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"Like twined cords we are stronger, Together we shall conquer!"

Position Paper on Senate Bill No. 258 and Senate Bill No. 1948
An Act to Provide Early Youth Suicide Intervention and Prevention Expansion

Date: March 12, 2026
Submitted to: Senate Committee on Youth – Public Hearing
Submitted by: Philippine Psychiatric Association (PPA)

I. Statement of Support

The Philippine Psychiatric Association (PPA) — the organization of Leaders, Educators, Advocates, Diagnosticians, Experts, Researchers, and Social Change Agents in Philippine mental health — submits this position paper for the Senate Committee on Youth's public hearing on Senate Bill No. 258 (Senator Villar) and Senate Bill No. 1948 (Senator Ejercito), both entitled the Youth Suicide Prevention Act.

Guided by its mission to uphold the highest bio-psycho-socio-spiritual standards of psychiatric care, the PPA views both bills as timely and important legislative measures. The DOH and DepEd, as the agencies mandated to deliver national health and education services, are the primary implementors. The PPA's role is to offer the clinical and psychiatric perspective of board-certified psychiatrists in support of these government-led efforts, and to coordinate with fellow mental health professionals — including psychologists, social workers, and counselors — toward the shared goal of youth suicide prevention.

II. Public Health Context

The following data underscores the urgency of this legislation:

- **National:** Nearly 1 in 5 young Filipinos have considered ending their lives (UPPI). In 2021, approximately 1.5 million Filipino youth reported suicidal attempts or tendencies — double the 2013 figure. Philippine National Police data recorded over 2,000 suicide deaths in the first half of 2025 alone.
- **Global:** Suicide is the 3rd leading cause of death among persons aged 15–29 worldwide (WHO, 2025).
- **Workforce Gap:** The Philippines has approximately 0.5 board-certified psychiatrists per 100,000 population, far below the WHO-recommended ratio — a gap most acute in schools and rural communities.
- **Structural Gap:** Despite RA 11036 (Mental Health Act of 2018), the full implementation of youth-specific programs and school-based mental health interventions continues to be a work in progress. SBN 258 and SBN 1948 seek to advance this effort.

III. Alignment with Established Frameworks

SBN 258/1948 is consistent with the DOH-WHO Philippine Council for Mental Health (PCMH) Strategic Framework 2024–2028 and the WHO LIVE LIFE initiative, which centers on: limiting access to means of suicide; responsible media engagement; fostering socio-emotional skills in adolescents; and early identification and management of those at risk. The bills' core provisions — Life Planning Education, Peer Counseling, School Psychologist Employment, Public Education Campaigns, and Youth Health Centers — reflect internationally recognized approaches and align with RA 11036. The PPA's specific observations on these provisions follow.

IV. Relevant Legal Framework

The Committee has noted three existing laws relevant to this hearing. The PPA offers the following observations on their relationship to SBN 258/1948:

- **RA 11036 — The Mental Health Act (2018):** This law established the national mental health policy framework, mandating integration of mental health services across all levels of care, including schools and communities. SBN 258/1948 should be explicitly harmonized with RA 11036 to avoid duplication and ensure coherent implementation across DOH, DepEd, and the NCMH. The areas that SBN 258/1948 seeks to strengthen — particularly school-based intervention and community outreach — are consistent with the continuing work of RA 11036 implementation.

- **RA 10627 — The Anti-Bullying Act (2013):** Bullying is a recognized risk factor for depression, anxiety, and suicidal behavior among youth. RA 10627 requires all elementary and secondary schools to adopt anti-bullying policies, including counseling referral mechanisms for both victims and perpetrators. SBN 258/1948 should be implemented in active coordination with existing RA 10627 mechanisms. Critically, RA 10627's counseling referral provisions should be connected to the mental health referral pathways established under SBN 258/1948 — ensuring that students identified through bullying reports are also screened for depression or suicidal ideation and referred for clinical assessment where indicated.

- **RA 12080 — The Basic Education Mental Health and Well-Being Promotion Act (2024):** Signed into law on December 9, 2024, this is the most recent and directly relevant legislation. RA 12080 mandates school-based mental health programs, establishes Mental Health and Well-Being Offices in every Schools Division Office, creates Care Centers in schools, and prescribes new plantilla positions for School Counselors and School Counselor Associates. SBN 258/1948 **must complement**, not duplicate, RA 12080. RA 12080 covers counseling and psychosocial support; it does not provide for psychiatric assessment, psychiatric management, or step-down care. SBN 258/1948 has a clear opportunity to fill this clinical gap — establishing the psychiatric and clinical tier of the mental health continuum within the school system.

V. Clinical Observations and Recommendations

The PPA wishes to underscore one overarching principle that should guide both bills: **depression and suicidal behavior are NOT personal weaknesses or character failings**. They are medical and public health concerns with biological, psychological, social, and spiritual dimensions that require holistic, team-based management. Stigma remains one of the most significant barriers to help-seeking in the Philippines, and all provisions of SBN 258/1948 — particularly its public education campaigns — should reflect this clinical reality.

Section 3 – Life Planning Education (LPE)

The PPA recommends that the LPE curriculum undergo clinical review by board-certified child and adolescent psychiatrists, board-certified psychiatrists, and licensed clinical psychologists before implementation. This is essential to avoid "contagion effects" — a documented risk where poorly designed content may inadvertently increase suicidal behavior among vulnerable youth (Gould et al., 2003; Niederkrotenthaler et al., 2010). The curriculum should **emphasize resilience, help-seeking behavior, and coping skills**, not only warning signs. Evidence supports the effectiveness of such strength-based, school-based programs in reducing suicidal ideation (Calear et al., 2016).

Section 4 – Public Education Campaign

The PPA is willing to participate in and support government-led suicide awareness campaigns under this bill, and to serve as a clinical resource in developing and reviewing educational materials. The PPA has conducted mental health caravans in schools and communities addressing suicide awareness and stigma, and is open to coordinating similar activities with DepEd and the DOH under this bill.

- **Safe Messaging:** All public materials should adhere to established safe messaging guidelines (IASP; WHO) to prevent unintended harm, including contagion effects.
- **Destigmatization:** Campaigns should normalize help-seeking and address cultural barriers, particularly the tendency to treat suicide and depression as personal or family shame rather than health concerns.

Section 5 – Peer Counseling Group Program

Peer support programs are a recognized, cost-effective component of school mental health. Young people are more likely to first disclose distress to a peer than to an adult (Gould et al., 2005). The PPA recommends that peer counselors receive structured training under the direct supervision of licensed mental health professionals, with their scope clearly defined as **peer support** and **referral facilitation** — not clinical assessment or therapy.

Section 6 – Employment of School Psychologist

The PPA considers this a meaningful provision and offers the following clinical observations:

6.1 Psychologist as Part of a Mental Health Team. The school psychologist should not function as a standalone resource. Depression and suicidal behavior are complex conditions that require coordinated, team-based care. The school psychologist is a critical member of a mental health team that includes the guidance counselor, school counselor, social worker, and — where clinically indicated — a board-certified psychiatrist. This team-based model is consistent with the multi-professional framework contemplated under RA 11036 and RA 12080, and SBN 258/1948 should reflect this approach rather than placing sole clinical responsibility on any single professional.

6.2 Psychologist-to-Student Ratio. SBN 258/1948 currently provides for one psychologist per school on a monthly consultancy basis. The PPA recommends the bill specify minimum service frequencies tied to enrollment size. The National Association of School Psychologists (NASP) recommends a ratio of 1 psychologist per 500–700 students for comprehensive mental health services (NASP, 2023). Schools with large enrollment or elevated risk profiles are likely to require more than one psychologist. A single monthly visit is insufficient where student populations are large; the bill should set a minimum ratio as a target for full implementation.

6.3 Criteria and Pathway for Referral to a Psychiatrist. The bill should include clear, operationalized criteria for when a student must be referred to a board-certified psychiatrist for clinical evaluation and management. Referral should be triggered when a student presents with: active suicidal ideation with intent or plan; a previous suicide attempt; severe depressive, psychotic, or other psychiatric symptoms; or where the school psychologist, guidance counselor, or school administrator determines that the student's clinical needs exceed the scope of school-based counseling. This referral pathway should be accessible to guidance counselors, school psychologists, and school administrators as part of a seamless continuum of care.

6.4 Structured Referral Pathway and Step-Down Care. The PPA recommends that SBN 258/1948 mandate a formal, tiered referral system linking the school mental health team to DOH-accredited psychiatric and mental health facilities, managed by board-certified psychiatrists. The pathway should cover: (a) initial identification by the guidance counselor or peer counselor; (b) assessment and management by the school psychologist; (c) referral to a board-certified psychiatrist where clinically indicated; (d) coordination with DOH-accredited outpatient or inpatient psychiatric facilities; and (e) step-down care and reintegration support upon the student's return to school. This continuum ensures no student identified as at-risk is lost between levels of care. Where applicable, RA 10627's existing counseling referral mechanisms should feed into this pathway, particularly for students identified through bullying reports.

6.5 Tele-Mental Health. Given the severe shortage of board-certified psychiatrists — particularly in geographically isolated and depressed areas — the bill should authorize tele-mental health consultations between school-based services and accredited board-certified psychiatrists. Evidence supports the feasibility and effectiveness of tele-mental health in low-resource settings (Hilty et al., 2013).

6.6 Licensure. Psychologists serving under this provision must be duly licensed by the Professional Regulation Commission (PRC).

Section 7 – Technical Assistance and Data Management

Reliable national data on youth suicidal behavior is foundational to any effective prevention strategy. The PPA supports the development of a suicide data collection system and recommends it be designed to capture incidence, demographics, referral outcomes, and treatment trajectories — drawing on WHO surveillance frameworks — and developed in coordination with academic institutions and the NCMH. Data collection under this provision should be harmonized with RA 11036's existing reporting mechanisms to avoid parallel and duplicative systems.

Section 8 – Establishment of Youth Health Centers

The PPA supports, and recommends the bill mandate, that the DOH shall establish Youth Health Centers. The PPA recommends the use of mandatory rather than permissive language in this section: the DOH shall, not may, establish these facilities. These centers are a critical node in the community mental health continuum, and the PPA further recommends:

- Youth Health Centers should serve as accessible referral destinations for students coming from school-based mental health pathways, providing outpatient psychiatric assessment, management, and psychosocial support beyond what the school setting can offer.
- Clear referral and counter-referral protocols between barangay health centers, Youth Health Centers, and tertiary psychiatric facilities should be specified in the IRR.
- These centers are an appropriate venue for postvention services following a suicide death in the community.

VI. Recommendation: Postvention Protocol

The PPA calls attention to a gap in both bills: the absence of a Postvention Protocol. Postvention — the coordinated response to those affected following a suicide — is a recognized component of international suicide prevention frameworks. Without it, schools and communities face an elevated risk of suicide clusters, where one death precipitates others in the same setting, particularly among young people (Haw et al., 2013).

The PPA recommends incorporating a postvention protocol into SBN 258/1948 or its IRR, covering:

- Crisis response by trained mental health professionals in affected schools or communities;
- Grief counseling and psychological first aid for students, staff, and families;
- Media and communication guidelines to prevent sensationalism;
- Follow-up monitoring of at-risk individuals identified in the aftermath.

The evidence for postvention in reducing subsequent suicide deaths is well-established (Andriessen et al., 2019; Jordan & McIntosh, 2011). The PPA is willing to contribute clinical input in the development of a locally appropriate postvention framework.

VII. Implementation Observations

- **Harmonization with Existing Laws:** SBN 258/1948 should be explicitly harmonized with RA 11036, RA 10627, and RA 12080 to prevent duplication, conflicting mandates, and fragmented service delivery across DOH, DepEd, and the NCMH. Specifically: RA 12080 covers counseling and psychosocial support; SBN 258/1948 should cover the clinical and psychiatric tier; and RA 10627's referral mechanisms should feed into the broader mental health pathway.
- **Funding:** The proposed PHP 50 million initial appropriation should be reviewed against the actual cost of nationwide implementation, including staffing, infrastructure for Youth Health Centers, and the referral pathway system.

- **Workforce:** Expanding the pipeline of board-certified psychiatrists, licensed psychologists, and trained counselors in underserved and rural areas will be critical. Incentive structures for mental health professionals serving in high-need communities merit consideration.
- **Monitoring and Evaluation:** The IRR should establish a monitoring and evaluation framework with periodic reporting to the DOH and DepEd Secretaries, with results made available to the public and to relevant congressional committees upon request.
- **Equity:** Programs must be designed to reach indigenous, LGBTQIA+, conflict-affected, and youth with disabilities — groups with compounded risk and the least access to services.

VIII. Conclusion

The PPA recognizes the legislative initiative represented by SBN 258 and SBN 1948 and agrees with their core principles. This position paper represents the PPA's clinical contribution to the legislative process, offered in the spirit of collaboration with the DOH, DepEd, and all stakeholders working toward the mental health and protection of Filipino youth. The PPA remains available as a clinical resource and collaborative partner as these bills move forward.

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