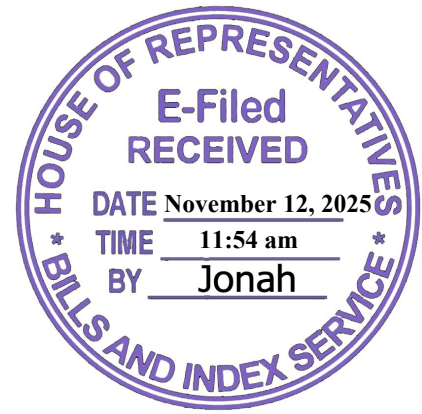


Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City, Metro Manila

TWENTIETH CONGRESS
First Regular Session

House Bill No. **5901**



Introduced by Honorable Ma. Alana Samantha Taliño Santos

AN ACT INSTITUTIONALIZING A NATIONAL MENTAL HEALTH CRISIS RESPONSE SYSTEM, MANDATING MINIMUM MENTAL HEALTH SERVICES IN SCHOOLS AND WORKPLACES, PROVIDING A DEDICATED FUNDING MECHANISM FOR COMMUNITY-BASED MENTAL HEALTH PROGRAMS, AND FOR OTHER PURPOSES

EXPLANATORY NOTE

The passage of Republic Act No. 11036, or the "Mental Health Act," marked a significant milestone in the promotion and protection of mental health in the Philippines. The Act established the right of every Filipino to mental health, mandated the integration of mental health services at all levels of the health system, and required the establishment of suicide prevention hotlines and community-based mental health programs (RA 11036 (2018)).

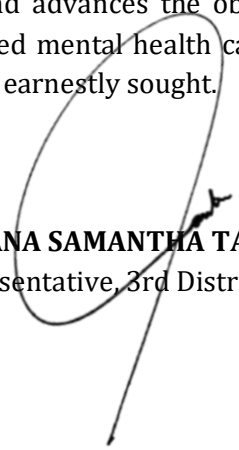
However, the COVID-19 pandemic, natural disasters, and increasing reports of mental health emergencies have exposed critical gaps in the country's mental health crisis response infrastructure. While Section 21 of RA 11036 requires the establishment of 24/7 hotlines for suicide prevention, it does not mandate a single, interoperable, and easily accessible 3-digit national hotline. The current system is fragmented, with multiple hotlines operated by various agencies and organizations, leading to confusion and delayed response during mental health crises.

Moreover, RA 11036 does not provide for the creation of regional command centers to coordinate crisis response, nor does it require the establishment of 24/7 multidisciplinary mobile crisis teams capable of providing immediate, on-site intervention for individuals experiencing acute mental health emergencies. Sections 15 and 16 of the Act focus on community-based services and facilities, but do not address the need for rapid, coordinated, and specialized crisis intervention.

The absence of a unified, nationwide crisis response system results in uneven access to emergency mental health care, particularly in geographically isolated and disadvantaged areas. Individuals in crisis, their families, and communities are often left without timely and appropriate support, increasing the risk of harm, suicide, and escalation of psychiatric emergencies.

This bill seeks to address these gaps by establishing a National Mental Health Crisis Response System. The proposed measure mandates the creation of a national, interoperable 3-digit mental health crisis hotline, the establishment of regional command centers, and the deployment of 24/7 multidisciplinary mobile crisis teams. These reforms aim to ensure that every Filipino, regardless of location, has immediate access to life-saving mental health crisis intervention and support.

By strengthening the country's mental health crisis response infrastructure, this bill upholds the right to mental health, promotes public safety, and advances the objectives of RA 11036 to provide comprehensive, integrated, and rights-based mental health care for all. In view of the foregoing, the immediate passage of this measure is earnestly sought.



MA. ALANA SAMANTHA TALIÑO SANTOS
Representative, 3rd District of Cotabato

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

SECTION 1. **Short Title.** — This Act shall be known as the “National Mental Health Crisis Response Act.”

SECTION 2. **Declaration of Policy.** — It is the policy of the State to protect and promote the right to mental health of all persons and to improve the quality of life of individuals and communities by ensuring timely, equitable, and rights-based crisis care. This Act operationalizes the policy in Republic Act No. 11036 by establishing a unified crisis response system with clear standards, minimum services in schools and workplaces, and dedicated funding for community-based programs.

SECTION 3. **Definition of Terms.** — As used in this Act: (a) Mental health crisis refers to any situation in which a person’s thoughts, feelings, or behaviors put them at risk of harm to self or others, or otherwise severely compromise their ability to care for themselves or function in the community, requiring rapid intervention. (b) Crisis response services include 24/7 hotlines, text/chat services, tele-triage, mobile crisis teams, behavioral health urgent/observation care, and post-crisis follow-up and linkage to treatment. (c) Mobile Crisis Team (MCT) refers to a multidisciplinary team (e.g., psychiatrist or physician, psychologist, nurse, social worker, and trained peer specialist) that provides on-site, de-escalation, assessment, brief interventions, and care coordination. (d) Schools include all public and private basic education schools, SUCs/LUCs, HEIs, and TVET institutions. (e) Workplaces include all public sector agencies and private establishments covered by the Labor Code. (f) Community-based mental health program refers to services provided at primary care and community levels, including barangay-based psychosocial support, counseling, family education, rehabilitation, and peer support.

SECTION 4. **Creation of the National Mental Health Crisis Response System (NMHCRS).** —

- (a) **Lead and Governance.** — The Department of Health (DOH), through the Philippine Council for Mental Health (PCMH), shall establish and oversee the NMHCRS. The PCMH shall serve as the national crisis command, with the NDRRMC, DILG, DepEd, CHED, TESDA, DOLE, CSC, DSWD, DICT, PhilHealth, and the National Privacy Commission as members.

(b) National Hotline. — The DOH, in coordination with the DICT, shall operate a single, easy-to-remember, three-digit national mental health crisis number that integrates voice, SMS, and digital chat channels, interoperable with 911 and LGU hotlines. Calls shall be free of charge on all networks.

(c) Regional Crisis Command Centers. — DOH Centers for Health Development shall host regional command centers to triage, dispatch MCTs, coordinate facility referrals, and monitor response times and outcomes.

(d) Response Standards. — The PCMH shall adopt service levels including: (1) call answer within 20 seconds; (2) tele-triage by a qualified counselor within 2 minutes; (3) MCT dispatch within 15 minutes in urban areas and 30 minutes in rural/GIDA settings, subject to local geography; and (4) post-crisis follow-up within 24–72 hours.

(e) Interoperability. — The DICT shall issue technical standards for data exchange, geolocation, and secure referrals among hotlines, EMS, LGUs, hospitals, and community providers.

SECTION 5. Mobile Crisis Teams (MCTs) and Facility Network. —

(a) Every province, highly urbanized city, independent component city, and cluster of municipalities shall maintain at least one MCT per 300,000 population, operating 24/7.

(b) Each MCT shall be equipped with an emergency vehicle, communication devices, emergency medications, and de-escalation tools; and staffed by at least four trained members per shift, including a health professional authorized to initiate emergency interventions.

(c) DOH shall accredit Behavioral Health Urgent Care/Observation Units in government and private hospitals to accept direct MCT referrals without ER delay, and to provide up to 23-hour observation and stabilization.

(d) DOH and DSWD shall ensure availability of short-stay crisis respite beds and community step-down services.

SECTION 6. Mandatory Minimum Mental Health Services in Schools. —

(a) Every school shall: (1) maintain a learner/staff-accessible crisis point-of-contact during class hours; (2) ensure 24/7 access to the national crisis hotline through posted materials and digital platforms; (3) employ or contract licensed mental health professionals at minimum ratios set by PCMH (to be phased in); (4) implement crisis triage and referral protocols; (5) adopt return-to-learn plans after a crisis; and (6) conduct evidence-based gatekeeper training for teachers and student leaders annually.

(b) DepEd, CHED, and TESDA, in coordination with DOH, shall issue implementing standards aligned with this Act and integrate them in accreditation and quality assurance.

SECTION 7. Mandatory Minimum Mental Health Services in Workplaces. —

(a) Employers shall: (1) provide confidential access to crisis support and referral; (2) ensure dissemination of the national hotline; (3) maintain a crisis response protocol including post-incident debriefing; (4) designate trained mental health first aiders per shift; and (5) adopt return-to-work accommodations after a crisis.

(b) DOLE and CSC shall issue standards, enforce compliance through labor inspections and HR audits, and integrate these in OSH programs.

SECTION 8. Community-Based Mental Health Programs. —

(a) LGUs shall establish or strengthen barangay-level psychosocial support, counseling, family education, substance use disorder interventions, and peer support, aligned with DOH standards.

(b) LGU primary care facilities shall be capable of basic mental health screening, brief interventions, and tele-psychiatry linkages with referral hospitals.

SECTION 9. Financing: Mental Health Crisis Response Fund (MHCRF). —

(a) There is hereby created a special account in the General Fund, the MHCRF, to finance: (1) the national hotline and digital platforms; (2) regional command centers; (3) MCTs, vehicles, equipment, and staffing; (4) school/workplace minimum services; and (5) community-based programs.

(b) Appropriations. — The amount necessary for the initial implementation shall be charged to the current appropriations of DOH and concerned agencies; thereafter, such sums as may be necessary shall be included in the annual General Appropriations Act. The MHCRF shall be automatically appropriated at not less than a formula-based amount per capita, with equity adjustments for GIDAs.

(c) Grants. — DOH shall administer performance-based grants to LGUs, schools, and workplaces that meet or exceed service and quality benchmarks.

SECTION 10. PhilHealth Coverage. — PhilHealth shall develop benefit packages for crisis assessment/stabilization, brief intervention, and post-crisis follow-up, and reimburse accredited MCT dispatch-linked services.

SECTION. 11. Training and Workforce Development. — DOH, CHED, PRC, DepEd, TESDA, and DOLE shall establish curricula and continuing professional development for crisis responders, including de-escalation, trauma-informed care, and suicide intervention.

SECTION 12. Data, Quality, and Privacy. —

(a) DOH shall define key performance indicators and require de-identified reporting on calls received, response times, dispositions, and outcomes.

(b) All processing of personal and health information under this Act shall observe confidentiality and privacy-by-design safeguards and applicable data protection laws and regulations.

(c) Facilities shall maintain incident logs and participate in learning collaboratives to reduce sentinel events.

SECTION 13. Coordination with Law Enforcement and EMS. — DILG, PNP, BFP, and LGUs shall ensure that crisis calls involving public safety are co-responded by MCTs with the least restrictive, health-first approach, and that EMS protocols prioritize stabilization and transfer to appropriate facilities.

SECTION 14. Non-Discrimination and Rights Protection. — All services under this Act shall be delivered in a manner that is least restrictive, culturally sensitive, and consistent with informed consent and patient rights. No person shall be denied crisis care due to inability to pay, age, sex, gender identity, disability, ethnicity, religion, or any other status.

SECTION 15. Incentives and Support for Compliance. — Tax incentives and procurement preferences shall be available for private facilities and employers investing in eligible crisis response infrastructure and services, as defined by DOH and DOF.

SECTION 16. Enforcement and Penalties. —

(a) Administrative sanctions may be imposed by DOH, DepEd, CHED, TESDA, DOLE, CSC, and LGUs for failure to comply with mandatory standards, including fines, suspension of accreditation, or other remedies after due process.

(b) Persistent noncompliance may be grounds for denial or revocation of licenses or permits, consistent with existing laws and regulations.

SECTION 17. Implementing Rules and Regulations (IRR). — Within one hundred twenty (120) days from the effectivity of this Act, the DOH, in consultation with member agencies and stakeholders, shall promulgate the IRR.

SECTION 18. Appropriations for 3-Year Scale-Up. — The NMHCRS shall be phased in over three (3) fiscal years with clear annual targets for hotline availability, MCT coverage, school/workplace compliance, and community program expansion.

SECTION 19. Separability. — If any provision of this Act is declared unconstitutional, the remainder shall not be affected.

SECTION 20. Repealing Clause. — All laws, decrees, orders, and issuances inconsistent with this Act are hereby amended or repealed accordingly. This Act supplements Republic Act No. 11036.

SECTION 21. Effectivity. — This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in two (2) newspapers of general circulation.

Approved,