A Review of Suicide Prevention Bills in Philippine Legislation and their Comparison with R.A. 11036: The Mental Health Act

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Abstract

The passage of R.A. 11036 (Mental Health Act) has been hailed as a victory for mental health advocates. While the law itself is a step in the right direction, it cannot be considered as a law that wholly confronts the problem of suicide. Rather, bills focusing on suicide prevention remain pending in Congress with no certainty as to their eventual fates. This study reviews the bills filed before the 13th up to the 19th Congress of the Philippines (2004 to 2024) and identifies the different steps they propose for suicide prevention. These proposed steps are compared with the provisions of R.A. 11036 to determine whether the existing law is sufficient to deal with the suicide problem or whether there is a need for further legislation specific to suicide prevention. Results showed that there were 32 suicide bills proposed in a span of 20 years. These bills can be divided into 7 themes and they stipulated 19 different steps for suicide prevention – out of which only 12 were partially covered by the Mental Health Act.

Keywords: Suicide; Philippines; Suicide Legislation; Suicide Prevention; Mental Health

Introduction

Suicide is a growing social problem in the Philippines. Before the COVID-19 pandemic, studies had already noted an increasing trend in the rates of suicide attempts and suicide-related deaths in the country (Quintos, 2019a; Redaniel et al., 2011). The phenomenon became an even more pressing concern since the pandemic and its social consequences began. In 2019, the Philippine Statistics Authority reported suicide to be the 31st leading cause of mortality – accounting for 2810 deaths. By the first

year of the pandemic, suicide became the 25th leading cause of mortality with a death toll of 4,420. This increase in suicide rates is not an isolated case. Other countries have also experienced similar spikes in suicide cases. Japan, for example, recorded more suicide deaths in October 2020 than the total COVID-19 deaths since the pandemic began up to that month (Wang et al., 2020). The upward trends related to suicide and other mental health problems presumably brought on by the pandemic are now even being considered as the next global pandemic (Ornell et al., 2021).

How can the Philippines respond to this threat? A common premise in the Sociological tradition of understanding social problems is that the social structure, when under threat due to a social problem, will come up with a response that is designed to resolve this societal threat. In Parsonian Sociology's AGIL Framework, the task of deciding how best to respond to the threat is done by the political social institution. This is done through the process of goal attainment – wherewith the government comes up with the political goal (policies or laws) that the rest of society must observe to respond to the social problem (Ritzer, 2008). It is important to understand that these social institutions and the people who represent them, though gifted with the presumption that they are functioning with regularity, are not infallible. As Blumer (1971) pointed out, in his discussion of how society deals with social problems, the process of coming up with a solution to a social problem does not necessarily result in an objective resolution of the social problem. The outcome of the proposed solution to the social problem can range from being very effective in resolving the problem to being ineffective.

One of the recent exercises of social legislation is the enactment in 2019 of R.A. No. 11036: Mental Health Act. This law affirms the basic rights of all Filipinos to mental health as well as the fundamental rights of people who require mental health services. Bills specifically made for suicide prevention, on the other hand, remain pending in Congress with no certainty as to their eventual fates. The passage of the Mental Health Act is a victory for mental health advocates and is a step in the right direction in recognizing the equal relevance of mental health with physical health for the maintenance and enjoyment of the life of persons. It remains to be seen, however, whether this law will provide sufficient contingencies in suicide prevention. This uncertainty about the capability of the Mental Health Act to deal with the growing suicide problem is the raison d'etre of this study.

This study reviewed the bills filed before the 13th up to the 19th Congress of the Philippines (2004 to 2024) to answer the following research questions: (1) what are the steps that these bills provide for suicide prevention? and (2) how are these bills similar and

different from the Mental Health Law? Finding the answers to these two questions will allow for a better evaluation of the necessity, or lack thereof, of a law specifically crafted for suicide prevention.

Methodology

This research follows an archival research design. To obtain the necessary data to answer its research questions, the researcher made use of the records of bills submitted before the two houses of Congress in the Philippines. The full texts of House bills from the 13th Congress up to the 19th Congress (covering all legislations from 2004 to 2024) are available on the respective websites of the House of Representatives (http://www.congress.gov.ph) and the Senate (https://www.senate.gov.ph). These digital libraries were systematically explored and the full texts of all bills related to suicide were obtained. These bills were analyzed and the specific steps related to suicide prevention proposed by the bills were extracted. These were then compared with the provisions of R.A. No. 11036 to identify which steps were already covered by the provisions of the existing law and which were not.

Results and Discussion

The results can be divided into two parts – each answering a research question. The first part discusses the suicide bills and how they are similar and different from each other. The second part discusses the suicide bills in comparison with R.A. 11036: The Mental Health Act.

The Suicide Bills Analyzed

The bills related to suicide from the 13th to the 19th Philippine Congress and the names of their respective principal authors are shown in Table 1.

Table 1

Bills Related to Suicide Submitted to the Philippine Congress (2004-2024)

	13th Congress (2004-07)	14th Congress (2007-10)	15th Congress (2010-13)	16th Congress (2013-16)	17th Congress (2016-2019)			18th Congress (2019-2022)			19th Congress (2023-25)
					1st Session	*2nd Session*	*3rd Session*	*1st Session*	*2nd Session*	*3rd Session*	
HOUSE OF REPRESENTATIVES (LOWER HOUSE OF CONGRESS)	H.B. 5028 (Mandanas)	H.B. 5697 (Santiago)	H.B. 4446 (De Venecia)	H.B. 2075 (De Venecia)	H.B. 5028 (De Venecia)	H.B. 5028 (Villafuerte)	H.B. 5028 (Nieto)	H.B. 1743 (Villafuerte)	H.B. 9127 (Villafuerte)		H.B. 5028 (Villafuerte)
					H.B. 2562 (Campos)			H.B. 5455 (Nieto)	H.B. 9138 (Tambunting)	H.B. 10468 (Cabochan)	H.B. 5107 (Tambunting)
					H.B. 5028 (Vargas)			H.B. 1408 (Vargas)			H.B. 4741 (Villafuerte)
					H.B. 5028 (Castelo)			H.B. 2489 (Castelo)			
					H.B. 5028 (Ocampo)	H.B. 7361 (Torres-Gomez)		H.B. 723 (Torres-Gomez)			
SENATE (UPPER HOUSE OF CONGRESS)	S.B. 1911 (Defensor-Santiago)	S.B. 1751 (Defensor-Santiago)	S.B. 1592 (Defensor-Santiago)	S.B. 398 (Defensor-Santiago)	S.B. 1163 (Villanueva)				S.B. 2188 (Revilla)		S.B. 1669 (Villar)
	S.B. 1946 (Defensor-Santiago)										S.B. 1570 (Revilla)

The bills enumerated in this table are comprehensive as of April 16, 2024

Analysis of the bills also showed that the majority of the bills were focused on suicide prevention among the youth cohort instead of suicide prevention in the Philippines as a whole. When the titles of the bills were analyzed, 25 out of 32 have the term "youth." Out of the seven other bills that did not bear the term in the title, three bore the term "student" instead, essentially suggesting that the emphasis was also on the youth cohort. The explanatory notes of the bills also seemed to emphasize rates of youth suicide and the youth as the at-risk group when it comes to suicide.

While there were 32 bills proposed about suicide, further analysis of the contents of these bills showed that many of these were almost, if not a complete, reiteration of each other. The only thing that usually changes is the names of the principal authors of the bills, total or partial revisions of the explanatory notes, some rearranging of the sections of the bills, and – rarely –the inclusion of one or two additional provisions in the bills. This being the case, the 32 bills can be reduced into seven different themes. The bills in Table 1 have been color-coded to show which bills are replications of the others.

Four of the bills – H.B. 9127, H.B. 9138, H.B. 10468, and S.B. 2188 – were proposed during the COVID-19 pandemic and its resultant quarantine. Five others – H.B. 5107, H.B. 4741, H.B. 2895, S.B. 1669, and S.B. 1570 – were proposed in 2023 when the country had relaxed much of the COVID-19 restrictions. None of these, however, were unique. Instead, they were still reiterations of older bills: H.B. 9138, H.B. 10468, H.B. 5107, H.B. 4741, S.B. 2188, S.B. 1669, and S.B. 1570 were essentially H.B. 2075 which was proposed a decade ago (2013), while H.B. 9127 and H.B. 2895 were essentially S.B. 1946 which was proposed more than a decade ago

(2005). A comparison between these bills proposed during the pandemic and their earlier versions showed that none of them bear any significant changes or additions that would reflect the Philippine experience during the pandemic.

Table 2
The 32 Suicide-Related Bills Listed according to Their Theme

Themes	N	Bills under the theme
Theme 1: Anti-Discrimination	1	H.B.5028
Theme 2: School-based Surveillance	4	S.B.1946; H.B.5697; H.B.9127; H.B. 2895
Theme 3: Research and Grant-giving	5	S.B.1911; S.B.1751; S.B.1592; S.B.398; H.B.3325
Theme 4: Structure-based prevention	2	H.B.7361; H.B.723
Theme 5: Suicide Education	2	H.B.2701; H.B.2489
Theme 6: Education, Rehabilitation, and Hotlines	3	H.B.5354; S.B.1163; H.B.1408
Theme 7: Youth Centers, Life Planning, and Counselling	15	H.B.4446; H.B.2075; H.B.1866; H.B.2652; H.B.7858; H.B.8278; H.B.1743; H.B.5445; H.B.9138; H.B.2188; H.B.10468; S.B. 1669; S.B. 1570; H.B. 5107; H.B. 4741

Table 2 shows the seven different themes of the suicide bills under study and the bills that fall under each theme. The succeeding discussions also explain the suicide prevention steps stipulated under each theme.

Theme 1: Anti-Discrimination

This theme is comprised of only one bill. It prohibits discrimination against any doctor, nurse, health professional, worker, employee or student,

public official, or employer who – on the grounds of their conscience – would refuse to provide services or information about services and process that may be undesirable in Philippine culture such as artificial birth control, abortion, sterilization, ligation, artificial insemination, assisted reproduction, human cloning, euthanasia, human embryonic stem cell research, fetal experimentation, and physician-assisted suicide. Based on its stipulations, it is not a bill designed specifically for suicide prevention. Nonetheless, it prevents access to two procedures oftentimes associated with suicide, such as euthanasia and physician-assisted suicide.

Theme 2: School-based Surveillance

This theme consists of four bills. These bills called for the establishment of a Task Force on Student Suicide comprised by the Department of Education, the Commission on Higher Education, and the Technical Education and Skills Development Authority. This Task Force has the following important tasks related to suicide prevention:

1. Collecting information from schools regarding incidences of suicide. This information includes prevalence, demographics (e.g., age and sex), factors, and circumstances (e.g., place of incident, manner of suicide, and whether it was consummated, frustrated, or attempted). This information is used by the Task Force as a basis to make findings, conclusions, and recommendations;

2. Developing and implementing nationwide student suicide early intervention and prevention strategies, and collecting, and analyzing data on existing similar services for the monitoring of their effectiveness for research, technical assistance, and policy development;

3. Assisting school heads in the timely assessment of students who are at risk of emotional disorders that may lead to suicide, making timely referrals for appropriate community-based mental health care and treatment, and providing immediate support and information resources to families of the student;

4. Assisting school heads in offering equal access to services for at-risk youth and the families and friends of students who recently committed suicide;

5. Providing continuous and up-to-date information and awareness

campaigns on the risk factors of suicide and early intervention and prevention services available.

The bills under this theme have also made reporting of incidences of student suicides mandatory for all schools in the country. Failures of schools to report student suicides are proposed to be penalized with administrative and criminal charges.

Theme 3: Research and Grant-giving

What is noticeable about the bills under this theme is that these bills were not envisioned to be the panacea to the problem of suicide. Instead, these are seen more as a springboard for future suicide prevention policies. To this effect, these bills mandate the Department of Health to coordinate with other government bodies, non-government organizations, and stakeholders for possible policy-making on nationwide youth suicide early intervention and prevention strategies. Central to this vision of being the springboard for future suicide prevention policies is its drive to gather more information about the phenomenon. The bills under this theme mandate the Department of Health to undertake research programs on the development and assessment of the efficacy of new and existing youth suicide early intervention techniques and technology and disseminate this information to the public. It also mandates the Department of Health to award grants to entities that are involved in suicide surveillance, research, and early intervention and prevention services and conduct evaluations on the effectiveness of the programs that will be given grants.

Theme 4: Structure-based Prevention

Out of the seven themes of suicide prevention legislation in this study, the bills under this theme were the only ones that approached the problem of suicide with an engineering-centric, rather than a socio-psychological, solution. The bills raised concerns about "accidents, deliberate jump-offs, and falls stemming from 'altered states of mind' in high-rise commercial and residential structures" in the country. Consequently, they propose the mandatory installation of railings (at least 1000mm in height) for balconies, landings, or porches.

Theme 5: Suicide Education

The bills under this theme mandate the Department of Education,

together with the Department of Health and the Department of Social Welfare and Development, to authorize the inclusion of suicide prevention as an integral part of health education.

Theme 6: Education, Rehabilitation, and Hotline

The bills under this theme propose several steps concerning suicide prevention. They propose the establishment of a "National Suicide Prevention Coordinating Council" comprised by government, academic, and civil society representatives tasked to identify, monitor, and review strategies for youth suicide early intervention, prevention, and response, and ensure adequate funding and efficient spending for programs concerning youth suicide. This Council is also mandated to coordinate with concerned national agencies in conducting a program of research and development on the efficacy of new and existing youth suicide early intervention techniques and technology.

The creation of a formal body to solve the social problem of suicide is not unique to the bills under this theme. The bills under Theme 2 have also proposed the creation of a similar entity. What makes the proposal of the bills under Theme 6 different from that of the bills under Theme 2 are the following:

(1) the formal body proposed under Theme 6 is more inclusive – it includes in its organizational framework representatives of the academe and civil societies as opposed to Theme 2's formal body which is to be comprised purely of different governmental bodies;

(2) the Task Force in Theme 2 was mandated to develop youth suicide early intervention and prevention strategies. The Council in Theme 6 is not mandated to develop its own. Instead, the Council is mandated to identify, monitor, and review existing strategies for the same and ensure that they will be adequately funded.

(3) The Council is also mandated to provide technical assistance grants for suicide research – a mandate that is also given to the Department of Health in Theme 3.

Beyond the establishment of the aforesaid Council, the bills under Theme 6 also propose the establishment of a "Youth Suicide Program." This

program is envisioned to accomplish the following tasks: (1) Integrating mental health and personality development education in basic and higher education curricula. The premise of these proposed inclusions in the academic curricula is that these will be able to tackle pertinent issues related to suicide in the classroom. In this vein, the task of the Youth Suicide Program is similar to what is proposed by the bills under Theme 5. What makes the proposed education-related suicide prevention step under Theme 6 different and possibly better than the proposal under Theme 5, however, is that the former proposes the inclusion into the curricula at both the basic and higher education level whereas the latter's proposal – under the limited jurisdiction of the Department of Education – only covers basic education;

(2) Developing mental health and personality development training modules and public campaigns to be implemented in communities, juvenile justice systems, foster care systems, and other youth support organizations and establishments;

(3) Formulating parent-education programs designed to increase family support and capacity for household-based early detection, response, and prevention;

(4) Coordinating with LGUs for programs on early intervention, prevention, and response strategies;

(5) Developing targeted intervention strategies for high-risk youth including those with mental health problems, substance abuse disorder, and other associated risk factors;

(6) Formulating a youth suicide rehabilitation program that aims to assist youth with previous history of suicidal behavior.

Finally, the bills under this theme propose the establishment of a 24/7 Suicide Hotline.

Theme 7: Youth Center, Life-Planning, and Counselling

The bills under this theme mandate the Department of Education, in coordination with the Department of Health, to formulate a "Life Planning Education" in elementary and secondary education. This Life Planning Education is comprised by discussions on self and identity, personal,

family, and community values, communication and interrelationship with others; sexuality and gender roles, etc. This stipulation of the bills under Theme 7 makes this theme the third of the seven themes to include curricular interventions in their steps against suicide prevention. Theme 7's proposed curricular intervention is similar to Theme 5's in scope: it only covers those in basic education (as compared to Theme 6 which covers basic and higher education). Unfortunately, this study is unable to ascertain how similar or different the contents of the curricular interventions are because the stipulation in Theme 5 did not enumerate what it wanted to be included in the lessons. It merely proposed that the lessons would be subsumed under the existing education in the curriculum. Neither Theme 6 nor Theme 7 also provided a complete enumeration of what specific lessons they wanted to be included in the curriculum. Instead, they merely provided general examples of what ought to be covered. This line of inquiry is likely more feasible if the analysis delves into the Implementing Rules and Regulations (IRRs) – but that is only possible for bills that have been passed into law.

Beyond Life Planning Education, the bills under Theme 7 proposed several other steps against suicide:

(1) Launching a public education campaign that will target the youth, their parents, teachers, school personnel, and the general public. This public education campaign will tackle the (a) increasing problem of youth suicide and suicidal behaviors, (b) the common warning signs of suicidal thoughts and intent, (c) how to respond to youth who exhibit signs, and (d) when and where to go for accurate assessments and help;

(2) Mandating the Department of Health to identify, monitor, and review strategies for youth suicide prevention and develop a suicide data collection system to provide reliable data about attempted suicides in the country;

(3) Establishing a mandatory Peer Counseling Program wherein students are taught basic counseling skills by the school psychologist or guidance counselor;

(4) Requiring the employment of at least one psychologist at the school to visit the school at least once a month and screen students for suicidal intent and tendencies, provide consultation to students and make referrals to mental healthcare when necessary, and offer support and information to the families of youth who are at risk for emotional-behavioral disorders which

may lead to suicide attempts; (5) Establishing Youth Health Centers – a network of health facilities and teen centers catering to young people to address their identified youth issues.

The Suicide Bills and R.A. 11036 (Mental Health Act) Compared

An analysis of the 32 suicide-related bills yielded 19 different steps toward suicide prevention. These 19 steps were compared with the provisions of the Mental Health Law to determine if these steps were already covered by existing legislation and were, therefore, no longer in need of a specific suicide-prevention law to enact them. The results of the comparison are provided in Table 3.

Table 3

Summary of Steps toward Suicide Prevention Proposed by the 32 Suicide-Related Bills and Their Corresponding Provision in R.A. 11036: The Mental Health Act

Proposed Steps	**Related Bills**	**Corresponding provision laid out in R.A. 11036**
Installation of railings for balconies, landings, or porches in high-rise buildings	H.B.7361 H.B.723	No corresponding provision
Prohibition of discrimination against health personnel and other persons who refuse to provide euthanasia or physician-assisted suicide or provide information on such services	H.B.5028	Section 7. Rights of Mental Health Professionals. Mental health professional shall have the right to: (f) Except in emergency situations, manage and control all aspects of his or her practice, including whether or not to accept or decline a service user for treatment;

Suicide Surveillance (collection of the prevalence, demographics, factors, and circumstances of suicide incidences)	S.B.1946 H.B.5697 H.B.9127 H.B. 2895 H.B.4446 H.B.2075 H.B.1866 H.B.2652 H.B.7858 H.B.8278 H.B.1743 H.B.5445 H.B.9138 H.B.2188 H.B.10468 H.B. 5107 H.B. 4741 S.B. 1669 S.B. 1570	Section 30. Duties and Responsibilities of the Department of Health (DOH). - To achieve the policy and objectives of this Act, the DOH shall: (c) Integrate mental health into the routine health information systems and identify, collate, routinely report and use core mental health data disaggregated by sex and age, and health outcomes, including data on complete and attempted suicides, in order to improve mental health service delivery: promotion and prevention strategies;
Development of suicide early intervention and prevention strategies	S.B.1946 H.B.5697 H.B.9127 H.B. 2895	Section 21. Suicide Prevention. - Mental health services shall also include mechanisms for suicide intervention, prevention, and response strategies, with particular attention to the concerns of the youth. Twenty-four seven (24/7) hotlines, to

		provide assistance to individuals with mental health conditions, especially individuals at risk of committing suicide, shall be set up, and existing hotlines shall be strengthened.
Undertaking of suicide research	S.B.1911 S.B.1751 S.B.1592 S.B.398 H.B.3325 H.B.5354 S.B.1163 H.B.1408	Section 28. Research and Development. - Research and development shall be undertaken, in collaboration with academic institutions, psychiatric, neurologic, and related associations, and nongovernment organizations, to produce the information, data, and evidence necessary to formulate and develop a culturally relevant national mental health program incorporating indigenous concepts and practices related to mental health. High ethical standards in mental health research shall be promoted to ensure that: research is conducted only with

the free and informed consent of the persons involved: researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting participants; potentially harmful or dangerous research is not undertaken all research is approved by an independent ethics committee, in accordance with applicable law.

Research and development shall also be undertaken vis-à-vis non-medical, traditional or alternative practices.

Section 30. Duties and Responsibilities of the Department of Health (DOH). - To achieve the policy and objectives of this Act, the DOH shall:

(d) Improve research capacity and academic collaboration on national priorities for research in mental health, particularly

		operational research with direct relevance to service development, implementation, and the exercise of human rights by persons with mental health conditions, including establishment of centers of excellence;
Provision of grants for suicide research Identification, monitoring, and review of suicide early intervention, prevention, and response strategies/ programs	Same as above S.B.1946 H.B.5697 H.B.9127 H.B. 2895 H.B.5354 S.B.1163 H.B.1408 H.B.4446 H.B.2075 H.B.1866 H.B.2652 H.B.7858 H.B.8278 H.B.1743 H.B.5445 H.B.9138 H.B.2188 H.B.10468 H.B. 5107 H.B. 4741 S.B. 1669 S.B. 1570	Section 40. Duties and Functions. - The Council shall exercise the following duties; (b) Monitor the implementation of the rules and regulations of this Act and the strategic plan for mental health, undertake mid-term assessments and evaluations of the impact of the interventions in achieving the objectives of this Act;
Policy-making on nationwide suicide early intervention and prevention strategies	S.B.1911 S.B.1751 S.B.1592 S.B.398	Section 30. Duties and Responsibilities of the Department of Health (DOH). - To achieve

	H.B.3325	the policy and objectives of this Act, the DOH shall: (a) Formulate, develop, and implement a national mental health program. In coordination with relevant government agencies, create a framework for Mental Health Awareness Program to promote effective strategies regarding mental healthcare, its components, and services, as well as to improve awareness on stigmatized medical conditions
Assessment of students who are at risk of emotional disorders which may lead to suicide and timely referrals for appropriate community-based mental health care and treatment.	S.B.1946 H.B.5697 H.B.9127 H.B. 2895	No corresponding provision
Establishment of a suicide hotline	H.B.5354 S.B.1163 H.B.140	Section 21. Suicide Prevention. - Mental health services shall also include mechanisms for suicide intervention,

		prevention, and response strategies, with particular attention to the concerns of the youth. Twenty-four seven (24/7) hotlines, to provide assistance to individuals with mental health conditions, especially individuals at risk of committing suicide, shall be set up, and existing hotlines shall be strengthened.
Inclusion of suicide education and related topics in school curricula	H.B.2701 H.B.2489 H.B.5354 S.B.1163 H.B.1408 H.B.4446 H.B.2075 H.B.1866 H.B.2652 H.B.7858 H.B.8278 H.B.1743 H.B.5445 H.B.9138 H.B.2188 H.B.10468 H.B. 5107 H.B. 4741 S.B. 1669 S.B. 1570	Section 23. Integration of Mental Health into the Educational System. - The State shall ensure the integration of mental health into the educational system, as follows: (a) Age-appropriate content pertaining to mental health shall be integrated into the curriculum at all educational levels; and (b) Psychiatry and neurology shall be required subjects in all medical and allied health courses,

including post-graduate courses in health.

Section 34. Duties and Responsibilities of the Department of Education (DepEd), Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA). - The DepED, CHED and TESDA shall:

(a) Integrate age-appropriate content pertaining to mental health into curriculum at all educational levels both in public and private institutions;

(b) Develop guidelines and standards on age-appropriate and evidence-based mental health programs both in public and private institutions;

(c) Pursue strategies that promote the realization of mental health and well-being in educational institutions; and

		(d) Ensure that mental health promotions in public and private educational institutions shall be adequately complemented with qualified mental health professionals.
Designign of parent-education programs designed to increase family support and capacity for household-based early detection, response, and prevention	H.B.5354 S.B.1163 H.B.1408	No corresponding provision
Youth suicide rehabilitation program for those with previous history of suicidal behavior	Same as above	No corresponding provision
Public awareness campaign	H.B.5354 S.B.1163 H.B.1408 H.B.4446 H.B.2075 H.B.1866 H.B.2652 H.B.7858 H.B.8278 H.B.1743 H.B.5445 H.B.9138 H.B.2188 H.B.10468	Section 22. Public Awareness. - The DOH and the LGUs shall initiate and sustain a heightened nationwide multimedia campaign to raise the level of public awareness on the protection and promotion of mental health and rights including, but not limited to, mental health and nutrition,

	H.B. 5107 H.B. 4741 S.B. 1669 S.B. 1570	stress handling, guidance and counseling, and other elements of mental health.
Support for families and friends of at-risk youth	S.B.1946 H.B.5697 H.B.9127	Section 6. Rights of Family Members, Carers and Legal Representatives. - Family members, carers and duly designated or appointed legal representative of the service user shall have the right to: (a) Receive appropriate psychosocial support from the relevant government agencies.; Section 30. Duties and Responsibilities of the Department of Health (DOH). - To achieve the policy and objectives of this Act, the DOH shall: (h) Provide support services for families and co-workers of service users, mental professionals, workers, and other service providers;

Mandatory reporting of incidences of student suicides with corresponding administrative and criminal charges for violation thereof	Same as above	No corresponding provision
Mandatory peer counselling program	H.B.4446 H.B.2075 H.B.1866 H.B.2652 H.B.7858 H.B.8278 H.B.1743 H.B.5445 H.B.9138 H.B.2188 H.B.10468 H.B. 5107 H.B. 4741 S.B. 1669 S.B. 1570	No corresponding provision
Employment of school psychologists for counselling and assessment	Same as above	Section 24. Mental Health Promotion in Educational Institutions. - Educational Institutions, such as schools, colleges, universities, and technical schools, shall develop policies and programs for students, educators, and other employees designed to: raise awareness on mental health issues,

		identified and provide support and servicesfor individuals at risk, and facility access, including referral mechanisms of individual with mental health conditions to treatment and psychosocial support. All public and private educational institutions shall be required to have a complement of mental health professionals.
Establishment of youth health centers	Same as above	Section 16. Community-based Mental Health Care Facilities. - The national government through the DOH shall fund the establishment and assist in the operation of community-based mental health care facilities in the provinces, cities and cluster of municipalities in the entire country based on the needs of the population, to provide appropriate mental health care services, and enhance the

	rights-based approach to mental health care. Each community-based mental health care facility shall in addition to adequate room, office or clinic, have a complement of mental health professionals, allied professionals, support staff, trained barangay health workers (BHWs) volunteer, family members of patients or service users, basic equipment and supplies and adequate stock of medicines appropriate at that level.

Table 3 shows that out of the 19 steps for suicide prevention stipulated in the bills, 12 had a corresponding provision in the Mental Health Act. There were 5 themes that had suicide prevention steps that were unaccounted for in the law. Themes 3, 4, and 7 had one proposed step each which is unaccounted for. Theme 2 had two proposed steps, and Theme 6 had three proposed steps that were unaccounted for. It is worth noting that the corresponding provisions do not always wholly cover the thought behind the suicide prevention steps. A common example of this is the suicide preventions steps wherein the corresponding provision in the Mental Health Act are coming from the law's Sections 5, 6, and 7. These three sections – which form Chapter II of R.A. 11036 – only discuss the rights accorded to mental health service users and other stakeholders such as their families, carers, and mental health professionals. While the law provides these stakeholders with demandable rights, it does not necessarily provide a concrete program or service that is related to suicide prevention. This means that the stakeholders will still find it difficult to enjoy the promises of this legislation.

Some provisions of the Mental Health Act are also left ambiguous. For example, while Sections 23 and 34 of R.A. 11036 mandate the inclusion of mental health in educational curricula, it is unclear if the coverage of mental health here includes suicide. This is important to note because schools might perceive suicide as a very sensitive topic and might opt not to include it in their instruction. Indeed, there is already precedence for this concern elsewhere: Emile Durkheim's Sociology of Suicide has been omitted from the syllabus out of fear of its capability to "trigger" and cause "undue distress" (Selvarajah, 2015). Therefore, even if the proposed step about including suicide education in the curriculum may be covered by the provisions of R.A. 11036, the challenge might be on the implementation. The sensitive nature of suicide as a subject matter may meet the same resistance that other topics sensitive to Philippine culture have experienced – such as the case of the mandated course on the Life and Works of Jose Rizal several decades ago (Abinales & Amoroso, 2005) and sex education as mandated by R.A. 10354 or simply known as the RH Law in the recent years (Geronimo, 2016). It is worth noting, however, that a recent study (Quintos, 2023a) showed that there was an increasing number of Filipino youth who were exposed to suicide – either because they had friends who had attempted the act or because they had thought of, or attempted, the act themselves. It has been found that people with previous suicide experiences tend to have more liberal attitudes toward suicide and are willing to be part of conversations centered on the subject matter (Quintos, 2023b). Given that the recent reports from the Philippine Statistics Authority indicate that suicide is becoming more prevalent, people might be more open to discussing it in a classroom setting.

To summarize, the proposed steps which have no corresponding provisions in the law are the following:

1. installation of railings for balconies, landings, or porches in high-rise buildings;
2. mandatory reporting of incidences of student suicides with corresponding administrative and criminal charges for violation thereof;
3. provision of grants for suicide research;
4. assessment of students who are at risk of emotional disorders that may lead to suicide and timely referrals for appropriate community-based mental health care and treatment;
5. youth suicide rehabilitation program for those with previous history of suicidal behavior;

6. mandatory peer counselling program;
7. parent-education programs designed to increase family support and capacity for household-based early detection, response, and prevention.

When it comes to societal responses to suicide, laws and programs can come in various forms. Some criminalize the act. This is grounded on the concept of felo de se or "felony of the self". In pre-modern times, this was done by arresting and bringing suicide attempters to trial, while those who succeeded in their suicide attempts had their properties confiscated. In modern times, some countries discount or void the will of persons who died due to suicide as well as their claims for insurance compensation. Beyond criminalization, however, countries have adopted three forms of response to suicide (Rosario, 2019). The first type is suicide prevention. Prevention in this type comes in the form of depriving or limiting the access of people to the means through which suicide can be undertaken. This includes the limitation of access to lethal means such as guns, substances, or even areas wherein suicide can effectively be committed. Among the steps proposed by the suicide bills that are unaccounted for by the Mental Health Act, one falls under this type. The two other types of response are suicide intervention and suicide regulation. Suicide intervention is done by identifying people who are at risk of suicide and providing programs through which they can be dissuaded from the act. These often come in the form of awareness and counseling programs. The majority of the proposed steps fall under this type of response. The third type, suicide regulation, is done when a country merely wishes to regulate who can be allowed to die by suicide by identifying requirements or a set of criteria as to when a suicide is deemed acceptable. This is the case for regulations on euthanasia and assisted voluntary dying. None of the proposed steps fall under this type of response. There is no example of this type of legislative response among the bills under study although there is a bill – H.B. 5028 – that prevents discrimination against health personnel who would refuse to participate in the conduct of, or give information about, euthanasia or physician-assisted deaths.

The installation of railings for balconies, landings, or porches in high-rise buildings can be considered a prudent move toward suicide prevention in the form of restriction of lethal means. This means that instead of reducing the risk of suicide of persons, the approach focuses on restricting access to means or methods of suicide that prove fatal such as guns, poisonous substances, and highly-elevated areas. This approach has been proven effective in reducing suicide incidences in the past (Ryan & Oquendo, 2020). A simple check of news articles in the past decade yields

information about more than a dozen cases of suicides that transpired in shopping malls in the country where victims jumped to their deaths from the upper floors of the buildings. Several more deaths have also transpired in condominium buildings in the country – some of which have become viral on social media because witnesses managed to capture the incident on their smartphones or, in at least one case, the victim himself has decided to live stream the act of suicide on social media. It is worth noting, however, that this step is limited in its effectiveness. Suicide by jumping from highly-elevated areas, while attention-catching, is not one of the most prevalent methods of suicide in the Philippines. Instead, the most common methods of suicide are hanging, shooting, ingesting poisonous substances, and slashing of the wrists (Redaniel et al., 2011; Quintos, 2017a). Furthermore, the restriction of access to lethal means – in this case, restriction against jumping – proposed in this bill is limited to high-rise buildings. Meanwhile, another notable area where people attempt suicide through the act of jumping is overlooked: train stations. Thus far, there are no bills proposed to require structures that can prevent people from jumping into train tracks, albeit the act is notable enough to warrant a senate resolution asking for inquiry on the matter (Senate Resolution No. 994, 16th Congress of the Philippines).

The mandatory reporting of suicide incidences among students may be a necessary step given the unreliability of suicide-related information that suicidologists usually have to deal with. For several centuries, suicide statistics had usually been underreported (De Leo, 2015) – a consequence of many factors such as stigma, limited frequency and extent of autopsies, a reluctance among medical examiners to declare a death as suicide and, in some societies, the criminal penalties associated with suicide that burdens either their mortal remains or their estate (Alvarez, 1972; Skinner et al., 2017; Gray et al., 2015; Stefan, 2016). In the case of the Philippines, Redaniel et al.'s study (2011) reported that there was indeed underreporting in terms of suicide data. This underreporting can partly be due to the stigma associated with suicide. Suicides are often treated as scandalous news that institutions of learning would likely prefer to not be associated with. The mandatory reporting of suicide incidences can help solve this data problem. Information that may be obtained from the proposed suicide reports will then be useful in future suicide-related studies (encouraged and strengthened by the proposed grants for suicide research) which can help in formulating more evidence-based suicide-related policies.

The proposal to assess students for their risk of suicide to make timely referrals to appropriate community-based mental health care and treatment is a welcome idea – albeit one that is not certain to succeed as it

is dependent on the instruments used and the resources available for such an undertaking. In a review of extant suicide risk assessment instruments and approaches, Lotito and Cook (2015) noted that attempts to assess the suicide risk among individuals are not always effective and that around 1 out of every 5 persons who commit suicide had a session with a mental health professional within 30 days from the day they committed the act. This is because persons who are intent on suicide tend to not readily admit suicide ideation or suicide planning to mental health professionals. These assessments are made more difficult by the fact that there is no single factor that can predict suicidal tendencies. Even when suicide assessment instruments are used, the effectiveness of these tools can leave much to be desired. In a systematic review of suicide assessment instruments, Harris et al. (2019) noted that some instruments used today can have a specificity value of as low as 27% and a positive predictive value of as low as 25%. The potential disadvantages of this proposed step are discussed succinctly by Mortali (2017) in this manner:

> Even with acceptable sensitivity and specificity, screening measures will necessarily miss some in the population who will go on to make suicide attempts, while identifying many more as at risk when they are not. The often transient or episodic nature of suicidality among young people makes screening this population even more difficult. Given that costs are involved each time a segment of the target group is screened, most school-based screening programs assess students only once a year, and in some cases, only once during a several-year period. The timing of the screening may increase or decrease the likelihood of identifying students in need of referral. (p. 500)

Another proposed step that is unaccounted for in R.A. 11036 is the establishment of a youth suicide rehabilitation program. The bills did not expound on what the legislators had in mind in terms of a rehabilitation program, only that they wanted one to be formulated to provide "assistance to youth with previous history of suicidal behavior." What is clear, however, is that this program would serve as a response - not a preemptive intervention – to suicide. In other countries, there are several strategies – or therapeutic modalities - employed by various treatment providers for suicide-related rehabilitation. These treatments can be categorized into pharmacotherapy – wherein predisposing factors of suicide are managed through medication – and psychotherapy – wherein suicide risk is treated through verbal and psychological techniques such as Cognitive Behavioral

Therapy and Dialectical Behavior Therapy. Both pharmacotherapeutic and psychotherapeutic approaches have been reported to be effective in curbing suicide based on a systematic review by Mann et al. (2021). These rehabilitation programs may also come in the form of either in-patient or out-patient treatment. While both in-patient and out-patient treatments are considered acceptable, the former has the advantage of providing greater surveillance of patients – allowing for fewer opportunities for repeat suicide attempts. The in-patient treatment also has the latent advantage of being able to isolate the patient from materials that could serve as lethal means of suicide such as guns, bladed objects, highly-elevated areas, and unregulated dosage of substances. Despite these advantages, in-patient rehabilitation also has its drawbacks. The process has been criticized for its tendency to be humiliating, stigmatizing, potentially coercive, isolating, and traumatic (Large & Kapur, 2018). For these reasons, in-patient treatment has been cautioned to be a potential causal factor, instead of a deterrent, for suicide (Large et al., 2017).

The mandatory peer counseling program is an interesting proposal to curb suicide. In other areas that have implemented a similar program, the usual rationale is two-fold. First, it is more economical to utilize students as partners in counselling efforts especially when the employment of psychologists is difficult due to costs and/or sheer lack of availability (Robinson et al., 1991). Second, young people suffering from suicide and related psychological crises tend to confide more with their peers than other potential sources of help (Morey et al. 1993). Indeed, a study about suicide experiences and help-seeking among Filipino undergraduate students (Quintos, 2023a) reported that the majority of Filipino youth who had suicide-related experiences in his study did not seek help during their crisis. However, among those who did, the most frequent choice for their help-seeking behavior was peers instead of more professional sources, such as guidance counselors or suicide hotlines. While these two reasons make the premise of peer counseling attractive, the proposed step also has its potential disadvantages. Lewis and Lewis (1996) cautioned about three potential pitfalls of such an endeavor:

First, serving as peer counselors for an issue as heavy as suicide – a topic that should be overseen by mental health professionals - is a big burden to be shouldered by mere students. Being peer counselors may be an excessive responsibility for people of such young ages. Second, the training and implementation of peer counseling programs need to be overseen by competent mental health professionals. This posits the need for mental health professionals who are not only versed in dealing with suicide

crises but also in how to conduct training for peer counselors and how to administer a peer counseling program. Unfortunately, in the bills wherewith this proposed step emanated from, the school psychologist's required duty to a school is just once a month. For all practical purposes, this makes the program a difficult undertaking. Third, Lewis and Lewis' research noted that adolescents who are attracted to the peer counselor role tended to have their own mental health issues – which might put them at risk of suicide if they were not excluded from the peer counselor role. Even among would-be peer counselors who are not suffering from any mental health issues, their exposure to suicide could make them more at risk of suicide because the process produces a normalizing atmosphere to the act and triggers a behavioral contagion. Lewis and Lewis' points are in agreement with what has been observed in the Philippines. In 2017, Adsuara reported about a support group that was formed on the popular social networking site, Twitter, by young Filipinos. This support group – essentially performing the role of peer counselors - was formed as a response to their perceived inadequacy of suicide hotlines in the Philippines during the time. Many of the volunteers of the support group were not formally trained on how to deal with suicide crises and were primarily motivated to help because of their own experiences of suicide and other mental health crises. This made the endeavor potentially dangerous to the would-be help-seekers and to themselves, especially because previous Philippine suicide studies (Quintos, 2017b; Quintos, 2019b) indicated that exposure to suicidal peers was a significant predictor of future suicide ideation and suicide attempts.

Finally, the proposed Parent-education program is also a commendable step. Data from the study as mentioned earlier on suicide and help-seeking (Quintos, 2023a) showed that the family is the second most frequent choice as a source of help for the Filipino youth during a suicide crisis. Furthermore, the family-suicide connection is important in scientific literature. Previous Philippine-based studies that looked into the prevalent reason for suicide found family problems as the most common reason for attempting suicide (Quintos, 2017a; Quintos, 2023a; Itao & Pederi, 2021) or identified family factors – especially relationship with parents - as significant correlates or predictors of suicide (Quintos, 2017b; Quintos, 2019b; Quintos, 2020; Lopiga, 2021; Lagman et al., 2021; Tan et al., 2019). Therefore, education-based support that would make families – particularly the parents – a source of help against suicide instead of the reason for suicide – is a big advantage.

Conclusion and Recommendation

The results showed that there were 32 suicide bills proposed in the Philippine Congress in a span of 20 years (2004 to March 2023). Within these 20 years, none of these bills were eventually passed into law. The Mental Health Act, in comparison, took 16 years before it was eventually passed into law (Samaniego, 2022). These bills, when their contents are analyzed, can be divided into seven themes, and they stipulate 19 different steps for suicide prevention – out of which only 12 are partially covered by R.A. 11036: Mental Health Act. Given the recent rise in the rates of suicide despite the existence of the Mental Health Act, policymakers and interest groups need to consider that there is a need for a suicide law beyond R.A. 11036. This paper recommends that the following considerations be undertaken when such a law is formulated.

A Need to Review the Extant Suicide Bills and Their Provisions

While it has been established that the Mental Health Act has limitations in its scope, it also cannot be said that the current direction of proposed suicide-related bills is wholly appropriate. The study has shown that the provisions from the most commonly proposed theme (Theme 7; N=15) are also often covered – albeit usually not focused on – by the provisions of the Mental Health Law. This suggests that while there is a necessity for a suicide-focused law in the Philippines, there is also a need for a reconfiguration of the current proposals to avoid redundancy and instead account for the steps in suicide prevention unaccounted for in the existing law. Future studies should also look into two aspects of suicide legislation: the content of suicide prevention laws in countries with low suicide rates, and the effectiveness of the proposed suicide prevention steps found in suicide-related bills based on empirical studies

A Need for a More Comprehensive and Responsive Suicide Law

It is also ill-advised to rely on the current set of suicide-related bills when formulating suicide-related legislation. This is because the current set of suicide-related bills is limited in scope in at least two ways: (1) target population and (2) contexts taken into consideration.

In terms of target population, the findings of this study showed that the majority of the bills are focused on suicide prevention among the youth cohort instead of suicide prevention in the Philippines as a whole. While

this focus on the youth is justifiable to an extent because the country has a predominantly young population and suicidological literature points to the youth as a cohort that is commonly at risk of suicide, this does not mean that the youth are the only age cohort that is at-risk. The elderly, for example, are also suffering from mental health issues including suicide. The case of the elderly is a prime cause for concern because their mental health issues are exacerbated by health problems, bereavement from the loss of loved ones, and retirement (Cruz et al, 2019). In terms of suicide laws in the form of suicide intervention, these older members of the population also have a lesser tendency than the young in terms of seeking help because of the social stigma associated with suicide – a cultural element that they embrace more than the younger generations (De Villa, 2022). As the demographic profile of the country shifts slowly to an inverted population pyramid – a situation projected to happen in the next decade (Delizo, 2022), it will become more and more prudent to make legislation with foci beyond the youth. In terms of context, suicide-related legislation would benefit from being responsive to certain contexts or situations that might serve as a contributory factor to suicide. Situations such as economic recessions, disasters, and catastrophes are often the kind of circumstances that suicide theories tend to identify as risk factors (Quintos, 2017c). The current set of proposals, however, leaves much to be desired. For example, 9 of the 32 suicide bills were proposed after the COVID-19 pandemic struck the country. None of these nine, however, are unique but are instead reiterations of a set of older bills submitted more than a decade ago. Despite being bills born during the pandemic, none underwent changes that may account for societal experiences during the pandemic and the surge in suicide rates. Beyond the COVID-19 threat, the country is situated in the Pacific Ring of Fire and also experiences an average of 20 typhoons annually. This means that the socio-economic security of the people is often imperiled, possibly putting them at a greater risk of suicide.

A Need to Check the Philippine Socio-Cultural Climate

The study also found that the current set of suicide-related proposals comes in the form of suicide surveillance, prevention, and intervention. None of the provisions of the bills pertain to any form of suicide regulation, such as voluntary assisted dying. This lack of proposals for suicide regulation does not likely stem from a general aversion to death – a 2017 Pulse Asia Survey showed that the majority of the respondents were in favor of the death penalty for certain heinous crimes, while a 2018 SWS Survey showed that the majority of their respondents favored death penalty for

certain heinous crimes, albeit this figure decreased to just 47% when other punishment options were available. Rather, the lack of suicide regulation in the provisions is likely due to the predominantly Roman Catholic socio-cultural background of the country. Roman Catholicism has a long history with suicide – with early Christians favoring suicide (in the form of deliberately seeking death by martyrdom) before St. Augustine declared the act immoral and a mortal sin in violation of the commandment against killing (Alvarez, 1972). This socio-cultural barrier to voluntary assisted dying and other forms of suicide regulation laws could either be part of the convictions of the legislators or of what the legislators believe to be part of the convictions of the voting public

The voting public's views on suicide might change in the succeeding years. As previously mentioned, data from the Philippine Statistics Authority points to an increasing number of people who are exposed to experiences of suicide. Furthermore, previous scholarly works have shown that the aforementioned kind of people tend to have more permissive views toward suicide (Quintos, 2023b; King et al., 1996; Eskin et al., 2014; Senf et al., 2022). It was also previously mentioned that the Philippine demographic profile was starting to change and that the next decade could see an aging Filipino population. In relation to this, there are many common reasons given by people for availing voluntary assisted dying, such as loss of autonomy, loss of ability to enjoy activities, and fear of suffering – especially those with malignancies, neurological diseases, and organ failures (Wiebe et al., 2018). These reasons are issues often experienced by an aging population. Even now, while the Philippine population is still predominantly young, chronic and potentially painful diseases (e.g., cancer) are already the third leading cause of death in the country (Montemayor, 2023). It can be argued, therefore, that there is a possible present and future need and support for assisted voluntary dying in the country.

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