MENTAL HEALTH STRATEGIC PLAN 2019-2023

PHILIPPINE COUNCIL
FOR MENTAL HEALTH

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MESSAGE FROM DOH

The passage of the Mental Health Act and the Universal Health Care Law paved the way for the strengthening of national efforts towards improving the Mental Health of all Filipinos.

Mental health is a topic often ignored because of the stigma and discrimination that surround it. By now, it should be clear that mental health is just as important as our physical health. It encompasses our emotional, psychological, and social well-being, and affects how we think, feel, and act. It also helps determine how we respond to stress, relate to others, and how effective we are at making healthy choices. Mental health supports healthy development at every stage of life. The more we discuss and verbalize issues in mental health, we allow greater chances to establish a connection with others. People's mental health should not be left unattended, and there should be no shame surrounding it.

The Department of Health (DOH) has been at the forefront in creating a national mental health policy, through Republic Act 11036, "The Mental Health Act". The passing of the law supported and highlighted the value of working together. The Philippine Council for Mental Health (PCMH), composed of representatives from other national government agencies, has been purposeful in setting up basic mental health services at both the hospital and community levels. Together with our academic partners, we placed a high value on research and standard setting. Through the harmonization of manuals and protocols, and the establishment of a registry of patients, we have reinforced the provision of psychiatric and psychosocial services in access sites across the country.

One of the objectives of the Mental Health law is the integration of mental health care in the basic health services, according to the Fourmula One Plus for Health (F1+) strategy. The Mental Health Strategic Plan will be a valuable guide for council members, policymakers, and service providers in forging partnerships and increasing investments in mental health.

The Mental Health Act and the Universal Health Care Law are instrumental in ensuring the proper valuation of mental health services as we continue to improve service delivery capability and access in terms of infrastructure, manpower, and resources. Sound mental health is a human right, so our drive to provide quality and accessible primary health care for all should allow this to be a reality for everyone, everywhere, and in whatever state of being they may be.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

MESSAGE FROM WHO

There can be no health without mental health. Amid the COVID-19 pandemic, we realized how valuable it is to be physically and mentally well as we keep ourselves and our families healthy.

In 2017, the two most common mental health conditions in the Philippines – anxiety and depression – accounted for over 800,000 years of life lived with disability in the country. Reported suicide rates in the country have been increasing over the past decades, particularly among young people. The latest figures from 2015 indicate that 17% of young people aged 13 to 15 had attempted suicide.[1]

It is difficult and heartbreaking to visualize this many people experiencing profound suffering from invisible wounds. In 2018, Republic Act No. 11036 – otherwise known as the Mental Health Act – was passed as the first national legislation supporting a universal right to mental health care. It promotes the integration of mental health services into primary health care facilities and in the communities.

I commend the collective efforts of various national government agencies, civil society organizations, the academe, and other stakeholders who have significantly contributed in shaping the National Mental Health Strategic Plan. We are working with a solid foundation with this legislation, but more collaborative and inclusive efforts need to be done. For the Future – towards the healthiest and safest region (WHO WPRO) identified the need for “Integrating mental health services into primary health care – and ensuring that primary health care workers are adequately skilled in mental health – is also the most viable way of ensuring that people get the mental health care they need”.

We need quality, evidence- and rights-based mental health care provided to those who need it most. We call on the implementation of innovative ways to expand the mental health workforce in health facilities and the communities as services cannot be provided by specialists alone. We must support persons with mental, neurological, and/or substance use conditions with the treatment, care, and support they need to thrive.

The support of World Health Organization to the Department of Health, through the National Mental Health Division and the Philippine Council for Mental Health, is a testament of our commitment to a valued, promoted, and protected mental health and well-being for all Filipinos.

Dr. Rabindra Abeyasinghe
WHO Representative to the Philippines

[1] WHO UNDP UNIATF Prevention and management of mental health conditions in the Philippines. The case for investment. May 2021 (unpublished)

AO	Administrative Order
BHW	Barangay Health Worker
CHED	Commission on Higher Education
CHR	Commission on Human Rights
CSC	Civil Service Commission
CSO	Civil Society Organization
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOLE	Department of Labor and Employment
DPCB	Disease Prevention and Control Bureau
DSWD	Department of Social Welfare and Development
ECCD	Early Childhood Care and Development
ENCDD	Essential Non-Communicable Diseases Division
GIDA	Geographically Isolated and Disadvantaged Areas
HRH	Human Resources for Health
IRB	Internal Review Board
IRR	Implementing Rules and Regulations
JMC	Joint Memorandum Circular
LGU	Local Government Unit
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological, and Substance Abuse
MOP	Manual of Procedures
NBI	National Bureau of Investigation
NCMH	National Center for Mental Health
NGA	National Government Agency

NGO	Non-government Organization
PAP	Psychological Association of the Philippines
PCHRD	Philippine Council for Health Research Development
PCMH	Philippine Council for Mental Health
PFA	Psychological First Aid
PGCA	Philippine Guidance Counselling Association
PhilHealth	Philippine Health Insurance Corporation
PLE	Persons with Lived Experience
PMHA	Philippine Mental Health Association
PNA	Philippine Neurological Association
PPA	Philippine Psychiatric Association
PRC	Professional Regulation Commission
PWD	Persons with Disability
SDG	Sustainable Development Goals
TESDA	Technical Education Skills and Development Authority
TWG	Technical Working Group
UHC	Universal Health Care
UHC IS	Universal Health Care Integration Sites
UN	United Nations
WHO	World Health Organization

The Mental Health Act Implementing Rules and Regulations (IRR) defines the following terms:

Mental Health refers to a state of well-being in which the individual realizes one's own abilities and potentials, copes adequately with the normal stresses of life, displays resilience in the face of extreme life events, works productively and fruitfully, and is able to make a positive contribution to the community;

Mental Health Professional refers to a medical doctor, psychologist, nurse, social worker, guidance counsellor or any other appropriately-trained and qualified person with specific skills relevant to the provision of mental health services;

Mental Health Worker refers to a trained person, volunteer or advocate engaged in mental health promotion, providing support services under the supervision of a mental health professional;

Mental Health Service Provider refers to an entity or individual providing mental health services as defined in the Mental Health Act, whether public or private, including, but not limited to, mental health professionals and workers, social workers and counsellors, peer counsellors, informal community caregivers, mental health advocates and their organizations, personal ombudsmen, and persons or entities offering non-medical alternative therapies;

Mental Health Services refer to psychosocial, psychiatric or neurologic activities and programs along the whole range of the mental health support services including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals;

Service user refers to a person with lived experience of any mental health condition including persons who require or are undergoing psychiatric, neurologic or psychosocial care;

Carer refers to the person, who may or may not be the patient's next of kin or relative, who maintains a close personal relationship and manifests concern for the welfare of the patient;

A **community-based mental health care facility** refers to a mental facility outside of a mental hospital.

MENTAL HEALTH

EXECUTIVE SUMMARY

On June 20, 2018, the President signed into law Republic Act (RA) No. 11036, otherwise known as the “Mental Health Act”. This took effect on July 5, 2018. The Implementing Rules and Regulations was signed on January 22, 2019 by the Secretary of Health, Dr. Francisco T. Duque III.

Sec. 40 of the Mental Health Act reads as follows:

“MANDATE - The Philippine Council for Mental Health, herein referred to as the Council, is hereby established as a policy-making, planning, coordinating and advisory body, attached to the DOH to oversee the implementation of this Act, particularly the protection of rights and freedom of persons with psychiatric, neurologic, and psychosocial needs and the delivery of a rational, unified and integrated mental health services responsive to the needs of the Filipino people.”

The Implementing Rules and Regulations for this Act state: “Within six (6) months after the effectivity of this IRR, the Council shall develop a strategic plan for implementation, including a balanced scorecard with indicators. It shall encompass the establishment of a multi-agency and/or multi-sector coordinating mechanism to ensure integrated participation of the regions, provinces, cities/ municipalities through regional and local mental health councils or other appropriate bodies”

This document is the Strategic Plan for the Philippine Council for Mental Health (PCMH). It describes the PCMH’s vision, mission, goals, and outcome objectives for Mental Health in the Philippines. It details outputs, key activities, and targets for the first five years of the implementation of the Mental Health Act (2019-2023) and the agencies or sectors responsible for these outputs and key activities. This includes outputs, key activities, and targets at the national, regional, and local levels. It also defines indicators and modes of verification for monitoring and evaluation. An electronic tool accompanying this Strategic Plan will be used as the scorecards for the PCMH and for specific agencies.

OVERVIEW OF THE SITUATION

Globally, mental health has become a development priority. The World Health Report (2001) estimates that 1 in 4 people in the world will be affected by mental or neurological disorders at some point in their lives. Depression affects an estimated 4.4% of people in the world. Anxiety disorders affect 3.6% of the population.

A fifth of global cases come from the Western Pacific, where 3.6% are affected by depressive disorders and 2.9% by anxiety.

In the Philippines, 3.3% of the population or 3,298,652 Filipinos live with depression. Suicide Mortality Rate is 3.2 (per 100,000 population).

The Global School-based Student Health Survey (2015) revealed that 16.8% of students aged 13-17 years attempted suicide and 11.6% seriously considered attempting suicide during the 12 months before the survey. Seven percent (7.1%) admitted to having used drugs one or more times during their life. *(WHO, 2015)*

In the Young Adult Fertility and Sexuality Survey, drug use was reported by 7.1% of males and 0.8% of females ages 15-24 years. The mean age at which drug use was initiated is 17.3 years for both males and females. In the same survey, the proportion of youth who have ever thought of suicide declined from 13.4% in 2002 to 8.7% in 2013. Proportion who attempted suicide remained at about 3% in both survey rounds. *(DRDF and UPPI, 2014)*

Mental, neuropsychological, and substance use disorders account for 2,311,800 DALYs or total number of years lost due to illness, disability, or premature death. Depressive disorders, anxiety disorders, and epilepsy are the main contributors to healthy years lost. *(WHO, 2018)*

Table 1. Estimated DALYs ('000) by cause, sex, Philippines, 2016 (WHO, 2018)

	All	Males	Females
All Causes	**33,905.0**	**19,361.4**	**14,543.5**
Mental and substance use disorders	**1,816.7**	**976.6**	**840.1**
1. Depressive disorders	383.5	165.9	217.6
a. Major depressive disorder	248.0	115.0	133.0
b. Dysthymia	135.5	50.9	84.6
2. Bipolar disorder	106.0	50.3	55.8
3. Schizophrenia	168.3	88.5	79.8
4. Alcohol use disorders	166.2	126.0	40.2
5. Drug use disorders	169.3	115.6	53.7
a. Opioid use disorders	113.4	77.8	35.6
b. Cocaine use disorders	2.8	2.0	0.8
c. Amphetamine use disorders	20.2	14.2	6.1
d. Cannabis use disorders	12.7	8.9	3.8
e. Other drug use disorders	20.2	12.8	7.5
6. Anxiety disorders	325.5	126.4	199.1
7. Eating disorders	37.5	5.7	31.7
8. Autism and Asperger syndrome	122.9	93.4	29.4
9. Childhood behavioral disorders	112.7	73.0	39.6
a. Attention deficit/ hyperactivity syndrome	6.9	4.7	2.2
b. Conduct disorder	105.8	68.4	37.5
10. Idiopathic intellectual disability	96.3	57.1	39.2
11. Other mental and behavioral disorders	128.6	74.7	53.9
Neurological conditions	**880.2**	**407.8**	**472.5**
1. Alzheimer disease and other dementias	95.7	40.2	55.5
2. Parkinson disease	95.7	8.1	6.5
3. Epilepsy	225.2	123.7	101.5
4. Multiple sclerosis	2.2	0.6	1.5
5. Migraine	325.6	114.0	211.6
6. Non-migraine headache	75.2	30.0	45.2
7. Other neurological conditions	141.7	91.2	50.5
Intentional injuries	**1386.7**	**1153.2**	**233.5**
1. Self-harm	174.9	121.6	53.3
2. Interpersonal violence	912.2	803.5	108.7
3. Collective violence and legal intervention	299.6	228.1	71.5

Table 2. Age-standardized* suicide rates (per 100,000 population) *(WHO, 2017)*

	2016	2015	2010	2000
Both sexes	3.7	3.8	4	3.1
Males	5.2	5.4	5.7	4.5
Females	2.3	2.3	2.3	1.8

**The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100,000 persons, where the weights are the proportions of persons in the corresponding age groups of the WHO standard population.*

Age-standardized suicide mortality rate per 100,000 population
Philippines, 2000-2016

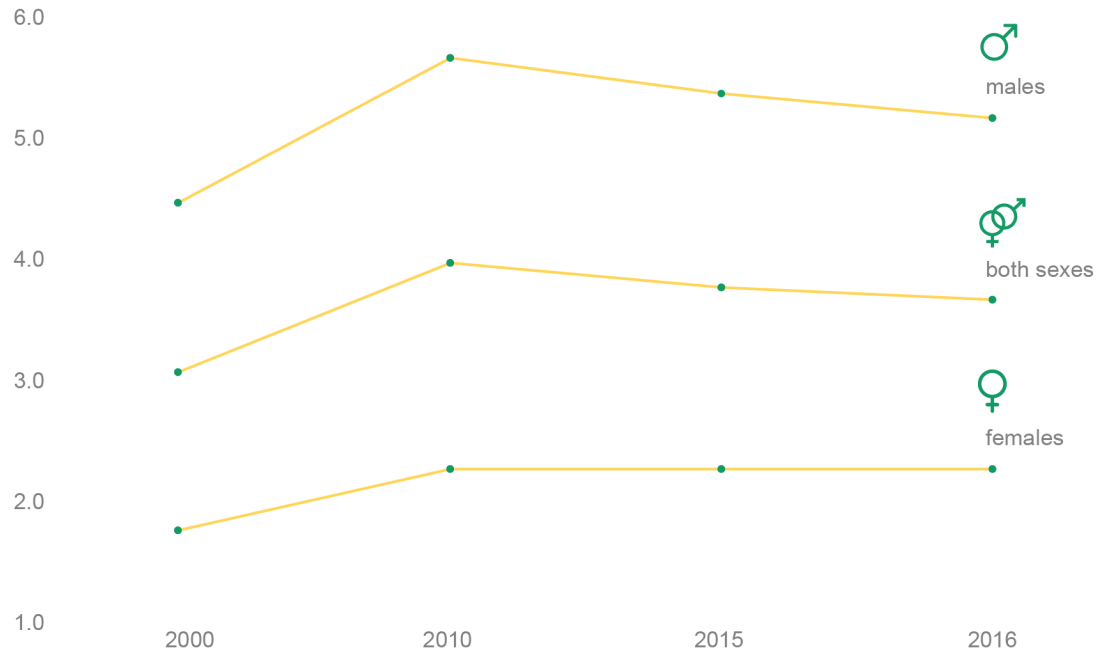


Table 3. Suicide mortality rate* (per 100,000 population) *(WHO, 2017)*

	2016	2015	2010	2005	2000
Both sexes	3.2	3.2	3.3	2.6	2.5
Males	4.3	4.5	4.7	3.7	3.5
Females	2.0	2.0	1.9	1.5	1.6

**Number of suicide deaths in a year, divided by the population and multiplied by 100,000.*

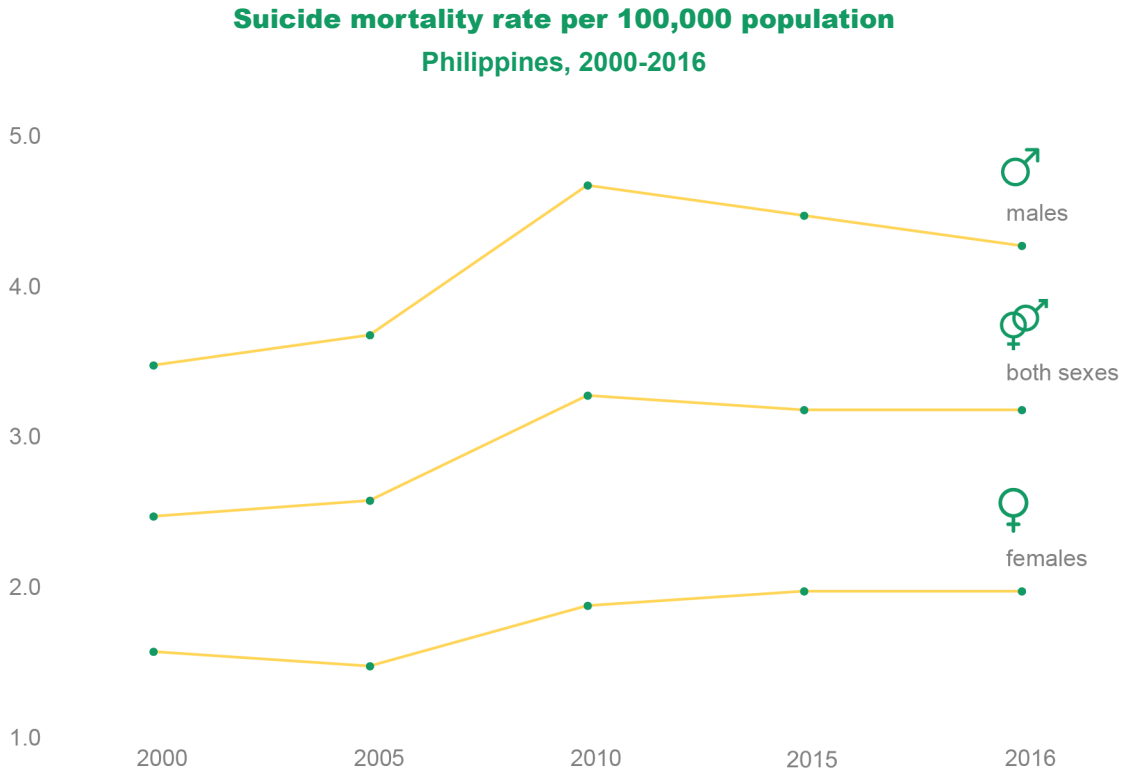
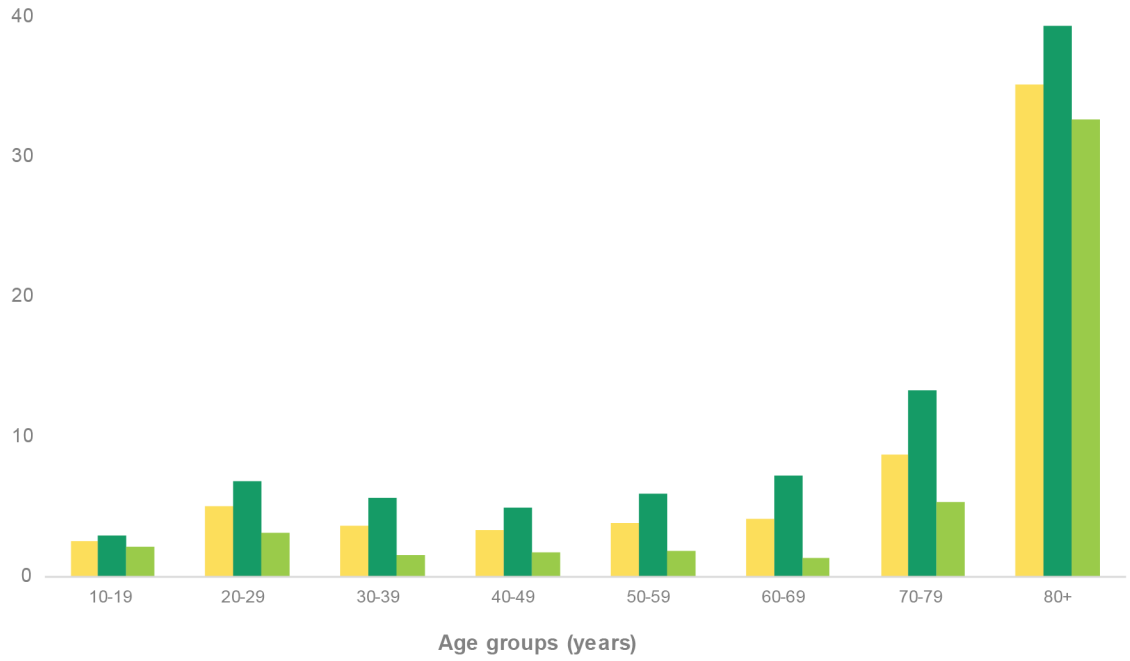


Table 4. Suicide rate estimates, crude, 10-year age groups *(WHO, 2017)*

	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
Both sexes	2.5	5.0	3.6	3.3	3.8	4.1	8.7	35.1
Males	2.9	6.8	5.6	4.9	5.9	7.2	13.3	39.3
Females	2.1	3.1	1.5	1.7	1.8	1.3	5.3	32.6

Suicide mortality rate estimates per 100,000 population

Philippines, 2016



Out-of-pocket payments

Of its total health expenditure, the Philippine government spends 0.22% on Mental Health, around ₱12.19 per capita. Persons with mental disorders pay mostly or entirely out of pocket for services and medicines. *(WHO, 2018)*

Meager human resources for mental health

There are 2,051 mental health professionals (including psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers working in mental health) working in government and non-government, 60 of whom are child psychiatrists. Counting these mental health professionals and other health workers that possesses some training in health care or mental health care, there are 2.02 mental health workers per 100,000 Filipinos. *(WHO, 2018).* Professional associations calculate that there are only 567 psychiatrists *(PPA, 2019)*, 483 neurologists *(PNA, 2019),* and 3,783 registered guidance counselors *(PGCA, 2019).* The Commission on Human Rights has only 147 Special Investigators and 84 lawyers across the country.

This means that for every 100,000 Filipinos:

There are 0.518 psychiatrists, 0.885 psychologists. 0.30 occupational therapists, and 0.26 speech therapists working in the mental health sector.

There are 0.001 mental hospitals, 0.083 mental health units in general hospitals, 0.211 mental health outpatient facilities, 0.002 mental health day treatment facilities, and 0.058 community residential facilities.

There are 4.129 beds in mental hospitals, 1.324 beds for mental health in general hospitals, and 2.045 in community residential facilities. (WHO, 2017)

There are 217 mental health outpatient 155 inpatient facilities in the country.

Table 5. Mental health outpatient facilities

Mental health outpatient services attached to a hospital	85
"Community-based / non-hospital" mental health outpatient facility	119
Other outpatient facility *(e.g. Mental health day care or treatment facility)*	1
Outpatient facility specifically for children and adolescents *(including services for developmental disorders)*	11
Other outpatient services for children and adolescents *(e.g. day care)*	1

Table 6. Mental health inpatient care facilities

Mental hospitals	1
Psychiatric units in general hospitals	84
Forensic inpatient units	1
Residential care facilities	59
Inpatient facility specifically for children and adolescents	11

Dominance of hospital-based services

Annually, 82,277 Filipinos with psychosis, bipolar disorder and depression -- 80.89 per 100,000 population -- are treated.

There were 70.8 visits per 100,000 population to mental health outpatient facilities attached to a hospital. Visits to community-based and other outpatient facilities are not reported. Neither were visits to outpatient facilities and other services specifically for children and adolescents.
There was a total of 3,365 inpatients, but the number of involuntary admissions is unknown.

For every 100,000 population, there are 4.13 mental hospital beds and 11.42 annual admissions to these mental hospitals; 1.32 general hospital psychiatric unit beds and 3.66 annual admissions to these psychiatric units; and 0.10 child and adolescent inpatient beds with 0.28 admissions. There are 2.04 residential care beds per 100,000 population, but annual admissions are not reported. There are no known forensic inpatient unit beds.

Hospital stays are usually long-term. Less than half (40%) of mental hospital inpatients stay for less than one year. Thirty-five percent (35%) stay one to five years and one out of every four (25%) inpatients stay more than five years. However, more than 75% of discharged inpatients receive a follow-up outpatient visit within one month. (WHO, 2018)

POLICIES ON MENTAL HEALTH

The **United Nations (UN) Convention on the Rights of Persons with Disabilities** ensures the protection of all persons with disabilities from discrimination of any kind on the basis of such disabilities. Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which may

The **Universal Declaration of Human Rights** provides for an individual's right to a standard of living adequate for the health and well-being of himself and of his family. This includes food, clothing, housing, medical care, and necessary social services. The right to security in the event of sickness and disability is also promoted. *(UNHRD, 1948)*

The **Sustainable Development Goals (SDGs)** is a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. The United Nations set goals that meet the urgent environmental, political and economic challenges facing our world. SDG 3 aims to ensure health lives and promote well-being for all at all ages. Mental health directly plays into this goal under the target to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing, one indicator of which is a reduction in suicide mortality rate; the target to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; and as an essential component of universal health coverage *(UN, 2012).* Moreover, many SDGs explicitly address social determinants of mental health.

Target 3.4. By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing.

Target 3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Target 3.8. Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all

In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders. In response, the World Health Organization (WHO) developed the **Mental Health Action Plan 2013-2020,** which global in its scope and is designed to provide guidance for national action plans. Its overall goal is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. It has six objectives: 1) to strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; and 4) to strengthen information systems, evidence and research for mental health. *(WHO, 2013)* Following the global action plan, Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific describes three separate and phased implementation options for core, expanded and comprehensive actions to address unique needs and distinct resources. The Regional Agenda further emphasizes an all-of-society and whole-of-government approaches are required to overcome the implementation challenges. *(WHO, 2015)*

In the Philippines, Republic Act No. 11036 (2018), otherwise known as the **Mental Health Act,** establishes a national mental health policy ensuring that all Filipinos enjoy the basic right to mental health and protecting the fundamental rights of people who require mental health services. It includes the rights of service users and other stakeholders, the quality of mental health services to be made available to the public, the education and promotion of mental health in educational institutions and workplaces, the mandate to conduct research and development on the subject matter, the duties and responsibilities of concerned government agencies, the institution of the Philippine Council for Mental Health, and the acts that are prohibited and penalties therefor. Annex 1 is the Mental Health Act and Annex 2 is its Implementing Rules and Regulations (IRR).

Republic Act No. 11223 (2018), otherwise known as the **Universal Health Care (UHC) Act,** reforms the healthcare system through a systemic approach, which includes financing, service delivery, local health system, regulation, and governance and accountability measures. It requires population-based health services with a primary care provider network, epidemiologic surveillance systems, and health promotion programs.

Republic Act No. 10754 (2016), an Act Expanding the Benefits and Privileges of Persons with Disability (PWD), expands the benefits and privileges of PWDs by amending the **Magna Carta for Persons with Disabilities.** PWDs are now entitled to at least twenty percent (20%) discount and exemption from VAT on the purchase of certain goods and services. Republic Act No. 7277 (1992), the Magna Carta for Disabled Persons, provides for policies ensuring the rehabilitation, self-development, and self-reliance of disabled persons. Its primary goal is to improve the total well-being of disabled persons by developing their skills and potentials and integrate them into the society. It determines who disabled persons are (which includes those suffering from mental illness), their rights and privileges, and the prohibited discriminatory acts against them. Moreover, the Act mandates the establishment of centers for special education in all regions of the country for those visually impaired, hearing impaired, and intellectually disabled.

DOH Administrative Order No. 2016-0039 (2016), **Revised Operational Framework for a Comprehensive National Mental Health Program,** provides for guiding principles and the framework of action for effectively implementing a comprehensive mental health program in the country. This includes a wide range of promotive, preventive, treatment, and rehabilitative services for persons who suffer from mental, neurological, and substance abuse (MNS) disorders. Various concerned sectors of the society are given roles and responsibilities to promote mental health and well-being, prevent MNS disorders and other forms of addiction, provide care, enhance recovery, and reduce morbidity, disability and mortality of persons suffering from these disorders. This was preceded by DOH Administrative Order No. 2007-0009 (2007), **Operational Framework for the Sustainable Establishment of a Mental Health Program.** This issuance provides for general guidelines for stakeholders in the government and private sector on the development and implementation of the National Policy on Mental Health through plans and programs. Guidelines as to service delivery, financing, regulation, and governance of the programs are given. Different strategies are also laid out to prioritize and address the concerns regarding the wellness of daily living, extreme life experiences, substance abuse and other forms of addiction, and mental disorders of affected individuals. Different committees are established both in the national and regional levels for implementation.

THE GAPS IN FOSTERING MENTAL HEALTH AND WELLBEING

Lazo, Lucita S. August 8, 2019. Theory of Change of the Philippine Mental Health Strategic Plan 2019-2023. Consultant's Technical Report submitted to the WHO Philippines Country Office

The Philippines seeks to achieve Health for All, but historically, it has low prioritization for mental healthcare. The mental health program and services in the Philippines suffers from enormous gaps as revealed in a Philippine Consortium for Health Research Development (PCHRD)- sponsored study that sought to define the mental health research agenda in the country. Also, system and operational gaps are implied and addressed in the Philippine Mental Health Act of 2018. These gaps include the inadequacy of mental health information for planning and implementation of programs and delivery of services, weak mental health governance and insufficiency of mental health services vis-à-vis the great demand from a huge population of 110 million Filipinos. A vital gap is the lack of a proactive effort to promote mental health & wellbeing and prevent mental disorders. These gaps are described below.

A. Need for a Human Rights-based Social Environment for Mental Health Promotion

The MH Act declares as a national policy that the "State commits itself to promoting the well-being of people by ensuring that mental health is valued, promoted and protected. (Section 2)" … Every Filipino has the right to mental health and has put the promotion of MH and prevention of mental health conditions at the forefront of its policy agenda. The promotion of mental health and wellbeing emphasizes the fact that a health care delivery system provides for the maintenance of health and wellness and not just treatment of illness. Attention focuses on the majority of the population who are well (a.k.a. the asymptomatic population) and not the minority who have been found to be sick. These are the individuals and groups of individuals with their specific cultural backgrounds who live and sustain healthy, satisfactory lives and contribute to the development of their community.

In the Philippines, socio-economic stressors, especially poverty, modernization, technology, violence, climate change, disasters, and extreme life experiences are major stressors in current life. Hence, resiliency building, and vulnerability reduction must become part of mental health promotion in the Philippines.

Stigma abounds in the Philippines and has constrained Filipinos from seeking help when they are experiencing mental symptoms. There is a need to develop health literacy that translate into health-seeking behaviors as Filipinos have a tendency to prioritize daily basic needs over mental

health treatment. Research on how their health-seeking behaviors can be improved in school and workplace settings is needed. This suggests the need for 1) mental health awareness: education of the public, parents, teachers, students, even service providers (guidance counselors, barangay health workers, etc.) in order to reduce stigma that results in poor help seeking behaviors; and 2) defining the concept of stigmatization in the Philippines. At present, stigma is defined based on Western studies and it is valuable to understand various factors leading to stigmatization in the Philippine context.

Diagnosis and treatment interventions, often patterned from Western models, have overshadowed indigenous and culturally sensitive approaches. Further, the disease and/or clinical orientation is geared toward the mentally and neurologically ill and not the greater majority who are mentally well or asymptomatic i.e. no manifest symptoms of mental health conditions.

Community MH Service Delivery. A community-based approach in mental health service delivery is envisaged. A wide array of issues need to be addressed such as the community reintegration process/ mechanism of a survivor, lack of MH professionals and workers at the grassroots level, accessibility of services linked with the integration of mental health services in health systems at all levels up to barangay level, sustainability of community-based mental health service delivery systems, protocol in handling cases of mental health problems at the barangay level, lack of programs, capacity building for health workers, including long-term capacity building programs for post-disaster communities, and assessment of the mhGAP implementation.

Educating the public is expected to reduce stigmatization of mental health conditions. There is a need to identify communication strategies to ensure that evidence-based researches are made available to the public. Mental health information must be made accessible through inclusion of mental health in school curriculum and barangay health education. Education must aim to develop the ability to cope with the psychosocial stressors of modern life. This also means that the capacity of socialization agents such as the parents, teachers, barangay health workers, the youth, and the like must be developed. To facilitate help-seeking, there must be a referral network and information on procedures for access to MH services that should be widely disseminated.

What is needed is to promote mental health and wellbeing in the family, communities, schools and workplaces. A life course perspective is needed to promote mental health at all stages of the life cycle, from birth to maturity. Promotive and preventive strategies must take into account optimizing brain health and the reduction of attendant life stressors at every stage of the life course at national and local levels.

B. Inadequate Mental Health Information

The IRR of the Mental Health Law of 2018 states in Section 29 that research should be undertaken to produce information that will guide the formulation of a culturally relevant national mental health program that incorporates indigenous concepts and practices. A national epidemiologic study on mental health shall be undertaken at regular intervals to be determined by the Philippine Council for Mental Health.

To strengthen the mental health information system, support should be given to the establishment of a data base on mental health considering that researches are added to the pool every year as students graduate from psychiatry, neurology and psychology training centers and colleges. The National Center for Mental Health (NCMH) called for a unified information system and to standardize the mental health service delivery system (Strategic Needs Assessment (SNA), July 2016). This requires the extremely fragmented network of public-private service providers to collaborate.

Also, the WHO AIMS (Assessment Instrument for Mental Health Systems) report recommended the institution of community surveillance of specific mental disorders. This includes epidemiological studies that establish the prevalence and risk factors of mental disorders by type, by region, and nationwide. Studies should analyze not only prevalence but the magnitude of the problem in order to guide policy making, planning, program monitoring, and evaluation.

Estimating the burden of disease is significantly hampered by the lack of epidemiological data in the country. The University of the Philippines (UP-PGH) is conducting an epidemiological survey on mental health and results are expected to be released in 2020. Gathered literature provides significant information on suicide, suicide ideation, non-suicidal self-injury (NSSI), and depression that may be the basis for policy development. There are few studies on risk factors of posttraumatic stress disorder (PTSD) and substance abuse. Research on schizophrenia is nil. “No study to date on the outcomes of schizophrenia or factors that may affect prognosis” (Bautista, et al, 2018).

Vital information is needed to rationalize the mental health delivery system and systematically determine the commensurate resources. In planning for an adequate mental health delivery system, it is useful to adopt a life course approach to ensure that the health needs at all stages of life are deliberately considered.

C. Weak Leadership and Governance

Governance includes the processes of policy making, planning of programs, resource allocation, implementation, monitoring and evaluation of programs. It involves various stakeholders and the end results of governance are the mental health service(s) delivered to the constituents in a specific jurisdiction. MH governance assigns duties, roles and responsibilities to duty bearers in order to facilitate the production of MH services. The MH Act defines the governance architecture for mental health in chapter VII, specifying the key duty bearers in the execution of the national policy on MH. The Philippine Council for Mental Health (PCMH), attached to the DOH, is the highest policy making body on mental health.

Under the decentralized governance system in the Philippines, MH service delivery is assigned to the Local Government Units (LGUs), but this set up has yielded very little positive results in the past years i.e. inadequate, inaccessible, ineffective mental health services.

Section 38 of the MH Law defines the duties and responsibilities of the LGUs in mental health governance. In section 39, the MH Act states that “each LGU shall establish or upgrade hospitals and facilities with adequate and qualified personnel, equipment and supplies to be able to provide mental health services and to address psychiatric emergencies.”

The MH Law (Section 37) stipulates that the DSWD will refer service users to MH facilities, professionals, workers and other service providers for appropriate care; provide or facilitate access to public or group housing facilities, counseling, therapy and livelihood training and other available skills development programs; formulate, develop and implement community resilience and psychosocial wellbeing training, including psychosocial support services during and after natural disasters and other calamities and develop and implement training and capacity building programs.

The roles of the national and local governments need to be elucidated and the local officials must be engaged more actively and motivate them to provide community based mental health services for their respective constituents.

The Lancet Commission’s call to reframe mental health explicitly states that MH is everybody’s business which implies that all Filipinos must be concerned with promoting mental health. This implies mobilization and harnessing of the NGO sector in MH governance and the need to strengthen organization of families and individuals with lived experiences in mental health disorders.

If the Philippines is to heed the call to reframe mental health, then an immediate imperative is to enforce a paradigm shift among the duty bearers. To begin with, the PCMH must be oriented to the transformative shifts in mental health as articulated in the Lancet Report.

Numerous gaps in governance can be found in various spheres such as the absence of local (LGU) policies for the implementation of the national MH policy, the need to involve non-health sectors and people with lived experiences, need to systematically identify the barriers to help seeking and provision MH care, capacity gaps in formulating and implementing MH programs, and in setting up community based mental health services, inadequate resources and ways of integrating MH services in primary health care.

Prevalence data analyzed by geographic and political districts will help define the accountabilities of the duty bearers in MH service delivery.

Attention must be paid to the quality of mental health care, the capacity of mental health professionals and building capacities at the community level to implement mental health programs and services. There is lack of data on facilities, public or private and the mental health status of the professionals (psychiatrists, neurologists and psychologists) themselves because they are supposed to serve as role models.

There is a need to examine the constraints and challenges in the MH system such as the inadequacy of human resources at the grassroots. Look into the need for permanent positions

(plantilla items) in government. There is a need to map mental health programs and services and determine the effectiveness, accessibility, responsiveness and other factors affecting implementation and compare facility programs versus community-based programs.

Operations research is needed to support the processes of accrediting mental health-friendly facilities by the DOH and Phil Health. Study the financial sustainability of mental health programs in terms of cost, expansion of PhilHealth packages to outpatient services including medication or some other form of MH coverage, etc.

D. Insufficient Mental Health Services

"Mental health services refer to psychosocial, psychiatric or neurologic activities and programs along the whole range of the mental health support services including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals." (MH Law, Section 4)

The Philippine Mental Health Act Sections 15-23 stipulate provisions on mental health services: 1) quality of MH services, 2) MH services at the community level, 3) community based mental health care services, 4) reportorial requirements, 5) psychiatric, psychosocial and neurologic services in Regional, Provincial and Tertiary Hospitals, 6) Duties and responsibilities of mental health facilities, 7) Drug screening Services, 8) Suicide Prevention, and 9) Public Awareness.

The gaps in MH service provision can be viewed from the standpoint of the claim holder i.e. families & clients and the duty bearers i.e. national and local government agencies in both the health and non-health sectors.

On the demand side or the claim holders' vantage point, the needs of the various population groups need to be segmented. Those with mental health conditions would have needs for specialist care (estimated to be some 20 % of the population) while the bigger majority (80 %) represent those with no diagnosed MH symptoms (asymptomatic) would have needs for maintenance of their wellbeing.

Stakeholder consultations have made apparent that there is a need for a suicide prevention program arising out of an increasing trend of suicide among the youth, and the need for an effective substance abuse program (to address addiction to drugs, tobacco, alcohol). These two concerns have been addressed in the MH Act (Section 21, Drug Screening Services and Section 22, Suicide Prevention)

A key issue is the accessibility of MH services. This entails the need for information to reach users and potential users on who provides what services and how to reach them as well as the procedures and protocols for accessing MH services. Thus, there is a need to have an institutional referral system and a protocol in handling mental disorders at various levels and settings (barangay/school/workplace), i.e. from self-care to expert care. This concerns the difficulty among patients and their families to search for referral networks and access services

of mental health service professionals/providers due to lack of data basing of such services and/or the database is not readily available. Counselors articulated this as a critical need for cases needing urgent pharmacological intervention.

On the supply side, a major concern is the availability, quality, affordability and sustainability of MH services, and psychotropic medicines and antiepileptic drugs. This involves the need to provide psychosocial support during and after natural disasters and other calamities and other extreme life experiences. The challenges to be addressed include the lack of MH human resources and at the same time, ensuring that the limited number of MH professionals and carers are protected from “burnout.”

THE ROAD TO THE STRATEGIC PLAN 2019-2023

On June 20, 2018, President Rodrigo signed the Mental Health Act into law. This took effect on July 5, 2018.

Sec. 40 of the Mental Health Act reads as follows: “MANDATE - The Philippine Council for Mental Health, herein referred to as the Council, is hereby established as a policy-making, planning, coordinating and advisory body, attached to the DOH to oversee the implementation of this Act, particularly the protection of rights and freedom of persons with psychiatric, neurologic, and psychosocial needs and the delivery of a rational, unified and integrated mental health services responsive to the needs of the Filipino people.”

The Implementing Rules and Regulations was signed by the Secretary of Health on January 22, 2019. The Implementing Rules and Regulations for this Act state: “Within six (6) months after the effectivity of this IRR, the Council shall develop a strategic plan for implementation, including a balanced scorecard with indicators. It shall encompass the establishment of a multi-agency and/or multi-sector coordinating mechanism to ensure integrated participation of the regions, provinces, cities/ municipalities through regional and local mental health councils or other appropriate bodies”

The Department of Health (DOH), in coordination with WHO, convened various stakeholders, primarily those involved in the development of the Mental Health Act and its IRR, to suggest a terms of reference for and nominate members of a technical working group (TWG) for the development of the strategic plan of the PCMH. DOH then issued a Department Personnel Order (DPO) creating this TWG, chaired by the DOH Disease Prevention and Control Bureau (DPCB) Director with the Essential Non-Communicable Diseases Division (ENCDD) Chief as vice-chair. The TWG was composed of representatives from the government/ duty-bearers, persons with lived experience (PLE)/ service users, service providers, and the academe. The national government agencies included the Department of the Interior and Local Government (DILG), Commission on Human Rights (CHR), Department of Social Welfare and Development (DSWD), Department of Labor and Employment (DOLE), Civil Service Commission (CSC), Department of Education (DepEd), Commission on Higher Education (CHED), Technical Education Skills and Development Authority (TESDA), National Bureau of Investigation (NBI), Philippine Health Insurance Corporation (PhilHealth), and National Center for Mental Health (NCMH). Persons with lived experience were represented by the Youth for Mental Health Coalition, Inc. (YMHC), #MentalHealthPH (MHPH), and the Alliance of Filipino Families for Mental Health (AFFMH). Service providers and academics included the Association of Municipal Health Officers of the Philippines (AMHOP), Philippine General Hospital-Department of Neuroscience

(PGH), World Association for Psychosocial Rehabilitation (WAPR), Psychological Association of the Philippines (PAP), Philippine Mental Health Association (PMHA), Philippine Psychiatric Association (PPA), and Philippine Guidance Counselling Association (PGCA).

More stakeholders were consulted to identify priority issues, actions, and areas of convergence. Four consultations were held with 1) DOH, 2) other government agencies and duty bearers, 3) persons with lived experience, and 4) service providers and academics. The results of these consultations and a review of relevant documents were relayed to the TWG, who built the strategic plan in a series of three workshops, each one lasting three days. The TWG then presented the resulting Strategic Plan 2019-2023 to the PCMH for approval.

STRUCTURE OF THE STRATEGIC PLAN

The strategic plan covers the period 2019-2023 and provides the overall direction in the implementation of the Mental Health Act. It is intended to guide the national government including the sub-national and local counterparts on key strategies to be pursued and a set of interventions to be scaled up to further enhance the population's access to mental health services.

Guiding Principles

The Philippine Council for Mental Health (PCMH) is guided by the objectives set forth by the Republic Act 11036 also known as the Mental Health Act which are:

(1) strengthen effective leadership and governance for mental health by, among others, formulating, developing, and implementing national policies, strategies, programs, and regulations relating to mental health;

(2) develop and establish a comprehensive, integrated, effective, and efficient national mental health care system responsive to the psychiatric, neurologic, and psychosocial needs of the Filipino people;

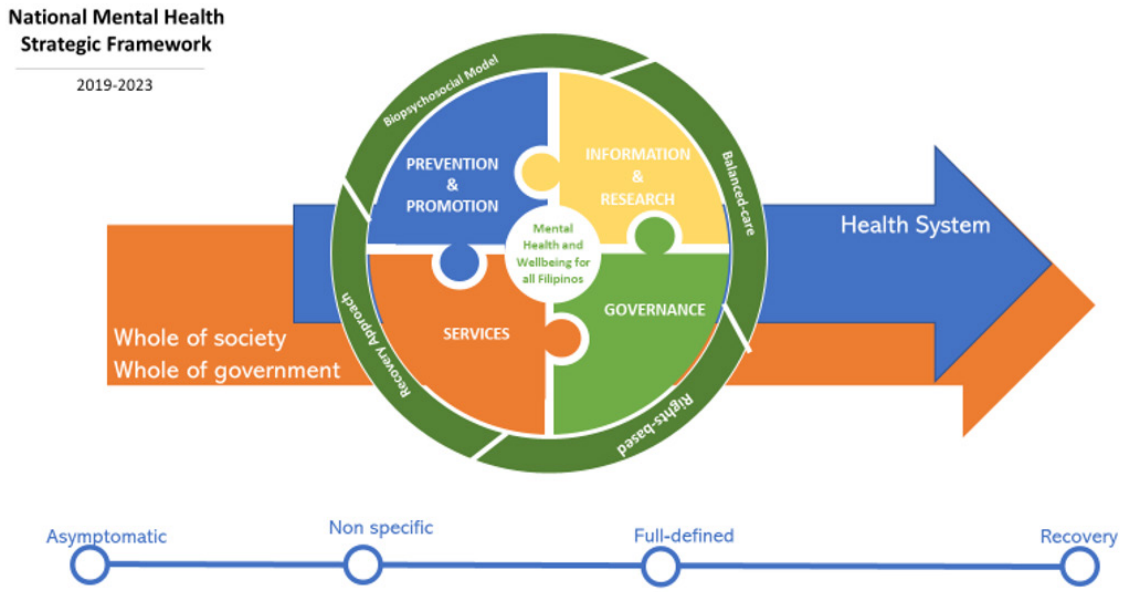
(3) protect the rights and freedoms of persons with psychiatric, neurologic, and psychosocial health needs;

(4) strengthen information systems, evidence and research for mental health;

(5) integrate mental health care in the basic health services; and

(6) integrate strategies promoting mental health in educational institutions, workplace, and in communities.

These objectives have given the Council confidence to pursue such framework because they are consistent with the global principles set forth by the Lancet Commission on Global Mental Health and Sustainable Development (October 2018)[i].



A staging approach to the classification and treatment of mental disorders recognizes that the experiences of mental health mental disorder between people and for the same person over time can range from asymptomatic, to non-specific mental distress and subsyndromal or subthreshold symptom profile, to full-defined syndrome, to recurrence or persistence, to treatment resistance. Opportunities for intervention at all stages vary. While the health system is relevant at the later stages of mental disorders, a whole of government and whole of society approach is needed to address relevant risk factors and strengthen environments to promote mental health at a population level.

The biopsychosocial model sees mental health as the unique outcome of the interaction of environmental, biological, and developmental factors across the life-course. This convergence means a non-reductionist approach that used knowledge from diverse disciplinary traditions to show the determinants of complex human concerns.

The balanced care model emphasizes the need for a balance between different service delivery platforms (community, primary, secondary, tertiary hospitals) and the importance of community and intersectoral interventions (provided outside of the health sector), such as employment opportunities, child protection services, measures to improve community-level understanding of mental disorders and the available services, long-term social care, and suicide prevention measures

A rights-based approach of the sustainable development agenda states that the “enjoyment of the highest attainable standard of physical and mental health” is a right of every person. The Mental Health Act affirms the basic right of all Filipinos to mental health as well as the fundamental rights of people who require mental health services. Finally, the recovery approach emphasizes the centrality of the person affected in defining their problems and what a successful outcome might be.

These principles overlie the PCMH Strategic Plan 2019-2023.

[i] The Lancet Commission on global mental health and sustainable development. Vikram Patel, Shekhar Saxena, Crick Lund, Graham Thornicroft, Florence Baingana, Paul Bolton, Dan Chisholm, Pamela Y Collins, Janice L Cooper, Julian Eaton, Helen Herrman, Mohammad M Herzallah, Yueqin Huang, Mark J D Jordans, Arthur Kleinman, Maria Elena Medina-Mora, Ellen Morgan, Unaiza Niaz, Olayinka Omigbodun, Martin Prince, Atif Rahman, Benedetto Saraceno, Bidyut K Sarkar, Mary De Silva, Ilina Singh, Dan J Stein, Charlene Sunkel, Jürgen Unützer. Lancet 2018; 392: 1553–98. Published Online October 9, 2018 http://dx.doi.org/10.1016/S0140-6736(18)31612-X

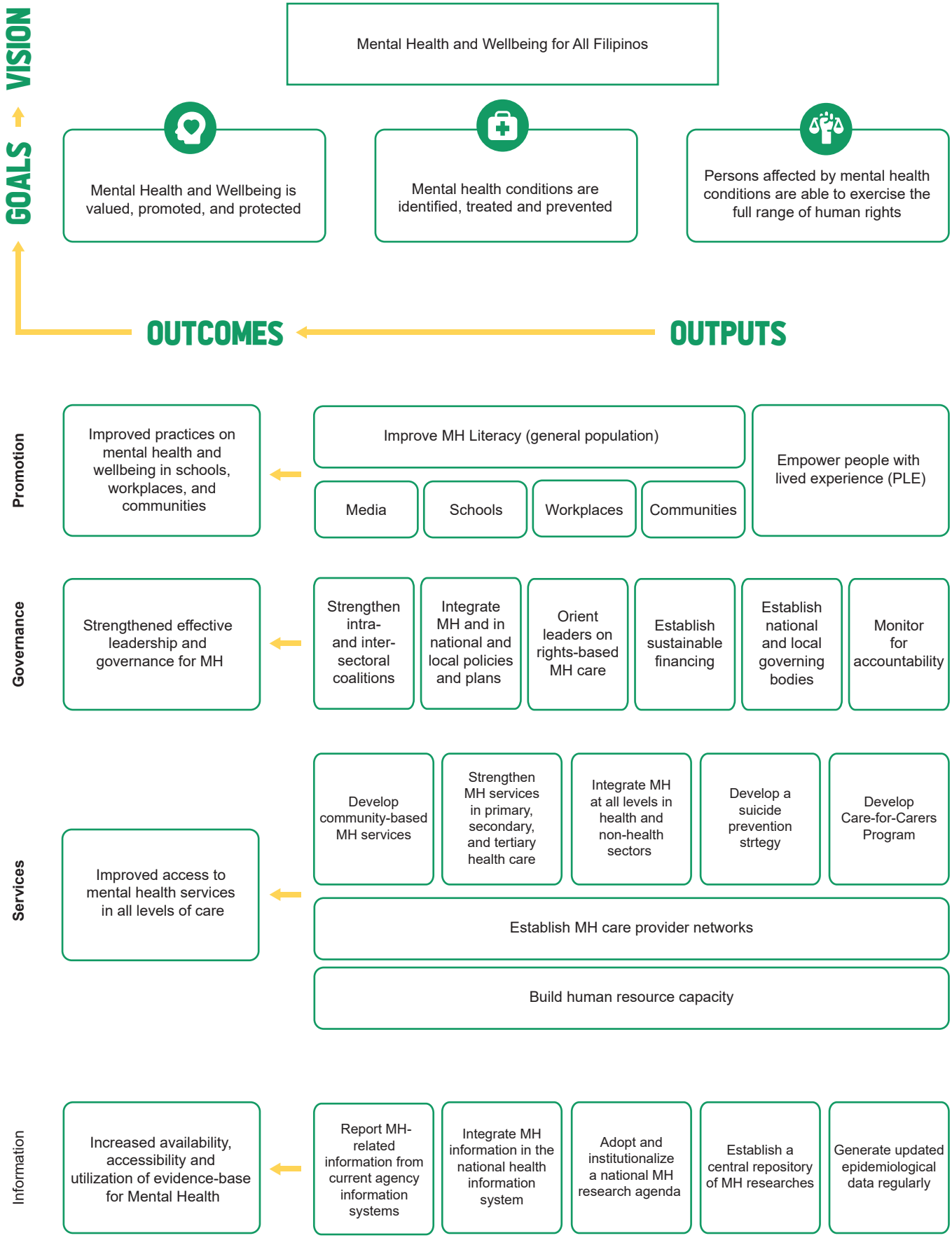
Theory of Change

The PCMH is cognizant of the huge challenges that need to be overcome in order to see changes in the mental health and wellbeing of all Filipinos. Building the systems and capacities from the community to primary, secondary, and tertiary health facilities while integrating an all of society and whole of government response would take several years to accomplish. Therefore, this five-year strategic plan balances the ambition of the Mental Health Act with currently available resources. It takes a phased approach to achieving results.

The Strategic Plan 2019-2023 is structured into:

- A vision for the distant future of mental health and wellbeing for all Filipinos;
- A continuing mission to value, promote and protect the basic right of all Filipinos to Mental Health, especially those who require Mental Health services;
- Three goals which will fulfil our mission and indicators to measure progress we will make by 2023 towards achieving these goals;
- Four pillars divided into five outcomes that, taken as a congruent parts of the entire puzzle, will allow us to achieve our goals.

THEORY OF CHANGE



MENTAL HEALTH STRATEGIC PLAN

Vision

Mental Health and wellbeing for all Filipinos

Mission

Value, promote and protect the basic right of all Filipinos to Mental Health and wellbeing and provide comprehensive, integrated, accessible and quality Mental Health programs and services

Goals

1. Mental health and wellbeing is valued, promoted, and protected

2. Mental health conditions are identified, treated and prevented

3. Persons affected by mental health conditions are able to exercise the full range of human rights

Mental health and wellbeing is valued, promoted, and protected.

INDICATORS	2020	2021	2022	2023	Agency Responsible
1. Increased proportion of the population, by age and sex, who: a. Practice self-care (stress management, physical activity, avoidance of alcohol and dangerous drugs) b. Seek MH services for psychosocial distress c. Believe that persons with MH disorders should be treated humanely		Research is in the pipeline for 2021	Establish baseline and targets		DOH
2. MH policies and programs are integrated in national and local plans and programs:					
a. Number of national government agencies implementing their mandate in accordance to the Mental Health Act	10 NGAs (includes NCMH, PHIC)				PCMH DOH
b. Proportion of national government agencies implementing the mental health workplace policy	60% of other NGAs (22 total including the PCMH members)	80% of other NGAs (27 total)	100% of NGAs (32 total)		NGA Reports to PCMH
c. Number of provinces, cities, and municipalities implementing their local mental health ordinance	58 implementation sites (49 provinces and 9 cities)				DOH and DILG Reports to PCMH

PRIORITY ACTION:

Guidelines, standards, and strategies that promote MH and wellbeing will be issued for health facilities, educational institutions, workplaces, and communities by 2020. Guidelines will include budget allocation for MH.

Mental health conditions are identified, treated and prevented.

INDICATORS	2020	2021	2022	2023	Agency Responsible
1. Suicide mortality rate (per 100,000 population)	3.20	3.17	3.14	3.10	WHO
2. Proportion of persons with mental disorders (psychosis, depression, anxiety disorders, substance use) and epilepsy who are using services (%)	Increase by 2%	Increase by 4%	Increase by 6%	Increase by 8%	DOH, Prevalence Research

The baseline for suicide mortality rate (per 100,000 population) of the Philippines is 3.2 based on the Mental Health Atlas 2017 Member State Profile (World Health Organization). The National Survey for Mental Health and Well-Being (NSMHW) will be used as a baseline once the study is completed. Number of deaths from suicide multiplied by 100,000 divided by then total number of deaths from all causes. Frequency of data collection is every 5 years. Baseline results will be ready by June 2021.

For the proportion of persons with mental disorders, cases of mental health conditions in receipt of services derived from routine information systems or, if unavailable baseline and follow-up survey of health facilities in one or more defined geographical areas of the country; will be divided by the total cases of mental health conditions in the sampled population, derived from national surveys, or if unavailable, subregional and gloal prevalence estimates. Frequency of data collection will be done annually.

Persons affected by mental health conditions are able to exercise the full range of human rights.

INDICATORS	2020	2021	2022	2023	Agency Responsible
1. Number of facilities providing MH care with a functioning IRB.	8 Pilot Sites	100% of Level 3 DOH-retained hospitals (70 hospitals) At least 1 private mental health facility in each of the 50% of the regions (8)	At least 1 private mental health facility in each of the 100% of the regions (17)		DOH, CHR
2. Percentage of complaint cases acted upon.	20%	30%	40%	50%	DOH, CHR

Indicators are used to monitor progress towards the protection of the rights of persons affected by mental health conditions. Internal Review Boards (IRB) only protect the rights of patients admitted into hospitals. Other persons affected by MH conditions, those in their homes, communities, or other settings, will also be protected by the Guidelines for Informed Consent to Treatment, Exceptions to Informed Consent, Advanced Directives, Legal Representatives and Supported Decision Making and by the Mental Health Act itself, specifically Section 44 (Penalty Clause). Over the span of this Strategic Plan 2019-2023, the number of complaints by persons with lived experience are expected to increase with the awareness of their rights. A system for tracking these cases and their resolution will be established to be able to monitor if all persons affected by mental health conditions are truly able to exercise the full range of human rights, and, moving forward, participate fully in society and at work, free from stigmatization and discrimination.

PILLARS

Operationalization of this Strategic Plan is anchored on four pillars: Promotion and Prevention, Leadership and Governance, Services, and Information and Research. These pillars overlap and are linked to deliver integrated mental health services. Each pillar is composed of outcomes and corresponding outputs and activities which will contribute to the goals, and eventually, the mission and vision of the PCMH.

OUTCOMES

1. Improved practices on mental health and wellbeing in schools, workplaces, and communities.
2. Strengthened leadership and governance for Mental Health
3. Improved access to mental health services in all levels of care
4. Increased availability, accessibility and utilization of evidence-based Mental Health Data

Mental Health Promotion and Prevention Outcome

1. Improved practices on mental health and wellbeing in schools, workplaces, and communities.

Outcome Indicator	Agency Responsible
Increased proportion of surveyed population, by age and sex, who: a. Practice self-care (stress management, physical activity, avoidance of alcohol and dangerous drugs) b. Seek Mental Health services for psychosocial distress c. Believe that persons with MH disorders should be treated humanely	DOH

Outcome Indicator

1. **Improved Mental Health Literacy (defined as knowledge and beliefs about mental well-being and mental disorders) by the general public and social advocates**
   a. Determine baseline knowledge, beliefs, attitudes, and practices regarding mental well-being and mental disorders
   b. Create an inventory of existing MH initiatives and activities in the Philippines
   c. Convene a multisectoral group of stakeholders including educators, social workers, faith-based groups, the Persons with Disability Affairs Office (PDAO), organizations of service users, families and carers, artists, athletes, the media, leaders in culture and art to develop a national mental health promotion and communication plan for a nationwide multimedia campaign to raise the level of public awareness on the protection and promotion of MH and rights
   d. Roll-out national MH promotion and communication plan

PRIORITY ACTION:

Baseline data and formative researches will be conducted in 2021. Information from these studies will be the bases for the nationwide communication strategy. Changes in knowledge, attitudes, and behavior

2. **People with lived experience of mental illness (PLE) are proactive in participating in the development and implementation of Mental Health policies, strategies, laws, and services**
   a. Develop modules for PLE
   b. Capacitate PLE to promote mental health and eliminate stigma and discrimination, e.g. by sharing their story
   c. Capacitate PLE organizations in organizational development and to advocate for development and implementation of MH policies, strategies, laws, and services

3. **Ethical reporting and portrayal of Mental Health and suicide is practiced by media**
   a. Hold media forums to increase media awareness of the magnitude of the problem and the availability of effective prevention strategies
   b. Convene film makers, media outlets, KBP, MTRCB, PIA, and PCMH to develop guidelines for ethical reporting of MH in the news, responsible and accurate content, and provision of trigger warnings

4. **Mental Health is mainstreamed in workplaces, schools, and communities using the life-course perspective**

Outcome Indicator	Targets				Agency Responsible
	2020	2021	2022	2023	
Proportion of public schools compliant with DepEd order on MH	5%	10%	15%	30%	DepEd
Proportion of public and private colleges and universities monitored with: • MH policies and wellness programs • trained mental health service providers	25%	50%	75%	100%	CHED
Proportion of public and private vocational institutions monitored with: • MH policies and wellness programs • trained mental health service providers	25%	50%	75%	100%	TESDA
Proportion of national government agencies with: • MH policies and wellness programs • trained mental health service providers	All PCMH member (6 total)	60% of other NGAs (22 total)	80% of other NGAs (27 total)	100% of NGAs (32 total)	CSC
Proportion of private companies inspected with MH policies and wellness programs	5%	25%	50%	90%	DOLE
Number of LGUs (provinces, cities, municipalities) with a local mental health ordinance		29 prov 4 cities (UHC IS)	34 prov 9 cities	39 prov 19 cities	DOH

Basic Education

A. Develop guidelines, standards, and strategies that promote MH and wellbeing among educators and learners in public and private educational institutions, including:

- policies against discrimination on the basis of mental disorders
- MH promotion activities
- capacity building and tools for identification of learners with MH concerns
- linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management
- determination of type and number of "adequate complement of MH professionals" and strategies to meet these needs as required by the MH Act
- system and tools for monitoring

B. Integrate age-appropriate content pertaining to MH in the K-12 curriculum in both public and private institutions:

1. Convene curriculum review committee to identify where MH content can be integrated in the current curriculum through issuance of special order
2. Develop MH content to be integrated in the revised curriculum
3. Implement and cascade revised curriculum, including development of learning materials and training of teachers on learning delivery of MH content
4. Review revised curriculum as necessary

Higher Education

A. Develop guidelines, standards, and strategies that promote MH and wellbeing among educators and learners in higher learning institutions, including:

- policies against discrimination on the basis of mental disorders
- MH promotion activities
- capacity building and tools for identification of learners with MH concerns
- linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management
- determination of type and number of "adequate complement of MH professionals" and strategies to meet these needs as required by the MH Act
- system and tools for monitoring

PRIORITY ACTION:

Guidelines on mainstreaming MH will be issued by DepEd (basic education), CHED (higher education), TESDA (vocational learning institutions), DOLE (private workplaces), CSC (government workplaces), and DOH

B. Integrate age-appropriate content and activities pertaining to MH in the college level in both public and private institutions

Vocational Education:

A. Develop guidelines, standards, and strategies that promote MH and wellbeing among educators and learners in vocational learning institutions, including:

- policies against discrimination on the basis of mental disorders
- MH promotion activities
- capacity building and tools for identification of learners with MH concerns
- linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management
- determination of type and number of "adequate complement of MH professionals" and strategies to meet these needs as required by the MH Act
- system and tools for monitoring

B. Integrate age-appropriate content and activities pertaining to MH in vocational training programs in both public and private institutions

Private Workplaces:

A. Develop guidelines, standards, and strategies that promote MH and wellbeing among workers in private workplaces, including:

- policies against discrimination on the basis of mental disorders
- determination of type and number of "adequate complement of MH professionals" as required by the MH Act
- linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management

B. Monitoring of private workplaces for compliance to guidelines, standards, and strategies for MH

Government Workplaces:

A. Develop guidelines, standards, and strategies that promote MH and wellbeing among workers in government workplaces, including:

- policies against discrimination on the basis of mental disorders
- determination of type and number of "adequate complement of MH professionals" as required by the MH Act
- linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management

B. Monitoring of government workplaces for compliance to guidelines, standards, and strategies for MH

Communities:

A. Review, formulate and develop regulations and guidelines to implement an effective mental health care and wellness policy within the territorial jurisdiction of each LGU, including:

- inclusion of MH in PDPFP or CDP and AIP
- inclusion of MH in the role of (expanded) local health boards or other appropriate bodies in implementing and monitoring of MH programs and their system of reporting to Regional MH Councils;
- a template for a local MH policy and policies against discrimination on the basis of mental disorders
- provision of "adequate complement of MH professionals" as required by the MH Act
- establishing a health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management, and linking it to schools, workplaces, communities, jails, custodial care centers, and vulnerable populations

SUPPORTING ACTIVITIES:

The biopsychosocial model emphasizes the influence of social determinants on mental health and wellbeing across the life-course. These determinants include poverty, unemployment, inequity, interpersonal violence, and adverse life events. Thus, PCMH may also choose to advocate for other policies related to mental health, e.g. Positive Discipline, Anti-discrimination on Sexual Orientation, Gender Identity, and Expression (SOGIE), Juvenile Justice,

B. Provision of technical assistance, support, and monitoring of LGUs to implement an effective mental health care and wellness policy

C. Review existing DSWD family modules (e.g. ECCD) and integrate MH literacy as appropriate

GOVERNANCE OUTCOME

2. Strengthened effective leadership and governance for Mental Health

Outcome Indicator	Targets				Agency Responsible
	2020	2021	2022	2023	
Government's total allocation for mental health as % of total government health expenditure.	2.75%	3.50%	4.25%	5.00%	NGA Reports to PCMH
Number of national government agencies implementing their mandate in accordance to the Mental Health Act.	8 NGAs	10 NGAs			PCMH Secretariat

Outputs and Key Activities

1. **Strong intra- and inter-sectoral coalitions**
   a. Form a multisectoral TWG to assist the PCMH in implementing its strategic plan, with members from the government, CSOs, the academe, and PLEs
   b. Convene a network of multi-sectoral CSO, PLE/service user, and advocates
   c. Capacitate a network of multi-sectoral CSO, PLE/service user, and advocates based on needs assessment
   d. Conduct multisectoral activities

2. **MH policies and programs are integrated in national and local plans and programs**
   a. Appoint focal persons for MH in each government agency to ensure integration of MH in sectoral programs
   b. Orientation, training, or workshop of leaders and executives of health and mental health-related sectors at the national and local levels on the implementation of MH Act, including policies, interventions, and budgeting
   c. Inclusion of MH programs in LGU Health Scorecard
   d. Inclusion of MH programs in Seal of Good Local Governance

3. **Leaders of health and non-health agencies, CSOs, PLEs, carers, support group members, advocates, and mental health service providers at all levels utilize a rights-based approach to mental health by completing the WHO QualityRights module**

4. **Sustainable financing for governance system**

a. Cover individual MH costs through PhilHealth outpatient and inpatient MH benefit packages
b. Propose a program convergence budgeting to DBM
c. Monitor appropriations for MH in GAA
d. Advocate for the inclusion of MH in the GAD Guidelines
e. Meet with development partners on MH program priorities

5. Functional, capacitated, and effective structure for national and local governing bodies

✦ **Philippine Council for Mental Health (PCMH)**

- Approve Manual of operations of PCMH
- Create the Mental Health Division in DOH
- Approve the PCMH's budget
- Conduct Biennial Mental Health Summits
- Conduct a midterm review of the Strategic Plan in 2022
- Complete the Strategic Planning for 2024-2028 process in 2023

✦ **National Center for Mental Health (NCMH)**

- Organizational Development process
- Develop the strategic plan for the transition to research and training facility as required by the MH Act, and to support the National Mental Health Research Agenda

✦ **Informed Consent**

- Develop guidelines for Informed Consent to Treatment, Exceptions to Informed Consent, Advanced Directives, Legal Representatives and Supported Decision Making
- Disseminate guidelines in 17 regions by 2020

✦ **Internal Review Board (IRB)**

- Appoint focal CHR commissioner for MH
- Develop guidelines for the creation of IRB
- Monitor compliance to the guidelines for the creation of the IRB
- Develop and conduct training and for IRB members (five modules)
- Monitor and assess performance of IRB

✦ **Regional mental health councils**

- Establish regional mental health councils in 16 regions by 2023

6. Monitoring and evaluation of policies, plans, programs, and services

- Develop a mechanism and tools for monitoring, evaluation, and reporting to include mental, neurological and substance use (MNS)
- Utilize agency scorecards to monitor accomplishments

SERVICE DELIVERY OUTCOME

3. Improved access to mental health services in all levels of care

Outcome Indicator	Targets				Agency Responsible
	2020	2021	2022	2023	
Proportion of LGUs (municipalities and cities) providing mental health services (%)	15%	30%	45%	60%	DOH

Increased number of LGUs (municipalities and cities) trained with mhGAP-IG and linked to a mh-MAP access site with registry of service users. By the end of 2020, each of the 81 provinces will have at least 3 LGUs providing MH services, which is defined as having staff trained with mhGAP-IG and linked to a mh-MAP access site with registry of service users.

Outputs and Key Activities

1. **Design the community-based mental health program**

   Community-based MH service facilities encompass public and private providers, including other facilities providing care for MH and psychosocial needs (e.g. schools, workplaces, custodial care facilities, residential and non-residential social welfare centers, jails, etc.)

   a. Conduct an assessment and mapping of mental health and psychosocial needs of different populations, families, couples, individuals across life span in health and non-health sectors
   b. Convene TWG to design primary outpatient community-based care
   c. Develop a strategy for MH and wellbeing during disasters and emergencies, including psychologic first aid (PFA), Mental Health and Psychosocial Support (MHPSS), pre-positioning MNS medications, and accessibility for PWD

2. **Build human resource capacity for MH**

   c. Train primary care staff in the evidence-based MH care standardized primary care training modules (traditional/nontraditional) prioritizing GIDA
   d. Provide post-training, mentoring, monitoring, and supervision of primary care staff trained with evidence-based MH care standardized primary care training modules (traditional/ nontraditional) prioritizing GIDA.
   e. Develop the basic medical curriculum for psychiatry, psychology, and neurology subjects
   f. Include psychiatry, psychology, and neurology in the medical and allied health curriculum
   g. Develop course-related mental health curricula for allied health courses
   h. Convene MH professionals, CHED, PRC, CSC and other stakeholders to develop a strategy for increasing the number of MH professionals and strengthening their career progression

3. **Establishment of MH care provider networks and referral systems as part of Universal**

Health Care (UHC)

a. Provide guidance for LGUs to set up MH care provider networks and referral systems following UHC guidelines
b. Set Up MH Care Provider Network and Referral Systems within the UHC system involving Public and Private Health and Non-Health Sectors. All 33 UHC Integration Sites (UHC IS) will be part of a MH Care Provider Network linking health and non-health settings, all levels of care, and comprehensive services

4. Strengthening of MH and wellbeing services in primary, secondary, and tertiary health care

a. Integrate Mental Health care in basic health and social services
b. Establish MH inpatient services in all DOH-retained hospitals
c. Develop evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.)
d. Train health workers on evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.)
e. Establish OPD Acute Psychiatric Units
f. Develop innovative ways of providing MH services, e.g. telepsychiatry
g. Establish psychosocial rehabilitation, reintegration and relapse prevention program
h. Improve access to medications for priority MNS conditions

5. Integration of MH and wellbeing services at all levels of non-health sectors, following guidelines issued as described in MH Promotion and Prevention outputs

a. Develop evidence-based standardized training module for non-mental health professionals (barangay health workers (BHW), teachers, human resource (HR) officers, police, fire officers, jail officers, etc.) contextualized in the local setting
b. Train non-MH professional mental health service providers on evidence-based standardized training module (traditional/ nontraditional) contextualized in the local setting with initial priority on GIDA
c. Train lay persons on community-based intervention for behavioral emergencies (Tulong, Alalay, Gabay module)
d. Develop directory of self-help groups as support to primary care service per geographic area and area of interest
e. Provide MH services in workplaces, schools, and communities, where feasible. These services will be included in the guidelines that will be issued by DOLE, CSC, DepEd, CHED, TESDA, and DOH. Some services may already be provided by the agency concerned. For example, schools provide MHPSS and PFA for students affected by armed conflict and natural disasters.

6. Development of a national suicide prevention strategy

a. Develop policies and guidelines on:
    - establishing hotlines and suicide prevention strategies
    - process flow for emergency health care response team for persons in suicide crisis situations and linking to emergency and support services
b. Develop evidence-based standardized training module for emergency mental health care

responders for persons in suicide crisis situations

c. Train first responders, health professionals and volunteers on evidence-based standardized training module for emergency mental health care responders for persons in suicide crisis situations
d. Develop guidelines for mainstreaming of suicide prevention in public health education and within other priority health programs (e.g. HIV/AIDS, adolescent and youth health, non-communicable diseases) as well as in special settings such as schools, workplace, and disaster-affected areas
e. Establish a system for suicide surveillance, including person with suicidal ideation

7. **Development of a Care for Carers Program, including training and debriefing of persons exposed to traumatic incidents, such as emergency workers, first responders, women and children protection desk officers, and social workers**

PRIORITY ACTION:

Administrative Order (AO) / Manual of Procedures (MOP) on guidelines for the design and implementation of community-based mental health care will be issued by DOH in 2020. The MOP will include:

- Facility standards at the community, primary, secondary, and tertiary levels (stepped care model)
- Services standards: clinical, psychosocial, MHPSS, drug treatment and rehabilitation and management of co-morbidities, support services for survivors of extreme life experiences (i.e. disaster, violence, etc.) other services (social services, nutrition, family support, accommodations, hospice care, etc.)
- Human resources standards (including task-sharing guidelines) and trainings
- Logistics
- Algorithms of the service user process flow from inpatient mental health facility care to primary outpatient community-based care
- Collection and reporting of service statistics, including:
  - **Continuity of Care:** Proportion of persons with chronic Mental Health condition discharged from an inpatient facility in the last year who were followed up within one month by community-based services
  - **Service Coverage:** Number of persons with MH conditions availing of primary health care services in the past year, disaggregated by age, sex, diagnosis (or chief complaint), and facility
  - **Service Coverage:** Number of persons with or at-risk for MH-related concerns (such as adverse life events, marital issues, family issues, self-awareness) availing of primary health care services in the past year,

Information and Research Outcome

4. Increased availability, accessibility and utilization of evidence-based Mental Health Data

Outcome Indicator	Targets				Agency Responsible
	2020	2021	2022	2023	
Proportion of LGUs (municipalities and cities) routinely collecting and reporting MH data to the PCMH (%)	15%	30%	45%	60%	DOH

By the end of 2020, each of the 81 provinces will have at least 3 LGUs providing MH services and routinely collect and report MH data to the PCMH.

Outputs and Key Activities

1. **MH-related information from current agency information systems are reported. Examples are DOLE's Labor Inspection Management Information System (LIMIS) and DepEd's Basic Education Information System (BEIS)**

2. **MH information is integrated in the national health information system**
   a. Revisit of existing MHIS and resource mapping
   b. Dialogue between data users and producers to take stock of their needs: Convene government health and non-health sectors and CSOs to define data needed for program monitoring, e.g. suicide as a notifiable disease, fiscal capacity of hospitals
   c. Design algorithm for data flow (include private facilities, non-health; data producers and users)
   d. Establish IT infrastructure (hardware and software)
   e. Issue JMC/JAO on Guidelines/ MOP for reporting MH data in national health information system and PCMH Scorecard
   f. Train data producers and users on reporting MH data in national health information system in a way that is consistent with human rights conventions
   g. Engage the LGUs in establishing a community surveillance of specific mental disorders, including suicide

PRIORITY ACTION:
MH information will be integrated in the national health information system by DOH in 2023. In the meantime,

3. **A national mental health research agenda is adopted and institutionalized towards developing a culturally relevant national mental health program incorporating indigenous concepts and practices. By 2023, there will be at least one research per region in line with the research priorities in the agenda.**
    a. Collaborate with PCHRD and NCMH in the development and implementation of a national research agenda on MH, including frequency of updating the national research agenda
    b. Disseminate national research agenda on MH to research institutions
    c. Call for proposals
    d. Conduct studies and disseminate results

4. **Central repository of MH researches is established**
    a. Issue policy directive on submission and access to research reports and data on MH to NCMH
    b. Issue policy directive to establish a network of data producers & data users to improve linkages and multisectoral (academe, social science community) collaboration in the conduct of researches on MH, including operations research and alternative interventions
    c. Establish a functional database
    d. MH research reports submitted by end users

5. **Updated epidemiological data on MH are regularly generated, including prevalence data of the priority mental health conditions and their determinants, across the life-course:**
        - suicide & self-harm
        - depression
        - schizophrenia and bipolar disorders
        - substance abuse
        - anxiety
        - epilepsy
        - dementia
        - developmental disorders
        - persons with or at-risk for MH concerns, e.g. adverse life events, chronic diseases, etc.

    a. Convene government health and non-health sectors and CSOs to define data needed for integration into NDHS, other relevant national surveys conducted by PSA and other national agencies

Annex 1:

REPUBLIC OF THE PHILIPPINES
Congress of the Philippines
Metro Manila

Seventeenth Congress
Second Regular Session

Begun and held in Metro Manila, on Monday, the twenty-fourth day of July, two thousand seventeen.

REPUBLIC ACT No. 11036

An Act Establishing a National Mental Health Policy for the Purpose of Enhancing the Delivery of Integrated Mental Health Services, Promoting and Protecting the Rights of Persons Utilizing Psychosocial Health Services, Appropriating Funds Therefor and Other Purposes

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled:

CHAPTER I

GENERAL PROVISIONS

Section 1. Short Title. - This Act shall be known as the "**Mental Health Act.**"

Section 2. Declaration of Policy. - The state affirms the basic right of all Filipinos to mental health as well as the fundamental rights of people who require mental health services.

The state commits itself to promoting the well-being of people by ensuring that; mental health is valued, promoted and protected; mental health conditions are treated and prevented; timely, affordable, high quality, and culturally-appropriate mental health case is made available to the public; mental health service are free from coercion and accountable to the service users; and persons affected by mental health conditions are able to exercise the full range of human rights, and participate fully in society and at work free from stigmatization and discrimination.

The State shall comply strictly with its obligations under the United Nations Declaration of Human Rights, the Convention on the rights of Persons with Disabilities, and all other relevant international and regional human rights conventions and declarations. The applicability of Republic act No. 7277, as amended, otherwise known as the "Magna Carta for Disabled Persons", to person with mental health conditions, as defined herein, is expressly recognized.

Section 3. Objectives. - The objectives of this Act are as follows:

(a) Strengthen effective leadership and governance for mental health by, among others, formulating, developing, and implementing national policies, strategies, programs, and regulations relating to mental health;

(b) Develop and establish a comprehensive, integrated effective and efficient national mental health care system responsive to the psychiatric, neurologic, and psychosocial needs of the Filipino people;

(c) Protect the rights and freedoms of persons with psychiatric, neurologic, and psychosocial needs; Filipino people;

(d) Strengthen information systems, evidence and research for mental health;

(e) Integrated mental health care in the basic health services; and

(f) Integrate strategies promoting mental health in educational institutions, the workplace, and in communities.

Section 4. Definitions. - As used in this Act, the following terms are defined as follows:

(a) Addiction refers to a primary chronic relapsing disease of brain reward, motivation, memory, and related circuitry. Dysfunctions in the circuitry lead to characteristic biological, psychological, social, and spiritual manifestations. It is characterized by the inability to consistently abstain impairment and behavioral control, craving, diminished recognition of significant problems with one's behavior and interpersonal relationships and a dysfunctional emotional response;

(b) Carer refers to the person, who may or may not be patient's next-of-kin or relative, who maintains a close personal; relationship and manifests concern for the welfare of the patient;

(c) Confidentiality refers to ensuring that all relevant information related to persons with psychiatric, neirologic, and psychological health needs is kept safe from access or use by, or disclosure to, persons or entities who are not authorizes to access, use, or possess such information;

(d) Deinstitutionalization refers to the process of transitioning service users, including persons with mental health conditions and psychosocial disabilities, from institutional and other segregated settings, to community-based settings that enable social participation, recovery-based approaches to mental health, and individualized care in accordance with the service user's will and preference;

(e) Discrimination refers to any distinction, exclusion or restriction which has the purpose or effect of nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. Special measure solely to protect the rights or secure the advancement of persons with decision-making impairment capacity shall not be deemed to be discriminatory;

(f) Drug Rehabilitation refers to the processes of medical or psychotherapeutic treatment of dependency on psychoactive substances such as alcohol, prescription drugs, and other dangerous drugs pursuant to Republic Act, 9165, otherwise known as the "Comprehensive Dangerous Drugs Act of 2002". Rehabilitation process may also be applicable to diagnosed behavioral addictions such as gambling, internet and sexual addictions. The general intent is to enable the patient to confront the psychological, legal, financial, social, and physical consequences. Treatment includes medication for co-morbid psychiatric or other medical disorders, counseling by experts and sharing of experience with other addicted individuals;

(g) Impairment or Temporary Loss of Decision-Making Capacity refers to a medically-determined inability on the part of a service user or any other person affected by a mental health condition, to provide informed consent. A service user has impairment or temporary loss of decision-making capacity when the

service user as assessed by a mental health professional is unable to do the following:

(1) Understand information concerning the nature of a mental health condition;

(2) Understand the consequences of one's decisions and actions on one's life or health, or the life or health of others;

(3) Understand information about the nature of the treatment proposed, including methodology, direct effects, and possible side effects; and

(4) Effectively communicate consent voluntarily given by a service user to a plan for treatment or hospitalization, or information regarding one's own condition;

(h) Informed Consent refers to consent voluntarily given by a service user to a plan for treatment, after a full disclosure communicated in plain language by the attending mental health service provider, of the nature, consequences, benefits, and risks of the proposed treatment, as well as available alternatives;

(i) Legal Representatives refers to a person designated by the service user, appointed by a court of competent jurisdiction, or authorized by this Act or any other applicable law, to act on the service user's behalf. The legal representative may also be a person appointed in writing by the service user to act on his or her behalf through an advance directive;

(j) Mental Health refers to a state of well-being in which the individual realizes one's own abilities and potentials, scopes adequately with the normal stresses of life, displays resilience in the face of extreme life events, works productively and fruitfully, and is able to make a positive contribution to the community;

(k) Mental Health Condition refers to a neurologic or psychiatric condition characterized by the existence of a recognizable, clinically-significant disturbance in an individual's cognition, emotional regulation, or behavioral that reflects a genetic or acquired dysfunction in the neurological, psychosocial, or developmental process underlying mental functioning. The determination of neurologic and psychiatric conditions shall be based on scientifically-accepted medical nomenclature and best available scientific and medical evidence;

(l) Mental Health Facility refers to any establishment, or any unit of an establishment, which has, as its primary fucntion, the provision of mental health services;

(m) Mental Heath Professional refers to a medical doctor, psychologist, nurse social worker or any other appropriately -trained and qualified person with specific skills relevant to the provision of mental health services.

(n) Mental Health Service Provider refers to an entity or individual providing mental health services as defines in this Act, whether public or private, including, but not limited to mental health professionals and workers, social workers and counselors, informal community caregivers, mental health advocates and their organizations, personal ombudsmen, and persons or entities offering nonmedical alternative therapies;

(o) Mental Health Service refer to psychosocial psychiatric or neurologic activities and programs along the whole range of the mental health support services including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals;

(p) Mental Health Worker refers to a trained person, volunteer or advocate engaged in mental health promotion, providing support services under the supervision of a mental health professional;

(q) Psychiatric or Neurologic Emergency refers to a condition presenting a serious and immediate threat to the health and well being of a service user or any other person affected by a mental health facilities and mental health condition, or any other person affected by a metal condition, or to the health or well-being of others, requiring immediate medical intervention;

(r) Psychosocial Problems refers to a condition that indicates the existence of dysfunctions in a person's behavior, thoughts and feelings brought about by sudden extreme, prolonged or cumulative stressors in the physical or social environment;

(s) Recovery-Based Approach refers to an approach to intervention and treatment centered on the strengths of a service user and involving the active participation, as equal partners in care, of persons with lived experiences in mental health. This requires integrating a service user's understanding of his or her condition into any plan for treatment and recovery;

(t) Service User refers to a person with lived experience of any mental health condition including persons who require or are undergoing psychiatric, neurologic or psychosocial care;

(u) Support refers to the spectrum of informal and formal arrangements or services of varying types and intensities, provided by the State, private entities, or communities, aimed at assisting a service user in the exercise of his or her legal capacity or rights, including; community services; personal assistants and ombudsman; powers of attorney and other legal and personal planning tools; peer support; support for self -advocacy; nonformal community caregiver networks; dialogue systems; alternative , and manual communication; and the use of assistive devices and technology; and

(v) Supported Decision Making refers to the act of assisting a service user who is not affected by an impairment or loss of decision-making capacity, in expressing a mental health-related preference, intention or decision. It includes all the necessary support, safeguards and measures to ensure protection from undue influence, coercion or abuse.

CHAPTER II

RIGHTS OF SERVICE USERS AND OTHER STAKEHOLDER

Section 5. Rights of Service Users. - Service users shall enjoy , on an equal and nondiscriminatory basis, all rights guaranteed by the Constitution as well as those recognizes under the United Nations Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities and all other relevant international and regional human rights conventions and declarations, including the right to:

(a) Freedom from social economic, and political discrimination and stigmatization, whether committed by public or private actors;

(b) Exercise all their inherit civil, political, economic, social, religious, educational, and cultural rights respecting individual qualities, abilities, and diversity of background , without discrimination on the basis of physical disability, age, gender, sexual orientation, race, color, language, religion or nationality, ethnic, or social origin;

(c) Access to evidence-based treatment of the same standard and quality, regardless of age, sex, socioeco-

nomic status, race, ethnicity or sexual orientation;

(d) Access to affordable essential health and social services for the purpose of achieving the highest attainable standard of mental health;

(e) Access to metal health service at all levels of the national health care system;

(f) Access to comprehensive and coordinated treatment integrating holistic prevention, promotion, rehabilitation, care and support, aimed at addressing mental health care needs through a multidisciplinary, user-driven treatment and recovery plan;

(g) Access to psychosocial care and clinical treatment in the least restrictive environment and manner;

(h) Humane treatment free from solitary confinement, torture, and other forms of cruel inhumane, harmful or degrading treatment and invasive procedures not backed by scientific evidence;

(i) Access to aftercare and rehabilitation when possible in the community for the purpose of social reintegration and inclusion;

(j) Access to adequate information regarding available multidisciplinary mental health services;

(k) Participate in metal health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation;

(l) Confidentiality of all information, communications, and records, in whatever form or medium stored, regarding the service user, any aspect of the service user's mental health, or any treatment or care received by the service user, which information, communications, and records shall not be disclosed to third parties without the written consent of the service user concerned or the service user's legal representative, except in the following circumstances:

(1) Disclose is required by law or pursuant to an order issued by a court of competent jurisdiction;

(2) The service user has expressed consent to the disclosure;

(3) A life-threatening emergency exists and such disclosure is necessary to prevent harm or injury to the service user or other persons;

(4) The service user is a minor and the attending mental health professional reasonably believes that the service user is a victim of child abuse; or

(5) Disclosure is required in condition with an administrative, civil, or criminal case against a mental health professional ethics, to the extent necessary to completely adjudicate, settle, or resolve any issue or controversy involved therein;

(m) Give informed consent before receiving treatment or care, including the right to withdraw such consent. Such consent shall be recorded in the service user's clinical record;

(n) Participate in the development and formulation of the psychosocial care or clinical treatment plan to be implemented;

(o) Designate or appoint a person of legal age to act as his or her legal representative in accordance with this Act, except in cases of impairment or temporary loss of decision-making capacity;

(p) Send or received uncensored private communication which may include communication by letter, telephone or electronic means, and receive visitors at reasonable times, including the service user's legal representative and representatives from the commission on Human Rights (CHR);

(q) Legal services, through competent counsel of the service user's choice. In case the service user cannot afford the service user cannot afford the service s of a counsel, the Public Attorney's Office, or a lega; aid institution of the service user or representative's choice, shall assist the service user;

(r) Access to their clinical records unless, in the opinion of the attending mental health professional, revealing such information would cause harm to the service user's health or put the safety of others at risk. When any such clinical records are withheld, the service user or his or her legal representative may contest such decision with the internal review board created pursuant to this Act authorized to investigate and resolve disputes, or with the CHR;

(s) Information, within the twenty-four (24) hours of admission to a mental health facility, of the rights enumerated in this section in a form and language understood by the service user; and

(t) By oneself or through a legal representative, to file with the appropriate agency, complaints of improperties, abuses in mental health care, violations of rights of persona with mental health needs, and seek to initiate appropriate investigation and action against those who authorized illegal or unlawful involuntary treatment or confinement, and other violations.

Section 6. Rights of Family Memebrs, 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.;

(b) With the consent of the concerned service user, participate in the formulation, development and implementation of the service user's individual treatment plan;

(c) Apply for release and transfer of the service user to an appropriate mental health facility;

(d) Participate in metal health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation.

Section 7. Rights of Mental Health Professionals. Mental health professional shall have the right to:

(a) A safe and supportive work environment;

(b) Participate in a continuous professional development program;

(c) Participate in the planning, development, and management of mental health services;

(d) Contribute to the development and regular review of standards for evaluating mental health services provided to service users;

(e) Participate in the development of mental and health policy and service delivery guidelines;

(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; and

(g) Advocate for the rights of a service user, in cases where the service user's wishes are at odds with those of his or her family or legal representatives.

CHAPTER III

TREATMENT AND CONSENT

Section 8. Informed Consent to Treatment. - Service users must provide informed consent in writing prior to the implementation by mental health professionals, workers, and other service providers of any plan or program of therapy or treatment, including physical or chemical restraint. All persons, including physical or chemical restraint. All persons, including service users, person with disabilities, and minors, shall be presumed to possess legal capacity for the purpose of this Act or any other applicable law, irrespective of the nature or effects of their mental health conditions or disability. Children shall have the right to express their views on all matters affecting themselves and have such views given due consideration in accordance with their age and maturity.

Section 9. Advance Directive. - A service user may set out his her preference in relation to treatment through a signed, dated, and notarized advance directive executed for the purpose. An advance directive may be revoked by a new advance directive or by a notarized revocation.

Section 10. Legal Representative. - A service user may designate a person of lega; age to act as his or her legal representative through a notarized document executed for that purpose.

(a) Functions. A service use's legal representative shall:

(1) Provide the service user with support and help: represent his or her interests; and receive medical information about the service user in accordance with this Act;

(2) Act as substitute decision maker when the service user has been assessed by a mental health professional to have temporary impairment of decision-making capacity;

(3) Assist the service user vis-a-vis the exercise of any right provided under this Act; and

(4) Be consulted with respect to any treatment or therapy received by the service user. The appointment of a legal representative may be revoked by the appointment of a new legal representative or by a notarized revocation.

(b) Declining an Appointment. A person thus appointed may decline to act as a service user's legal representative. However, a person who declines to continue being a service user's legal representative must take reasonable steps to inform the service user, as well as the service user's attending mental health professional or worker, of such decision.

(c) Failure to Appoint. - If the service user fails to appoint a legal representative, the following persons shall act as the service user's representative, in the order provided below:

(1) The spouse, if any, unless permanently separated from the service user by a decree issued by a

court of competent jurisdiction, or unless such spouse has abandoned or been abandoned by the service user for any period which has not yet come to an end:

(2) Non-minor children;

(3) Either parent by mutual consent, if the service user is a minor;

(4) Chief, administrator, or medical director of a mental health care facility; or

(5) A person appointed by a Court.

Section 11. Supported Decision Making. - A service user may designate up to three (3) persons or "supporters", including the service user's legal representative, for the purposes of supported decision making. These supporters shall have the authority to: access the service user's medical information; consult with the service user vis-a-vis any proposed treatment or therapy; and be present during service user's appointments and consultations with mental health professionals, workers and other service providers during the course of treatment or therapy.

Section 12. Internal Review Board. - Public and private health facilities are mandated to create their respective internal review boards to expeditiously review all cases, disputes, and controversies involving the treatment, restraint or confinement of service users within their facilities.

(a) The Board shall be composed of the following:

(1) A representative from the Department of Health (DOH);

(2) A representative from the CHR;

(3) A person nominated by an organization representing service users and their families duly accredited by the Philippine Council for Mental Health; and

(4) Other designated members deemed necessary, to be determined under the implementing rules and regulations (IRR).

(b) Each internal review board shall have the following powers and functions:

(1) Conduct regular review, monitoring, and audit of all cases involving the treatment, confinement or restraint of service users within its jurisdiction;

(2) Inspect mental health facilities to ensure that service users therein are not being subjected to cruel, inhumane, or degrading conditions or treatment:

(3) Motu propio, or upon the receipt of a written complaint or petition filed by a service user or a service user's immediate family or legal representative, investigate cases, disputes, and controversies involving the involuntary treatment, confinement or restraint of a service user; and

(4) Take all necessary action to rectify or remedy violations of a service user's rights vis-à-vis treatment, confinement or restraint, including recommending that an administrative, civil or criminal case be filed by the appropriate government agency.

Section 13. Exceptions to Informed Consent. - During psychiatric or neurologic emergencies, or when there is impairment or temporary loss of decision-making capacity in whether physical or chemical, may be administered or implemented pursuant to the following safeguards and conditions:

(a) In compliance with the service user's advance directives, if available, unless doing so would pose an immediate risk of serious harm to the patient or another person;

(b) Only to the extent that such treatment or restraint is necessary, and only while a psychiatric or neurologic emergency, or impairment or temporary loss of capacity, exists or persists;

(c) Upon the order of the service user's attending mental health professional, which order must be reviewed by the internal review board of the mental health facility where the patient is being treated within fifteen (15) days from the date such order was issued, and every fifteen (15) days thereafter while the treatment or restraint continues; and

(d) That such involuntary treatment or restraint shall be in strict accordance with guidelines approved by the appropriate authorities, which must contain clear criteria regulating the application and termination of such medical intervention, and fully documented and subject to regular external independent monitoring, review, and audit by the internal review boards established by this Act.

CHAPTER IV

MENTAL HEALTH SERVICES

Section 14. Quality of Mental Health Services. - Mental health services provided pursuant to this Act shall be:

(a) Based on medical and scientific research findings;

(b) Responsive to the clinical, gender, cultural and ethnic and other special needs of the individuals being served;

(c) Most appropriate and least restrictive setting:

(d) Age appropriate; and

(e) Provided by mental health professionals and workers in a manner that ensures accountability.

Section 15. Mental Heath Services at the Community Level. - Responsive primary mental health services shall be developed and integrated as part of the basic health services at the appropriate level of care, particularly at the city, municipal, and barangay level. The standards of metal health services shall be determined by the DOH in consultation with stakeholders based on current evidences.

Every local government unit (LGU) and academic institution shall create their own program in accordance with the general guidelines set by the Philippine Council for Mental Health, created under this Act, in coordination with other stakeholders. LGUs and academic institutions shall coordinate with all concerned government agencies and the private sector for the implementation of the program.

Section 16. Community-based Mental Heath 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.

Section 17. Reportorial Requirements. - LGUs through their health offices shall make a quarterly report to the Philippine Conucil for Mental Health through the DOH. The report shall include, among others, the following data: number of patients/service users attended to and or served, the respective kinds of mental illness or disability, duration and result of the treatment, and patients/users' age, gender, educational attainment and employment without disclosing the identities of such patients/service user for confidentiality.

Section 18. Psychiatric, Psychosocial, and Neurologic Services in Regional, Provincial, and Tertiary Hospitals. - All regional, provincial, and tertiary hospitals, including private hospitals rendering service to paying patients, shall provide the following psychiatric, psychosocial, and neurologic services;

(a) Short-term, in-patient, hospital care in a small psychiatric or neurologic ward for service users exhibiting acute psychiatric or neurologic symptoms;

(b) Partial hospital care for those exhibiting psychiatric symptoms or experiencing difficulties vis-à-vis their personal and family circumstances;

(c) Out-patient in close collaboration with existing mental health programs at primary health care centers in the same area;

(d) Home care services for services users with special needs as a result of, among others, long-term hospitalization, noncompliances with or inadequacy of treatment, and absence of immediate family;

(e) Coordination with drug rehabilitation center vis-a-vis the care, treatment, and rehabilitation of persons suffering from addiction and other substance-induced mental health conditions; and

(f) A referral system involving other public and private health and social welfare service providers, for the purpose of expanding access to programs aimed at preventing mental illness and managing the condition of persons at risk of developing mental, neurologic, and psychosocial problems.

Section 19. Duties and Responsibilities of Mental Health Facilities. - Mental health facilities shall:

(a) Establish policies, guidelines, and protocols for minimizing the use of restrictive care and involuntary treatment;

(b) Inform service user of their rights under this Act and all other pertinent laws and regulations;

(c) Provide every service user, whether admitted for voluntary treatment, with complete information regarding the plan of treatment to be implemented;

(d) Ensure that informed consent is obtained from service users prior to the implementation of any

medical procedure or plan of treatment or care, except during psychiatric or neurologic emergencies or when the service user has impairment or temporary loss of decision-making capacity;

(e) Maintain a register containing information on all medical treatments and procedures administered to service users; and

(f) Ensure that legal representatives are designated or appointed only after the requirements of this Act and the procedures established for the purpose have been observed, which procedures should respect the autonomy and preferences of the patient as far as possible.

Section 20. Drug Screening Services. - Pursuant to its duty to provide mental health service and consistent with the policy of treating drug dependency as a mental health issue, each local health care facility must be capable of conducting drug screening.

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.

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, stress handling, guidance and counseling, and other elements of mental health.

CHAPTER V

EDUCATION, PROMOTION OF MENTAL HEALTH IN EDUCATIONAL INSTITUTIONS AND IN THE WORKPLACE

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 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 services for individuals at risk, and facility access, including referral mechanisms of individual with metal health conditions to treatment and psychosocial support.

All public and private educational institutions shall be required to have a complement of mental health professionals.

Section 25. Mental Health Promotion and Policies in the Workplace. - Employers shall develop appropriate policies and programs on mental health issues, correct the stigma and discrimination associated with mental conditions, identify and provide support for individuals with mental health conditions to

treatment and psychosocial support.

CHAPTER VI

CAPACITY BUILDING, RESEARCH AND DEVELOPMENT

Section 26. Capacity Building, Reorientation, and Training. - In close coordination with mental health facilities, academic institutions, and other stakeholders, mental health professionals, workers, and other service providers shall undergo capacity building, reorientation, and training to develop their ability to deliver evidence-based, gender-sensitive, culturally appropriate and human rights-oriented mental health services, with emphasis on the community and public health aspects of metal health.

Section 27. Capacity Building of Barangay Health Workers (BHWs). - The DOH shall be responsible for disseminating information and providing training programs to LGUs. The LGUs, with technical assistance from the DOH, shall be responsible for the training of BHWs and other barangay volunteers on the promotion of mental; health. The DOH shall provide assistance to LGUs with medical supplies and equipment needed by BHWs to carry out their functions effectively.

Section 28. Research and Development. - Reasearch 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 metal 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, inaccordance with applicable law.

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

Section 29. The National Center for Mental Health (NCMH). - The NCMH, formerly the National Mental Hospital being the premiere training and research center development of interventions on mental and neurological services in the country.

CHAPTER VII

DUTIES AND RSPONSIBILITIES OF GOVERNMENT AGENCIES

Section 30. Duties and Responsibilities of the Departmnent of Health (DOH). - To achieve 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;

(b) Ensure that a safe, therapeutic, and hygienic environment with sufficient privacy exists in all mental

health facilities and, for this purpose, shall be responsible for the regulation, licensing, monitoring, and assessment of all mental health facilities;

(c) Integrated 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;

(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;

(e) Ensure that all public and private mental health institution uphold the right of patients to be protected against torture or cruel, inhumane, and degrading treatment;

(f) Coordinate with the Philippine Health Insurance Corporation to ensure that insurance packages equivalent to those covering physical disorders of comparable impact to the patient, as measured by Disability-Adjusted Life Year or other methodologies, are available to patients affected by mental health conditions;

(g) Prohibit forced or inadequately remunerated labor within mental health facilities, unless such labor is justified as part of an accepted therapeutic treatment program;

(h) Provide support services for families and co-workers of service users, mental professionals, workers, and other service providers;

(i) Develop alternatives to institutionalization, particularly community, recovery-based approaches to treatment aimed at receiving patients discharged from hospitals, meeting the needs expressed by persons with mental health conditions, and respecting their autonomy, decisions, dignity, and privacy;

(j) Ensure that all health facilities shall establish their respective internal review boards. In consultation with stakeholders, the DOH shall promulgate the rules and regulations, necessary for the efficient disposition of all proceedings, matters, and cases referred to or reviewed by the internal review board;

(k) Establish a balanced system of community-based and hospital-based mental health services at all levels of the public health care system from the barangay, municipal, city, provincial, regional to the national level; and

(l) Ensure that all health workers shall undergo human rights trainings in coordination with appropriate agencies or organizations.

Section 31. Duties and Responsibilities of the Commission on Human Tights (CHR). - The CHR shall:

(a) Establish mechanisms to investigate, address, and set upon complaints to impropriety and abuse in the treatment and care received by service users, particularly when such treatment or care is administered or implemented voluntarily;

(b) Inspect mental health facilities to ensure that service users therein are not being subjected to cruel, inhumane, or degrading conditions or treatment;

(c) Investigate all cases involving involuntary treatment, confinement, or care or service users, for the purpose of ensuring strict compliance with domestic and international standards respecting the legality, quality, and appropriateness of such treatment, confinement, or care; and

(d) Appoint a focal commissioner for mental health tasked with protecting and promoting the rights of service users and other persons utilizing mental health services or confined in mental health facilities, as well as the rights of mental health professionals and workers. The focal commissioner shall, upon a finding that a mental health facility, mental health professional, or mental health worker has violated any of the rights provided for in this Act, take all necessary actions to rectify or remedy such violation, including recommending that an administrative, civil, or criminal case be filed by the appropriate government agency.

Section 32. Investigative Role of the Commission on Human Rights (CHR). - The investigative role of the CHR as provided in the pertinent provisions of this Act shall be limitted to all violations of human rights involving civil and political rights consistent with the powers and functions of the CHR under Section 18 of Article XIII of the Constitution.

Section 33. Compliant and Investigation. - The DOJ, CHR and Department of Justice shall receive all complaints of improprieties and abuses in mental health care and shall initiate appropriate investigation and action.

Further, the CHR shall inspect all places where psychiatric service users are held for involuntary treatment or otherwise, to ensure full compliance with domestic and international standards governing the legal basis for treatment or otherwise, to ensure full compliance with domestic and international standards governing the legal basis for treatment and detention quality of medical care and living standards.

The CHR may. motu propio, file a complaint against erring mental health care institutions should they find any noncompliance, based on its investigations.1a\^/phi1

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.

Section 35. Duties and Responsibilities of the Department of Labor and Employment (DOLE) and the Civil Service Commission (CSC). - The DOLE and CSCshall:

(a) Develop guidelines and standards on appropriate and evidence-based mental health programs for the

workplace as described in this Act; and

(b) Develop policies that promote mental health in the workplace and address stigma and discrimination suffered by people with mental health conditions.

Section 36. Duties and responsibilities of the Department of Social Welfare and Development (DSWD). - The DSWD shall:

(a) Refer service users to mental health facilities, professionals, workers, and other service providers for appropriate care;

(b) Provide or facilitate access to public or group housing facilities, counselling, therapy, and livelihood training and other available skills development programs; and

(c) In coordination with the LGUs and the DOH, formulate, develop, and implement community resilience and psychosocial well-being training, including psychosocial support services during and after natural disaster and other calamities.

Section 37. Duties and Responsibilities of the Local Government Units (LGUs). - The LGUs shall:

(a) Review, formulate, and develop the regulations and guidelines necessary to implement an effective mental health care and wellness policy within the territorial jurisdiction of each LGU, including the passage of a local ordinance on the subject of mental health, consistent with existing relevant national policies and guidelines;

(b) Integrate mental health care services in the basic health care services, and ensure that mental health services are provided in primary health care facilities and hospitals, within their respective territorial jurisdictions;

(c) Establish training programs necessary to enhance the capacity of mental health care service providers at the LGU level, in coordination with appropriate national government agencies and other stakeholders;

(d) Promote deinstitutionalization and other recovery-based approaches to the delivery of mental health care services;

(e) Establish, reorient, and modernize mental health care facilities necessary to adequately provide mental health services, within their respective territorial jurisdictions;

(f) Where independent living arrangements are not available, provide or facilitate access to public housing facilities, vocational training and skills development programs, and disability or pension benefits;

(g) Refer service users to mental health facilities, professionals, workers, and other service providers for appropriate care; and

(h) Establish a multi-sectoral stakeholder network for the identification, management, and prevention of mental health conditions.1âwphi1

Section 38. Upgrading of Local Hospitals and Health Care Facilities. - Each LGU. Upon its determination of necessity based on well-supported data provided by its local health office, shall establish or upgrade hospitals and facilities with adequate and qualified personnel, equipment and supplies to be

able to provide mental health services and to address psychiatric emergencies: Provided, That people in geographically isolated and/or high populated and depressed areas shall have the same level of access and shall not be neglected by providing other means such as home visits or mobile health care clinic, as needed; Provided further, That the national government shall provide additional funding and other necessary assistance for the effective implementation of this provision.

CHAPTER VIII

THE PHILIPPINE COUNCIL FOR MENTAL HEALTH

Section 39. Mandate. The Philippine Council for Mental health, herein referred to as the Council, is hereby established as a policy-making planning, coordinating and advisory body, attached to the DOH to oversee the implementation of this Act, particularly the protection of the rights and freedom of persons with psychiatric, neurologic, and psychosocial needs and the delivery of rational, unified and integrated mental health services responsive to the needs of the Filipino people.

Section 40. Duties and Functions. - The Council shall exercise the following duties;

(a) Develop and periodically update, in coordination with the DOH, a national multi-sectoral strategic plan for mental health that further operationalizes the objectives of this Act which shall include the following:

> (1) The country's target and strategies in protecting the rights of Filipinos with mental health needs and in promoting mental health and the well-being of Filipinos, as provided in this Act;
>
> (2) The government's plan in establishing a rational, unified and integrated service delivery network for mental health services including the developmental health human resources and information system for mental health; and
>
> (3) The budgetary requirements and a corollary investment plan that shall idetntify the sources of funds for its implementation;

(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;

(c) Ensure the implementation of the policies provided in this Act, and issue or cause issuance of orders, or make recommendations to the implementing agencies as the Council considers appropriate;

(d) Coordinate the activities and strengthen working relationships among national government agencies, LGUs, and nongovernment agencies involved in mental health promotion;

(e) Coordinate with foreign and international organizations regarding data collection, research and treatment modalities for persons with psychiatric, neurologic and substance use disorder and other addictions;

(f) Coordinate joint planning and budgeting of relevant agencies to ensure funds for programs and projects indicated in the strategic medium-term plan are included in the agency's annual budget;

(g) Call upon other government agencies and stakeholders to provide data and information in formulating policies and programs, and to assist the Council in the performance of its functions; and

(h) Perform other duties and functions necessary to carry out the purpose of this Act.

Section 41. Composition. - The Council shall be composed of the following:

(a) Secretary of DOH as Chairperson;

(b) Secretary of DepED;

(c) Secretary of DOLE;

(d) Secretary of the Department of the Interior and Local Government (DILG);

(e) Chairperson of CHR;

(f) Chairperson of CHED;

(g) One (1) from the academe/research;

(h) One (1) representative from medical or health professional organizations;

(i) One (1) one representative from nongovernment organizations (NGOs) involved in mental health issues.

The members of the Council from the government may designate their permanent authorized representatives.

Within thirty (30) days from the effectivity of this Act, the members of the Council from the academe/research, private sector and NGOs shall be appointed by the President of the Philippines from a list of three (3) nominees submitted by the organizations, as endorsed by the Council.

Members representing the academe/research, private sector and NGOs of the Council shall serve for a term of three (3) years. In case a vacancy occurs in the Council, any person chosen to fill the position vacated by a member of the Council shall only serve the unexpired term of said member.

Section 42. Creation of the DOH Mental Health Division. - There shall be created in the DOH, a Mental Health Division, under the Disease Prevention and Control Bureau, staffed by qualified mental health specialists and supported with an adequate yearly budget. It shall implement the National Mental Health Program and, in addition, shall also serve as the secretariat of the Council.

CHAPTER IX

MENTAL HEALTH FOR DRUG DEPENDENTS

Section 43. Voluntary Submission of a Drug Dependent to Confinement, treatment and Rehabilitation. - Persons who avail of the voluntary submission provision and persons charged pursuant to Republic Act No. 9165, otherwise known as the "Comprehensive Dangerous Drugs Act of 2002", shall undergo an examination for mental health conditions and. if found to have mental health conditions, shall be covered by the provision of this Act.

CHAPTER X

MISCELLANEOUS PROVISIONS

Section 44. Penalty Clause. - Any person who commits any of the following acts shall, upon conviction by final judgment, be punished by imprisonment of not less than six (6) months, but not more than two (2) years, or a fine of not less than Ten thousand pesos (P10,000.00), but not more than Two hundred thousand pesos (P200,000.00), or both, at the discretion of the court:

(a) Failure to secure informed consent of the service user, unless it falls under the exceptions provided under Section 18 of this Act;

(b) Violation of confidentiality of information, as defined under Section 4(c) of this Act;

(c) Discrimination against a person with mental-health condition, as defined under Section 4(e) of this Act; and

(d) Administering inhumane, cruel, degrading or harmful treatment not based on medical or scientific evidence as indicated in Section 5(h) of this Act;

If the violation is committed by a juridical person, the penalty provided for in this Act shall be imposed the directors, officers, employees or other officials or persons therein responsible for the offense.

If the violation is committed by an alien, the alien offender shall be immediately deported after service of sentence without need of further proceedings.

These penalties shall be without prejudice to the administrative or civil liability of the offender, or the facility where such violation occurred.

Section 45. Appropriations. - The amount needed for the initial implementation of this Act shall be charged against the 2018 appropriations of the DOH for the following maintenance and other operating expenses of the national mental health program, capital outlays for the development of psychiatric facilities among selected DOH hospitals, and formulation of the strategic plan for mental health.

For the succeeding years, the amount allocated for mental health in the DOH budget and in the budget of other agencies with specific mandates provided in this Act shall be based on the strategic plan formulated by the Council, in coordination with other stakeholders. The amount shall be included in the National Expediture Program (NEP) as basis for the General Appropriations Bill (GAB).

Section 46. Implementing Rules and Regulations (IRR). - The Secretary of Health in coordination with the CHR, DSWD, DILG, DepED, CHED, TESDA, DOLE, CSC and together with associationsor organizationsrepresenting service users and mental professionals, workers, and other service providers, shall issue the IRR necessary for the effective implementation of this Act within one hundred twenty (120) days from the effectivity thereof.

Section 47. Separability Clause. - If any provision on this Act is declared unconstitutional or invalid by a court of copmpetent jurisdiction, the remaining provisions not affected thereby shall continue to be in full force and effect.

Section 15. Repealing Clause. - All laws, decrees, executive orders, department or memorandum orders

and other administrative issuances or parts thereof which are inconsistent with the provisions of this Act are hereby modified, suspended or repealed accordingly. accordingly.

Section 18. Effectivity. This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in at least two (2) newspapers of general circulation.

Approved,

PANTALEON D. ALVAREZ
Speaker of the House of Representatives

AQUILINO "KOKO" PIMENTEL III
President of the Senate

This Act which is a consolidation of Senate Bill No. 1354 and House Bill 6452 was finally passed by the Senate and the House of Representatives on February 12, 2018.

CESAR STRAIT PAREJA
Secretary General
House of Representatives

LUTGARDO B. BARBO
Secretary of Senate

Approved: June 20, 2018

RODRIGO ROA DUTERTE
President of the Philippines

Annex 2:

Implementing Rules and Regulations

IMPLEMENTING RULES AND REGULATIONS OF REPUBLIC ACT NO. 11036, OTHERWISE KNOWN AS THE MENTAL HEALTH ACT

The following Rules and Regulations are hereby issued to implement Republic Act No. 11036, **"AN ACT ESTABLISHING A NATIONAL MENTAL HEALTH POLICY FOR THE PURPOSE OF ENHANCING THE DELIVERY OF INTEGRATED MENTAL HEALTH SERVICES, PROMOTING AND PROTECTING THE RIGHTS OF PERSONS UTILIZING PSYCHIATRIC, NEUROLOGIC AND PSYCHOSOCIAL HEALTH SERVICES, APPROPRIATING FUNDS THEREFOR, AND FOR OTHER PURPOSES."**

CHAPTER I

GENERAL PROVISIONS

SECTION 1. Short Title. – These Rules shall be known as the Implementing Rules and Regulations (IRR) of Republic Act 11036, otherwise known as The Mental Health Act, herein referred to as "the Act".

SEC. 2. *Declaration of Policy.* – The State affirms the basic right of all Filipinos to mental health as well as the fundamental rights of people who require mental health services.

The State commits itself to promoting the well-being of people by ensuring that: mental health is valued, promoted and protected; mental health conditions are treated and prevented; timely, affordable, high quality and culturally-appropriate mental health care is made available to the public; mental health services are free from coercion and accountable to the service users; and persons affected by mental health conditions are able to exercise the full range of human rights, and participate fully in society and at work, free from stigmatization and discrimination.

The State shall comply strictly with its obligations under the United Nations Declaration of Human Rights, the Convention on the Rights of Persons with Disabilities, and all other relevant international and regional human rights conventions and declarations. The applicability of Republic Act No. 7277, as amended, otherwise known as the "Magna Carta for Disabled Persons", to persons with mental health conditions, as defined herein, is expressly recognized.

SEC. 3. *Objectives.* – The objectives of this IRR are, as follows:

a) Strengthen effective leadership and governance for mental health by, among others, formulating, developing, and implementing national policies, strategies, programs, and regulations relating to mental health;
b) Develop and establish a comprehensive, integrated, effective, and efficient national mental health care system responsive to the psychiatric, neurologic, and psychosocial needs of the Filipino people;
c) Protect the rights and freedoms of persons with psychiatric, neurologic, and psychosocial health needs;
d) Strengthen information systems, evidence and research for mental health;
e) Integrate mental health care in the basic health services; and
f) Integrate strategies promoting mental health in educational institutions, workplace, and in communities.

SEC 4. *Definitions.* – The terms are defined as follows:

a) *Addiction* refers to a primary chronic relapsing disease of brain reward, motivation, memory, and related circuitry. Dysfunctions in the circuitry lead to characteristic biological, psychological, social, and spiritual manifestations. It is characterized by the inability to consistently abstain, impairment and behavioral control, craving, diminished recognition of significant problems with one's behavior and interpersonal relationships and a dysfunctional emotional response;
b) *Carer* refers to the person, who may or may not be the patient's next of kin or relative, who maintains a close personal relationship and manifests concern for the welfare of the patient;
c) *Confidentiality* refers to ensuring that all relevant information related to persons with psychiatric, neurologic, and psychosocial health needs is kept safe from access or use by, or disclosure to, persons or entities who are not authorized to access, use, or possess such information;
d) *Deinstitutionalization* refers to the process of transitioning service users, including persons with mental health conditions and psychosocial disabilities, from institutional and other segregated settings, to community-based settings that enable social participation, recovery-based approaches to mental health, and individualized care in accordance with the service user's will and preference;
e) *Discrimination* refers to any distinction, exclusion or restriction which has the purpose or effect of nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political,

economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. Special measures solely to protect the rights or secure the advancement of persons with decision-making impairment capacity shall not be deemed to be discriminatory;

f) *Drug Rehabilitation* refers to the processes of medical or psychotherapeutic treatment for dependency on psychoactive substances such as alcohol, prescription drugs, and other dangerous drugs pursuant to Republic Act No. 9165, otherwise known as the "Comprehensive Dangerous Drugs Act of 2002." Rehabilitation process may also be applicable to diagnosed behavioral addictions such as gambling, internet and sexual addictions. The general intent is to enable the patient to confront his or her addiction/s and cease substance abuse to avoid the psychological, legal, financial, social, and physical consequences. Treatment includes medication for co-morbid psychiatric or other medical disorders, counseling by experts and sharing of experience with other addicted individuals;

g) *Impairment or Temporary Loss of Decision-Making Capacity* refers to a medically-determined inability on the part of a service user or any other person affected by a mental health condition, to provide informed consent. A service user has impairment or temporary loss of decision-making capacity when the service user as assessed by a mental health professional is unable to do the following:

   1) Understand information concerning the nature of a mental health condition;
   2) Understand the consequences of one's decisions and actions on one's life or health, or the life or the health of others;
   3) Understand information about the nature of the treatment proposed, including methodology, direct effects, and possible side effects; and
   4) Effectively communicate consent to treatment or hospitalization, or information regarding one's own condition;

h) *Informed Consent* refers to consent voluntarily given by a service user to a plan for treatment, after a full disclosure communicated in plain language by the attending mental health service provider, of the nature, consequences, benefits, and risks of the proposed treatment, as well as available alternatives;

i) *Legal Representative* refers to a person designated by the service user, appointed by a court of competent jurisdiction, or authorized by this Act or any other applicable law, to act on the service user's behalf. The legal representative may also be a person appointed in writing by the service user to act on his or her behalf through an advance directive;

j) *Mental Health* refers to a state of well-being in which the individual realizes one's own abilities and potentials, copes adequately with the normal stresses of life, displays resilience in the face of extreme life events, works productively and fruitfully, and is able to make a positive contribution to the community;

k) *Mental Health Condition* refers to a neurologic or psychiatric condition characterized by the existence of a recognizable, clinically-significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a genetic or acquired dysfunction in the neurobiological, psychosocial, or developmental processes underlying mental functioning. The determination of neurologic and psychiatric conditions shall be based on scientifically-accepted medical nomenclature and best available scientific and medical evidence;

l) *Mental Health Facility* refers to any establishment, or any unit of an establishment, which has, as its primary function, the provision of mental health services;

m) *Mental Health Professional* refers to a medical doctor, psychologist, nurse, social worker, guidance counselor or any other appropriately-trained and qualified person with specific skills relevant to the provision of mental health services;

n) *Mental Health Service Provider* refers to an entity or individual providing mental health services as defined in this Act, whether public or private, including, but not limited to, mental health professionals and workers, social workers and counselors, peer counselors, informal community caregivers, mental health advocates and their organizations, personal ombudsmen, and persons or entities offering non-medical alternative therapies;

o) *Mental Health Services* refer to psychosocial, psychiatric or neurologic activities and programs along the whole range of the mental health support services including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals;

p) *Mental Health Worker* refers to a trained person, volunteer or advocate engaged in mental health promotion, providing support services under the supervision of a mental health professional;

q) *Psychiatric or Neurologic Emergency* refers to a condition presenting a serious and immediate threat to the health and well-being of a service user or any other person affected by a mental health condition, or to the health and well-being of others, requiring immediate medical intervention;

r) *Psychosocial Problem* refers to a condition that indicates the existence of dysfunctions in a person's behavior, thoughts and feelings brought about by sudden, extreme, prolonged or cumulative stressors in the physical or social environment;

s) *Recovery-Based Approach* refers to an approach to intervention and treatment centered on the strengths of a service user and involving the active participation, as equal partners in care, of persons with lived experiences in mental health. This requires integrating a service user's understanding of his or her condition into any plan for treatment and recovery;

t) *Service User* refers to a person with lived experience of any mental health condition including persons who require, or are undergoing psychiatric, neurologic or psychosocial care;
u) *Support* refers to the spectrum of informal and formal arrangements or services of varying types and intensities, provided by the State, private entities, or communities, aimed at assisting a service user in the exercise of his or her legal capacity or rights, including: community services; personal assistants and ombudsmen; powers of attorney and other legal and personal planning tools; peer support; support for self-advocacy; non-formal community caregiver networks; dialogue systems; alternate communication methods, such as non-verbal, sign, augmentative, and manual communication; and the use of assistive devices and technology; and
v) *Supported Decision Making* refers to the act of assisting a service user who is not affected by an impairment or loss of decision-making capacity, in expressing a mental health-related preference, intention or decision. It includes all the necessary support, safeguards and measures to ensure protection from undue influence, coercion or abuse.

CHAPTER II

RIGHTS OF SERVICE USERS AND OTHER STAKEHOLDERS

SEC. 5. *Rights of Service Users.* – Service users shall enjoy, on an equal and nondiscriminatory basis, all rights guaranteed by the Constitution as well as those recognized under the United Nations Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities and all other relevant international and regional human rights conventions and declarations, including the right to:

a) Freedom from social, economic, and political discrimination and stigmatization, whether committed by public or private actors;
b) Exercise all their inherent civil, political, economic, social, religious, educational, and cultural rights respecting individual qualities, abilities, and diversity of background, without discrimination on the basis of physical disability, age, gender, sexual orientation, race, color, language, religion or nationality, ethnic, or social origin;
c) Access to evidence-based treatment of the same standard and quality, regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation;
d) Access to affordable essential health and social services for the purpose of achieving the highest attainable standard of mental health;
e) Access to mental health services at all levels of the national health care system;
f) Access to comprehensive and coordinated treatment integrating holistic prevention, promotion, rehabilitation, care and support, aimed at addressing mental health care needs through a multi-disciplinary, user-driven treatment and recovery plan;
g) Access to psychosocial care and clinical treatment in the least restrictive environment and manner;
h) Humane treatment free from solitary confinement, torture and other forms of cruel, inhumane, harmful or degrading treatment and invasive procedures not backed by scientific evidence;
i) Access to aftercare and rehabilitation when possible in the community for the purpose of social reintegration and inclusion;
j) Access to adequate information regarding available multidisciplinary mental health services;
k) Participate in mental health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation;
l) Confidentiality of all information, communications, and records, in whatever form or medium stored, regarding the service user, any aspect of the service user's mental health, or any treatment or care received by the service user, which information, communications, and records shall not be disclosed to third parties without the written consent of the service user concerned or the service user's legal representative, except in the following circumstances:

    1) Disclosure is required by law or pursuant to an order issued by a court of competent jurisdiction;
    2) The service user has expressed consent to the disclosure;
    3) A life-threatening emergency exists and such disclosure is necessary to prevent harm or injury to the service user or to other persons;
    4) The service user is a minor and the attending mental health professional reasonably believes that the service user is a victim of child abuse; or
    5) Disclosure is required in connection with an administrative, civil, or criminal case against a mental health professional or worker for negligence or a breach of professional ethics, to the extent necessary to completely adjudicate, settle, or resolve any issue or controversy involved therein;

m) Give informed consent before receiving treatment or care, including the right to withdraw such consent. Such consent shall be recorded in the service user's clinical record;

n) Participate in the development and formulation of the psychosocial care or clinical treatment plan to be implemented;
o) Designate or appoint a person of legal age to act as his or her legal representative in accordance with this Act, except in cases of impairment or temporary loss of decision-making capacity;
p) Send or receive uncensored private communication which may include communication by letter, telephone or electronic means, and receive visitors at reasonable times, including the service user's legal representative and representatives from the Commission on Human Rights (CHR);
q) Legal services, through competent counsel of the service user's choice. In case the service user cannot afford the services of a counsel, the Public Attorney's Office, or a legal aid institution of the service user or representative's choice, shall assist the service user;
r) Access to their clinical records unless, in the opinion of the attending mental health professional, revealing such information would cause harm to the service user's health or put the safety of others at risk. When any such clinical records are withheld, the service user or his or her legal representative may contest such decision with the internal review board created pursuant to this Act authorized to investigate and resolve disputes, or with the CHR;
s) Information, within twenty four (24) hours of admission to a mental health facility, of the rights enumerated in this section in a form and language understood by the service user; and
t) By oneself or through a legal representative, to file with the appropriate agency, complaints of improprieties, abuses in mental health care, violations of rights of persons with mental health needs, and seek to initiate appropriate investigation and action against those who authorized illegal or unlawful involuntary treatment or confinement, and other violations.

SEC. 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;
b) With the consent of the concerned service user, participate in the formulation, development, and implementation of the service user's individualized treatment plan;
c) Apply for release and transfer of the service user to an appropriate mental health facility; and
d) Participate in mental health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation.

SEC. 7. ***Rights of Mental Health Professionals.*** – Mental health professionals shall have the right to:

a) A safe and supportive work environment;
b) Participate in a continuous professional development program;
c) Participate in the planning, development, and management of mental health services;
d) Contribute to the development and regular review of standards for evaluating mental health services provided to service users;
e) Participate in the development of mental health policy and service delivery guidelines;
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; and
g) Advocate for the rights of a service user, in cases where the service user's wishes are at odds with those of his or her family or legal representative.

CHAPTER III

CONSENT TO TREATMENT AND SAFEGUARDS

SEC. 8. ***Informed Consent to Treatment.*** – Service users must provide informed consent in writing prior to the implementation by mental health professionals, workers and other service providers of any plan or program of therapy or treatment, including physical or chemical restraint. All persons, including service users, persons with disabilities, and minors, shall be presumed to possess legal capacity for the purposes of this Act or any other applicable law, irrespective of the nature or effects of their mental health condition or disability. Children shall have the right to express their views on all matters affecting themselves and have such views given due consideration in accordance with their age and maturity.

The Department of Health (DOH) shall develop guidelines relative to obtaining and documenting informed consent. At a minimum, an informed consent shall respect the following principles:

a) Voluntarism, indicating that consent is given without threat or coercion, undue influence or manipulation;
b) Competency, indicating that the service user can understand information about a decision, understand the potential consequences of the decision, and communicate the decision;
c) Disclosure, indicating that the service provider has adequately disclosed information on the treatment plan including the possible benefits and negative effects/risks of the proposed treatment; possible alternatives to the proposed treatment; the possible benefits and risks of not accepting the proposed treatment and/or of choosing one of the alternatives;
d) Understanding, indicating that the service user possesses the capacity to understand information relevant to the specific circumstances and appreciate the foreseeable consequences of making (or failing to make) a decision;
e) Decision, indicating that the service user is authorizing and allowing the mental health professional, workers, and other service providers to execute the proposed treatment plan which is consistent with their authentic preferences or advance directives.

SEC. 9. ***Exceptions to Informed Consent.*** – During psychiatric or neurologic emergencies, or when there is impairment or temporary loss of decision-making capacity on the part of a service user, treatment, restraint or confinement, whether physical or chemical, may be administered or implemented pursuant to the following safeguards and conditions:

a) In compliance with the service user's advance directives, if available, unless doing so would pose an immediate risk of serious harm to the patient or another person;
b) Only to the extent that such treatment or restraint is necessary, and only while a psychiatric or neurologic emergency, or impairment or temporary loss of capacity, exists or persists;
c) Upon the order of the service user's attending mental health professional, which order must be reviewed by the internal review board of the mental health facility where the patient is being treated within fifteen (15) days from the date such order was issued, and every fifteen (15) days thereafter while the treatment or restraint continues; and
d) That such involuntary treatment or restraint shall be in strict accordance with guidelines approved by the appropriate authorities, which must contain clear criteria regulating the application and termination of such medical intervention, and fully documented and subject to regular external independent monitoring, review, and audit by the internal review boards established by this Act.

SEC. 10. ***Advance Directive.*** – A service user may set out his or her preference in relation to treatment through a signed, dated, and notarized advance directive executed for the purpose. An advance directive may be revoked by a new advance directive or by a notarized revocation.

SEC. 11. ***Legal Representative.*** – A service user may designate a person of legal age to act as his or her legal representative through a notarized document executed for that purpose.

a) *Functions.* A service user's legal representative shall:

1) Provide the service user with support and help; represent his or her interests; and receive medical information about the service user in accordance with this Act;
2) Act as substitute decision maker when the service user has been assessed by a mental health professional to have temporary impairment of decision-making capacity;
3) Assist the service user *vis-à-vis* the exercise of any right provided under this Act; and
4) Be consulted with respect to any treatment or therapy received by the service user. The appointment of a legal representative may be revoked by the appointment of a new legal representative or by a notarized revocation.

b) *Declining an Appointment.* A person thus appointed may decline to act as a service user's legal representative. However, a person who declines to continue being a service user's legal representative must take reasonable steps to inform the service user, as well as the service user's attending mental health professional or worker, of such decision.
c) *Failure to Appoint.* If the service user fails to appoint a legal representative, the following persons shall act as the service user's legal representative, in the order provided below:

1) The spouse, if any, unless permanently separated from the service user by a decree issued by a court of competent jurisdiction, or unless such spouse has abandoned or been abandoned by the service user for any period which has not yet come to an end;
2) Non-minor children;

3) Either parent by mutual consent, if the service user is a minor;
4) Chief, administrator, or medical director of a mental health care facility; or
5) A person appointed by the court.

SEC. 12. ***Supported Decision Making.*** – A service user may designate up to three (3) persons or "supporters", including the service user's legal representative, for the purposes of supported decision making. These supporters shall have the authority to: access the service user's medical information; consult with the service user *vis-à-vis* any proposed treatment or therapy; and be present during a service user's appointments and consultations with mental health professionals, workers, and other service providers during the course of treatment or therapy.

SEC. 13. ***General Guidelines.*** - Within ninety (90) days from the effectivity of the IRR, DOH in coordination with the CHR and other relevant stakeholders shall develop guidelines to fully operationalize the provisions regarding *Informed Consent to Treatment, Exceptions to Informed Consent, Advance Directive, Legal Representative* and *Supported Decision Making.*

SEC. 14. ***Internal Review Board.*** - Public and private health facilities are mandated to create their respective internal review boards to expeditiously review all cases, disputes, and controversies involving the treatment, restraint or confinement of service users within their facilities.

Health facilities shall refer to the mental health facilities as defined in this IRR.

The DOH, in coordination with appropriate agencies and guidance from the PCMH, shall issue guidelines and rules of practice relating to the operationalization of the IRB in mental health facilities within six (6) months after the effectivity of the IRR.

a) The Board shall be composed of the following:

1) A representative from the Department of Health (DOH);
2) A representative from the Commission of Human Rights (CHR);
3) A person nominated by an organization representing service users and their families duly accredited by the Philippine Council for Mental Health; and
4) Other members deemed necessary, to be invited by the IRB as ad hoc resource persons when a subject matter expertise is needed.

b) Each internal review board shall have the following powers and functions:

1) Conduct regular review, monitoring, and audit of all cases involving the treatment, confinement or restraint of service users within its jurisdiction;
2) Inspect mental health facilities to ensure that service users therein are not being subjected to cruel, inhumane, or degrading conditions or treatment;
3) *Motu proprio*, or upon the receipt of a written complaint or petition filed by a service user or a service user's immediate family or legal representative, investigate cases, disputes, and controversies involving the involuntary treatment, confinement or restraint of a service user; and
4) Take all necessary action to rectify or remedy violations of a service user's rights vis-à-vis treatment, confinement or restraint, including recommending that an administrative, civil, or criminal case be filed by the appropriate government agency.

CHAPTER IV

MENTAL HEALTH SERVICES

SEC. 15. ***Quality of Mental Health Services.*** – Mental health services provided pursuant to this Act shall be:

a) Based on medical and scientific research findings;
b) Responsive to the clinical, gender, cultural and ethnic and other special needs of the individuals being served; such as the economic, social, and spiritual needs of the individuals;
c) Most appropriate and least restrictive setting;

d) Age-appropriate; and
e) Provided by mental health professionals and workers in a manner that ensures accountability.

Further, mental health services shall be accessible, available, affordable, and acceptable; delivered by an adequate number of competent health workers who have been trained to provide mental health care according to their level and setting; provide reasonable accommodation to persons with disabilities; and guided by high professional and ethical standards.

Periodic review of the quality of mental health services by the Philippine Council for Mental Health based on the reportorial requirements stipulated in Section 18 of this IRR is necessary to ensure quality mental health services.

SEC. 16. ***Mental Health Services at the Community Level.*** – Responsive primary mental health services shall be developed and integrated as part of the basic health services at the appropriate level of care, particularly at the city, municipal, and barangay levels. The standards of mental health services shall be determined by the DOH in consultation with stakeholders based on current evidences.

Mental health services at the community level that encompass wellness promotion, prevention, treatment, and rehabilitation shall be inclusive and responsive to the needs of the vulnerable population. These services must also actively link peer supports, education, livelihood and employment, social services, and other community support services.

Every local government unit (LGU) and academic institution shall create their own program in accordance with the general guidelines set by the Philippine Council for Mental Health, created under this Act, in coordination with other stakeholders. LGUs and academic institutions shall coordinate with all concerned government agencies and the private sector for the implementation of the program.

The Department of Health, in collaboration with related associations/organizations engaged in mental health services at the community level, shall provide further guidance and technical assistance on the design, implementation and evaluation of mental health programs for the LGUs, academic institutions and workplaces within two years after the effectivity of the IRR.

SEC. 17. ***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.

For the purpose of this IRR, a community-based mental health care facility refers to a mental health facility outside of a mental hospital.[1]

Examples of community-based mental health care facilities include, but are not limited to, community mental health centers: outpatient care centers, halfway houses, crisis centers, drop-in centers, and other facilities offering services to help address the distinct needs and unique characteristics of the population, including well-being enhancement programs.

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.

The DOH shall develop guidelines in the establishment of community-based mental health care facilities.

SEC. 18. ***Reportorial Requirements.*** – LGUs through their health offices shall make a quarterly report to the Philippine Council for Mental Health through the DOH. Subject to the Data Privacy Act, the report shall include, among others, the following data: number of patients/service users attended to and/or served, the respective kinds of mental illness or disability, duration and result of the treatment, and patients'/service users' age, gender, educational attainment and employment without

[1] World Health Organization. (2005) *World Health Organization Assessment Instrument for Mental health Systems* (WHO-AIMS)

disclosing the identities of such patients/service users for confidentiality. Information on the mode of confinement, whether voluntary or involuntary, shall be reported.

SEC. 19. ***Psychiatric, Psychosocial, and Neurologic Services in Regional, Provincial, and Tertiary Hospitals.*** – All regional, provincial, and tertiary hospitals, including private hospitals rendering service to paying patient, shall provide the following psychiatric, psychosocial, and neurologic services:

a) Short-term, in-patient hospital care in a small psychiatric or neurologic ward for service users exhibiting acute psychiatric or neurologic symptoms;
b) Partial hospital care for those exhibiting psychiatric symptoms or experiencing difficulties *vis-à-vis* their personal and family circumstances;
c) Out-patient services in close collaboration with existing mental health programs at primary health care centers in the same area;
d) Home care services for service users with special needs as a result of, among others, long-term hospitalization, non-compliance with or inadequacy of treatment, and absence of immediate family;
e) Coordination with drug rehabilitation centers *vis-à-vis* the care, treatment, and rehabilitation of persons suffering from addiction and other substance-induced mental health conditions; and
f) A referral system involving other public and private health and social welfare service providers, for the purpose of expanding access to programs aimed at preventing mental illness and managing the condition of persons at risk of developing mental, neurologic, and psychosocial problems.

SEC. 20. ***Duties and Responsibilities of Mental Health Facilities.*** – Mental health facilities shall:

a) Establish policies, guidelines and protocols for minimizing the use of restrictive care and involuntary treatment;

Circumstances surrounding any instance of unavoidable seclusion or restraint shall be properly documented and reported.

b) Inform service users of their rights under this Act and all other pertinent laws and regulations;

Mental health service providers shall be trained and educated to provide accurate, adequate and relevant information to the service users and their family members, carers, or appointed support decision makers.

c) Provide every service user, whether admitted for voluntary treatment, with complete information regarding the plan of treatment to be implemented;
d) Ensure that informed consent is obtained from service users prior to the implementation of any medical procedure or plan of treatment or care, except during psychiatric or neurologic emergencies or when the service user has impairment or temporary loss of decision-making capacity;
e) Maintain a register containing information on all medical treatments and procedures administered to service users compliant with the Data Privacy Act; and clinical treatments and procedures which include, but not limited to pharmacologic and non-pharmacologic interventions such as, medications, food supplements and any herbal or alternative preparations, experimental drugs (e.g. clinical trials), psychotherapies, neurostimulation interventions; and other clinical interventions.

The register must also include reports on adverse reactions (if applicable) to the treatments and procedures, subject to a document retention policy set out by DOH.

f) Ensure that legal representatives are designated or appointed only after the requirements of this Act and the procedures established for the purpose have been observed, which procedures should respect the autonomy and preferences of the patient as far as possible.

SEC. 21. ***Drug Screening Services.*** – Pursuant to its duty to provide mental health services and consistent with the policy of treating drug dependency as a mental health issue, each local health care facility must be capable of conducting drug screening.

Drug screening services may include any one or a combination of, but not limited to, laboratory examination, administration of risk assessment scales and screening questionnaires as deemed appropriate.

SEC. 22. ***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.

In collaboration with other national agencies and stakeholders, the DOH shall develop a national suicide prevention strategy as part of its national mental health program.

A national suicide prevention strategy includes, among other components, the following:

a) Emergency mental health care for persons in suicide crisis situations;
b) Mainstreaming of suicide prevention in public health education and within other priority health programs such as HIV/AIDS, adolescent and youth health, and noncommunicable diseases, as well as in special settings such as schools, workplace, and disaster areas;
c) Training of first responders, health professionals and volunteers to recognize suicidal behaviors, provide telephone counseling, and support those bereaved by suicide;
d) Responsible media reporting and handling of suicide events; and
e) Establishing a system for suicide surveillance. Twenty-four seven (24/7) helplines or crisis hotlines shall be coordinated and linked to available appropriate services within the territorial jurisdiction of the crisis call as applicable. The DOH, in partnership with other agencies and stakeholders, shall develop policies and guidelines on establishing hotlines and suicide prevention strategies, and linking to emergency and support services.

SEC. 23. ***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, stress handling, guidance and counseling, and other elements of mental health.

Activities on public awareness shall also include advocacy for respecting, protecting and promoting the rights of persons with psychosocial disabilities and other vulnerable population, in coordination with related associations/organizations of service user, families and carer groups, the Persons with Disability Affairs Office (PDAO), and other support systems.

CHAPTER V

EDUCATION, PROMOTION OF MENTAL HEALTH IN EDUCATIONAL INSTITUTIONS AND IN THE WORKPLACE

SEC. 24. ***Integration of Mental Health into the Educational System.*** – The State shall ensure the integration of the 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

Within two years after the effectivity of this IRR, age-appropriate content for the promotion of mental health and prevention of mental health conditions shall be made available and accessible to all educational institutions at all levels, from preschool to post-graduate school, including alternative learning systems and schools for populations with special needs. Various strategies deemed appropriate for the population, may be used, from integration into current curricula (for example, values formation, science, homeroom) to special course offerings.

The materials for use in the curricula and offerings shall be developed by the Department of Education (DepEd), Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA), in coordination with mental health experts.

b) Psychiatry and neurology shall be required subjects in all medical and allied health courses, including post-graduate courses in health.

The CHED shall ensure the integration of psychiatry and neurology subjects in all medical and allied health courses appropriate to the context of the degree pursued.

SEC. 25. ***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, identify and provide support and services for individuals at risk, and facilitate access, including referral mechanisms of individuals with mental health conditions to treatment and psychosocial support.

The DepEd, CHED, and TESDA in coordination with other relevant government agencies and stakeholders, shall provide guidance in the development and implementation of mental health policy and programs to educational institutions to:

a) promote mental health;
b) provide basic support services for individuals at risk or already have a mental health condition; and
c) establish efficient linkages with other agencies and organizations that provide or make arrangements to provide support, treatment and continuing care.

All public and private educational institutions shall be required to have a complement of mental health professionals.

SEC. 26. ***Mental Health Promotion and Policies in the Workplace.*** – Employers shall develop appropriate policies and programs on mental health in the workplace designed to: raise awareness on mental health issues, correct the stigma and discrimination associated with mental health conditions, identify and provide support for individuals at risk, and facilitate access of individuals with mental health conditions to treatment and psychosocial support.

CHAPTER VI

CAPACITY BUILDING, RESEARCH AND DEVELOPMENT

SEC. 27. ***Capacity-Building, Reorientation, and Training.*** – In close coordination with mental health facilities, academic institutions, and other stakeholders, mental health professionals, workers, and other service providers shall undergo capacity-building, reorientation, and training to develop their ability to deliver evidence-based, gender-sensitive, culturally-appropriate and human rights-oriented mental health services, with emphasis on the community and public health aspects of mental health.

The DOH, following the guidelines set by the PCMH, shall:

a) Undertake steps to reorient policy makers and health professionals at national and local levels towards community- based and recovery-oriented services that respect, protect and promote human rights; and
b) In addition to reorientation, training and capacity-building, provide systems for support, supervision, monitoring and evaluation of the reorientation, training and capacity building towards improved quality of care and human rights conditions in inpatient, outpatient and other community-based mental health and related services.

SEC. 28. ***Capacity Building of Barangay Health Workers (BHWs).*** – The DOH shall be responsible for disseminating information and providing training programs to LGUs. The LGUs, with technical assistance from the DOH, shall be responsible for the training of BHWs and other barangay volunteers on the promotion of mental health. The DOH shall provide assistance to LGUs with medical supplies and equipment needed by BHWs to carry out their functions effectively.

The LGUs shall ensure the capacity building and supervision of the BHWs for the promotion of mental health, advocacy for patient's rights, case finding, identification and referral.

SEC. 29. ***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; and 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.

A national epidemiologic study on mental health shall be undertaken at regular intervals to be determined by the Philippine Council for Mental Health.

SEC. 30. ***The National Center for Mental Health (NCMH).*** – The NCMH, formerly the National Mental Hospital, being the premiere training and research center under the DOH, shall expand its capacity for research and development of interventions on mental and neurological services in the country.

Thus, in the next two (2) years from the effectivity of this IRR, the National Center for Mental Health shall undergo evaluation and revisit its current framework with the end in view of formulating a strategic plan to ensure the fulfillment of its mandate leading to the transformation of its statutory framework and programs with focus on research, training, and rights-oriented psychiatric, neurologic, and psychosocial conditions services.

The National Center for Mental Health shall:

a) Coordinate with stakeholders in the formulation of a research agenda for mental and neurological health and contribute to the national unified health research agenda;
b) Collaborate with government agencies as well as local and international academic institutions and other organizations to undertake and publish research on mental and neurological health; and
c) Develop research-based local models of care to effect the best health outcomes encompassing both physical and mental health.
d) Reorientation of its present program as an institution providing predominantly clinical service, to a facility primarily designed to serve the needs for training, education and research.
e) Develop a program that provides a balance of hospital based care and strengthened community based mental health care, collaborating actively with other mental health facilities in the communities;
f) Design appropriate and relevant capacity-building programs for various mental health providers in coordination or collaboration with academic institutions, professional organization or non-government organizations to render its program inclusive especially in MH programs with collaborating sectors at all levels; and
g) Act as Repository of Researches pertaining to Mental Health governed by the guidelines approved by the DOH.

CHAPTER VII

DUTIES AND RESPONSIBILITIES OF GOVERNMENT AGENCIES

SEC. 31. ***Duties and Responsibilities of the Department of Health (DOH).*** – To achieve 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 health care, its components, and services, as well as to improve awareness on stigmatized medical conditions;
b) Ensure that a safe, therapeutic, and hygienic environment with sufficient privacy exists in all mental health facilities and, for this purpose, shall be responsible for the regulation, licensing, monitoring, and assessment of all mental health facilities. Appropriate guidelines shall include appropriate health human resource, equipment and processes per level of care and facility;
c) Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age, and health outcomes, including data on completed and attempted suicides, in order to improve mental health service delivery, promotion and prevention strategies;

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 the establishment of centers of excellence;
e) Ensure that all public and private mental health institutions uphold the right of patients to be protected against torture or cruel, inhumane, and degrading treatment;
f) Coordinate with the Philippine Health Insurance Corporation to ensure that insurance packages equivalent to those covering physical disorders of comparable impact to the patient, as measured by Disability-Adjusted Life Year or other methodologies, are available to patients affected by mental health conditions;

Outpatient and inpatient benefit packages for priority mental health conditions shall be available within two years after the effectivity of this IRR, as determined in the National Mental Health Program;

g) Prohibit forced or inadequately remunerated labor within mental health facilities, unless such labor is justified as part of an accepted therapeutic treatment program;
h) Provide support services for families and co-workers of service users, mental health professionals, workers, and other service providers;
i) Develop alternatives to institutionalization, particularly community, recovery-based approaches to treatment aimed at receiving patients discharged from hospitals, meeting the needs expressed by persons with mental health conditions, and respecting their autonomy, decisions, dignity, and privacy;
j) Ensure that all health facilities shall establish their respective internal review boards. In consultation with stakeholders, the DOH shall promulgate the rules and regulations necessary for the efficient disposition of all proceedings, matters, and cases referred to, or reviewed by, the internal review board;
k) Establish a balanced system of community-based and hospital-based mental health services at all levels of the public health care system from the barangay, municipal, city, provincial, regional to the national level; and
l) Ensure that all health workers shall undergo human rights trainings in coordination with appropriate agencies or organizations;
m) In collaboration with associations/organizations engaged in mental health services at the community level, shall provide further guidance and technical assistance in the design and implementation of mental health programs for the LGUs and academic institutions within two years after the effectivity of this IRR;
n) Formulate, develop and implement an efficient, effective, and sustainable supply chain of quality medicines for mental health conditions within the context of the community including prepositioning of drugs during disasters; and
o) Develop efficient linkages with other agencies and organizations that provide or make arrangements to provide accessible, available, affordable, and acceptable mental health services as well as continuing care.

SEC. 32. Duties and Responsibilities of the Commission on Human Rights (CHR). – The CHR shall:

a) Establish mechanisms to investigate, address, and act upon complaints of impropriety and abuse in the treatment and care received by service users, particularly when such treatment or care is administered or implemented involuntarily;

For the purpose of interpreting CHR's duties and responsibilities, *impropriety* shall be defined as the administering of treatment and care without consent; failure to comply with recognized standards on treatment and care; and abuse and exploitation of consent given by the service user. Consent gained by the use of force or coercion shall also be considered as an act of impropriety.

In exercising its duty to inspect mental health facilities, CHR shall have an unimpeded right to monitor and visit mental health facilities.

b) Inspect mental health facilities to ensure that service users therein are not being subjected to cruel, inhumane, or degrading conditions or treatment;

The CHR shall inspect mental health facilities to ensure their compliance with the requirements and standards set by related laws regarding mental health

For the purpose of this Section, *cruel, inhuman, and degrading treatment* shall be defined as "deliberate and aggravated treatment or punishment, inflicted by a person in authority or agent of a person in authority against another person in custody, which

attains a level of severity sufficient to cause suffering, gross humiliation or debasement to the latter. The assessment of the level of severity shall depend on all the circumstances of the case, including the duration of the treatment or punishment, its physical and mental effects and, in some cases, the sex, religion, age and state of health of the victim."

c) Investigate all cases involving involuntary treatment, confinement, or care of service users, for the purpose of ensuring strict compliance with domestic and international standards respecting the legality, quality, and appropriateness of such treatment, confinement, or care; and
d) Appoint a focal commissioner for mental health tasked with protecting and promoting the rights of service users and other persons utilizing mental health services or confined in mental health facilities, as well as the rights of mental health professionals and workers. The focal commissioner shall, upon a finding that a mental health facility, mental health professional, or mental health worker has violated any of the rights provided for in this Act, take all necessary actions to rectify or remedy such violation, including recommending that an administrative, civil, or criminal case be filed by the appropriate government agency.

The Focal Commissioner for Mental Health shall oversee matters concerning the implementation of the duties and responsibilities of the Commission under the Mental Health Act. The Focal Commissioner shall ensure that a budget is allocated to enable and ensure the undertaking of its duties and responsibilities under the Act. However, the final decision on all matters affecting external stakeholders will still come from the Commission *en Banc*. The decision of the Commission *en Banc* decision will prevail over that of the Focal Commissioner.

SEC. 33. ***Investigative Role of the Commission on Human Rights (CHR).*** – The investigative role of the CHR as provided in the pertinent provisions of this Act shall be limited to all violations of human rights involving civil and political rights consistent with the powers and functions of the CHR under Section 18 of Article XIII of the Constitution.

The Commission on Human Rights shall investigate, on its own or on complaint from any party, all forms of civil, political, economic, social, and cultural human rights violations, including all rights deriving therefrom as recognized and accepted under international human rights law.

SEC. 34. ***Complaint and Investigation.*** – The DOH, CHR and Department of Justice (DOJ) shall receive all complaints of improprieties and abuses in mental health care and shall initiate appropriate investigation and action.

Further, CHR shall inspect all places where psychiatric service users are held for involuntary treatment or otherwise to ensure full compliance with domestic and international standards governing the legal basis for treatment and detention, quality of medical care and treatment standards. The CHR may, *motu proprio,* file a complaint against erring mental health institutions should they find any noncompliance, based on their investigation.

Within six (6) months after the effectivity of this IRR, the three (3) agencies shall provide joint implementation guidelines for the effective implementation of this provision.

SEC. 35. ***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 the curriculum at all educational levels both in public and private institutions;
b) Develop guidelines and standards on age-appropriate and evidenced-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.

The DepEd, CHED, and TESDA, in coordination with other relevant government agencies and stakeholders, shall provide guidance in the development and implementation of mental health policy and programs to educational institutions including the integration of mental health in the curriculum, consistent with the provisions and functions of educational institutions under Sections 24 and 25 of this IRR.

SEC. 36. ***Duties and Responsibilities of the Department of Labor and Employment (DOLE) and the Civil Service Commission (CSC).*** – The DOLE and the CSC shall:

a) Develop guidelines and standards on appropriate and evidenced-based mental health programs for the workplace as described in this Act;
b) Develop policies that promote mental health in the workplace and address stigma and discrimination suffered by people with mental health conditions.

The CSC, in consultation with stakeholders, shall issue appropriate policies and guidelines for the National Government Agencies (NGAs), Local Government Units (LGUs), State Universities and Colleges (SUCs) and local universities and colleges and Government Owned and Controlled Corporations (GOCCs), to develop standards and promote inclusive and evidence-based mental health programs in the workplace, which will focus on, but not limited to, advocacy, education and training; mental health services, among others.

The DOLE shall issue appropriate guidelines in the development and implementation of policy and programs to promote mental health in the workplace in coordination with DOH and in consultation with mental health professionals and stakeholders. DOLE shall also develop mental health programs for Overseas Filipino Workers.

The DOLE shall provide assistance to the employers in the development and promotion of mental health programs in the workplace, including access to appropriate mental health services.

Appropriate guidelines shall be developed within six (6) months after the effectivity of this IRR.

SEC. 37. ***Duties and Responsibilities of the Department of Social Welfare and Development (DSWD).*** – The DSWD shall:

a) Refer service users to mental health facilities, professionals, workers, and other service providers for appropriate care;
b) Provide or facilitate access to public or group housing facilities, counseling, therapy, and livelihood training and other available skills development programs;
c) In coordination with the LGUs and the DOH, formulate, develop, and implement community resilience and psychosocial well-being training, including psychosocial support services during and after natural disasters and other calamities; and
d) Develop and implement training and capacity building programs to effectively discharge the agency's role according to this Act.

Appropriate guidelines shall be developed within six (6) months after the effectivity of this IRR.

SEC. 38. ***Duties and Responsibilities of the Local Government Units. (LGUs).*** – LGUs shall:

a) Review, formulate, and develop the regulations and guidelines necessary to implement an effective mental health care and wellness policy within the territorial jurisdiction of each LGU, including the passage of a local ordinance on the subject of mental health, consistent with existing relevant national policies and guidelines;
b) Integrate mental health care services in the basic health care services, and ensure that mental health services are provided in primary health care facilities and hospitals, within their respective territorial jurisdictions;
c) Establish training programs necessary to enhance the capacity of mental health service providers at the LGU level, in coordination with appropriate national government agencies and other stakeholders;
d) Promote deinstitutionalization and other recovery-based approaches to the delivery of mental health care services;
e) Establish, re-orient, and modernize mental health care facilities necessary to adequately provide mental health services, within their respective territorial jurisdictions;
f) Where independent living arrangements are not available, provide or facilitate access to public housing facilities, vocational training and skills development programs, and disability or pension benefits;
g) Refer service users to mental health facilities, professionals, workers, and other service providers for appropriate care;
h) Establish a multi-sectoral stakeholder network for the identification, management, and prevention of mental health conditions;
i) Establish and maintain drug screening services for the common prevalent drugs of abuse, using acceptable standard and up to date basic screening equipment and procedures;

j) Ensure appropriation to support and sustain the effective provision of mental health services in their respective territorial jurisdiction; and

k) In coordination with appropriate local agencies, ensure mental health and other services are provided to vagrants with mental health problems who are in their respective territorial jurisdiction.

Appropriate guidelines shall be developed within one (1) year after the effectivity of this IRR.

SEC. 39. ***Upgrading of Local Hospitals and Health Care Facilities.*** **–** Each LGU, upon its determination of the necessity based on well-supported data provided by its local health office, shall establish or upgrade hospitals and facilities with adequate and qualified personnel, equipment and supplies to be able to provide mental health services and to address psychiatric emergencies: *Provided,* That people in geographically isolated and/or highly populated and depressed areas shall have the same level of access and shall not be neglected by providing other means such as home visits or mobile health care clinics, as needed: *Provided, further,* That the national government shall provide additional funding and other necessary assistance for the effective implementation of this provision.

CHAPTER VIII

THE PHILIPPINE COUNCIL FOR MENTAL HEALTH

SEC. 40. ***Mandate.*** – The Philippine Council for Mental Health, herein referred to as the Council, is hereby established as a policy-making, planning, coordinating and advisory body, attached to the DOH to oversee the implementation of this Act, particularly the protection of rights and freedom of persons with psychiatric, neurologic, and psychosocial needs and the delivery of a rational, unified and integrated mental health services responsive to the needs of the Filipino people.

Within six (6) months after the effectivity of this IRR, the Council shall develop a strategic plan for implementation, including a balanced scorecard with indicators. It shall encompass the establishment of a multi-agency and /or multi-sector coordinating mechanism to ensure integrated participation of the regions, provinces, cities/municipalities through regional and local mental health councils or other appropriate bodies.

SEC. 41. ***Duties and Functions.*** – The Council shall exercise the following duties:

a) Develop and periodically update, in coordination with the DOH, a national multi-sectoral strategic plan for mental health that further operationalizes the objectives of this Act which shall include the following:

    1) The country's targets and strategies in protecting rights of Filipinos with mental health needs and in promoting mental health and the well-being of Filipinos, as provided in this Act;
    2) The government's plan in establishing a rational, unified and integrated service delivery network for mental health services including the development of health human resources and information system for mental health; and
    3) The budgetary requirements and a corollary investment plan that shall identify the sources of funds for its implementation;

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;

c) Ensure the implementation of the policies provided in this Act, and issue or cause issuance of orders, or make recommendations to the implementing agencies as the Council considers appropriate;

d) Coordinate the activities and strengthen working relationships among national government agencies, LGUs, and non-government agencies involved in mental health promotion;

e) Coordinate with foreign and international organizations regarding data collection, research and treatment modalities for persons with psychiatric, neurologic and substance use disorders and other addictions;

f) Coordinate joint planning and budgeting of relevant agencies to ensure funds for programs and projects indicated in the strategic medium-term plan are included in the agency's annual budget;

g) Call upon other government agencies and stakeholders to provide data and information in formulating policies and programs, and to assist the Council in the performance of its functions; and

h) Perform other duties and functions necessary to carry out the purposes of this Act.

SEC. 42. ***Composition.*** **–** The Council shall be composed of the following:

a) Secretary of DOH as Chairperson;
b) Secretary of DepEd;
c) Secretary of DOLE;
d) Secretary of the Department of the Interior and Local Government (DILG);
e) Chairperson of CHR;
f) Chairperson of CHED;
g) One (1) representative from the academe/research;
h) One (1) representative from medical or health professional organizations; and
i) One (1) representative from non-government organizations (NGOs) involved in mental health issues.

The members of the Council from the government may designate their permanent authorized representatives.

The members of the Council from the academe/research, private sector and NGOs shall be appointed by the President of the Philippines from a list of three nominees submitted by the organizations, as endorsed by the Council.

Members representing the academe/research, private sector and NGOs of the Council shall serve for a term for three (3) years. In case a vacancy occurs in the Council, any person chosen to fill the position vacated by a member of the Council shall only serve the unexpired term of said member.

SEC. 43. ***Creation of the DOH Mental Health Division.*** **-** There shall be created in the DOH, a Mental Health Division, under the Disease Prevention and Control Bureau, staffed by qualified mental health specialists and support staff with permanent appointments and supported with an adequate yearly budget. It shall implement the National Mental Health Program and, in addition, shall also serve as the secretariat of the Council.

To ensure governance and performance accountability, teams shall be organized within the Mental Health Division - one unit to act as the secretariat to the Council and a separate unit to manage the National Mental Health Program. The staff of the units shall have the functional training and competencies necessary for their roles and responsibilities, in compliance with CSC requirements.

CHAPTER IX

MENTAL HEALTH FOR DRUG DEPENDENTS

SEC. 44. ***Voluntary Submission of a Drug Dependent to Confinement, Treatment and Rehabilitation.*** – Persons who avail of the voluntary submission provision and persons charged pursuant to Republic Act No. 9165, otherwise known as the "Comprehensive Dangerous Drugs Act of 2002", shall undergo an examination for mental health conditions and, if found to have mental health conditions, shall be covered by the provisions of this Act.

CHAPTER X

MISCELLANEOUS PROVISIONS

SEC. 45. ***Penalty Clause.*** – Any person who commits any of the following acts, shall, upon conviction by final judgment, be punished by imprisonment of not less than six (6) months but not more than two (2) years, or a fine of not less than Ten thousand pesos (P10, 000.00), but not more than Two hundred thousand pesos (P200, 000.00), or both, at the discretion of the court:

a) Failure to secure informed consent of the service user, unless it falls under the exceptions provided under Sec. 13 of this Act;
b) Violation of the confidentiality of information, as defined under Sec. 4(c) of this Act;
c) Discrimination against a person with a mental health condition, as defined under Sec. 4(e) of this Act; and
d) Administering inhumane, cruel, degrading or harmful treatment not based on medical or scientific evidence as indicated in Sec. 5 (h) of this Act.

If the violation is committed by a juridical person, the penalty provided for in this Act shall be imposed upon the directors, officers, employees or other officials or persons therein responsible for the offense.

If the violation is committed by alien, the alien offender shall be immediately deported after service of sentence without need of further proceedings.

These penalties shall be without prejudice to the administrative or civil liability of the offender, or the facility where such violation occurred.

SEC. 46 ***Appropriations.*** - The amount needed for the initial implementation of this Act shall be charged against the appropriations of the DOH for the following: maintenance and other operating expenses of the national mental health program, capital outlays for the development of psychiatric facilities, personnel services among selected DOH hospitals, and formulation of the strategic plan for mental health.

For the succeeding years, the amount allocated for mental health in the DOH budget and in the budget of other agencies with specific mandates provided in this Act shall be based on the strategic plan formulated by the Council, in coordination with other stakeholders. The amount shall be included in the National Expenditure Program (NEP) as basis for the General Appropriations Bill (GAB).

SEC. 47. ***Separability Clause.*** – If any provision of this Act is declared unconstitutional or invalid by a court of competent jurisdiction, the remaining provisions not affected thereby shall continue to be in full force and effect.

SEC. 48. ***Repealing Clause.*** – All laws, decrees, executive orders, department or memorandum orders and other administrative issuances or parts thereof which are inconsistent with the provisions of this Act are hereby modified, superseded or repealed accordingly.

SEC. 49. ***Effectivity.*** – These Rules shall take effect fifteen (15) days after publication in the *Official Gazette* or in at least two (2) newspapers of general circulation.

This *"Implementing Rules and Regulations of Republic Act No. 11036, Otherwise Known as The Mental Health Act"* is hereby approved by the Department of Health this 22nd day of January 2019 in the City of Mandaluyong, Republic of the Philippines.

FRANCISCO T. DUQUE III, MD, MSc
Secretary
Department of Health

Annex 3:

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023

VISION

Mental health and wellbeing for all Filipinos

MISION

Value, promote and protect the basic right of all Filipinos to Mental Health and wellbeing and provide comprehensive, integrated, accessible and quality Mental Health programs and services

	Indicators	Baseline			Targets					Mode of Verification			Risks and Assumptions
		Year	Value	Source	2020	2021	2022	2023	2030	Source of Data	Formula	Frequency of Reporting	
GOALS													
1. Mental health and wellbeing is valued, promoted, and protected	1. Increased proportion of the population, by age and sex, who: a. Practice self-care (stress management, physical activity, avoidance of alcohol and dangerous drugs) b. Seek Mental Health services for psychosocial distress c. Believe that persons with MH disorders should be treated humanely					Research is in the pipeline for 2021	Establish baseline and targets			Survey		Every 5 years	Assumption: Community-based services will be available and accessible. Risk: Lack of services or poorly implented policies and programs may reinforce stigma and negative perceptions.
	2. MH policies and programs are integrated in national and local plans and programs												
	a. Number of national government agencies implementing their mandate in accordance to the Mental Health Act				10 NGAs (includes NCMH, PHIC)					PCMH, DOH			
	b. Proportion of national government agencies implementing the mental health workplace policy				60% of other NGAs (22 total including the PCMH members)"	80% of other NGAs (27 total)"	100% of NGAs (32 total)"			NGA Reports to PCMH	Numerator: Number of NGAs with MH programs and plans Denominator: Number of NGAs (32 as of 2018 COA report)	Annual	
	c. Number of provinces, cities, and municipalities implementing their local mental health ordinance				58 Implementation Sites (49 provinces and 9 cities) *Note: 6/58 - has no training on MHGAP 23/58 - has no access site*					DOH and DILG Reports to PCMH	Cumulative Count	Annual	
2. Mental health conditions are identified, treated and prevented	1. Suicide mortality rate (per 100,000 population)	2017	3.2	WHO, 2018: World Health Statistics	3.20 Use as Baseline Result of National Survey for Mental Health and Well-Being (NSMHW) of UP-PGH	3.17	3.14	3.10		PSA	Numerator: Number of deaths from suicide multiplied by 100,000 Denominator: Total number of deaths from all causes	Every 5 years	Baseline results due in July 2020. Rational target TBD in 2021.
	2. Proportion of persons with mental disorders (psychosis, depression, anxiety disorders, substance use) and epilepsy who are using services (%)	2020		KMITS,RIS, Prevalence Research	Increase by 2%	Increase by 4%	Increase by 6%	Increase by 8%		DOH, Prevalence Research	Numerator: Cases of mental health conditions in receipt of services derived from routine information systems or, if unavailable baseline and follow-up survey of health facilities in one or more defined geographical areas of the country; Denominator: Total cases of mental health conditions in the sampled population, derived from national surveys, or if unavailable, subregional and gloal prevalence estimates.	Annual	Assumption: Functionality will be defined in the IRB guidelines.

	Indicators	Baseline			Targets					Mode of Verification			Risks and Assumptions
		Year	Value	Source	2020	2021	2022	2023	2030	Source of Data	Formula	Frequency of Reporting	
3. Persons affected by mental health conditions are able to exercise the full range of human rights	Number of facilities providing MH care with a functioning IRB				8 Pilot Sites	100% of Level 3 DOH-retained hospitals (70 hospitals) At least 1 private mental health facility in each of the 50% of the regions (8)	At least 1 private mental health facility in each of the 100% of the regions (17)			CHR DOH	Count	Annual	Assumption: Functionality will be defined in the IRB guidelines.
	Percentage of cases acted upon				20%	30%	40%	50%					

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023
Mental Health Promotion and Prevention

	Indicators	Baseline			Targets					Mode of Verification			Risks and Assumptions
		Year	Value	Source	2020	2021	2022	2023	2030	Source of Data	Formula	Frequency of Reporting	
OUTCOMES													
1. Improved practices on mental health and wellbeing in schools, workplaces, and communities	a. Proportion of public schools implementing the DepEd order on MH				5%	10%	15%	30%		DepEd	Numerator: Number of schools monitored and found to be compliant with the provisions of the DepEd order on MH in Schools Denominator: Total number of schools (40,000 as of 2019)	Annual	
	b. Proportion of public and private colleges and universities monitored with: - MH policies and wellness programs - trained mental health service providers"				25%	50%	75%	100%		CHED		Annual	
	c. Proportion of public and private vocational education institutions monitored with: - MH policies and wellness programs - trained mental health service providers				25%	50%	75%	100%		TESDA		Annual	
	d. Proportion of national government agencies implementing the mental health workplace policy				All PCMH members (6 total)	60% of other NGAs (22 total)	80% of other NGAs (27 total)	100% of NGAs (32 total)		NGA Reports to PCMH	Numerator: Number of NGAs with MH programs and plans Denominator: Number of NGAs (32 as of 2018 COA report)	Annual	
	e. Proportion of private companies inspected with MH policies and wellness programs				5%	25%	50%	90%		DOLE	Numerator: Number of private companies compliant Denominator: Number of private companies inspected based on DOLE's target for inspection	Annual	Expected output/indicators in this matrix will give similar results with Promo Score Card under 4.2 (Mainstreaming in Workplaces). Data on the compliance of companies to the issued DO will be derived from the MIS
	f. Number of provinces, cities, and municipalities implementing their local mental health ordinance					29 prov 4 cities (UHC IS)	32 prov 58 cities	40 prov 73 cities		DOH and DILG Reports to PCMH	Cumulative Count	Annual	

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing source
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
OUTPUTS AND KEY ACTIVITIES																		
1. Improved MH Literacy (defined as knowledge and beliefs about mental well-being and mental disorders) by the general public and social advocates																		
a. Determine baseline knowledge, beliefs, attitudes, and practices regarding mental well-being and mental disorders	Study Report					Yes			Survey	Yes/No	Every 5 years	DOH						
b. Create an inventory of existing MH initiatives and activities in the Philippines	Study Report				Yes				PCMH members	Yes/No	Every 5 years	DOH	Organizations will participate in the survey; standardized form shall be made available and accessible					
c. Convene a multisectoral group of stakeholders including educators, social workers, faith-based groups, the Persons with Disability Affairs Office (PDAO), organizations of service users, families and carers, artists, athletes, the media, leaders in culture and art to develop a national mental health promotion and communication plan for a nationwide multimedia campaign to raise the level of public awareness on the protection and promotion of MH and rights	Comnunications Plan					Yes			DOH	Yes/No	Every 5 years	DOH	Prior to the creation of communication plan, needs assessment shall be conducted. Communication plan shall be supported by various organizations; MH promotion and communication plan is targetted, costed, and uses innovative strategies. MH promotion and communication plan covers, but is not limited to, the following topics: Selfcare; Skills building for children and adolescents (i.e. emotion regulation, resiliency, and grit); Positive Discipline; Risks on mental health issues and suicide; Wholeness for Families; Unobtrusive therapies; Quality Rights; Ethics; MH and nutrition; stress handling, guidance and counseling, and other elements of MH; also advocacy for respecting, protecting and promoting the right of persons with psychosocial disabilities and other vulnerable populations		1,000,000	3,000,000		DOH HPCS, CSRs, donors
d. Roll-out national MH promotion and communication plan							Yes		DOH	Yes/No	Every 5 years	DOH	Funding shall be made available; various organizations shall implement the national communication plan on MH			5,000,000	5,000,000	DOH, partners
2. People with lived experience of mental illness (PLE) are proactive in participating in the development and implementation of MH policies, strategies, laws, and services											Annually	PCMH	Activities will be supported by the various organizations; organizations shall coordinate with DOH MH Secretariat with the registration information; Registration shall observe Data Privacy Act and other related policies and laws					
a. Develop modules for PLE	Modules developed for the PLEs					Yes			Modules	Yes/No		DOH						
b. Capacitate individual PLEs to promote mental health and eliminate stigma and discrimination, e.g. by sharing their story	Regions with at least 25 trained PLE						9	17	Training reports	Count	Annual	DOH, CSOs	First year will be training of trainors, while the succeeding years shall be dedicated for training as needs arise	1,500,000	1,000,000	500,000	300,000	DOH, CSO

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing source
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
c. Capacitate PLE organizations in organizational development and to advocate for development and implementation of MH policies, strategies, laws, and services	Cumulative number of PLE organizations signing up with CSO network				Establish baseline		10% increase	10% increase	PCMH reports	Count	Annual	DOH, CSOs	PLE organizations will be part of the CSO network. Trained PLEs will also serve as possible IRB members.	3,000,000	3,000,000	3,000,000	3,000,000	DOH
3. Ethical reporting and portrayal of mental health and suicide and other issues is practiced by media																		
a. Hold media forums to increase media awareness of the magnitude of the problem and the availability of effective prevention strategies	Number of media forums held	2019	0		1	1	1	1	Activity reports	Count	Annual	DOH, CSOs		500,000	500,000	500,000	500,000	DOH HPCS
b. Convene film makers, media outlets, KBP, MTRCB, PIA, and PCMH to develop guidelines for ethical reporting of MH in the news, responsible and accurate content, and provision of trigger warnings	Evidence-based standardized guidelines on responsible media reporting and handling of suicide events developed	2019	No			Yes			Media guidelines	Yes/No	Every 5 years	DOH, MH Experts	KBP, PANA, PCOO (PIA), MTRCB will all collaborate with PCMH. MOA is cleared with concerned stakeholders. Media organizations are supportive of this initiative. Safeguard will be in place in the event of breach of MOA (e.g. instances of sensationalization). Data Privacy Act and other related laws and policies will be enforced and observed	1,000,000				DOH HPCS
4. Ethical reporting and portrayal of mental health and suicide and other issues is practiced by media																		
4.1 Mainstreaming in schools	Proportion of public schools compliant with DepEd order on MH				5%	10%	15%	30%	School Health Monitoring	**Numerator:** Number of schools monitored and found to be compliant with the provisions of the DepEd order on MH in Schools **Denominator:** Total number of schools (40,000 as of 2019)		DepEd	School health personnel and guidance counselors will serve as monitors in line with the implementation of OK sa DepEd.					
	Proportion of public and private colleges and universities monitored with: • MH policies and wellness programs • trained mental health service providers				25%	50%	75%	100%				CHED						

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing source
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
a. Develop guidelines, standards, and strategies that promote MH and wellbeing among educators and learners in public and private educational institutions, including: • policies against discrimination based on mental disorders • MH promotion activities • capacity building and tools for identification of learners with MH concerns • linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management • determination of type and number of "adequate complement of MH professionals" and strategies to meet these needs as required by the MH Act • system and tools for monitoring	Proportion of public and private vocational education institutions monitored with: • MH policies and wellness programs • trained mental health service providers				25%	50%	75%	100%				TESDA							
	• Memo / Department Order on MH and wellbeing programs and policies in the basic education sector issued by DepEd	2019	No	Pilot testing	Yes				Memo/DO	Yes/No		DepEd	DOH and MH experts provide technical assistance in the development of guidelines, standards, and strategies					
	• Memo/ Department Order on MH and wellbeing programs and policies in colleges and universities issued by CHED	2020	No		Yes				Memo/DO	Yes/No		CHED						
	• Memo/ Department Order on MH and wellbeing programs and policies in vocational education institutions issued by TESDA	2021	No		Yes				Memo/DO	Yes/No		TESDA						
b. Integrate age-appropriate content pertaining to MH in the K-12 curriculum in both public and private institutions: 1. Convene curriculum review committee to identify where MH content can be integrated in the current curriculum through issuance of special order 2. Develop MH content to be integrated in the revised curriculum	Memo circular for implementation of revised curriculum issued	2019	No			Yes			Revised curriculum with MH content	Yes/No		DepEd	DepEd to ensure a mental health subject matter expert is included in the convening curriculum review committee; DepEd to closely coordinate with DOH and other stakeholders					
c. Integrate age-appropriate content and activities pertaining to MH in the college level in both public and private institutions																		
d. Integrate age-appropriate content and activities pertaining to MH in vocational training programs in both public and private institutions																		

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing source
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
4.2 Mainstreaming in workplaces	Proportion of national government agencies with: • MH policies and wellness programs • trained mental health service providers				All PCMH members (6 total)	60% of other NGAs (22 total)	80% of other NGAs (27 total)	"100% of NGAs (32 total)"	NGA reports	Numerator: Number of NGA with MH policies and wellness programs	Annual	CSC	Cooperation from all included stakeholders shall be ensured. Total number of institutions set from the start to ensure consistency in baseline. Each responsible agency shall enforce penal provisions for non-compliant organizations/ institutions.					
	Proportion of private companies inspected with MH policies and wellness programs					Establish baseline	50%	90%	OSH Report LMIS	Numerator: Number of private companies compliant according to OSH Checklist Denominator: Number of private companies inspected based on DOLE's target for inspection	Annual	DOLE						
a. Develop guidelines, standards, and strategies that promote MH and wellbeing among workers in private and public workplaces, including: • policies against discrimination based mental disorders • determination of type and number of "adequate complement of MH professionals" as required by the MH Act • linking into the health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management	• Department Order on MH and wellbeing promotion programs and policies in private companies issued by DOLE	2019	No		Yes				Memo/DO	Yes/No		DOLE	DOH and MH experts provide technical assistance in the development of guidelines, standards, and strategies.					DOLE
	• Memo/ Department Order on MH and wellbeing promotion programs and policies in government agencies issued by CSC	2020	No		Yes				Memo/DO	Yes/No		CSC						CSC
b. Monitoring of public and private workplaces for compliance to guidelines, standards, and strategies for MH												DOLE and CSC						
4.3 Mainstreaming in communities	Number of LGUs (provinces, cities, municipalities) with a local mental health ordinance					29 prov 4 cities (UHC IS)	34 prov 9 cities	39 prov 19 cities	DOH	Count	Annual	DOH	Assumption: Local MH ordinances contain the essential components identified in the JMC on Guidelines for Localization of the MH Act and establishing MH promotion programs in communities issued by DILG					

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing source
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
a. Review, formulate and develop regulations and guidelines to implement an effective mental health care and wellness policy within the territorial jurisdiction of each LGU, including: • inclusion of MH in Provincial Development and Physical Framework Plan (PDPFP) or Comprehensive Development Plan (CDP) and Annual Investment Program (AIP) • inclusion of MH in the role of (expanded) local health boards or other appropriate bodies in implementing and monitoring of MH programs and their system of reporting to Regional MH Councils; • templates for localization of the MH Act and for policies against discrimination based on mental disorders • provision of "adequate complement of MH professionals" as required by the MH Act • establishing a health care provider network/ local referral system to address mental health needs and crises, including Suicide Prevention and Management, and linking it to schools, workplaces, communities, jails, custodial care centers, and vulnerable populations	• JMC on Guidelines for Localization of the MH Act and establishing MH promotion programs in communities issued by DILG				Yes				Guidelines for Localization of MH Act	Yes/No		DOH	DOH and DILG to work together with other TWG members to develop Guidelines for Localization.	100,000				
b. Provision of technical assistance, support, and monitoring of LGUs to implement an effective mental health care and wellness policy	• Number of LGUs provided by DOH with technical assistance, support, and monitoring to implement an effective mental health care and wellness policy					29 prov 4 cities (UHC IS)	34 prov 9 cities	39 prov 19 cities		Count	Annual	DOH						
c. Review existing family modules (e.g. ECCD) and integrate MH literacy as appropriate						Yes				Yes/No	Annual	DSWD						
SUPPORTING ACTIVITIES																		
Advocate/ campaign for other mental health-related laws, e.g. Positive Discipline, SOGIE, Juvenile Justice																		

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023
Governance and Leadership

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
OUTCOME																		
2. Effective leadership and governance for mental health	a. Government's total allocation for mental health as % of total government health expenditure	2019	2.65%	DOH ENCDD	2.75%	3.50%	4.25%	5.00%	NGA Reports to PCMH	Numerator: Budget allocation (in local currency) specifically or attributed for promotion of mental health and wellbeing at all stages and throughout the life-course Denominator: Total health expenditures (in local currency) x 100	Annual							
	b. Number of national government agencies implementing their mandate in accordance to the Mental Health Act				8 NGAs	10 NGAs			PCMH Secretariat		Annual	PCMH	.					
OUTPUTS AND KEY ACTIVITIES																		
1. Strong intra- and inter-sectoral coalition																		
a. Form a multisectoral TWG to assist the PCMH in implementing its strategic plan, with members from the government, CSOs, the academe, and PLEs	TOR, clusters or committes, and term limits of National MH TWG included in Department Personnel Order (DPO)			Yes					DPO convening the TWG	Yes/No				1,052,800				
b. Convene a multi-sectoral network of registered NGOs, formal and informal PLE organizations, and advocacy groups in schools, workplaces, and communities	Goals, Objectives, Action Plan, and registration processes for CSOs developed				Yes				CSO Network Action Plan	Yes/No	One-time	PCMH, TWG						
c. Capacitate a network of multi-sectoral CSO, PLE/service user, and advocates based on needs assessment	Number of CSO, PLE/service user, and advocacy groups capacitated to advocate for MH policy and program planning, implementation, and monitoring & evaluation, including the content of the MH Act, basic service package, MH promotion messages, localization of the MH Act, and budgeting					12	25	50	PCMH Report	Count	Annual	PCMH, TWG		444,000	488,400	537,240	590,964	
	Number of CSO, PLE/service user, and advocacy groups participating in policy and program planning, implementation, and monitoring & evaluation					6	12	25	Activity reports	Count	Annual	PCMH, TWG		87,000	95,700	105,270	115,797	
d. Conduct multisectoral activities														87,000	95,700	105,270	115,797	
2. MH policies and programs are integrated in national and local plans and programs																		

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
a. Appoint focal persons for MH in each government agency	Proportion of national government agencies with focal person appointed for MH				All PCMH members (6 total)	60% of other NGAs (22 total)	80% of other NGAs (27 total)	100% of NGAs (32 total)	NGA Reports	**Numerator:** Number of government agencies with an MH focal person **Denominator:** Total number of government agencies"	Annual	CSC	The 2018 COA Report lists 32 NGAs. **Assumption:** CSC guidelines will mandate NGAs to appoint/ designate a focal person on MH in coordination with DOH, specifying criteria for selection and role of MH focal person (e.g. reviewing all program strategies for MH component). Study will be conducted to determine the MH needs of various stakeholders in each sector.					
b. Orientation, training, or workshop of leaders and executives of health and mental health-related sectors at the national and local levels on the implementation of MH Act, including basic service package, MH promotion messages, relevant policies, evidence-based interventions, and budgeting	a. Number of NGAs covered			All PCMH Members	All NGAs					Count	Annual	PCMH	PCMH mobilizes the DOH and DILG to educate leaders and policymakers at the national and local levels.	222,000	244,200	268,620	295,482	
	b. Number of LGUs covered (from DOH)				29 prov 4 cities (UHC IS)	49 prov 44 cities 30% mun	69 prov 84 cities 60% mun	79 prov 122 cities	DILG/DOH Reports	Count	Annual	DOH		222,000	244,200	268,620	295,482	with LGU share
	c. Number of LGU leagues oriented (from DILG)				Leagues of provinces, cities and municipalities oriented on MH Act				DILG/DOH Reports	Count	Annual	DOH	Orientations, trainings, or workshops can begin with Leagues in 2019.					
d. Inclusion of MH programs in LGU Health Scorecard	MH programs included in LGU Health Scorecard				Yes				DOH issuance on LGU HSC	Yes/No	Annual	DOH						
e. Inclusion of MH programs in Seal of Good Local Governance	MH programs included in Seal of Good Local Governance					Yes			DILG issuance on SGLG	Yes/No	Annual	DILG						
3. Leaders of health and non-health agencies, CSOs, PLEs, carers, support group members, advocates, and mental health service providers at all levels utilize a rights-based approach to mental health	Number of participants completing the Quality Rights e-training module, including: 1. PCMH members				All PCMH members				Certificates of Completion of QualityRights									
	2. Leaders of national health and non-health agencies				25%	30%	75%	100%										
	3. Local government leaders				25%	50%	75%	100%										
	4. MH service providers				25%	50%	75%	100%										
	5. CSO members, PLEs, carers, support group members, advocates				25%	50%	75%	100%										

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
4. Sustainable financing for governance system	Government budget allocation for mental health in the following:																	
	a. Specifically for mental health: DOH	2019	2.65%	2.65%	2.75%	3.50%	4.25%	5.00%	DOH Report		Annual	DOH						
	b. Specifically for or attributed for mental health: other NGAs • DILG • DepEd • CHED • TESDA • DOLE • CSC • CHR • DSWD				Establish baselines			at least 3%	NGA Reports		Annual	Concerned NGAs						
	c. Specifically for mental health: LGUs								IRA, LGU through LHB report		Annual	LGUs	Assumption: DILG will provide national policy guidance.					
	d. Budget attributed for mental health							at least 5%	NGA Reports		Annual	Concerned NGAs						
	e. Other financing institutions								NEDA report		Annual	PCMH						
a. Cover individual MH costs through PhilHealth	PhilHealth outpatient and inpatient MH benefit package approved				Yes				PhilHealth			PhilHealth						
	Utilization of outpatient MNS benefit package as to number of claims and PhilHealth payouts per year								PhilHealth		Annual	PhilHealth						
	Utilization of inpatient MNS benefit package as to number of claims and PhilHealth payouts per year								PhilHealth		Annual	PhilHealth						
	Number of facilities implementing/ contracted on PhilHealth MNS packages								PhilHealth		Annual	PhilHealth						
b. Propose a program convergence budgeting to DBM	Proposed program convergence budget done; include MH in budget priorities								DBM			PCMH	PCMH will coordinate with DBM					
c. Monitor appropriations for MH in GAA	NGA budgets are adequate to meet the targets in the Five-year Strategic Plan								NGA budgets	Yes/No		PCMH	NGAs will fulfill their responsibilities as stated in the Five-year Strategic Plan for the PCMH					
d. Advocate for the inclusion of MH in the GAD Guidelines	GAD Guidelines include a proportion for MH and wellbeing, e.g. for victims of GBV and families in crisis								GAD Guidelines	Yes/No		PCMH	PCMH and TWG will coordinate with PCW and DBM	1,000,000	1,000,000	1,000,000	1,000,000	
e. Meet with development partners on MH program priorities	Number of development partners committing to work on MH issues								PCMH Report	Count		PCMH	PCMH and CSOs will explore alternative sources of funding other than the usual development partners	87,000	95,700	105,270	115,797	
5. Functional, capacitated, and effective structure for national and local governing bodies											One-time							
5.a PCMH																		
1. Manual of operations of PCMH approved	Manual of operations to define structure and processes of PCMH			Drafted	Approved				PCMH Report									
2. Creation of the Mental Health Division					Yes													
3. Approval of the PCMH's budget	Proportion of annual budget requirement funded				100%	100%	100%	100%										
4. Biennial Mental Health Summit	Biennial mental health summit conducted			Yes		Yes		Yes								6,000,000		7,000,000

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
		Year	Value	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
5. Midterm review of the Strategic Plan	Midterm review conducted						Yes						Assumption: Baselines have been established. Some outputs can be reported on. Targets will be revisited based on progress at midterm.				5,000,000	
6. Strategic Planning (2024-2028)	Strategic planning workshop conducted							Yes										5,000,000
5.b NCMH																		
1. Organizational Development process					Yes									20,000,000				
2. Development of strategic plan for the transition to research and training facility as required by the MH Act, and to support the National Mental Health Research Agenda	Approved strategic plan for transition of NCMH to research and training facility					Yes			NCMH Report		Annually	NCMH	CSOs tapped for technical assistance in the design and implementation of NCMH's capacity development plan	5,000,000				
5.c Informed Consent																		
Develop guidelines for Informed Consent to Treatment, Exceptions to Informed Consent, Advanced Directives, Legal Representatives and Supported Decision Making	Guidelines for Informed Consent approved			Yes					DOH, CHR			DOH, CHR						
Dissemination of guidelines	Number of regions oriented on the guidelines				17									80,000				
5.d Informed Consent																		
1. Appoint focal CHR commissioner for MH	Issuance appointing focal commissioner for MH signed by CHR			Yes					CHR									
2. Develop guidelines for the creation of IRB	IRB Guidelines approved			Drafted	Approved				DOH									
3. Monitoring of compliance to the guidelines for the creation of the IRB	Number and percentage of health facilities with IRB created				8 Pilot Implementation Sites	100% DOH-retained and Level 3 hospitals, 1 private facility in 8 regions	100% DOH-retained and Level 3 hospitals 1private facility in 12 regions,	100% DOH-retained and Level 3 hospitals and 1 private facility in 17 regions	CHR		Annually	DOH HFSRB		120,000	120,000	120,000	120,000	
4. Develop and conduct training and for IRB members (5 modules)	Proportion of IRB members trained				100%				DOH, CHR	Numerator: Number of persons trained Denominator: Number of members of IRBs created in target facilities	Annually	DOH, CHR		381,000	419,100	461,010	507,111	
5. Monitoring and assessment of performance of IRB														120,000	120,000	120,000	120,000	
5.e Regional mental health councils																		
Establish regional mental health councils	Number of regional mental health councils formed through the Regional Development Council				4	8	12	16	DOH Reports	Count	Annual	DOH		1,052,800				
6. Monitoring and evaluation of policies, plans, programs, and services	Proportion of NGAs who meet agency targets in their agency scorecard to the PCMH				50%	70%	90%	100%	PCMH Scorecard	Numerator: Number of NGAs meeting at least 50% of their targets (green light) Denominator: Number of NGAs in PCMH scorecards	Quarterly	PCMH						

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023
Mental Health Services

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
OUTCOME																		
3. Improved access to mental health services in all levels of care	Proportion of LGUs (municipalities and cities) providing mental health services (%)	2019	RIS/ KMITS		15%	30%	45%	60%	DOH	Count	Annual		Assumptions: MH indicators will be integrated into the routine health information system in 2022. In the meantime, DOH will provide this data.					
OUTPUTS AND KEY ACTIVITIES																		
1. Design the community-based mental health program	AO/ MOP on guidelines for the design and implementation of community-based mental health care developed, including: • Facility standards at the community, primary, secondary, and tertiary levels (stepped care model) • Services standards: clinical, psychosocial, MHPSS, drug treatment and rehabilitation and management of co-morbidities, support services for survivors of extreme life experiences (i.e. disaster, violence, etc.) other services (social services, nutrition, family support, accommodations, hospice care, etc.) • Human resources standards (including task-sharing guidelines) and trainings • Logistics • Algorithms of the service user process flow from inpatient mental health facility care to primary outpatient community-based care • Collection and reporting of service statistics	2019	No		Yes				Manual of Procedures	Yes/No		DOH						
a. Needs assessment of mental health and psychosocial needs of different populations, families, couples, individuals across life span in health and non-health sectors	MH needs of service users from DepEd, CHED, DOLE, DILG, CSC, DOH, DSWD & PSA have been identified, including: • quality gaps • quantity gaps • capacity gaps • financial gaps	2019	No		Yes				Needs Assessment Report		Updated every 5 years as part of planning cycle	PCMH	DOH will design and lead study. All agencies will collect data from their stakeholders based on standard tools.	2,000,000				DOH
b. Convene TWG to design primary outpatient community-based care					Yes									2,000,000				
2. Build human resource capacity for MH	Increased percentage of RHUs with staff trained on contextualized mhGAP-IG	2016	27%			50%	75%	100%	DOH Report	Number of RHUs with at least one MD, RN, or RHM who completed mhGAP-IG training divided by the total number of RHUs in the country	Annual	DOH						

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
a. Training of primary care staff in the evidence-based MH care standardized primary care training modules (traditional/ nontraditional) prioritizing GIDA.	Number of LGUs with trained primary care staff in the evidence-based MH care standardized primary care training modules (traditional/nontraditional) prioritizing GIDA: a. Doctor b. Nurse c. Midwife	2016	751 MDs 535 RNs 19 RMs 18 Others		243	567	972	1634	MH Program Reports	Count	Annual	DOH	All Provinces train at least 3 LGUs per year	6,561,000	8,748,000	10,935,000	17,874,000	
d. Post-training, mentoring, monitoring, and supervision of primary care staff trained with evidence-based MH care standardized primary care training modules (traditional/ nontraditional) prioritizing GIDA.						Yes	Yes	Yes	MH Program Reports	Yes/No	Annual	DOH	Regional coordinators monitor trained staff twice a year.	8,500,000	8,500,000	8,500,000	8,500,000	
e. Development of basic medical curriculum for psychiatry, psychology, and neurology subjects						Yes			Document of medical undergraduate curriculum	Yes/No		CHED (Technical Committee on Medical Education), MH Experts						
f. Inclusion of psychiatry, psychology, and neurology in the medical and allied health curriculum						Yes				Yes/No		CHED (Technical Committee on Medical Education), MH Experts						
g. Development of course-related mental health curriculum for allied health courses						Yes				Yes/No		CHED (Technical Committee on Medical Education), MH Experts						
h. Convene MH professionals, CHED, PRC, CSC and other stakeholders to develop a strategy for increasing the number of MH professionals and strengthening their career progression					Yes					Yes/No		DOH, PPA, PAP, PGCA, PNA						
3. Build human resource capacity for MH																		
a. Provide guidance for LGUs to set up MH care provider networks and referral systems	AO/ Guidelines for setting up Mental Health Care Provider Network and Referral Systems involving public and private health and non-health sectors issued by DOH				Yes				AO Document	Yes/No	Every 5 years	DOH	Assumption: Establishment of HCPNs is part of the ongoing process of implementing the UHC Law and DOH will ensure that multi-sectoral MH services are included in the HPCNs.					
b. Set Up MH Care Provider Network and Referral Systems within the UHC system involving Public and Private Health and Non-Health Sectors														1,176,000	1,293,600	1,422,960	1,565,256	
4. Strengthened MH and wellbeing services in primary, secondary, and tertiary health care																		
a. Mental Health care is integrated in basic health and social services	Number of Medicine Access Sites in primary care	2019	133		150	300	450	600	DOH	Count	Annual	DOH		168,000,000	470,400,000	846,720,000	1,317,120,000	
b. Establish MH services in all DOH-retained hospitals	Number of hospitals with Emergency Psychiatric and Neurologic Services and/or Acute Psychiatric/Neurologic Units	2019	14			21	28	37		Count	Annual	DOH			51,800,000	51,800,000	66,600,000	

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
c. Develop evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.)	Evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.) developed				Yes							DOH, MH Experts		5,000,000				
d. Training of HRH on evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.)	Number of hospitals with trained HRH on evidence-based standardized modules for psychiatric and neuro emergencies (acute psychosis, etc.)				14	21	28	37						1,890,000	945,000	945,000	1,215,000	
e. Develop innovative ways of providing MH services, e.g. telepsychiatry	Number of regional/ national teleclinical service delivery network	2019	1			1	3 (Luzon, Visayas, Mindanao)	1 per region		Count	Annual	DOH			7,000,000	21,000,000	98,000,000	
f. Improve access to medications for priority MNS conditions	Medications for priority MNS conditions listed in the PNF	2019	Yes							Yes/No	Annual updates	DOH						
	A system for an efficient, effective, and sustainable supply chain of quality medicines for MH conditions within the context of the community including pre-positioning of drugs during disasters is developed and implemented				Yes					Yes/No	Once	DOH						
5. Integration of MH and wellbeing services at all levels of health and non-health sectors																		
a. Development of evidence-based standardized training module(s) for non-professional mental health service providers (BHWs, teachers, HR officers, etc.) contextualized in the local setting						Yes				Yes/No		DOH			5,000,000			

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
b. Training of non-MH professional service providers on evidence-based standardized training module (traditional/nontraditional) contextualized in the local setting with initial priority on GIDA	Number of LGUs with trained BHWs					324	729	1134	DOH	Count	Annual	DOH			26,244,000	32,805,000	32,805,000	
	Number of MH service providers in the workplace (e.g. HR staff) trained								DOH, CSOs, and MH providers	Count	Annual	DOLE CSC	Assumptions: Private companies seek CSOs to provide MH training for their staff. LGUs to fund and implement the training program as part of the inclusion of MH in their local development plans for sustainability. LGUs may collaborate with DOH,DOLE & CSC on the conduct of training						
	Number of school personnel trained on: • Supporting Enabling and Empowering Students (SEES) manual on PFA • MHPSS • School-based MH Program								DepEd	Count	Annual	DepEd	Training on School-based MH will be provided for in DepEd's Guidelines for Promotion of MH and Wellbeing among educators and learners.					
	Number of college/university personnel trained on ___								CHED	Count	Annual	CHED						
	Number of vocational educational institution personnel trained on ___								TESDA	Count	Annual	TESDA						
	Proportion of police, jail officers, fire officers, and others trained				25%	50%	100%		DILG	Count	Annual	DILG	Assumptions: CSC will issue Guidelines on the Implementation of MH law by all government agencies to facilitate conduct of these interventions.					
c. Training of lay persons on community-based intervention for behavioral emergencies (Tulong, Alalay, Gabay module)					243	567 (additional 4 per province)	972 (additional 5 per province)	1634	DOH	Count	Annual	DOH		65,610,000	87,480,000	109,350,000	174,960,000	
d. Develop directory of self-help groups as support to primary care service per geographic area and area of interest					Yes						Update annually	DOH						

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
e. Provide MH services in workplaces, schools, and other settings	Basic Education: Number of students affected by armed conflict and natural disasters provided MHPSS and PFA in schools								DepEd		Annual	DepEd						
	Higher Education:								CHED		Annual	CHED						
	Vocational Education:								TESDA		Annual	TESDA						
	Government Workplaces:								CSC		Annual	CSC						
	Police stations and jails: Proportion of police stations and jails providng MH services				25%	50%	100%		DILG		Annual	DILG	Assumptions: CSC will issue Guidelines on the Implementation of MH law by all government agencies to facilitate conduct of these interventions.					
	Provision of MH services in the 71 DSWD centers/residential care facilities and field offices and DSWD's Human Resource Services								DSWD		Annual	DSWD		5,500,000	5,500,000	7,000,000	7,000,000	
6. Development of a national suicide prevention strategy	Decrease suicide mortality rate (per 100,000 population)	2017	3.2		Establish national baseline				PSA	No. deaths from suicide divided by total no. deaths multiplied by 100,000	Every 5 years	DOH						
a. Develop policies and guidelines on: • establishing hotlines and suicide prevention strategies • process flow for emergency health care response team for persons in suicide crisis situations and linking to emergency and support services					Yes					Yes/No		DOH			5,000,000			
b. Develop evidence-based standardized training module for emergency mental health care responders for persons in suicide crisis situations						Yes				Yes/No		DOH	Assumption: MH experts will be sources of technical assistance.		5,000,000			
c. Train first responders, health professionals and volunteers on evidence-based standardized training module for emergency mental health care responders for persons in suicide crisis situations	Number of first responders, health professionals and volunteers trained in suicide prevention and management					100	150	250	Training reports	Count	Annual	DOH			1,800,000	2,700,000	4,500,000	
d. Deveop guideleines for mainstreaming of suicide prevention in public health education and within other priority health programs (e.g. HIV/AIDS, adolescent and youth health, NCD) as well as in special settings such as schools, workplace, and disaster areas					Yes				Suicide prevention guidelines	Yes/No	Every 10 years	DOH	Assumption: Guidelines to be adopted by DOLE, CSC, DepEd, CHED, TESDA, DILG					
e. Establish a system for suicide surveillance						Yes				Yes/No		DOH			5,000,000			
7. Develop a Care for Carers Program, including training, debriefing of persons exposed to traumatic incidents						Yes			Carers Training Module	Yes/No		DOH, PAP, other MH Experts	Assumption: WHO evidence-based standardized training modules for mental health carers will be contextualized in the local setting.					

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023
Information and Research

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
OUTCOME																		
4. Increased availability, accessibility and utilization of evidence-based Mental Health Data	Proportion of LGUs (municipalities and cities) routinely collecting and reporting MH data to the PCMH (%)	2019		RIS/ KMITS	15%	30%	45%	60%		**DOH**	Count	Annual						
OUTPUTS AND KEY ACTIVITIES																		
1. MH-related information from current agency information systems are reported												All other agencies						
	Cases of violation of human rights in relation to MH are reported				Yes				CHR MAREIS			CHR	Assumption: CHR is performing its mandates under the Section 32-33					
	DOLE to report compliance of establishments using the Labor Inspection MIS	2019	No		Yes				DOLE LIMIS	Yes/No		DOLE	DOLE LIMIS (labor inspection management information system) is focused on enforcement and inspection activities					
	Suicide attempts and completed; number of personnel trained in PFA; and number of cases of bullying are reported				Yes				DepEd BEIS									
2. MH information is integrated in the national health information system							Pilot	Institutional-ization	DOH CO	Yes/No	Bi-annual	NCMH	Assumptions: There are existing general health information systems (iClinicSys, iHOMIS, NCMH, FHSIS) but are fragmented. KMITS is developing a national health information system for UHC. Monitoring of implementation to be done by the concerned agencies. Risk: Data Privacy Law may retard data collection/ sharing.	9,000,000	6,500,000	6,500,000	6,500,000	
a. Revisit of existing MHIS and resource mapping																		
b. Dialogue between data users and producers to take stock of their needs: Convene government health and non-health sectors and CSOs to define data needed for program monitoring, e.g. suicide as a notifiable disease, fiscal capacity of hospitals																		
c. Design algorithm for data flow (include private facilities, non-health; data producers and users)																		
d. Establish IT infrastructure (hardware and software)																		
e. Issue JMC/JAO on Guidelines/ MOP for reporting MH data in national health information system and PCMH Scorecard																		

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
f. Train data producers and users on reporting MH data in national health information system in a way that is consistent with human rights conventions																		
g. Engage the LGUs in establishing a community surveillance of specific mental disorders, including suicide																		
3. A national mental health research agenda is adopted and institutionalized towards developing a culturally relevant national mental health program incorporating indigenous concepts and practices.	Number of MH researches completed in line with the research priorities in the agenda						1	1 per region	WAPR, PCHRD, NCMH, PMHA, Academe, Professional groups, Regional Consortia	Count	Bi-annual	DOH, NCMH, Regional Consortia, PCHRD	**Assumption:** There is an existing Mental Health Agenda funded by PCHRD **Risk:** NCMH to become a general hospital	27,500,000	38,500,000	35,500,000	32,500,000	
a. Collaborate with PCHRD and NCMH in the development and implementation of a national research agenda on MH, including frequency of updating the national research agenda				Yes						Yes/No								
b. Disseminate national research agenda on MH to research institutions				Yes	Yes					Yes/No								
c. Call for proposals					Yes	Yes				Yes/No								
d. Conduct studies and disseminate results					Yes	Yes	Yes	Yes		Yes/No								
4. Central repository of MH researches is established												NCMH	**Assumptions:** NCMH, under the law, is mandated to transform into a research institution; as yet it does not have a database or researches. Data producers & users would be willing to collaborate **Risks:** NCMH to become a general hospital. Need for more funding for data storage (i.e. rental of cloud rental space). "	109,000,000	49,000,000	42,000,000	42,000,000	
a. Issue policy directive on submission and access to research reports and data on MH to NCMH																		
b. Issue policy directive to establish a network of data producers & data users to improve linkages and multisectoral (academe, social science community) collaboration in the conduct of researches on MH, including operations research and alternative interventions																		
c. Establish a functional database																		

	Indicators	BASELINE		TARGETS					MODE OF VERIFICATION			AGENCY	ASSUMPTIONS AND RISKS	BUDGET REQUIREMENTS				fund-ing
			Val-ue	2019	2020	2021	2022	2023	Source of Data	Formula	Frequency of Reporting			2020	2021	2022	2023	
d. MH research reports submitted by end users																		
5. Updated epidemiological data on MH are regularly generated, including prevalence data of the priority mental health conditions, risks, and their determinants, across the life-course: • suicide & self harm • depression • schizophrenia and bipolar • disorders • substance abuse • anxiety • epilepsy • dementia • developmental disorders • persons with or at-risk for MH concerns, e.g. adverse life events, chronic diseases, etc.												DOH	Risk: Delay in the completion of studies	14,000,000	31,000,000	23,500,000	23,500,000	
a. PCMH to establish intervals for the conduct of epidemiological studies				Yes														
b. Completion of prevalence studies to enable estimation of disease burden					Yes													
c. Improvements of methodology							Yes											
d. Second round of epidemiologic studies								Yes										
e. Convene government health and non-health sectors and CSOs to define data needed for integration into NDHS and other relevant national surveys					Yes													
f. Lobbying & advocacy with PSA for inclusion of MH data in national surveys						Yes							**Assumption:** PSA would be amenable to the inclusion of MH data in national surveys **Risk:** Feasibility of inclusion					
g. Sign MOA between NCMH and PSA re: inclusion of MH data in NDHS							Yes											

Annex 4:

NATIONAL MENTAL HEALTH STRATEGIC PLAN 2019-2023
Budget Summary

STRATEGIC PILLARS	BUDGET (PHP)				
	2020	2021	2022	2023	TOTAL
MENTAL HEALTH PROMOTION	6,100,000	5,500,000	12,000,000	8,800,000	32,400,000
GOVERNANCE AND LEADERSHIP	31,308,400	2,923,000	9,091,300	8,276,430	51,599,130
MENTAL HEALTH SERVICES	262,737,000	653,592,600	1,024,941,963	1,589,354,256	3,530,625,819
INFORMATION AND RESEARCH	159,500,000	125,000,000	107,500,000	104,500,000	496,500,000
TOTAL	459,647,420	787,017,621	1,153,535,285	1,710,932,709	4,111,133,035

Annex 5:

Performance Standards

The performance scorecards are electronic tools that reflect the overall as well as stakeholder- / agency-specific accountabilities towards delivering the results spelled out in the National Mental Health Strategic Plan 2019-2023. The status of achievement of the indicators and targets in the Strategic Plan are meant to be monitored, updated, and reported on a quarterly basis so that they feed into the regular meeting agenda and serve as an evidence-based decision support system of the Philippine Council for Mental Health (PCMH) and its member-agencies. There are currently thirteen scorecards which will document the contribution of the following stakeholders in realizing the goals of the National Mental Health Act:

1. Overall/Consolidated Performance Scorecard
2. Philippine Council for Mental Health (PCMH) Scorecard
3. Department of Health (DOH) Scorecard
4. National Center for Mental Health (NCMH) Scorecard
5. Philippine Health Insurance Corporation (PHIC) Scorecard
6. Department of Labor and Employment (DOLE) Scorecard
7. Department of Interior and Local Government (DILG) Scorecard
8. Department of Education (DepEd) Scorecard
9. Commission on Higher Education (CHED) Scorecard
10. Technical Education and Skills Development Authority (TESDA) Scorecard
11. Department of Social Welfare and Development (DSWD) Scorecard
12. Civil Service Commission (CSC) Scorecard
13. Commission on Human Rights (CHR) Scorecard

Each agency scorecard consists of an overall performance dashboard (for both results and financial delivery) as well as outcome-specific performance tracking sheets. The latter provides a per-indicator, per-target, and per-budget line account of what has been accomplished vs. planned. Where targets were either not met or even partially met, the template likewise asks the agency to describe in detail the actions initiated, if any, to address its targets and the extent of progress made towards achieving the targets so far.

The scorecard employs a simple “traffic light” system for reflecting performance and is meant to facilitate analysis of where relative progress has been made and where gaps persist in order to prioritize/focus the succeeding actions, plans, and decisions of PCMH and the rest of the stakeholders:

Traffic Light	Performance Level	Relative Status and Action Point
	Target not met (i.e. only 0-50% achieved); if the target is qualitative, a “red” means that no significant action has been initiated to achieve the objective	Comparative weakness in performance and the need for substantial efforts for improvement
	Target partially met (i.e. 51-79%); if the target is qualitative, a “yellow” means significant action has been initiated and some progress has been made to achieve the objective	Comparatively good performance that must be maintained and optimized to reach target goals
	Target substantively met (i.e. 80-100%); if the target is qualitative, a “green” means significant progress has been made to achieve the objective	Comparatively excellent performance that merits actions to sustain high level of delivery
	Target has no performance data available	Need for data completion / submission
	Target not applicable for the period being monitored	

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
GOAL									
1. Mental health and wellbeing is valued, promoted, and protected									
1.1.Proportion of the population, by age and sex, who:	TBD (on-going 2021; with UP-CPH AHEAD Project)					Preparations for the Survey; Survey Reports	• Survey commissioned/awarded to UPCPH; • Funding assured from DOH-PCHRD; • Inception Reporting already conducted		DOH
a. Practice self-care (stress management, physical activity, avoidance of alcohol and dangerous drugs);		TBD	TBD						
b. Seek Mental Health services for psychosocial concerns;		TBD	TBD						
c. Recognizes (knowledge, attitude and practices) that persons with mental disorders should be treated humanely.		TBD	TBD						
1.2. MH policies and programs are integrated in national and local plans and programs:									
1.2.1. Number of national government agencies implementing their mandate in accordance with the Mental Health Act	0 (2019)	10	10			Annual Reports; Master List based on MH Act	• All Implementing NGAs (CHED, CHR, CSC, DepEd, DILG, DOH, DOLE, DSWD, TESDA, NCMH, PhilHeath)		PCMH DOH
1.2.2. Proportion of national government agencies implementing the mental health workplace policy based on the policy issued by CSC (MC 04, s.2020 & MC01: on OSH)	0		60% (22 NGAs including PCMH Members)	80% (27 of NGAs including PCMH)	100%	Annual Reports Master List of NGAs Policy Issuance	• All Implementing NGAs		CSC in collaboration with all NGAs
1.2.3. Number of provinces, cities, and municipalities implementing their local mental health ordinance	0	0	59 (all UHC Implementation Sites)	32 prov; 58 cities	40 prov; 73 cities	Annual Reports Master List of Provinces, Cities, and Municipalities Joint Memo Circular			DILG DOH

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
1.2.4. (Proxy) Number and proportion of provinces, cities, and municipalities implementing/trained in mhGAP						Post-activity Report Census/ Master List	• total of 1,259: 76 cities, 1,183 municipalities implementing/trained in mhGAP		DOH
1.2.5. (Proxy) Number and proportion of provinces, cities, and municipalities accredited as Medicine Access Program access site as defined by its Administrative Issuance		All Provinces Per Region 3 Mun. 1 City (until 2023)				RIS of MAP Access Sites	• total of 362 access sites: • 64 cities; 32 provinces and 266 municipalities accredited as MAP Access Site		
2. Mental health conditions are identified, treated and prevented									
2.1. Proportion of persons with mental disorders (psychosis, depression, anxiety disorders, substance use) and epilepsy who are using services (%)	*TBD** **as part of the SIMH M&E Framework*	*TBD**	*TBD**			Annual Reports CHD Reports			DILG DOH
2.2. (Proxy) Proportion of persons with mental disorders (psychosis, depression, anxiety disorders, substance use) and epilepsy who are accessing MAP-MH sites						Annual Report RIS of MAP Access Sites, Census / Master List	• Psychosis (Schizophrenia): 78,348 • Anxiety Disorder: 64,317 • Mood disorder: 19,754 • Dementia: 1,599 • Epilepsy: 7,926 • Substance Abuse Disorders: 10,093		DOH
3. Persons affected by mental health conditions are able to exercise the full range of human rights									
3.1. Number of facilities providing MH care with a functioning IRB	0		8 *(pilot sites)*	100% DOH-retained Level 3 hospitals; 1 private hospital in 8 Regions	100% DOH-retained hospital (All levels)	Annual Reports Master List of DOH-Retained Hospitals (all levels)	• 8 IRB Pilot Sites		DOH

0-50% No significant action initiated *51-79% Significant action has been initiated and some progress has been made* *80-100% Significant progress has been made*

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
OUTCOME									
1. Improved practices on mental health and wellbeing in schools, workplaces, and communities									
1.1. Proportion of public schools monitored as to the implementation of the DepEd order on MH	0	5%	10%	15%	30%	Administrative Issuance (Memo, Order) *to be confirmed with DepEd Monitoring Tool			DepEd
1.2. Proportion of surveyed population, by age and sex, who practice self-care, seek Mental Health services for psychosocial distress, and believe that persons with MH disorders should be treated humanely	TBD	TBD	TBD			Survey data (UP-CPH) Reports			PCMH
1.3. Proportion of public and private colleges and universities monitored with MH policies, wellness programs and trained mental health service providers	0	25%	50%	75%	100%	Monitoring Reports Annual Reports Administrative Issuance (Memo, Dept. Order) Monitoring Tool			CHED
1.4. Proportion of public and private vocational education institutions monitored with MH policies and wellness programs, and trained mental health service providers	0	183 Public	50%	75%	100%	Monitoring Reports Annual Reports Administrative Issuance (Memo, Dept. Order) Implementing Guidelines for Mental Health Monitoring Tool	• For private and public focal persons capacity building programs (workplace and students)* **accomplishments based on number of public institutions*		TESDA

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
1.5. Proportion of national government agencies implementing the mental health workplace policy based on the policy issued by CSC (MC 04, s.2020)	0		60%	80%	100%		Establishment of Mental Health Program, pursuant to CSC MC No. 4, s. 2020 re: Mental Health Program in the Public Sector;		CSC in collaboration with all NGAs
1.6. Proportion of private companies inspected with MH policies and wellness programs as issued by DOLE in Department Order No. 208, series of 2020: " Guidelines for the Implementation of Mental Health Workplace Policies and Programs for the Private Sector"	0	5%	25%	50%	75%	Inspection / Monitoring Reports	• Accomplishment Report (89.9% compliant as of 30 June 2021)		DOLE
2. Strengthened effective leadership and governance for MH									
2.1. Government's total allocation for mental health as % of total government health expenditure	2.65%	2.75%	3.5%	4.25%	5%	Budget Allocation GAA	**2020** • MH drugs=114,986,624 • MH program=81,164,560 • % of NMHP budget to DOH total Budget= 3.07% **2021** • MH drugs=165,965,828.60 • MH program=120,000,000 • % of NMHP budget to DOH total Budget= 3%		DOH
2.2. Number of national government agencies with programs and plans addressing the Mental Health needs of their stakeholders ** to be revisited						NGA Reports			PCMH

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
3. Improved access to mental health services									
3.1. Proportion of LGUs (provinces, municipalities and cities) providing mental health services (%) *cross-reference with Goal level indicator (1.2.4)	TBD	15%	30%	45%	60%	LGU Reports			DILG DOH LGUs
4. Increased availability, accessibility and utilization of evidence-based Mental Health Data									
4.1 Proportion of LGUs (municipalities and cities) routinely collecting and reporting MH data to the PCMH (%)	TBD	15%	30%	45%	60%	LGU Reports (paper-based or electronic through iClinicSys) MH Registries of CHDs			DILG DOH LGUs
5. Sustainable mental health (MH) governance and accountability structure supports the operationalization of the Mental Health Act, promoting and financing the scale up of services and protection of human rights									
5.1. Mental Health Ordinance as one of the metrics on the Seal of Good Local Governance				**included**		LGU Scorecard DILG Report			DILG
5.2. Number of persons who received mental health interventions where: Advanced Directive is explained to service user / patient and Informed Consent is documented						IRB Report			MHO/ CHO, Hospitals, All MH Facilities DSWD

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
6. Access to comprehensive, integrated and quality psychiatric, neurologic, psychosocial, and social care services across all settings especially in community-based settings									
6.1. Service coverage for people living with mental health conditions disaggregated according to local government unit, target conditions below, service user/patient profile, PhilHealth membership, utilization of PhilHealth benefit package (inpatient and outpatient), services received, MAP-MH enrolment, settings (community, primary care, general hospital, specialist), number of follow ups (face-to-face and digital)						Results of the prevalence study iClinicSys, HOMIS, PhilHealth Report, DDAPTP Report			Independent study through PCHRD RHUs Hospitals PhilHealth LGU
6.2. Number of service users enrolled in MAP-MH (per locality) *cross reference with Goal indicator 2.3 (proxy)						RHU Report CHD Report			RHUs Hospitals
6.3. Number of persons with psychosocial, mental and intellectual disabilities, in accordance to Republic Act No. 10754, who received disability benefits						DSWD Report DOH Report			All LGU through DILG
6.4. Number of persons with MNS conditions identified and received services through other DOH Programs: Maternal and Child Health, Tuberculosis, HIV, Cancer or End-Stage illness						DOH Program Report			DOH
6.5. Number of people from the emergency affected population (general public, health workers, people living with mental health conditions) due to disasters, man-made conflicts, or pandemics, who received psychosocial interventions: Psychosocial Counselling, Social Amelioration Program, and Unemployment Benefits						Post-activity Report Census / Master List Annual Reports			CHO/MH, DSWD, DOLE- OWWA, CSC, SSS *through MHPSS Cluster

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

Indicators	Baseline	Target				Means of Verification	Objectively Verifiable Indicators	Status	Agency
		2020	2021	2022	2023				
6.6. Percent (%) Treatment coverage for selected mental, neurological and substance use disorders in areas where affordable, quality mental health services are offered **cross reference with Goal indicator 2.2						iClinicSys, HOMIS, PhilHealth Report, DDAPTP Report			RHUs Hospitals PhilHealth LGU
7. Strengthened mental health research, evidence generation and utilization, and information systems									
7.1. % of BHS, RHUs and hospitals using standard information system						PHO Report			PHO
7.2. Number of translated researches to policy, guidelines or guidance document (evidence-guided planning)						DOH Report Policy Issuance/ Documents			DOH

0-50% No significant action initiated

51-79% Significant action has been initiated and some progress has been made

80-100% Significant progress has been made

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