Date of Hearing: March 25, 2026

ASSEMBLY COMMITTEE ON EDUCATION
Darshana R. Patel, Chair
AB 2003 (Berman) – As Introduced February 17, 2026

SUBJECT: Pupil health: suicide prevention

SUMMARY: Requires the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), in consultation with the California Department of Education (CDE) and the California Department of Public Health (CDPH), to develop an evidence-based online training program that is accessible, free of charge, statewide to train staff, students, and parents as part of a local educational agency (LEA) or charter school's policy on pupil suicide prevention; and requires an LEA that conducts suicide risk screenings to report data on those screenings to the CDE, as specified. Specifically, **this bill**:

1) Amends a requirement in existing law to require that the BHSOAC, in consultation with the CDE and the CDPH, instead of the CDE, develop an evidence-based online training program that is accessible, free of charge, statewide to train school staff, students, and parents as part of an LEA's policy on suicide prevention.

2) Requires the BHSOAC to ensure that the training program:

   a) Is evidence-based, trauma informed, and culturally and linguistically competent;

   b) Is consistent with the model pupil suicide prevention policy developed by the CDE;

   c) Addresses the needs of high-risk groups, as specified in existing law;

   d) Can track aggregate, statewide usage; and

   e) Can assess trainee knowledge before and after training is provided in order to measure training outcomes.

3) Requires that an LEA that conducts suicide risk screenings, including under a school-linked behavioral health program or the LEA's policy on pupil suicide prevention, to report data on those screenings to the CDE.

4) Requires that, in collecting and reporting this data, the LEA ensure that all of the following:

   a) Data is reported in a deidentified, aggregate format that protects pupil privacy consistent with state and federal data privacy laws;

   b) Data is consistent with the requirements of the model pupil suicide prevention policy developed by the CDE;

   c) Data includes, but is not limited to, the number of screenings conducted and all of the following information for each screening:

i) The pupil's age;

ii) The pupil's grade;

iii) The pupil's gender;

iv) The pupil's race;

v) The pupil's ethnicity;

vi) The severity level of suicide risk identified;

vii) Whether the pupil is identified as belonging to any high-risk groups, including, but not limited to, high-risk groups as defined in existing law, or any other high-risk groups identified in the LEA's policy on pupil suicide prevention, to the extent known and applicable;

viii) Any other relevant data that may support local suicide prevention efforts; and

ix) Data is reported to the CDE on at least an annual basis.

5) Requires the CDE to compile the data and post statewide aggregate data on its website to inform policy and program development.

6) Requires the CDE, to promote consistency across behavioral health systems statewide, coordinate this data collection with the State Department of Health Care Services (DHCS), including, as appropriate, data collection frameworks established under the Children and Youth Behavioral Health Initiative (CYBHI) and the school-linked statewide fee schedule.

EXISTING LAW:

1) Requires the governing boards of school districts, county offices of education (COEs), the state special schools, and charter schools which serve students in grades 7 to 12 to adopt, before the beginning of the 2017–18 school year, a policy on student suicide prevention for students in those grades. (Education Code (EC) 215)

2) Requires that these policies address, at a minimum, procedures relating to suicide prevention, intervention, and postvention. (EC 215)

3) Requires the policies to be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. (EC 215)

4) Requires that the policies specifically address the needs of high-risk groups, including youth bereaved by suicide, youth with disabilities, mental illness, or substance use disorders, youth experiencing homelessness or in out-of-home settings, students in foster care, and lesbian, gay, bisexual, transgender, or questioning youth. (EC 215)

5) Requires that the policy address any training to be provided to teachers of students in grades 7 to 12 on suicide awareness and prevention. (EC 215)

6) Requires that materials approved by an LEA for training include how to identify appropriate mental health services, both at the schoolsite and also within the larger community, and when and how to refer youth and their families to those services. (EC 215)

7) States that materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials. (EC 215)

8) Requires the policy to be written to ensure that school employees act only within the authorization or scope of their credential or license. (EC 215)

9) Requires the CDE to assist LEAs in developing policies for student suicide prevention, to develop and maintain a model policy to serve as a guide for LEAs. (EC 215)

10) Requires that LEAs update their suicide policies every five years. (EC 215)

11) Requires the CDE to identify one or more evidence-based online training programs that an LEA can use to train school staff and students as part of its policy on suicide prevention. (EC 216)

12) Requires the CDE, in identifying an online program, to ensure that:

    a) The training program is evidence based;

    b) The training program is consistent with the model pupil suicide prevention policy developed by the CDE;

    c) The training program addresses the needs of high-risk groups;

    d) The training program can track aggregate, statewide usage; and

    e) The training program can assess trainee knowledge before and after training is provided in order to measure training outcomes. (EC 216)

13) Requires the CDE to provide a grant to a COE, upon application by the COE, for it to acquire a training program identified by the CDE and disseminate that training program to LEAs. (EC 216)

14) Requires the COE to make the training program available to LEAs at no cost. (EC 216)

FISCAL EFFECT: Unknown

COMMENTS:

Need for the bill. The author states, "Too many communities across California have been devastated by youth suicides, including my hometown of Palo Alto. We must do everything we possibly can to prevent these tragedies. AB 2003 responds to the ongoing youth mental health crisis by developing and providing a free, evidence based, online suicide prevention training program for all students 13 and older, K-12 school staff, and parents. Specifically, this bill would

require the Behavioral Health Services Oversight and Accountability Commission, in consultation with the California Department of Education and the California Department of Public Health, to develop a permanent suicide prevention training program available statewide. Suicide is preventable, and this training is essential to give Californians the knowledge, tools, and resources to know what to look for and feel confident in supporting youth in their life who need help.

AB 2003 would also compile deidentified suicide risk screening data statewide. If schools conduct suicide risk screenings, those schools would share data with the California Department of Education. This data would include age, grade, gender, race and ethnicity, severity level of suicide risk identified, and whether students are in any high-risk groups. This would inform policy, prevention planning, early intervention strategies, and help understand where resources and support are needed most. In total, AB 2003 would provide free access to life-saving training and the essential data needed to combat the ongoing youth mental health crisis."

Building on prior statewide training. AB 1808 (Committee on Budget), Chapter 52, Statutes of 2018, CDE to identify, and each COE to make available, an online training program in suicide prevention that schools can use to train school staff and pupils, consistent with the local policies on suicide prevention. This language was also approved by this Committee in AB 2632 (Berman) of the 2017-18 Session. The budget appropriated $1.2 million for a statewide license for this training so that any LEA could use it as part of training related to their suicide prevention policy.

Key outcomes of that training include:

- Over 20,000 middle and high school students accessed the training;
- 98% of staff reported feeling confident helping someone at risk;
- 95% of students reported feeling confident helping others;
- 96% of students and 97% of staff reported knowing how to use resources if they were struggling; and
- 25% of staff and 35% of students reported having someone in mind with whom to use their new skills.

Funding available for the development of the training. The BHSOAC reports that in January of this year its members voted to approve $1.5 million in funding to develop the training required by this bill, and that it intends for the training to be made available on multiple platforms. They also note that while the prior training was not available to elementary school staff, this training will be made available to all school staff.

Collecting data from student suicide risk screenings. This bill would require LEAs that conduct suicide risk screenings to report that data to the CDE, and would require the CDE to post aggregated data on its website. The bill requires that this be done in accordance with state and federal privacy laws regarding student information.

According to the BHSOAC, many schools voluntarily conduct suicide-risk screenings but lack unified standards for collecting or reporting data. They state that without statewide aggregation of key demographic and risk-severity information, California cannot identify emerging trends, disparities among high-risk groups, or regions needing targeted support, and that this leads to fragmented practices and missed opportunities for early intervention.

This bill proposes to require that information about individual students screened, including the student's age, grade, gender, race and ethnicity, severity of risk identified, and whether they belong to a high risk group, such as those with substance use disorders and those who are LGBTQ. While the bill requires that all information be reported in compliance with laws regulating the privacy of student information, t***he Committee may wish to consider that***, as most of California's LEAs are small and a small number of students may be screened for suicide risk, maintaining the privacy of sensitive student information may be challenging.

Youth suicide in California. According to the Lucile Packard Foundation for Children's Health, the **suicide rate for youth** in California and the United States was increasing even before the COVID-19 pandemic.

They note that since then, the pandemic's extended social isolation and other stressors presented newly compounding risk factors for suicide along with more common factors such as mental illness, access to lethal means, poor family communication, and exposure to others' suicidal behavior.

According to the Lucile Packard Foundation for Children's Health, in California, suicide rates for young people ages 15 to 24 increased from 6.9 per 100,000 youth in 2007-2009 to 8.9 per 100,000 youth in 2017-2019, a nearly 30% increase. In 2019, the number of suicides among California youth differed greatly by age, gender, and race/ethnicity. According to the CDPH, suicide is the second leading cause of death for young people ages 10-25 between 2019 and 2021.

Recommendations on training school staff in suicide prevention. Numerous policy documents on suicide prevention recommend that teachers and other school staff be trained on this topic, generally viewing school staff as "gatekeepers" who can play a critical role in preventing suicide. Among them:

- The United States Surgeon General and the National Action Alliance for Suicide Prevention's National Strategy for Suicide Prevention, recommends that teachers and school counselors, among others who are on the front lines of suicide prevention, be trained on suicide prevention.

- The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) recommends educating all staff about the importance of suicide prevention, training all staff to recognize suicide risk, and training selected staff to assess and refer students at risk of suicide to appropriate services.

- The World Health Organization recommends "training all school staff in the capacity to talk among themselves and with the students about life and death issues, improving their skills in identifying distress, depression and suicidal behavior, and increasing their knowledge about available support are crucial means of suicide prevention."

- The CDE's model suicide prevention strategy recommends training of school staff. Specifically, the policy recommends annual training of all school staff on risk factors and warning signs of suicide, suicide prevention, intervention, referral, and postvention, including appropriate ways to interact with a youth who is demonstrating emotional distress or is suicidal.

Evidence-based approaches for suicide prevention. This bill requires that the online training developed by the BHSOAC be evidence-based. The Suicide Prevention and Resource Center (SPRC) defines "evidence-based practice" as the use of current best evidence when making health decisions that affect communities. SPRC states that this practice includes making decisions based on available scientific evidence, using data and information systems to assess program efficacy, engaging communities in decision-making, and disseminating knowledge on effective approaches. The efficacy of suicide prevention is generally assessed using pre- and post-test evaluations that examine the impacts of training on user understanding of suicide and suicide prevention practices, or, less commonly, by identifying community-wide changes in the incidence of suicidal behaviors or events.

Few peer-reviewed articles provide scientific assessments of specific suicide prevention programs, but the existing research identifies certain practices that improve the effectiveness of suicide prevention. These practices include:

- Training personnel to differentiate between suicide risk factors (which suggest that students may be at risk for suicidal thinking) and warning signs (which indicate that students are in imminent danger of attempting suicide). Depression is considered a risk factor, while substance abuse, communication of intent to commit suicide, severe anxiety, and extreme agitation are considered suicide warning signs;

- Combining suicide screening with effective referral resources, so that school personnel know where to send at-risk students for help;

- Incorporating considerations of diversity into the design and implementation of suicide prevention protocols; and

- Incorporating communication training into suicide prevention protocols, so that school personnel know not only how to identify students at risk, but how to communicate with students about suicide and distress. Studies suggest that surveillance training, which teaches staff to identify suicide risks and warning signs, may not be fully effective unless it is paired with communication training that teaches staff to engage in transactional conversations with students, so that students feel safe explicitly sharing, rather than concealing, signs of their distress or suicide risk. This concept is supported by reports that even healthcare professionals and family members of suicidal persons find it difficult to directly converse about suicide risk. In addition, a study conducted in a Georgia school district showed that one year after implementation of a widely-used suicide prevention training program, increased knowledge about suicide alone did not increase suicide risk identifications among staff. However, large increases in suicide risk identifications were noted among staff who already had strong communicative relationships with students.

High risk groups. This bill requires that the suicide training to be developed address the needs of specific groups of students who are at higher risk of suicide. Research indicates the following about risk factors for the specific groups named in this bill:

- Youth bereaved by suicide: Young people appear to be particularly affected by others' suicides. Research has found that the relative risk of suicide following exposure to another individual's suicide was 2 to 4 times higher among 15- to 19-year-olds than among other age groups, and that between 1 percent and 5 percent of teen suicides occur

in "suicide clusters." A phenomenon known as "suicide contagion" refers to the increased risk of suicide for individuals bereaved by the suicide of others.

- Youth with disabilities: Research shows that adolescents with particular disabilities, such as chronic pain, loss of mobility, disfigurement, multiple sclerosis, and spinal cord injuries are at higher risk of suicide. People with multiple sclerosis, for example, are more than twice as likely as the general population to attempt suicide and almost twice as likely to actually complete suicide.

- Youth with mental illness and substance abuse disorders: Nearly 90% of all suicides are associated with a diagnosable mental health or substance-abuse disorder. People experiencing depression, manic-depressive disorder, anxiety disorders, borderline personality disorder, schizophrenia, and conduct disorders are at elevated risk for suicide.

- Youth experiencing homelessness: Limited research suggests that more than half of homeless and runaway youth have attempted suicide.

- Youth in foster care: Limited research suggests that youth in foster care are more than twice as likely to commit suicide and nearly four times as likely to attempt suicide as their peers.

- Youth in juvenile detention: Youth involved with the juvenile justice system are four times more likely to commit suicide than their peers.

- Lesbian, gay and bisexual youth: LGBTQ youth are four times more likely to attempt suicide than their straight peers. Nearly half of young transgender people have seriously considered suicide, and one-quarter report having made a suicide attempt.

Research identifies several other factors associated with elevated risk of suicide:

- Research indicates that a past history of suicide attempts is the best predictor of future attempts. Youth who have engaged in self-harm are also at elevated risk.

- Analysis from the RAND Corporation also shows significant regional differences in suicide rates in California, with the highest rates – roughly double those of the regions with the lowest rates – in the rural northern counties of the state.

- In California, Native Hawaiian and Pacific Islander (Samoan, Guamanian, Chamorro only) are at elevated risk, and according to an analysis of data from the CDPH, between 2005 and 2010 the rate of suicide among this group doubled, while increasing 17% in the white population.

Recommended Committee amendments. Staff recommends that the bill be amended to

1) Remove the requirement that individual student information be reported to the CDE, and instead require that LEAs conducting suicide risk screenings report the total number of students they screen annually, and the type of screening they use; and

2) Add "and available" before the word "statewide" in Section 1 of the bill.

Arguments in support. The Behavioral Health Services Oversight and Accountability Commission writes, "California expanded access to school-based suicide prevention training under AB 1808 (Committee on Budget, Chapter 32, Statutes of 2018), enabling more than 20,000 students and school staff to complete an online evidence-based program, with overwhelmingly positive outcomes: 95% of students and 98% of staff reported feeling confident in helping a peer who may be considering suicide.

However, when funding expired in 2024, schools across the state lost access to this essential no-cost resource, leaving districts – especially those with fewer local funds – with inconsistent and inequitable prevention tools despite increasing mental health needs.

At the same time, many schools voluntarily conduct suicide-risk screenings but lack unified standards for collecting or reporting data. Without statewide aggregation of key demographic and risk-severity information, California cannot identify emerging trends, disparities among high-risk groups, or regions needing targeted support. This leads to fragmented practices and missed opportunities for early intervention.

AB 2003 provides the needed solution. The bill directs the Commission to develop a free, accessible, trauma-informed, and culturally and linguistically competent online training program for students ages 13 and older, school staff, and caregivers, ensuring that every layer of a student's support network is equipped to recognize warning signs and respond effectively.

AB 2003 also requires local educational agencies that conduct suicide-risk screenings to report standardized data to the CDE, allowing schools and the state to identify disparities, target supports, and intervene earlier with vulnerable subgroups, helping to improve youth stability, safety, and well-being."

Related legislation. AB 1808 (Assembly Committee on Budget), Chapter 32, Statutes of 2018, requires the CDE to identify one or more evidence-based online training programs that a LEA can use to train school staff and pupils as part of the local educational agency's policy on pupil suicide prevention.

AB 2246 (O'Donnell) Chapter 642, Statutes of 2016 requires local educational agencies (LEAs) to adopt policies for the prevention of student suicides, and requires the CDE to develop and maintain a model suicide prevention policy.

AB 58 (Salas), Chapter 428. Statutes of 2022, requires an LEA, on or before January 1, 2025, to review and update its policy on pupil suicide prevention, and encourages LEAs to provide suicide awareness and prevention training to teachers, beginning with the 2024-25 school year. Requires the CDE to develop and issue resources and guidance to LEAs on how to conduct suicide awareness and prevention training remotely, by June 1, 2024.

AB 1767 (Ramos), Chapter 694, Statutes of 2019, extends the requirement to adopt suicide prevention policies from grades 7 to 12 to kindergarten through grade six.

AB 2639 (Berman), Chapter 437, Statutes of 2018, requires that LEAs update their suicide prevention policies every five years.

AB 739 (Lowenthal) of the 2011-12 Session would have required the SBE and the Curriculum Development and Supplemental Materials Commission to include suicide prevention instruction and mental illness awareness instruction in the health education framework for pupils in grades 7 to 12 during the next revision of the framework. The bill would have authorized a school district, commencing with the 2012–13 school year, to provide suicide prevention instruction and mental illness awareness instruction to pupils in grades 7 to 12. This bill was held in the Assembly Appropriations Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

AIDS Healthcare Foundation / Impulse Group
American Academy of Pediatrics, California
Behavioral Health Services Oversight and Accountability Commission
Cal Voices
California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
California Association of Marriage and Family Therapists
California Association of Social Rehabilitation Agencies
California Association of Student Councils
California Behavioral Health Association
California Children's Hospital Association
California School-based Health Alliance
California Youth Empowerment Network
Disability Rights California
Gente Organizada
Human Response Network
Lgbtq+ Inclusivity, Visibility, and Empowerment (LIVE)
Mental Health America of California
On the Margins, INC
Prc/black Leadership Council
Reach LA
Stanford Medicine Children's Health
Steinberg Institute
Vietnamese American Arts and Letters Association
1 individual

Opposition

None on file

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