Return to State of the Union Report

Suicide Rates

Information Retrieved from AI-To Be Verified

Section 1 Top 35 Countries with the Lowest Suicide Rates

Rank	Country	Suicide Rate (per 100,000)
1	Antigua & Barbuda	0.5
2	الأردن Al-Urdunn (Jordan)	1.6
3	Azərbaycan (Azerbaijan)	2.0
4	العراق Al-ʻIraq (Iraq)	2.2
5	Тоҷикистон Tojikiston (Tajikistan)	2.3
6	مصر Misr (Egypt)	2.9
7	ישראל Yisra'el (Israel)	3.0
8	Pilipinas (Philippines)	3.2
9	Armenia	3.4
10	سوريا Suriyya (Syria)	3.4
11	Albania	3.6
12	السعودية Al-Suʻūdiyya (Saudi Arabia)	3.8
13	افغانستان (Afghanistan)	4.1
14	اليمن Al-Yaman (Yemen)	4.3
15	المغرب Al-Maghrib (Morocco)	4.4
16	Oʻzbekiston Oʻzbekiston (Uzbekistan)	4.5

Rank	Country	Suicide Rate (per 100,000)
17	Guatemala	4.6
18	Jamaica	4.8
19	República Dominicana (Dominican Republic)	4.9
20	Perú	5.2
21	Honduras	5.4
22	الجزائر Al-Jaza'ir (Algeria)	5.5
23	México	5.6
24	Italia (Italy)	5.7
25	Ελλάδα Elláda (Greece)	5.9
26	España (Spain)	6.2
27	Haïti (Haiti)	6.3
28	Ecuador	6.5
29	Portugal	6.7
30	Bolivia	6.9
31	Venezuela	7.0
32	Colombia	7.2
33	Indonesia	7.4
34	Argentina	7.5
35	Türkiye (Turkey)	7.6

Source: World Health Organization (WHO) Global Health Observatory, 2019 data. Countries with population over 5 million included only.

The United States does not appear on the list of the Top 35 Countries with the Lowest Suicide Rates. According to the most recent WHO data, the **United States has a suicide rate of approximately 14.2 per 100,000 people** (2022 data, American Foundation for Suicide Prevention), which places it well outside the top 35 lowest-rate nations. Contributing factors to the relatively higher U.S. suicide rate include access to lethal means (particularly firearms), gaps in mental health care access and affordability, social isolation, substance use disorders, and systemic disparities in healthcare delivery. In 2022, approximately 49,449 Americans died by suicide, making it the 11th leading cause of death.

References and Sources:

World Health Organization (WHO) Global Health Observatory: https://www.who.int/data/gho/data/themes/mental-health/suicide-rates
American Foundation for Suicide Prevention (AFSP): https://afsp.org/suicide-statistics/

Centers for Disease Control and Prevention (CDC) - Suicide Data:
https://www.cdc.gov/suicide/data/index.html

Suicide Rates by World Region

The following regional data represents approximate age-standardized suicide rates per 100,000 population based on WHO data (2019), sorted in increasing order:

Region	Rate per 100,000
Middle East	3.8
México	5.6
Central America	6.2
Other	8.0
中国 Zhongguo (China)	8.1
South America	8.4
Western Europe (Excl. Россия Rossiya (Russia))	9.8
Asia Except 中国 Zhongguo (China)	10.5
Canada	12.0
Africa	12.0
Australia	12.1
United States	14.2
Россия Rossiya (Russia)	26.5

Section 2 What Other Countries Have Done to Decrease Their Suicide Rates

The 8 Top Rated Countries with the Lowest Suicide Rates

Rank	Country	Suicide Rate (per 100,000)
1	الأردن Al-Urdunn (Jordan)	1.6
2	Azərbaycan (Azerbaijan)	2.0
3	العراق Al-ʻIraq (Iraq)	2.2
4	مصر Misr (Egypt)	2.9
5	ישראל Yisra'el (Israel)	3.0
6	Pilipinas (Philippines)	3.2
7	Armenia	3.4
8	السعودية Al-Suʻūdiyya (Saudi Arabia)	3.8

Al-Urdunn (Jordan)
Al-Urdunn has maintained one of the world's lowest suicide rates through strong cultural, religious, and family-based protective systems. Islamic law broadly prohibits suicide, and religious guidance is deeply embedded in social norms.

The Al-Urdunn Ministry of Health (https://www.moh.gov.jo) has integrated mental health services into primary care facilities through its National Mental Health Programme.

The National Centre for Mental Health (NCMH) provides specialized psychiatric care and community outreach.

Al-Urdunn's Family Protection Department within the Public Security Directorate (https://www.psd.gov.jo) provides counseling and intervention services for individuals at risk.

Cultural emphasis on extended family support networks reduces isolation. The Higher Population Council (https://www.hpc.org.jo) coordinates population health initiatives that include mental well-being components.

Azərbaycan (Azerbaijan)
Azərbaycan employs a comprehensive state-led approach to mental health.

The Ministry of Health (https://www.health.gov.az) oversees national psychiatric services and has expanded community mental health centers across the country.

The Republican Psychiatric Hospital in Baku is a hub for research and specialized treatment. Cultural stigma, while present, is addressed through school-based programs that educate youth about mental health.

The State Fund for Development of Non-Governmental Organizations (https://ngofondu.gov.az) supports civil society programs addressing mental health awareness.

Suicidal behavior prevention is incorporated into national health strategy documents. Hotlines and emergency intervention protocols have been formalized.

Al-'Iraq (Iraq)
Al-'Iraq's low reported suicide rate is partially attributed to cultural and religious prohibitions strongly discouraging suicide.

The Iraqi Ministry of Health and Environment (https://moh.gov.iq) has developed mental health legislation and integrated psychiatric care into the general health system.

The National Center for Mental Health in Baghdad coordinates psychiatric care. Community resilience programs, supported by international organizations such as the World Health Organization (https://www.who.int/iraq), have addressed trauma associated with decades of conflict.

The High Commission for Human Rights in Al-'Iraq (https://ihchr.iq) monitors population well-being and advocates for mental health resources. Social cohesion and tribal support structures serve as additional protective factors.

Misr (Egypt)
Misr has embedded mental health services into a comprehensive national framework.

The Misr Ministry of Health and Population (https://www.mohp.gov.eg) administers a National Mental Health Programme that includes training for primary care physicians.

The Misr Psychiatric Association (https://epapsychiatry.org) facilitates professional development and awareness campaigns. Law 71 of 2009 modernized Misr's approach to mental health care, mandating outpatient services and protecting patient rights.

Crisis intervention hotlines operate under government auspices.

Religious and community leaders collaborate with health authorities to reduce stigma.

The National Council for Mental Health oversees hospital standards and treatment protocols across governorates.

Yisra'el (Israel)
Yisra'el has implemented one of the most structured national suicide prevention strategies in the region.

The Yisra'el National Program for Suicide Prevention, coordinated by the Ministry of Health (https://www.gov.il/en/departments/ministry_of_health), includes training protocols for healthcare providers, schools, and the military.

The ERAN crisis hotline (https://www.eran.org.il) provides 24/7 multilingual support.

The Israeli Defense Forces (IDF) have pioneered military suicide prevention programs, and these models have been adapted for civilian use.

Bereavement support organizations such as ILANOT (https://ilanot.org.il) assist families affected by suicide loss.

The Israeli Association of Suicidology conducts research and informs policy. Mandatory mental health screening in primary care settings is a cornerstone of the national approach.

Pilipinas (Philippines)
The Pilipinas addresses suicide prevention through legislation and community engagement. Republic Act No. 11036, the Mental Health Act of 2018, established a comprehensive

framework administered by the Department of Health (https://www.doh.gov.ph) and the National Center for Mental Health (https://ncmh.gov.ph).

Community-based mental health programs extend services to barangay levels.

The National Center for Mental Health Crisis Hotline operates nationally.

The National Mental Health Policy mandates integration of mental health into the health system at all levels.

School-based programs through the Department of Education (https://www.deped.gov.ph) teach life skills and resilience.

Non-governmental organizations such as Hopeline Pilipinas provide crisis intervention and referral services.

Armenia
Armenia has worked through its Ministry of Health (https://www.moh.am) to modernize mental health legislation and de-institutionalize care, moving from hospital-centric models to community-based services.

The Armenian law on Psychiatric Care governs standards and patient protections.

The Arabkir Medical Centre and Republican Psychiatric Hospital in Yerevan serve as training and treatment hubs. Armenia benefits from close collaboration with WHO Europe in implementing mental health action plans.

Civil society organizations including the Armenian Mental Health Association have trained practitioners and raised public awareness. International diaspora support networks also provide resources and funding for domestic mental health programs.

Al-Su‘ūdiyya (Saudi Arabia)
Al-Su‘ūdiyya’s low suicide rate is sustained through a combination of religious, legal, and healthcare measures.

The Al-Su‘ūdiyya Ministry of Health (https://www.moh.gov.sa) has invested substantially in mental health infrastructure, including dedicated psychiatric hospitals and clinics in all regions.

The National Mental Health Programme promotes training of healthcare providers and awareness campaigns.

The National Center for Promotion of Mental Health (NCPMH) coordinates public education efforts.

Islamic religious guidance strongly prohibits suicide, and imams and community leaders regularly address mental well-being in religious settings.

King Faisal Specialist Hospital & Research Centre (https://www.kfshrc.edu.sa) leads clinical research in psychiatry.

The Kingdom has developed a National Mental Health Strategy aligned with international best practices.

Section 3 What the U.S. Can Do to Decrease Its Suicide Rates

Overview of Strategies to Reduce Suicide Rates in the United States

Reducing suicide in the United States requires a multi-pronged, coordinated strategy involving federal agencies, state governments, healthcare systems, private corporations, non-profit organizations, and individual citizens. The following describes in detail what each sector must undertake:

Government Agencies

The Substance Abuse and Mental Health Services Administration (SAMHSA) (https://www.samhsa.gov) must expand the 988 Suicide and Crisis Lifeline, increase funding for crisis centers, and ensure equitable access to mental health services across all geographic and demographic populations.

The Centers for Disease Control and Prevention (CDC) (https://www.cdc.gov/suicide) must enhance surveillance of suicide data, fund community-based prevention programs, and publish annual reporting to track progress.

The National Institute of Mental Health (NIMH) (https://www.nimh.nih.gov) must increase research funding for early intervention, evidence-based treatment methods, and the epidemiology of suicide risk factors.

The Veterans Affairs (VA) (https://www.mentalhealth.va.gov) must expand veteran mental health programs, improve access to crisis services, and rigorously implement the Veterans Crisis Line outreach efforts.

The Department of Education (https://www.ed.gov) must mandate mental health education in K-12 curricula, fund school counselors, and create safe reporting environments for at-risk students.

The Department of Defense (DoD) (https://www.defense.gov) must continue expansion of its Suicide Prevention and Response programs for active duty service members and military families.

Government Officials

Members of Congress must prioritize the passage and funding of the Mental Health Reform Act and ensure sustained appropriations for the 988 Lifeline.

The President and executive branch must issue executive orders requiring federal agencies to adopt suicide prevention training for all federal employees and contractors.

State governors must adopt comprehensive suicide prevention plans in alignment with the National Strategy for Suicide Prevention and require coverage of mental health and substance use treatment under state Medicaid programs.

State legislators must enact means restriction legislation, including laws on firearm storage that demonstrate high effectiveness in reducing impulsive suicide. Local officials must dedicate public health funding to community mental health centers, especially in rural and underserved areas.

Corporations

Private corporations bear significant responsibility in addressing mental health as a workforce issue. Employers must provide comprehensive mental health benefits including behavioral health parity coverage under the Mental Health Parity and Addiction Equity Act. Companies must offer Employee Assistance Programs (EAPs) that include crisis counseling, therapy referrals, and substance use treatment. Human resources departments must train managers in Mental Health First Aid (https://www.mentalhealthfirstaid.org) to recognize early warning signs and connect employees to care.

Technology companies, including social media platforms, must implement algorithmic safeguards that reduce exposure to harmful content, actively promote crisis resources, and comply with digital safe messaging guidelines established by SAMHSA and the American Foundation for Suicide Prevention (AFSP) (https://afsp.org).

Insurance companies must be held to strict mental health parity standards and eliminate discriminatory coverage limits on behavioral health services.

Organizations

Non-profit organizations play a critical role in suicide prevention. The American Foundation for Suicide Prevention (AFSP) (https://afsp.org) must expand its Talk Saves Lives education programs to additional communities and train more volunteers.

The National Alliance on Mental Illness (NAMI) (https://www.nami.org) must broaden its helpline (1-800-950-NAMI), increase peer support programs, and advocate for legislative change.

The American Association of Suicidology (AAS) (https://suicidology.org) must continue to certify crisis counselors and publish research.

The JED Foundation (https://jedfoundation.org) must expand campus mental health programs at colleges and universities.

Crisis Text Line (https://www.crisistextline.org) must secure sustainable funding and scale its text-based support services. Faith-based organizations must integrate mental health outreach into their pastoral care and community programs.

Private Individuals and Community Action
Individual citizens can take meaningful steps: learning the warning signs of suicidal ideation, completing Mental Health First Aid training, removing or safely securing firearms and medications in homes with at-risk individuals, checking in on isolated friends, family members, and neighbors, and reducing stigma by speaking openly about mental health.

Community organizations should fund local crisis centers, support peer mentoring programs, and organize community wellness events.

Schools and universities must create inclusive environments that support students' mental and emotional well-being and make counseling services readily accessible without stigma.

Section 4 References

The following references were used in the preparation of Sections 2 and 3 of this document:

World Health Organization (WHO) - Mental Health Action Plan: https://www.who.int/publications/i/item/9789241506021

American Foundation for Suicide Prevention (AFSP): https://afsp.org

Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov

Centers for Disease Control and Prevention (CDC) - Suicide Prevention: https://www.cdc.gov/suicide

National Institute of Mental Health (NIMH): https://www.nimh.nih.gov/health/statistics/suicide

Israel National Program for Suicide Prevention: https://www.gov.il/en/departments/ministry_of_health

ERAN Crisis Hotline - Israel: https://www.eran.org.il

Philippines Department of Health - Mental Health: https://www.doh.gov.ph

National Center for Mental Health Philippines: https://ncmh.gov.ph

Saudi Arabia Ministry of Health: https://www.moh.gov.sa

Jordan Ministry of Health: https://www.moh.gov.jo

Egyptian Psychiatric Association: https://epapsychiatry.org

National Alliance on Mental Illness (NAMI): https://www.nami.org

JED Foundation - Campus Mental Health: https://jedfoundation.org

Crisis Text Line: https://www.crisistextline.org

Mental Health First Aid USA: https://www.mentalhealthfirstaid.org

Veterans Crisis Line: https://www.veteranscrisisline.net

988 Suicide and Crisis Lifeline: https://988lifeline.org

American Association of Suicidology: https://suicidology.org

Section 5 Draft of a House Bill

118th CONGRESS
1st Session

H.R. ___

A BILL

To establish a comprehensive national framework for the prevention and reduction of suicide rates in the United States, and for other purposes.

Short Title: The National Suicide Prevention and Mental Health Investment Act

SECTION 1. Definitions.

In this Act:

(1) Secretary means the Secretary of Health and Human Services.
(2) Administration means the Substance Abuse and Mental Health Services Administration (SAMHSA).
(3) Crisis Services means any service, including telephone hotlines, text-based support, mobile crisis teams, walk-in crisis centers, or short-term inpatient stabilization, providing immediate mental health intervention to individuals experiencing a mental health crisis or suicidal ideation.
(4) Suicide means the act of intentionally causing one's own death.
(5) Suicidal Ideation means thoughts about, consideration of, or planning of suicide.
(6) Evidence-Based Practice means a program, practice, or policy that is based on rigorous scientific research demonstrating effectiveness in reducing suicide risk or improving mental health outcomes.
(7) Mental Health Parity means the requirement that mental health and substance use disorder benefits are provided at no less favorable levels than medical and surgical benefits under health insurance plans.
(8) Means Restriction means policies, laws, or practices that limit access to lethal means by individuals at risk for suicide, including but not limited to firearms, medications, and high-risk locations.
(9) Safe Messaging Guidelines means standards established for media and communications regarding portrayals of suicide to prevent contagion and promote help-seeking behavior.
(10) Postvention means support provided to individuals, communities, and organizations following a suicide death to prevent suicide contagion and promote healing.
(11) At-Risk Population means any demographic group identified through epidemiological data as experiencing disproportionately elevated rates of suicidal ideation, attempts, or deaths, including but not limited to veterans, LGBTQ+ youth, indigenous populations, and rural communities.
(12) Gatekeeper Training means education programs that train individuals to recognize warning signs of suicide and connect those at risk to appropriate resources.

SECTION 2. Enacting Clause.

(a) FINDINGS. Congress finds that:

(1) Suicide is the 11th leading cause of death in the United States, claiming approximately 49,449 lives annually as of the most recent available data.

(2) The United States suicide rate of approximately 14.2 per 100,000 individuals substantially exceeds rates in peer nations that have implemented comprehensive national suicide prevention programs.

(3) International evidence demonstrates that coordinated national action, means restriction, mental health integration, and public awareness campaigns significantly reduce suicide mortality.

(4) Mental health services remain inaccessible or unaffordable for millions of Americans due to geographic, financial, and systemic barriers.

(5) It is the policy of the United States to reduce suicide rates through coordinated investment in prevention, intervention, treatment, and postvention services.

(b) PURPOSE. The purpose of this Act is to establish a comprehensive, evidence-based national suicide prevention framework that mobilizes federal, state, and local governments; private sector entities; healthcare providers; communities; and individuals to systematically reduce suicide rates in the United States.

SECTION 3. Requirements by Government Agencies.

(a) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA).

(1) SAMHSA shall administer and expand the 988 Suicide and Crisis Lifeline to ensure 24-hour, 7-day-a-week access to crisis intervention services for all Americans regardless of location, language, or ability to pay, consistent with models employed in nations including Australia's Lifeline Australia program and Canada's national crisis line framework.[1]

(2) SAMHSA shall develop and disseminate standardized Safe Messaging Guidelines for media organizations, social media platforms, schools, and healthcare providers, in accordance with evidence-based standards utilized by Deutschland's national media council and England's Samaritans safe messaging guidance.[78]

(3) SAMHSA shall issue annual National Suicide Prevention Strategy Reports to Congress identifying geographic and demographic disparities and progress toward measurable reduction benchmarks.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC).

(1) The CDC shall collect, analyze, and publish comprehensive suicide surveillance data on at least an annual basis, disaggregated by age, race, ethnicity, sex, geography, and method.

(2) The CDC shall fund community-based suicide prevention programs through the Suicide Prevention Resource Center (SPRC) and shall prioritize at-risk populations.

(3) The CDC shall evaluate the effectiveness of funded programs using standardized metrics and publish findings publicly.

(c) NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH).

(1) NIMH shall increase research grant funding for suicide prevention, early intervention, and treatment science, with a goal of doubling funded research within five years.

(2) NIMH shall establish a National Suicide Research Consortium to coordinate multi-site studies across institutions, modeled on collaborative mental health research networks in Sverige[5] and Suomi.[6]

(d) DEPARTMENT OF VETERANS AFFAIRS (VA).

(1) The VA shall implement universal suicide risk screening at all VA healthcare facilities and require documented follow-up actions.

(2) The VA shall expand the Veterans Crisis Line staffing and outreach and integrate peer support specialists into all VA mental health programs.

(e) DEPARTMENT OF EDUCATION.

(1) The Department of Education shall require grantee states to adopt and implement comprehensive school-based mental health frameworks, including suicide prevention education from middle school through post-secondary institutions, consistent with frameworks employed in Norge[4] and République française.[9]

(2) The Department of Education shall provide grant funding for increased school counselor ratios, targeting the goal of one counselor per 250 students.

SECTION 4. Requirements by Government Officials.

(a) CONGRESS. Members of the House and Senate shall:

(1) Annually appropriate no less than 00,000,000 for suicide prevention programs administered by SAMHSA, CDC, NIMH, and the VA collectively.

(2) Enact full enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) by authorizing the Departments of Labor, Treasury, and Health and Human Services to impose substantial penalties on non-compliant health plans.

(3) Pass means restriction legislation including federal safe storage requirements for firearms, consistent with policies enacted in Canada[2] and Australia.[1]

(b) PRESIDENT OF THE UNITED STATES. The President shall:

(1) Issue an executive order requiring that all executive branch agencies adopt and implement a written Suicide Prevention and Employee Mental Health Plan within 180 days of enactment.

(2) Designate a senior White House official as National Suicide Prevention Coordinator to lead interagency implementation of this Act.

(c) STATE GOVERNORS AND LEGISLATURES. State executives and legislators shall:

(1) Adopt state-level suicide prevention plans aligned with the National Strategy for Suicide Prevention within 24 months of enactment, consistent with the structured national plans of Sverige[5] and Suomi.[6]

(2) Enact legislation requiring means restriction at bridges and other high-risk locations identified in state epidemiological data.

(3) Expand Medicaid coverage of mental health services to include all evidence-based outpatient and inpatient treatments without annual limits.

SECTION 5. Requirements by Corporations.

(a) EMPLOYERS. All employers with 50 or more full-time employees shall:
    (1) Provide comprehensive mental health benefits, including behavioral health coverage, in all offered health insurance plans, in full compliance with the Mental Health Parity and Addiction Equity Act.
    (2) Offer an Employee Assistance Program (EAP) that includes access to at least six sessions of counseling per year at no cost to the employee, crisis intervention referrals, and substance use treatment coordination.
    (3) Provide Mental Health First Aid training, or equivalent gatekeeper training approved by SAMHSA, to all supervisory personnel within 12 months of enactment, consistent with requirements implemented by employers in Norge[4] and Deutschland.[7]

(b) TECHNOLOGY AND SOCIAL MEDIA COMPANIES. Corporations operating social media platforms, search engines, or digital communications services accessible to U.S. residents shall:
    (1) Implement and maintain algorithmic safeguards to reduce the recommendation of content that promotes, glorifies, or provides instruction on suicide, consistent with frameworks adopted in England[8] and Australia.[1]
    (2) Display crisis resource information, including the 988 Suicide and Crisis Lifeline, to users who search for or interact with suicide-related content.
    (3) Adopt and publish annual compliance reports demonstrating adherence to SAMHSA Safe Messaging Guidelines.

(c) INSURANCE COMPANIES. Health insurance providers shall:
    (1) Eliminate all prior authorization requirements for emergency mental health crisis services and acute psychiatric inpatient stabilization.
    (2) Maintain network adequacy standards for mental health providers equivalent to those applied to primary care and specialty medical providers.

SECTION 6. Requirements by Private Citizens.

(a) GUN OWNERS. Any individual who owns a firearm shall:
    (1) Store firearms safely using a gun lock or secured storage device when not in active use, consistent with the safe storage requirements of Canada[2] and Australia.[1]
    (2) Cooperate with voluntary temporary transfer programs that allow at-risk individuals' firearms to be voluntarily stored outside the home during mental health crises.

(b) COMMUNITY MEMBERS. All individuals are encouraged to:
    (1) Complete gatekeeper or Mental Health First Aid training at least once every five years, supported by federally funded training subsidies under this Act.
    (2) Report concerns about individuals exhibiting warning signs of suicidal ideation to appropriate crisis services, healthcare providers, or emergency services.
    (3) Refrain from sharing, distributing, or publicizing content that violates Safe Messaging Guidelines with respect to suicide.

SECTION 7. Penalty Clauses.

(a) CORPORATE VIOLATIONS. Any corporation that violates Section 5 of this Act shall be subject to:
    (1) A civil monetary penalty of not less than $50,000 and not more than $1,000,000 per violation, per year, imposed by the Secretary.
    (2) Public reporting of violations on the SAMHSA website.
(b) INSURANCE VIOLATIONS. Any insurer found in violation of mental health parity requirements under this Act shall be subject to:
    (1) A fine of $100 per insured person per day of noncompliance.
    (2) Mandatory corrective action plans subject to federal oversight.
(c) STATE GOVERNMENT NONCOMPLIANCE. States that fail to adopt suicide prevention plans as required under Section 4(c)(1) within the specified timeframe shall be subject to:
    (1) Withholding of up to 5 percent of Community Mental Health Services Block Grant funding.

SECTION 8. Effective Dates and Implementation.

(a) This Act shall take effect on the date of enactment, except as otherwise provided.
(b) SAMHSA shall issue implementing regulations within 180 days of enactment.
(c) Employer requirements under Section 5(a) shall take effect 12 months after the date of enactment.
(d) Technology company requirements under Section 5(b) shall take effect 9 months after the date of enactment.
(e) State plans under Section 4(c)(1) shall be submitted within 24 months of enactment.
(f) The Secretary shall submit a comprehensive implementation status report to Congress 24 months after enactment and every 2 years thereafter.

SECTION 9. Appropriations or Budgetary Notes.

(a) AUTHORIZATION OF APPROPRIATIONS. There are authorized to be appropriated:
    (1) $300,000,000 annually to SAMHSA for expansion of the 988 Suicide and Crisis Lifeline and mobile crisis services for fiscal years 2024 through 2030.
    (2) $150,000,000 annually to the CDC for suicide surveillance, community prevention programs, and evaluation.
    (3) $200,000,000 annually to NIMH for suicide research and the National Suicide Research Consortium.
    (4) $100,000,000 annually to the Department of Veterans Affairs for enhanced veteran suicide prevention programs.
    (5) $75,000,000 annually to the Department of Education for school mental health programs and counselor staffing grants.
    (6) $50,000,000 annually to SAMHSA for gatekeeper and Mental Health First Aid training subsidies for employers and community organizations.

(b) FUNDING SOURCES. Appropriations under this section shall be drawn from general Treasury funds and supplemented by any applicable reprogrammed funds from existing mental health block grants, subject to Congressional authorization.
(c) BUDGETARY OFFSET. The Congressional Budget Office shall provide a cost estimate of this Act within 30 days of introduction. The Appropriations Committees of the House and Senate shall identify appropriate budgetary offsets to ensure fiscal neutrality in accordance with applicable pay-as-you-go rules.

Endnotes

1. Australia's Lifeline Australia national crisis line: https://www.lifeline.org.au
2. Canada's national distress line network (Crisis Services Canada): https://www.crisisservicescanada.ca
3. Yisra'el national suicide prevention program - Ministry of Health: https://www.gov.il/en/departments/ministry_of_health
4. Norge Ministry of Health suicide prevention: https://www.regjeringen.no
5. Sverige National Suicide Prevention Strategy - Public Health Agency: https://www.folkhalsomyndigheten.se
6. Suomi National Institute for Health and Welfare: https://thl.fi
7. Deutschland's Federal Centre for Health Education (BZgA): https://www.bzga.de
8. England's Samaritans safe messaging guidance: https://www.samaritans.org
9. République française national mental health program - Ministry of Health: https://www.solidarites-sante.gouv.fr
10. Nippon's suicide prevention plan - Ministry of Health, Labour and Welfare: https://www.mhlw.go.jp
11. Zhongguo Mental Health Law - National Health Commission: http://www.nhc.gov.cn