DepEd Malay.	3.86	1.16	Viable
5. Workplace wellness programs are viable and backed by the LGU Human Resource Office.	3.12	1.02	Moderately Viable
Grand Mean	3.75	.821	Viable

Table 1 presents the operational viability of the Wellness of Daily Living component of the LGU Malay Mental Health Ordinance. The component obtained a grand mean of 3.75 (SD = 0.821), interpreted as Viable, indicating that stakeholders generally perceived wellness-related interventions as feasible and sustainable within existing local mechanisms. This pattern is consistent with evidence that school- and community-based

preventive programs can strengthen social-emotional and mental-health outcomes when they are systematically implemented and supported (Durlak et al., 2011; World Health Organization [WHO], 2013).

Among the indicators, Disease Prevention and Control Initiatives obtained the highest mean ($M = 4.26$, $SD = 0.922$), interpreted as Highly Viable. This finding indicates that preventive health interventions, including immunization campaigns and community health promotion activities, are well institutionalized and consistently implemented within the municipality. The high viability reflects the effectiveness of policy support, organizational commitment, and resource allocation in strengthening population-based health programs. This observation is supported by the World Health Organization (2021), which emphasized that sustainable public health outcomes are achieved when preventive programs are reinforced through coordinated policies, adequate financing, and multisectoral implementation.

Similarly, School-Based Health and Wellness Programs ($M = 3.86$, $SD = 1.16$) and Family Wellness Programs ($M = 3.80$, $SD = 0.948$) were both interpreted as Viable, suggesting that wellness initiatives within educational institutions and families are generally operational despite existing implementation constraints. This pattern is consistent with evidence that well-implemented school-based social and emotional learning interventions can improve students' social-emotional competencies and related outcomes, while sustained community and family support remains important for broader mental-health promotion (Durlak et al., 2011; WHO, 2022).

Likewise, Healthy Lifestyle Programs, which include nutrition, exercise, and stress management, obtained a mean of 3.72 ($SD = 1.07$) and were interpreted as Viable. This indicates that health-promotion activities are generally feasible within the municipality, although implementation may vary across barangays and sectors. Such variability is consistent with literature emphasizing that sustainable health programs depend on coherent governance, adequate resources, and implementation capacity (Baum & Friel, 2017; WHO, 2022).

Conversely, Workplace Wellness Programs recorded the lowest mean ($M = 3.12$, $SD = 1.02$), interpreted as Moderately Viable. This finding suggests that workplace-based mental health promotion remains relatively underdeveloped compared with other wellness initiatives. Differences in employer participation, organizational priorities, and institutional commitment may have contributed to this lower rating. The finding supports the need for clearer implementation mechanisms, including designated mental health focal persons, dedicated funding, standardized wellness activities, and regular monitoring, consistent with the broader WHO call to strengthen environments that promote and protect mental health (WHO, 2022).

The quantitative findings were further validated through the qualitative data gathered during the Focus Group Discussions (FGDs). Participants consistently acknowledged the implementation of community-based wellness activities, particularly physical exercise programs. One participant shared:

"Ano, sumba kami... may zumba doon sa may plaza."

(Well, we do Zumba... there's Zumba at the plaza.)

This statement corroborates the quantitative findings by confirming that wellness activities are available and implemented at the community level, particularly through organized physical fitness activities.

However, the qualitative findings also revealed inconsistencies in program implementation. Another participant stated:

"Minsan lang sila diyan nagzuzumba."

(They only conduct Zumba sessions there occasionally.)

This verbatim provides contextual explanation for why the overall component was interpreted only as Viable rather than Highly Viable. Although wellness programs exist, their implementation appears inconsistent across communities, suggesting that continuity and sustainability remain implementation challenges. This finding reflects a bottom-up implementation issue in which local execution influences the overall effectiveness of policy interventions.

Moreover, qualitative findings expanded the interpretation of the quantitative results by revealing psychosocial concerns that were not fully reflected in the survey responses. One participant expressed:

"Mama, boring ako, wala akong kausap, gusto ko may friend ako na makausap."

(Mom, I'm bored. I have no one to talk to—I wish I had a friend I could talk to.)

This statement emphasizes that wellness extends beyond physical health promotion to include emotional and social well-being. Although physical wellness activities are being implemented, participants continue to experience loneliness and limited social support, indicating that psychosocial interventions require further strengthening. The findings suggest the need to enhance counseling services, peer support groups, and community engagement activities that foster meaningful interpersonal relationships.

The integration of quantitative and qualitative findings demonstrates methodological triangulation through convergence, complementarity, and expansion. Convergence was observed in the confirmation that wellness programs are operational within the municipality. Complementarity emerged as qualitative findings explained the variations in implementation consistency reflected in the quantitative ratings. Expansion was

likewise evident, as participants' narratives revealed psychosocial needs and implementation realities that were not fully captured through numerical indicators alone.

Overall, the integrated findings demonstrate that the Wellness of Daily Living component of the LGU Malay Mental Health Ordinance is operationally Viable, supported by well-established preventive health programs and generally functional school- and family-based wellness initiatives. Nevertheless, several implementation gaps remain evident, including irregular scheduling of community wellness activities, limited monitoring and evaluation mechanisms, inadequate workplace wellness programs, shortages of trained mental health personnel, and insufficient access to structured psychosocial support services such as counseling and peer support groups.

These findings imply that while the ordinance has established a functional foundation for promoting mental wellness, further efforts are necessary to strengthen program sustainability, institutionalize workplace-based wellness initiatives, and expand psychosocial support systems. This interpretation is consistent with World Health Organization guidance on community-based mental health services (World Health Organization, 2021) and with evidence that sustainable local mental health delivery depends on coordinated governance, workforce capacity, primary-care integration, and continuity mechanisms (Baum & Friel, 2017; Lally et al., 2019; van Ginneken et al., 2013).

Table 2. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Extreme Life Experience

Extreme Life Experience	Mean	SD	Interpretation
1. MHPSS (Mental Health and Psycho-social Support) during disasters is feasible for the LGU.	3.46	1.26	Viable
2. Hiring and retaining a licensed psychologist for the municipality is viable under the LGU's budget.	2.38	1.26	Slightly Viable
3. Training and sustaining barangay-level counselors is operationally feasible as mandated by RA 11036.	2.94	1.33	Moderately Viable
4. Psychological First Aid (PFA) during emergencies can be implemented consistently.	3.42	1.29	Viable
5. LGU mechanisms for coordinating emergency mental health support are sustainable.	3.38	1.26	Moderately Viable
Grand Mean	3.11	1.005	Moderately Viable

Table 2 presents the level of operational viability of the Extreme Life Experience component of the LGU Malay Mental Health Ordinance. The component obtained a grand mean of 3.11 (SD = 1.005), interpreted as Moderately Viable. This indicates that emergency-related mental health interventions were perceived to be somewhat feasible; however, notable limitations remain in terms of sustainability, workforce capacity, and institutional support. From a systems and implementation perspective, this suggests that while mechanisms for emergency mental health response exist, they are not yet fully institutionalized or consistently operational across all levels.

Among the indicators, Mental Health and Psychosocial Support (MHPSS) during disasters obtained the highest rating ($M = 3.46$, $SD = 1.26$), interpreted as Viable. This indicates that the LGU possesses the capacity to provide psychosocial interventions during emergencies and disaster situations. Likewise, Psychological First Aid (PFA) was also rated Viable ($M = 3.42$, $SD = 1.29$), indicating that immediate mental health response mechanisms can be implemented with relative consistency. Similarly, the LGU mechanisms for coordinating emergency mental health support received a Moderately Viable rating ($M = 3.38$, $SD = 1.26$), suggesting that coordination structures are in place although further strengthening is necessary to improve efficiency and inter-agency collaboration.

These findings are consistent with disaster mental-health literature emphasizing Mental Health and Psychosocial Support and Psychological First Aid as important components of emergency response, particularly when frontline personnel are trained and linked to functioning referral and coordination systems (Inter-Agency Standing Committee [IASC], 2007; WHO, 2013). The moderate ratings therefore suggest that the policy framework exists but requires stronger institutionalization, refresher training, and inter-agency coordination to become reliably operational.

In contrast, training and sustaining barangay-level counselors obtained a mean of 2.94 ($SD = 1.33$), interpreted as Moderately Viable. This indicates challenges in maintaining a competent and sustainable community-based mental-health workforce. Evidence on task-sharing shows that non-specialist and community health workers can extend mental-health coverage, but effectiveness depends on structured training, supervision, referral support, and continuing capacity development (van Ginneken et al., 2013).

The lowest-rated indicator was the hiring and retention of a licensed psychologist, which obtained a mean of 2.38 ($SD = 1.26$) and was interpreted as Slightly Viable. This finding reflects a significant structural limitation within the LGU mental health system. Philippine literature consistently reports a shortage of

licensed mental health professionals, particularly in local government settings, resulting in greater reliance on non-specialized personnel despite the mandates of Republic Act No. 11036 or the Mental Health Act of 2018. Consequently, workforce shortages continue to affect service quality, continuity, and long-term implementation of mental health programs.

Overall, the findings indicate that the Extreme Life Experience component is Moderately Viable, demonstrating strengths in emergency response interventions such as MHPSS and Psychological First Aid but revealing considerable weaknesses in workforce capacity, sustainability, and institutional support. These findings suggest that while emergency mental health mechanisms are functional, strengthening human resources, institutional coordination, and long-term program support remains necessary to achieve a more resilient and sustainable local mental health system.

The quantitative findings were further supported by the qualitative results obtained from the Focus Group Discussions (FGDs). Participants revealed that the moderate viability of this component was largely influenced by their limited exposure to disaster-related mental health services. One participant shared:

"Wala namang krisis na ganon sa nangyari... Wala namang nangyari."
(There wasn't really any crisis like that... nothing really happened.)

This verbatim response suggests that the absence of recent crisis events limits community members' direct experience with psychosocial support interventions. Consequently, disaster-related mental health services remain less visible and are often perceived as having limited relevance during non-emergency periods. The finding helps explain why respondents perceived the component as only Moderately Viable, despite the presence of existing emergency response mechanisms.

From a triangulated perspective, the integration of the quantitative and qualitative findings demonstrates convergence and complementarity. The quantitative results indicate that emergency mental health interventions are operational but constrained by structural limitations, while the qualitative findings explain that community members rarely experience or recognize these interventions because they are primarily activated during disaster situations. This suggests that operational viability depends not only on the availability of emergency mental health systems but also on their visibility, accessibility, utilization, and perceived relevance within the community.

The integrated findings further identified several implementation gaps affecting the Extreme Life Experience component. These include (1) low visibility of emergency mental health programs during non-disaster periods; (2) limited community awareness and familiarity with MHPSS and Psychological First Aid services; (3) insufficient simulation drills and preparedness activities that reinforce system readiness; (4) an inadequate number of trained personnel capable of sustaining emergency psychosocial interventions; and (5) weak institutionalization of emergency mental health systems beyond reactive or crisis-driven implementation.

Overall, the quantitative and qualitative findings converge in demonstrating that the Extreme Life Experience component is operationally Moderately Viable, with existing disaster mental health support systems becoming more visible primarily during actual emergencies. These findings highlight the importance of continuous capacity-building initiatives, simulation exercises, community awareness programs, and institutional strengthening so that emergency mental health services remain visible, accessible, and sustainable even outside disaster situations. This interpretation is consistent with the Inter-Agency Standing Committee (2007) and World Health Organization guidance emphasizing the integration of mental health and psychosocial support into routine preparedness, referral, and community health systems (World Health Organization, 2021).

Table 3. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Mental Disorder

Mental Disorder	Mean	SD	Interpretation
1. LGU can provide assessment and treatment services for persons with mental disorders through the MHO.	4.08	1.04	Viable
2. Counseling and therapy services are feasible and can be integrated into community health centers.	3.90	1.11	Viable
3. Referral systems to specialized mental health facilities are functional and sustainable.	3.66	1.18	Viable
4. Anti-stigma and public awareness campaigns about mental disorders can be regularly conducted.	3.46	1.21	Viable
5. Peer and support groups for persons with mental disorders can be established and maintained at the barangay level.	3.16	1.20	Moderately Viable
Grand Mean	3.65	.974	Viable

Table 3 presents the level of operational viability of the Mental Disorder component of the LGU Malay Mental Health Ordinance. The component obtained a grand mean of 3.65 (SD = 0.974), interpreted as Viable. This indicates that mental health services related to assessment, treatment, referral, and awareness were generally feasible and sustainable within the LGU, although certain components required further strengthening. From an implementation perspective, this suggests that the LGU has established foundational mechanisms for delivering mental health services, particularly within primary care and referral systems, but still faces constraints in ensuring consistent and comprehensive service delivery at the community level.

Among the indicators, the LGU's capacity to provide assessment and treatment services obtained the highest mean (M = 4.08, SD = 1.04), interpreted as Viable. This indicates that primary-level mental health services are increasingly being integrated into local health systems. Likewise, the referral system to specialized mental health facilities received a mean of 3.66 (SD = 1.18), also interpreted as Viable, suggesting that referral pathways for higher-level mental health care were functional within the municipality. Similarly, the implementation of anti-stigma and public awareness campaigns obtained a mean of 3.46 (SD = 1.21), interpreted as Viable, indicating that advocacy and mental health awareness initiatives were regularly implemented by the LGU.

These findings align with Philippine literature showing that implementation of the Mental Health Act depends on accessible community-based services, adequate workforce, referral pathways, and sustained local capacity (Lally et al., 2019; Alibudbud, 2023). The qualitative accounts in the present study further show that treatment availability does not by itself guarantee continuity of care when specialist access and family support during crises remain limited.

In contrast, peer and support groups at the barangay level obtained a mean of 3.16 (SD = 1.20), interpreted as Moderately Viable. This indicates several implementation challenges in establishing and sustaining community-based support systems. These include the lack of trained facilitators or mental health advocates at the barangay level, limited funding and logistical support, inconsistent community participation, persistent stigma toward mental health, and the absence of structured and continuous program implementation. These findings reflect a gap in bottom-up implementation where stronger community engagement and localized support mechanisms remain necessary.

Notably, counseling and therapy services integrated into community health centers obtained a mean of 3.90 (SD = 1.11), interpreted as Viable under the study's stated 3.41-4.20 range. This indicates that counseling and therapy are generally feasible within the local system, although service continuity may still be affected by the limited availability of trained mental health professionals, infrastructure constraints, and increasing demand. Existing literature indicates that the Philippines continues to experience shortages and uneven distribution of mental health professionals and services, particularly at the community level, which can constrain accessibility and sustainability (Alibudbud, 2023).

Overall, the findings indicate that the Mental Disorder component is Viable, particularly regarding treatment services, referral mechanisms, and mental health awareness initiatives. However, several implementation gaps remain in sustaining counseling services and establishing community-based peer support systems. These findings emphasize the need for continued investments in human resources, capacity-building, and community engagement to strengthen local mental health service delivery.

The quantitative findings were further supported by the qualitative data obtained through the Focus Group Discussions (FGDs), which provided deeper insights into the experiences of service users and their families. Participants emphasized the positive impact of treatment, particularly medication, in managing mental health conditions. One participant stated:

*"Kumuha ako ng gamot... salamat... sa binigay na gamot... Laking tulong."
(I received medicine... thank you... for the medicine you provided... it was a great help.)*

This verbatim response supports the quantitative finding that treatment services were available and beneficial, indicating that pharmacological interventions were accessible and contributed to improved well-being among service users.

However, the qualitative findings also revealed the challenges experienced by families during severe behavioral episodes. One participant shared:

*"Pangwasak... giba-giba ang pinto..."
(Destructive... the door was completely smashed...)*

This response illustrates the severity of behavioral manifestations associated with mental health conditions and highlights the emotional, physical, and financial burden experienced by caregivers.

Similarly, participants described the lack of institutional support available during crisis situations. One informant stated:

*"Wala. Kami lang ang pamilya."
(None. It was only our family.)*

This finding indicates that families frequently served as the primary caregivers without adequate psychosocial or institutional assistance, thereby increasing caregiver burden and vulnerability.

When behavioral crises intensified, participants reported relying on alternative sources of assistance rather than formal mental health crisis services. One participant explained:

"Sa barangay... makapagpatawag ng pulis."

(In the barangay... (we can) call the police.)

This response suggests that crisis management frequently depended on barangay officials or law enforcement instead of specialized mental health crisis intervention services, highlighting existing limitations within the local mental health response system.

From a mixed-methods triangulated perspective, the integration of the quantitative and qualitative findings demonstrates convergence, complementarity, and expansion. The quantitative findings confirm that treatment, referral, and awareness services are operational and generally viable within the municipality. The qualitative findings complement these results by revealing that although services are available, families continue to experience significant challenges during crisis situations due to limited psychosocial support and insufficient community-based intervention mechanisms. Furthermore, the qualitative evidence expands the quantitative findings by illustrating the lived experiences of caregivers, including emotional distress, caregiving burden, and dependence on informal crisis response systems.

The integrated findings indicate that while the LGU has established a functional system for mental health treatment and referral, strengthening community-based crisis intervention and psychosocial support services remains essential. Specifically, the findings highlight several implementation gaps, including (1) limited availability of counseling and psychotherapy services at the community level, (2) insufficient community-based peer support groups, (3) inadequate crisis intervention services outside health facilities, (4) heavy dependence of families on informal caregiving and law enforcement during mental health crises, and (5) the continuing shortage of trained mental health professionals to sustain comprehensive service delivery.

Overall, the quantitative and qualitative findings converge in demonstrating that the Mental Disorder component is operationally Viable, supported by existing treatment, referral, and awareness mechanisms. However, strengthening community-based psychosocial support, crisis intervention systems, family-centered services, and workforce capacity remains necessary to ensure a more responsive, inclusive, and sustainable local mental health care system. This interpretation is consistent with the World Health Organization (2021), which emphasizes that effective mental health systems should extend beyond facility-based care through strengthened community services and psychosocial support networks. Likewise, evidence suggests that community-based crisis intervention and active family involvement significantly improve treatment outcomes and long-term recovery, particularly in low- and middle-income settings where access to specialized mental health services remains limited (World Health Organization, 2021).

Table 4. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Neurologic Disorders

Neurologic Disorders	Mean	SD	Interpretation
1. Services for common neurological disorders can be provided at the primary health care level.	3.40	1.19	Moderately Viable
2. Referral systems for neurological cases are viable and supported by partner hospitals.	3.32	1.13	Moderately Viable
3. Awareness and information programs on neurological disorders can be consistently implemented.	3.56	1.12	Viable
4. Barangay and municipal health workers can be trained to detect and manage neurological disorders.	3.24	1.13	Moderately Viable
5. Coordination with specialists and hospitals for neurological cases is feasible.	3.24	1.23	Moderately Viable
Grand Mean	3.37	.962	Moderately Viable

Table 4 presents the level of operational viability of the Neurologic Disorders component of the LGU Malay Mental Health Ordinance. The component obtained a grand mean of 3.37 (SD = 0.962), interpreted as Moderately Viable. This indicates that services for neurologic conditions were somewhat feasible at the LGU level; however, limitations persisted in system capacity, workforce availability, and referral coordination. The findings suggest that while neurologic services are operational within the municipality, their implementation remains constrained by structural and health system limitations.

Among the indicators, awareness and information programs on neurologic disorders obtained the highest mean ($M = 3.56$, $SD = 1.12$), interpreted as Viable. This indicates that the LGU is capable of implementing health promotion and educational initiatives that support early detection and prevention of neurologic conditions. Likewise, the provision of primary health care services for common neurologic

disorders received a mean of 3.40 (SD = 1.19), interpreted as Moderately Viable, suggesting that frontline health facilities are capable of managing basic neurologic conditions within the primary care setting.

These findings are consistent with the policy direction toward integrating mental and neurologic care into community and primary-care settings (Lally et al., 2019; WHO, 2019). However, the moderate overall rating indicates that basic local capacity has not yet translated into consistently accessible neurologic assessment, specialist support, rehabilitation, and follow-up.

In contrast, the referral system for neurologic cases obtained a mean of 3.32 (SD = 1.13), interpreted as Moderately Viable. This indicates existing gaps in access to specialized neurologic services. Similarly, the training of barangay and municipal health workers (M = 3.24, SD = 1.13) and coordination with specialists and hospitals (M = 3.24, SD = 1.23) were likewise interpreted as Moderately Viable, suggesting limitations in workforce capacity, specialist availability, and inter-facility collaboration.

The pattern is also consistent with evidence that neurologic care requires early detection, referral, and access to higher-level diagnostic and rehabilitation services, while local implementation can be constrained by workforce and service-capacity limitations (GBD 2016 Neurology Collaborators, 2019; van Ginneken et al., 2013). In Malay, the qualitative evidence particularly points to specialist access and referral continuity as the principal operational constraints.

The quantitative findings were further supported by the qualitative results obtained through the Focus Group Discussions (FGDs), which provided deeper insights into participants' experiences in accessing neurologic services.

One participant emphasized the absence of specialized professionals within the municipality by stating:

"Dapat sa psychiatrist ako... Wala po... Kalibo pa."

(I should see a psychiatrist... There is none here... the nearest one is in Kalibo.)

This verbatim response indicates that patients are required to travel outside the municipality to access specialized care, reinforcing the quantitative finding that referral systems remain only Moderately Viable because of the limited availability of specialists within the LGU.

Participants also expressed limited confidence in the ability of local health workers to manage neurologic conditions. When asked whether trained personnel could adequately handle neurologic cases, one informant responded:

"Hindi po." (It's not.)

This response reflects participants' perception that local frontline health workers have limited competence in managing neurologic disorders. It further supports the quantitative finding that workforce training and capacity-building remain significant challenges within the LGU health system.

From a mixed-methods triangulated perspective, the integration of the quantitative and qualitative findings demonstrates convergence and complementarity. The quantitative findings indicate that awareness initiatives and primary-level neurologic services are operational and generally viable. The qualitative findings complement these results by explaining that despite the availability of basic services, patients continue to encounter difficulties accessing specialized care because of the absence of neurologic specialists and perceived limitations in local workforce competence. These qualitative insights provide important contextual evidence that is not fully captured by the numerical ratings alone.

The integrated findings indicate that the Neurologic Disorders component remains Moderately Viable, with strengths in awareness programs and primary health care services but continuing weaknesses in specialist availability, workforce capacity, referral coordination, and inter-facility collaboration. Specifically, the findings highlight several implementation gaps, including (1) limited availability of neurologic specialists within the municipality, (2) inadequate referral pathways for specialized neurologic services, (3) insufficient training and capacity-building among barangay and municipal health workers, (4) weak coordination between local health facilities and specialized hospitals, and (5) geographic barriers that require patients to travel outside the municipality to receive specialized neurologic care.

Overall, the quantitative and qualitative findings converge in demonstrating that the Neurologic Disorders component is operationally Moderately Viable, reflecting existing strengths in health promotion and primary-level service delivery while revealing important structural limitations that affect accessibility and continuity of neurologic care. These findings underscore the need to strengthen referral systems, expand workforce capacity, improve coordination between primary and specialized care providers, and increase access to neurologic specialists. This interpretation is consistent with global evidence that neurological disorders impose a substantial burden and require stronger health-system integration, workforce capacity, referral pathways, and access to appropriate services (GBD 2016 Neurology Collaborators, 2019; WHO, 2022).

Table 5. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Substance Abuse and Other Forms of Addiction

Substance Abuse and Other Forms of Addiction	Mean	SD	Interpretation
1. Community-based rehabilitation programs for substance abuse are sustainable.	3.36	1.16	Moderately Viable
2. Preventive education on substance abuse can be implemented in schools and workplaces.	3.84	1.10	Viable
3. Counseling and support services for persons with addiction are operationally viable.	3.78	1.11	Viable
4. LGU collaboration with law enforcement, NGOs, and barangays for substance abuse programs is sustainable.	3.84	1.09	Viable
5. Outreach and public awareness campaigns on substance abuse are feasible and effective.	3.82	1.19	Viable
Grand Mean	3.72	.977	Viable

Table 5 presents the level of implementation and operational viability of the LGU of the Malay Mental Health Ordinance in terms of Substance Abuse and Other Forms of Addiction. The findings revealed a grand mean of 3.72 (SD = 0.977), interpreted as Viable. This indicates that substance abuse-related programs were generally feasible and sustainable within the LGU, supported by existing institutional mechanisms and intersectoral collaboration.

Among the indicators, preventive education on substance abuse (M = 3.84, SD = 1.10), LGU collaboration with law enforcement, NGOs, and barangays (M = 3.84, SD = 1.09), and outreach and public awareness campaigns (M = 3.82, SD = 1.19) obtained the highest ratings and were interpreted as Viable. These results indicate that preventive and promotive strategies were comparatively well established. The pattern is consistent with evidence that substance-use interventions are strengthened when prevention, brief intervention, referral, and multisectoral coordination are linked across community and primary-care settings (Degenhardt et al., 2019; Kaner et al., 2018).

Similarly, counseling and support services for persons with addiction (M = 3.78, SD = 1.11) were interpreted as Viable, indicating that treatment and recovery support were operational within the LGU. However, the full-paper findings also identify weaknesses in rehabilitation continuity and follow-up; therefore, the viable rating should be interpreted as evidence of functioning services rather than complete or uniformly sustained coverage.

In contrast, community-based rehabilitation programs (M = 3.36, SD = 1.16) obtained the lowest mean and were interpreted as Moderately Viable. This finding indicates challenges in sustaining rehabilitation services over the long term. Philippine evidence continues to identify system constraints in community mental health delivery, particularly limitations in resources, workforce, integration, and continuity of care (Alibudbud, 2023; Lally et al., 2019). These constraints help explain why rehabilitation and aftercare can remain less stable than prevention and awareness activities even when local programs are already operating.

The comparatively lower rating for community-based rehabilitation indicates that prevention activities are more established than longer-term treatment, rehabilitation, and reintegration mechanisms. This pattern is consistent with international standards emphasizing that effective drug-use prevention should be linked with accessible, evidence-based treatment, rehabilitation, and coordinated community systems rather than operating as an isolated activity (United Nations Office on Drugs and Crime & World Health Organization, 2018). The finding therefore supports stronger aftercare, monitoring, referral, and continuity mechanisms within the local program.

The qualitative findings further support the quantitative results by providing deeper insight into the implementation of substance abuse programs within the community. Participants confirmed that prevention activities are visible and actively implemented, particularly in school settings. One participant shared:

"Nakikita ko na mga pulis ay nag-school-to-school." (*We see police going from school to school.*)

This verbatim statement supports the quantitative findings that preventive education and awareness campaigns are actively implemented and highly visible within the community. It also corroborates the findings of the United Nations Office on Drugs and Crime & World Health Organization (2018), which emphasized that school-based and community-led prevention initiatives involving law enforcement and local stakeholders are effective strategies for reducing substance use among adolescents.

However, the qualitative findings also revealed limitations regarding rehabilitation services. When asked about the Community-Based Rehabilitation Program, one participant responded:

"Hindi pa." (*I haven't yet.*)

This verbatim response indicates limited awareness of existing rehabilitation programs among some community members. The finding suggests that although preventive efforts are evident and visible, rehabilitation services are not yet widely communicated or fully understood by the community. Limited

awareness may contribute to the underutilization of available recovery services and reflects gaps in information dissemination, community engagement, and program accessibility.

The integration of the quantitative and qualitative findings demonstrates convergence and complementarity. The quantitative results established that the Substance Abuse and Other Forms of Addiction component is operationally Viable, particularly in preventive education, public awareness campaigns, counseling services, and inter-agency collaboration. The qualitative findings complemented these results by confirming that prevention activities are visible within the community while simultaneously revealing limited public awareness regarding rehabilitation services. These findings provide a more comprehensive understanding of why rehabilitation programs received a relatively lower rating than preventive interventions.

Overall, the integrated findings indicate that the Substance Abuse and Other Forms of Addiction component of the LGU Malay Mental Health Ordinance is operationally Viable, particularly in preventive education, awareness campaigns, counseling services, and inter-agency collaboration. However, the relatively lower rating of community-based rehabilitation programs, reinforced by qualitative evidence on limited community awareness, highlights the need to strengthen sustainability mechanisms. These include improving communication and information dissemination strategies, enhancing workforce capacity, ensuring adequate resource allocation, and standardizing the implementation of rehabilitation programs to achieve more effective and sustained outcomes.

This interpretation is supported by empirical evidence emphasizing that substance use prevention programs become more effective when complemented by accessible, well-communicated, and adequately resourced treatment and rehabilitation services. The United Nations Office on Drugs and Crime & World Health Organization (2018) emphasized that sustainable drug demand reduction requires not only preventive education but also evidence-based treatment and rehabilitation services that are accessible and properly disseminated at the community level.

Table 6. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Provision of Services for Mental, Neurologic, and Substance Use (MNS) Disorders

Provision of Services for MNS Disorders	Mean	SD	Interpretation
1. Primary-level facilities can provide continuous assessment and treatment for MNS disorders.	3.50	1.24	Viable
2. Referral mechanisms for MNS cases are feasible and sustainable.	3.42	1.14	Viable
3. Provision of free psychotropic drugs is operationally viable under LGU support.	3.74	1.20	Viable
4. Health workers can be trained consistently to manage MNS disorders.	3.28	1.35	Moderately Viable
5. Monitoring and follow-up systems for MNS disorder patients are sustainable.	3.34	1.13	Moderately Viable
Grand Mean	3.45	1.039	Viable

Table 6 presents the level of implementation and operational viability of the LGU of the Malay Mental Health Ordinance in terms of the Provision of Services for Mental, Neurological, and Substance Use (MNS) Disorders. The findings revealed a grand mean of 3.45 (SD = 1.039), interpreted as Viable. This indicates that MNS-related services were generally feasible and sustainable within the LGU, although several operational areas require further strengthening to ensure continuity and effectiveness of service delivery.

Among the indicators, the provision of free psychotropic drugs ($M = 3.74$, $SD = 1.20$) obtained the highest mean and was interpreted as Viable. This finding suggests that access to essential psychotropic medicines is relatively well-supported at the LGU level, enabling service users to receive necessary pharmacological treatment. Likewise, primary-level facilities providing continuous assessment and treatment ($M = 3.50$, $SD = 1.24$) and referral mechanisms for MNS cases ($M = 3.42$, $SD = 1.14$) were likewise interpreted as Viable, indicating that foundational service delivery and referral systems were operational. These findings suggest that mental health services have been integrated into primary healthcare, thereby improving accessibility and continuity of care for individuals with mental, neurological, and substance use disorders.

In contrast, training of health workers ($M = 3.28$, $SD = 1.35$) and monitoring and follow-up systems for patients ($M = 3.34$, $SD = 1.13$) obtained the lowest ratings and were interpreted as Moderately Viable. These findings indicate important implementation gaps affecting the long-term sustainability of MNS service delivery. Specifically, these include: (1) lack of regular and standardized training programs for health workers resulting in uneven competency levels; (2) limited access to specialized mental health and rehabilitation training, particularly at the barangay level; (3) shortage of trained personnel to sustain continuous service delivery; (4) absence of standardized refresher training and capacity-building mechanisms; (5) fragmented or paper-based patient record systems that hinder efficient tracking; (6) lack of integrated digital health information systems across LGUs; and (7) weak follow-up protocols resulting in inconsistent monitoring of

patient recovery and relapse prevention. These findings suggest that although MNS services exist, their long-term effectiveness is constrained by limited workforce capacity and inadequate patient monitoring systems.

The quantitative findings further indicate that Substance Abuse and Other Forms of Addiction obtained a grand mean of 3.72, interpreted as Viable, suggesting that prevention and treatment programs for substance use disorders were generally operational within the LGU. This demonstrates that substance use-related interventions form a functioning component of the overall MNS service delivery system.

The qualitative findings further support and enrich the quantitative results by providing contextual evidence on how substance abuse prevention initiatives were implemented and experienced within the community. Participants consistently described school-based prevention programs as actively operational and highly visible, particularly those involving law enforcement personnel conducting awareness and information dissemination activities within educational institutions. One participant stated:

"Nakikita ko na mga pulis ay nag-school to school." (*We see police going from school to school.*)

This verbatim response suggests that prevention programs were actively conducted in schools and community settings through the participation of law enforcement agencies. It supports the quantitative finding that preventive interventions were operational and visible within the community and reflects active inter-sectoral collaboration in substance abuse prevention.

However, qualitative findings also revealed limitations regarding awareness of rehabilitation services. When participants were asked about the Community-Based Rehabilitation Program, one participant responded:

"Hindi pa." (*I haven't yet.*)

This verbatim response indicates that despite the existence of rehabilitation initiatives, some community members remained unreached or insufficiently informed about available services. The finding suggests that while prevention campaigns were highly visible, rehabilitation services were not widely communicated or fully understood by the public. This reflects gaps in service awareness, communication, and accessibility, including the lack of consistent information dissemination channels, absence of centralized service directories, limited visibility of rehabilitation programs, insufficient barangay-level orientation regarding Community-Based Rehabilitation Programs, weak inter-agency communication, lack of targeted communication strategies, minimal engagement of frontline workers, and inadequate information, education, and communication (IEC) materials. These gaps suggest that existing rehabilitation services are not fully accessible because they are not effectively communicated to community members.

The integration of the quantitative and qualitative findings demonstrates convergence and complementarity. The quantitative results established that the Provision of Services for Mental, Neurological, and Substance Use (MNS) Disorders was operationally Viable, particularly in medication access, preventive interventions, primary care integration, and referral mechanisms. The qualitative findings complemented these results by confirming the visibility and implementation of prevention programs while simultaneously revealing important gaps in rehabilitation awareness, workforce capacity, monitoring systems, and long-term continuity of care. Together, these findings provide a more comprehensive explanation of why medication access and prevention activities received relatively higher ratings, whereas rehabilitation services and patient follow-up systems remained comparatively weaker.

Overall, the integrated findings indicate that the Provision of Services for Mental, Neurological, and Substance Use (MNS) Disorders is operationally Viable, with notable strengths in access to psychotropic medications, preventive programs, and the integration of mental health services within primary healthcare. However, the findings also reveal critical gaps in workforce training, continuity of care, patient monitoring systems, and community awareness of rehabilitation services. These gaps highlight the need to strengthen capacity-building initiatives, improve monitoring and referral mechanisms, enhance rehabilitation communication strategies, and establish more systematic patient follow-up processes to ensure a more comprehensive, accessible, and sustainable mental health service delivery system at the LGU level.

This interpretation is consistent with existing literature emphasizing that the effectiveness of Mental, Neurological, and Substance Use (MNS) service delivery depends largely on a competent health workforce, integrated service delivery models, and sustained community engagement. The World Health Organization (2022) emphasized that deficiencies in workforce training and fragmented service integration remain major barriers to effective mental health care, particularly within primary care and community-based settings. Likewise, the World Health Organization (2021) reported that limited public awareness of available mental health services and weak information dissemination systems contribute to the underutilization of rehabilitation and treatment services, ultimately affecting overall system performance, accessibility, and continuity of care.

Table 7. Level of Implementation and Operational Viability of the LGU Malay Mental Health Ordinance in terms of Enhancement of Mental Health Facilities and Partnerships

Enhancement of Mental Health Facilities and Partnerships	Mean	SD	Interpretation
1. Upgrading of mental health facilities under HFEP is operationally feasible.	2.54	1.29	Slightly Viable
2. Partnerships with NGAs, NGOs, CSOs, and faith-based groups are sustainable.	3.30	1.24	Moderately Viable
3. Continuous involvement of LGU offices in mental health program implementation is viable.	3.50	1.09	Viable
4. Collaboration with schools, churches, and barangays for mental health initiatives can be maintained.	3.58	1.18	Viable
5. Implementation of RA 11036, DOH AO 2016-0039, and other mental health policies at the LGU level is feasible.	3.56	1.29	Viable
Grand Mean	3.29	.980	Moderately Viable

Table 7 presents the level of implementation and operational viability of the LGU of the Malay Mental Health Ordinance in terms of the Enhancement of Mental Health Facilities and Partnerships. The findings revealed a grand mean of 3.29 (SD = 0.980), interpreted as Moderately Viable. This indicates that while partnerships and collaborative mechanisms were somewhat feasible within the LGU, infrastructure development and sustained intersectoral coordination remained constrained. The quantitative findings suggest that mental health services and partnerships were present within the LGU health system but continued to experience structural and resource-related limitations.

Among the indicators, collaboration with schools, churches, and barangays (M = 3.58, SD = 1.18), implementation of Republic Act 11036 and related policies (M = 3.56, SD = 1.29), and continuous involvement of LGU offices (M = 3.50, SD = 1.09) obtained the highest ratings and were all interpreted as Viable. These findings indicate that governance structures and multi-sectoral engagement were relatively strong and could be maintained. Likewise, partnerships with National Government Agencies (NGAs), Non-Government Organizations (NGOs), Civil Society Organizations (CSOs), and faith-based organizations (M = 3.30, SD = 1.24) were interpreted as Moderately Viable, suggesting that although these collaborations exist, their sustainability may be affected by inconsistent coordination, resource constraints, and varying levels of stakeholder engagement.

In contrast, the upgrading of mental health facilities under the Health Facilities Enhancement Program (HFEP) (M = 2.54, SD = 1.29) obtained the lowest mean and was interpreted as Slightly Viable. This finding indicates significant challenges in infrastructure development at the LGU level. Overall, the findings suggest that the Enhancement of Mental Health Facilities and Partnerships component is Moderately Viable, with strengths in policy implementation and collaborative governance but notable weaknesses in infrastructure development and the sustainability of multi-sectoral partnerships.

The facilities and partnership findings are consistent with evidence that mental-health systems can remain underdeveloped when financing, workforce, infrastructure, and community-based service capacity are limited (Lally et al., 2019; WHO, 2022). From a governance perspective, fragmented responsibilities and weak coordination across sectors can also undermine policy coherence and continuity, strengthening the case for formalized inter-agency agreements, defined referral responsibilities, and routine joint monitoring (Baum & Friel, 2017). In Malay, these system constraints help explain why infrastructure upgrading and formal partnerships were less viable than several community-facing components.

The qualitative findings further supported and explained these quantitative results by highlighting participants' lived experiences in accessing mental health services. One participant emphasized the absence of locally available psychiatrists within the municipality by stating:

"Wala po... Kalibo pa (psychiatrist)." (*There is none... It's still in Kalibo (psychiatrist).*)

This verbatim response indicates that individuals requiring specialized mental health services must travel outside the municipality, particularly to Kalibo, to obtain psychiatric consultation, diagnosis, and treatment. Another participant similarly emphasized the need for specialist assessment by stating:

"...dapat sa psychiatrist ako..." (*...I should see a psychiatrist...*)

These responses reveal several structural limitations within the local mental health system, including the absence of in-municipality psychiatric services, limited availability of specialized mental health professionals, inadequate facility capacity to provide comprehensive mental health care, limited psychotropic medication management, and insufficient integration of mental health services into primary healthcare. Consequently, individuals continue to rely heavily on referral partnerships with higher-level facilities, exposing them to financial, geographical, and time-related barriers in accessing appropriate care.

Participants also emphasized the importance of referral systems in obtaining appropriate diagnosis and treatment. One participant explained:

"...kailangan yung ano ni Doc para sa referral... kasi doon magma-matter yung diagnosis."
(...the doctor's recommendation is needed for the referral... because the diagnosis will depend on it.)

This response suggests that local health facilities primarily function as first-line providers, while specialized diagnosis and advanced treatment remain dependent on external partner institutions. The finding complements the quantitative result that referral partnerships are operational but that their effectiveness depends on the efficiency and accessibility of referral systems.

Despite these structural limitations, participants expressed positive perceptions regarding the quality of services provided by local health personnel. One participant shared:

"...maganda yung serbisyo..." (...the service is good...)

Similarly, participants acknowledged that mental health programs were already operational within the municipality. One informant stated:

"Na-implement, sir." (It has been implemented, sir.)

These verbatim responses indicate that although frontline services were generally appreciated and mental health programs were recognized as being implemented at the local level, structural constraints continue to limit the full implementation of the ordinance. These limitations include the absence of psychiatrists and limited access to clinical psychologists, inadequate facility capacity, reliance on external referral systems, and insufficient integration of mental health services within local primary healthcare settings.

The integration of the quantitative and qualitative findings demonstrates convergence and complementarity. The quantitative findings established that the Enhancement of Mental Health Facilities and Partnerships component was Moderately Viable, particularly in governance, policy implementation, and multi-sectoral collaboration. The qualitative findings complemented these results by confirming that mental health programs were operational and that frontline services were positively perceived while simultaneously revealing critical structural gaps in specialist availability, infrastructure, referral dependence, and service accessibility. Together, these findings provide a more comprehensive explanation of why governance and collaborative mechanisms received relatively higher ratings, whereas infrastructure development and specialist availability remained significant concerns.

Overall, the integrated findings indicate that the Enhancement of Mental Health Facilities and Partnerships component is operationally Moderately Viable. While the LGU has established functional governance structures, implemented Republic Act 11036, and maintained collaborative partnerships across multiple sectors, significant gaps remain in mental health infrastructure, specialist workforce availability, facility upgrading, and sustainable partnership mechanisms. These findings suggest that greater investment in health facility enhancement, recruitment of psychiatrists and other mental health specialists, strengthening of referral networks, and institutionalization of multi-sectoral partnerships is necessary to ensure comprehensive, accessible, and sustainable mental health service delivery within the LGU.

Research Question 2: What policy recommendations can be proposed to enhance the implementation and operational viability of the LGU Malay Mental Health Ordinance?

Table 8. Evidence-Based Policy Recommendations for the Operational Viability of the LGU Malay Mental Health Ordinance

Project Embrace Component	Findings	Conclusion	Policy Recommendation
1. Wellness of Daily Living	GM=3.75 (Viable); strong prevention and school/family programs; weak workplace initiatives; inconsistent delivery; psychosocial gaps	Programs are operational but lack consistency and holistic wellness integration	PRIORITY 7 - Sustain and standardize. Institutionalize a comprehensive wellness policy that standardizes program delivery across settings; strengthen workplace mental health programs; and integrate psychosocial support services at the community and school levels
2. Extreme Life Experience	GM=3.11 (Moderately Viable); strong MHPSS/PFA; weak human resources and awareness	The system is reactive with a limited workforce and low visibility	PRIORITY 1 - Immediate. Develop a proactive disaster and crisis mental health policy by expanding MHPSS capacity, hiring and training counselors, and implementing sustained mental health awareness campaigns
3. Mental Disorder	GM=3.65 (Viable); strong assessment and referral; weak peer support groups	Services are accessible but lack continuity of care	PRIORITY 5 - Consolidate continuity. Strengthen continuity of care policies through expanded counseling services, establish barangay-based support groups, and implement structured follow-up and case management systems
4. Neurologic Disorders	GM = 3.37 (Moderately Viable); weak primary care capacity	The service area remains underdeveloped	PRIORITY 3 - Strengthen referral capacity. Enhance primary healthcare capacity through targeted training of health personnel, and strengthen referral systems and linkages with higher-level facilities

5. Substance Abuse	GM = 3.72 (Viable) but fragmented; weak rehabilitation follow-up	Programs lack sustainability	PRIORITY 6 - Sustain rehabilitation and aftercare. Institutionalize integrated rehabilitation and reintegration programs, strengthen aftercare and monitoring systems, and adopt long-term community-based recovery policies
6. MNS Services	GM = 3.45 (Viable); inconsistent medication supply; weak monitoring systems	Basic services exist but are unstable	PRIORITY 4 - Improve continuity and monitoring. Establish a reliable supply chain management system for medicines and strengthen monitoring and reporting mechanisms for service delivery
7. Facilities & Partnerships	GM = 3.29 (Moderately Viable); partnerships are mostly informal	Weak institutionalization of collaborations and infrastructure	PRIORITY 2 - Formalize infrastructure and partnerships. Formalize partnerships through Memoranda of Agreement (MOAs), invest in mental health infrastructure, and strengthen inter-agency collaboration mechanisms
OVERALL, POLICY DIRECTION	GM = 3.48 (Mixed viability); gaps in HR, funding, and M&E across components	Viability is multidimensional and system-dependent	Adopt a systems-based mental health policy framework integrating (1) sustainable financing, (2) human resource development, (3) robust M&E systems, (4) institutionalized partnerships, and (5) community engagement strategies to ensure long-term program sustainability

Table 8 presents the evidence-based policy recommendations developed from the findings of the study to address the identified gaps in the operational viability of the LGU Malay Mental Health Ordinance. The recommendations focus on strengthening workforce capacity, improving service delivery, expanding mental health infrastructure, and enhancing inter-agency collaboration to ensure more consistent, sustainable, and effective implementation of Project EMBRACE across all components.

For Wellness of Daily Living, the findings indicate that while prevention programs are operational, inconsistencies remain in workplace mental health initiatives and psychosocial support services. The study therefore recommends institutionalizing a comprehensive wellness policy that standardizes program implementation and integrates psychosocial support across schools, workplaces, and communities.

The Extreme Life Experience component revealed that the existing system remains reactive due to limited human resources and inadequate awareness activities. Consequently, expanding Mental Health and Psychosocial Support (MHPSS), increasing the number of trained counselors, and implementing sustained mental health awareness campaigns are recommended.

Although Mental Disorder services were rated viable, continuity of care remains limited because of weak peer support systems. The study therefore recommends strengthening counseling services, establishing barangay-based support groups, and implementing structured follow-up and case management systems.

For Neurologic Disorders, findings indicate that primary healthcare capacity remains underdeveloped. The study recommends enhancing healthcare personnel training while strengthening referral systems and linkages with higher-level health facilities.

Although Substance Abuse programs were found to be viable, rehabilitation and follow-up services remain fragmented. The study recommends institutionalizing integrated rehabilitation and reintegration programs while strengthening aftercare and long-term community-based recovery systems.

For Provision of Services for Mental, Neurologic, and Substance Use Disorders, inconsistent medicine supply and weak monitoring systems were identified. Accordingly, the study recommends establishing a reliable supply chain management system for essential medicines and strengthening monitoring and reporting mechanisms.

Finally, Facilities and Partnerships were found to be only moderately viable because collaborations remain largely informal and infrastructure development is limited. The study therefore recommends formalizing partnerships through Memoranda of Agreement (MOAs), investing in mental health infrastructure, and strengthening inter-agency collaboration mechanisms.

Overall, the proposed policy direction recommends adopting a systems-based mental health policy framework integrating sustainable financing, human resource development, robust monitoring and evaluation systems, institutionalized partnerships, and community engagement strategies to ensure the long-term sustainability of Project EMBRACE and the LGU Malay Mental Health Ordinance.

Ethical Considerations

Administrative permission to conduct the study was obtained from the Local Government Unit of Malay, the Municipal Health Office, and other concerned offices. Participation was voluntary, written informed consent was secured, and participants were informed of confidentiality, anonymity, withdrawal rights, and the audio-recording procedure for FGDs. The full study further reports that ethical clearance was secured before

data collection. Administrative permission from the LGU should not be presented as a substitute for formal ethics approval.

Conclusion

The study found that the LGU Malay Mental Health Ordinance is generally operationally viable, but viability differs across the seven Project EMBRACE components. Wellness of Daily Living ($M = 3.75$), Mental Disorder ($M = 3.65$), Substance Abuse and Other Forms of Addiction ($M = 3.72$), and Provision of Services for MNS Disorders ($M = 3.45$) were rated Viable, indicating established preventive, treatment, referral, and community-based mechanisms. In contrast, Extreme Life Experience ($M = 3.11$), Neurologic Disorders ($M = 3.37$), and Enhancement of Mental Health Facilities and Partnerships ($M = 3.29$) were only Moderately Viable. These lower-rated areas identify the principal weaknesses in specialist availability, crisis-response workforce, infrastructure, referral coordination, formalized partnerships, monitoring, and continuity of care. Qualitative findings generally converged with these quantitative patterns by showing that services were present and valued while also revealing gaps in specialist access, psychosocial support, rehabilitation awareness, and reliance on external referral facilities. Accordingly, the ordinance has a functional local foundation, but its long-term operational viability depends on strengthening the system conditions that support continuity and specialized care.

Recommendations

Policy action should be prioritized according to the lowest-rated Project EMBRACE components. First, for Extreme Life Experience ($M = 3.11$), the LGU Malay, Municipal Health Office, and Municipal Disaster Risk Reduction and Management Office should expand crisis-response capacity through designated and trained mental health/psychosocial support personnel, regular psychological first-aid refresher training, a documented crisis referral pathway, and an annual budget line for emergency mental health response. Second, for Enhancement of Mental Health Facilities and Partnerships ($M = 3.29$), the LGU should develop a phased mental health infrastructure and equipment plan and formalize referral and service-sharing arrangements with hospitals, specialists, schools, civil-society organizations, and other government agencies through memoranda of agreement with defined responsibilities, referral procedures, and monitoring indicators. Third, for Neurologic Disorders ($M = 3.37$), the Municipal Health Office should strengthen primary-care recognition and referral through targeted staff training, standardized referral protocols, and scheduled specialist or teleconsultation linkages where feasible. For the viable components, the emphasis should shift from establishing services to improving continuity and reliability. The Municipal Health Office should maintain a monitored supply system for essential psychotropic medicines, strengthen case tracking and follow-up for MNS disorders, institutionalize barangay-based peer or family support mechanisms for mental disorders, and improve aftercare and reintegration pathways for substance-use clients. Wellness programs should be standardized across barangays, schools, workplaces, and family settings rather than implemented as isolated activities. To support all components, the LGU should establish a simple integrated monitoring and evaluation mechanism that assigns responsible offices, annual targets, service indicators, referral completion measures, and periodic review of Project EMBRACE performance. Future research should use longitudinal and outcome-based designs to examine service utilization, continuity of care, client outcomes, and the effect of workforce, financing, and referral improvements over time.

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