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California Legislature

Joint Oversight Hearing
Assembly Health Committee and Select Committee on Native American Affairs
Assemblymembers Bonta and Ramos, Chairs

Suicide Prevention and Intervention in California Indian Communities

Tuesday, May 12, 2026 — 2:00 p.m.
1021 O Street, Room 1100

INTRODUCTION

Suicide represents a critical and persistent public health crisis among American Indian and Alaska Native (AI/AN) communities in the United States. Across decades of research, AI/AN populations have consistently experienced the highest suicide rates of any racial or ethnic group, with disparities particularly pronounced among adolescents and young adults.[i] In California, home to the largest Native population in the country, Native youth ages 10 to 25 experienced the highest suicide rate from 2016 to 2021, according to the state Department of Public Health (DPH), despite making up the smallest ethnic demographic.[ii] This hearing will provide committee members with the opportunity to hear testimony and recommendations from numerous tribal members regarding current policy gaps and possible recommendations on how to prevent suicide in California Indian communities.

BACKGROUND

Nationally, AI/AN communities experience suicide rates significantly higher than the general population, with estimates suggesting rates nearly double the United States (U.S.) average. Suicide is among the leading causes of death for Native youth, particularly those between the ages of 15 and 24, and remains a major contributor to premature mortality across the lifespan.[iii] [iv] Young males are disproportionately affected, though concerning increases in suicidal ideation and attempts have also been documented among young females in recent years.[v] Data indicate high levels of psychological distress among AI/AN adults, with more than one-third reporting moderate to severe symptoms.[vi] According to the *AI/AN Suicide Fact Sheet* from the National Indian Health Board, the non-Hispanic AI/AN suicide rate increased by nearly 20% from 2015 to 2020, compared to less than 1% in the overall U.S. population. Despite this elevated need, a majority of those experiencing distress do not access behavioral health services. Among youth, emerging research suggests increasing rates of suicidal ideation and persistent vulnerability, even as statewide prevention efforts have expanded.

Risk Factors. According to the National Alliance on Mental Illness (NAMI) the higher risk of suicide in Native communities is a complex issue and depends on many different factors including mental health conditions, substance use disorders, intergenerational trauma, and community-wide socioeconomic disparities. It is also critical to recognize the interplay of these

different factors. Individual-level poverty and limited access to healthy food and clean water, which are often the legacy of displacement and lack of investment, commonly lead to physical health conditions – compounding an individual's risk of developing a mental health condition. The historical mistreatment, forced displacement and oppression of Native peoples has had long-term multigenerational impacts, including trauma and depression. Understanding this historical context is critical to understand higher rates of suicide in these communities.[vii] Suicidal ideation among Native American youth is a complex and multifaceted issue that requires a comprehensive understanding of the risk factors that contribute to suicide-related behavior. Traditional psycho-centric models of suicide, primarily focused on individual psychopathology, have been inadequate in capturing the nuanced experiences of AI/AN youth, who often navigate unique cultural, historical, and social challenges that can contribute to suicide-related behavior.[viii]

The Suicide Prevention Resource Center[ix] identified several risk factors for AI/AN populations. These risk factors include:

1) **Alcohol and drug use:** According to the National Violent Death Reporting System 2003–2009, of AI/AN suicide decedents tested for alcohol, 36% were legally intoxicated at the time of death. There were proportionally more positive test results for alcohol among AI/AN decedents than there were for any other racial or ethnic group. In 2011, AI/AN populations had the highest rate of current illicit drug use (13.4%) among those ages 12 or older compared to any other single racial/ethnic group, and illicit drug use is a risk factor for suicide. The overall rate for all racial/ethnic groups was 8.7%.

2) **Historical trauma:** Attempts to eliminate AI/AN culture—such as forced relocation, removal of children to boarding schools, prohibition of the practice of native language and cultural traditions, and outlawing of traditional religious practices—have affected multiple generations of AI/AN people and contribute to high rates of suicide among them.

3) **Alienation:** In an analysis of suicide notes to determine motivation, alienation among AI/AN people was double that of white people. Alienation causes a loss of well-being when the individual feels emotionally disconnected from their family of origin or culture.

4) **Acculturation:** AI/AN tribal members with greater adaptation to the mainstream culture reported increased psychosocial stress, less happiness, and greater use of drugs or alcohol to cope with the stress of navigating the differences between two cultures. In some AI/AN tribes, there is more pressure to acculturate, greater conflict regarding traditional cultural practices, and a high suicide rate among adolescents and young adults.

5) **Discrimination:** Studies of AI youth found that discrimination was as important a predictor of suicidal ideation as poor self-esteem and depression. This association may be more common among reservation youth than their urban counterparts. LGBTQ AI/AN people experience even more prejudice and discrimination and have higher rates of suicide deaths, attempts, and ideation than heterosexual AI/AN people and LGBTQ people of other racial/ethnic backgrounds.

6) **Community violence:** AI/AN youth are two-and-a-half times more likely to experience trauma than non-AI/AN youth. Much of this trauma involves victimization from non-AI/AN perpetrators or from family violence and abuse.

7) **Mental health services access and use:** Only 10% to 35% of AI adolescents and young adults use professional health services during a suicidal episode.

Protective Factors. The Suicide Prevention Resource Center[x] further reports that across all racial and ethnic populations, some of the most significant protective factors are effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills; and, contacts with caregivers. In addition, they identify the following protective factors specific to AI/AN communities:

1) **Community control:** In a Canadian study of data from the British Columbia Coroner's Office, tribes with no suicides had more indicators of cultural continuity. Cultural continuity was defined as having infrastructure, such as the presence of cultural facilities; sovereignty, such as self-government; having title to their traditional lands; and the provision of services within the community, including education, police, and fire, health care delivery, and child and family services. In another Canadian study, preliminary evaluative data and community member narratives indicated that community control in designing and carrying out suicide prevention programming can be effective toward preventing suicide.

2) **Cultural identification:** AN tribal members following a more traditional way of life reported greater happiness, more frequent use of religion and spirituality to cope with stress, and less frequent use of drugs and alcohol to cope with stress. Two studies of AI youth in the Midwest found that those who had a stronger ethnic/cultural identity were better able to cope with acculturative stress and less likely to have suicidal thoughts.

3) **Spirituality:** Commitment to tribal cultural spirituality (forms of spirituality deriving from traditions that predate European contact) is significantly associated with a reduction in suicide attempts. People with a high level of cultural spiritual orientation have a reduced prevalence of suicide compared with those with low levels of cultural spiritual orientation.

4) **Family connectedness:** Connectedness to family and discussing problems with family and friends are protective against suicide attempts among AI/AN youth.

Prevention Strategies. In 2022, the Centers for Disease Control and Prevention (CDC) recommended that a comprehensive public health approach to suicide prevention, with attention to strategies that aim to reduce health inequities among AI/AN persons, is needed. These strategies might include strengthening access to and delivery of culturally relevant care, including telehealth for mental health concerns and well-being, increasing training and hiring of AI/AN providers, promoting community engagement and cultural traditions, increasing coping and problem-solving skills (e.g., AI Life Skills Training), increasing training to recognize and respond to suicide risk, making postvention programs (activities that reduce risk and promote healing after a suicide death) more available to AI/AN survivors of suicide loss, and promoting the 988 Suicide and Crisis Lifeline. [xi] Youth-focused interventions are particularly critical given the high rates of suicide among young people. Programs that promote cultural identity, leadership development, and peer support have shown promise in reducing risk factors and enhancing protective factors. School-based initiatives, when designed in partnership with tribal communities, can provide accessible entry points for prevention while reinforcing cultural values and connections.

CONCLUSION

Addressing suicide in AI/AN communities in California requires a comprehensive, multi-level approach that integrates data improvement, service expansion, and cultural responsiveness. Strengthening data systems is a foundational step, as is investment in tribal behavioral health infrastructure. Prevention efforts should prioritize culturally grounded programs, particularly those focused on youth, and recognize traditional practices as central components of care.

Enhancing crisis response systems and ensuring their cultural relevance will improve access to immediate support, while expanded postvention services can help communities recover and prevent further harm. Finally, meaningful tribal consultation and partnership must be embedded in all aspects of policy development and implementation, reflecting a commitment to sovereignty and self-determination.

Suicide among AI/AN communities in California is both a profound public health challenge and a reflection of broader structural inequities. While the burden is significant, the evidence is clear that effective solutions exist. Culturally grounded, community-led approaches—supported by accurate data, equitable funding, and strong tribal-state partnerships—offer the most promising path forward.

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