

Suicide in Colorado

Complex Issues in a Diverse State

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Some 1,287 Coloradans lost their lives to suicide in 2019.¹ This was not only an increase from the year before — it was also a higher number of suicides than has ever been recorded in the state.

The rate of suicide in Colorado remained the same between 2018 and 2019, but the number of lives lost each year in the state has been slowly increasing since 2013. The most recent data available from the Centers for Disease Control and Prevention (CDC) show that in 2018, Colorado had one of the 10 highest age-adjusted suicide death rates in the nation, at 21.9 deaths per 100,000 people.² Higher-than-national rates of death by suicide have been a consistent trend in Colorado, along with other mountain states like Montana and Wyoming.

These numbers are startling, but a closer look at the data — recently updated by the Colorado Department of Public Health and Environment (CDPHE) — sheds light on the myriad dynamics that are at play for this seventh-leading cause of death in our state.³

In this report, the Colorado Health Institute (CHI) explores 10 data stories that illuminate how people's lives may be impacted by suicide based on different risks or social and cultural identities. Each story includes highlights of just some of the resources and work being done nationally or locally to prevent suicide.

While many of the stories focus on mental health as a risk factor, suicide is complex. Physical health challenges, lack of social supports, access to lethal methods, and situational causes like loss of a job or loved one can also contribute to the risk. As outlined in [The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention](#), released by the U.S. Department of Health and Human Services and Office of the Surgeon General on January 19, 2021, suicide prevention efforts need to address both environmental and individual factors that can contribute to suicide.⁴ This includes upstream factors like economic and financial stability, housing stability, and social connectedness.

There is always hope, and many people and organizations in our state and nation are engaged in creating policies and communities that support

the well-being of anyone who is at risk of suicide and those who have been affected by it.

For those seeking help, Colorado Crisis Services is available for support 24/7 at 1.844.493.8255 or by texting TALK to 38255. [Walk-in center locations](#) are also available.



A NOTE ON THE DATA IN THIS REPORT

All data on suicide in Colorado in this report come from the Colorado Suicide Data Dashboard, which is maintained by the Colorado Department of Public Health & Environment Vital Statistics Program and [Colorado Violent Death Reporting System](#).

CHI has not analyzed the statistical significance of the data points, and has confirmed that neither causation nor correlation between circumstances can be established based on available data in CDPHE's Colorado Suicide Data Dashboard. For example, it is unclear how much overlap exists between people with reported circumstances of receiving current mental health treatment, people who have a diagnosed mental health problem, and those with a current depressed mood. See [CDPHE's Colorado Suicide Data Dashboard Guide](#) for more detail on data definitions and methodology.

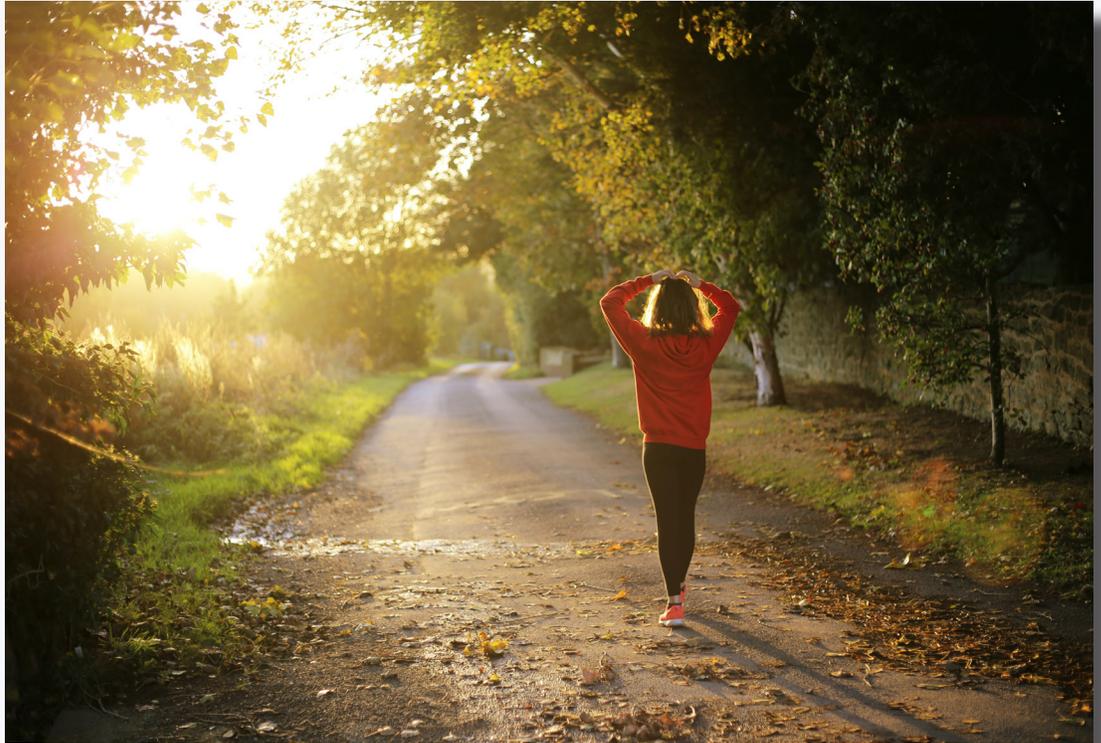
STORY ONE

Mental Health Challenges Are a Risk Factor for Suicide — But Many Go Untreated

Many people who have died by suicide in Colorado were reported as having a current depressed mood or a diagnosed mental health problem like depression, anxiety, or other conditions such as schizophrenia. But less than a third were identified as currently receiving mental health care.

As a state, Colorado has a higher prevalence of mental health issues and lower rates of access to care according to Mental Health America's [2021 State of Mental Health in America report](#). Colorado has an overall ranking of 47 out of 50 states and the District of Columbia, based on account 15 measures of mental health and substance use prevalence among adults and youth as well as access to care.⁵

Access to mental health care remains a persistent challenge in Colorado: More than one in 10 Coloradans reported not getting needed treatment for mental health issues in 2019, according to the



[Colorado Health Access Survey](#).⁶ The number of suicide deaths where a current diagnosed mental health problem was reported has increased over time, but gaps in treatment persist.

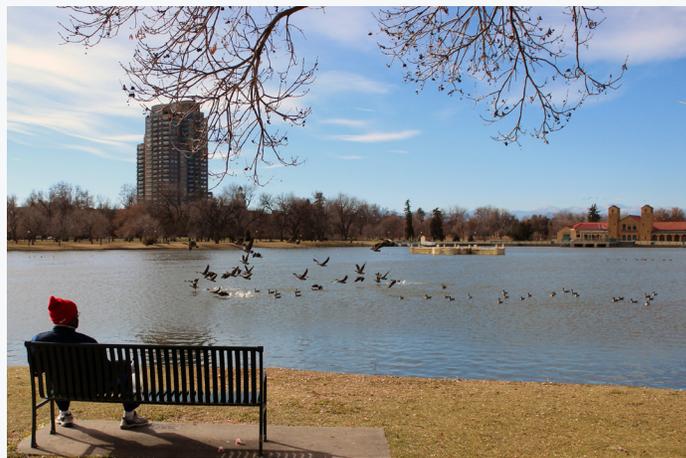
Policy changes aimed at improving access to mental health care may be partly responsible for the increase in diagnosis (see Figure 1): Between 2004-2008, prior to the implementation of key legislation like the [Mental Health Parity and Addiction Equity Act](#) and

The 2019 Colorado Health Access Survey found that **cost and coverage** were the largest barriers for people who didn't get needed mental health services.

the [Patient Protection and Affordable Care Act \(ACA\)](#), which improved insurance coverage for mental health care, 38.0% of people who died by suicide in Colorado had a reported current diagnosed mental health problem.^{7,8} After implementation of these policies, the rate increased to more than half (54.4% between 2014-2018). This likely reflects more people having access to at least an initial appointment with a mental health provider, or more awareness of mental health challenges on the part of primary care providers.

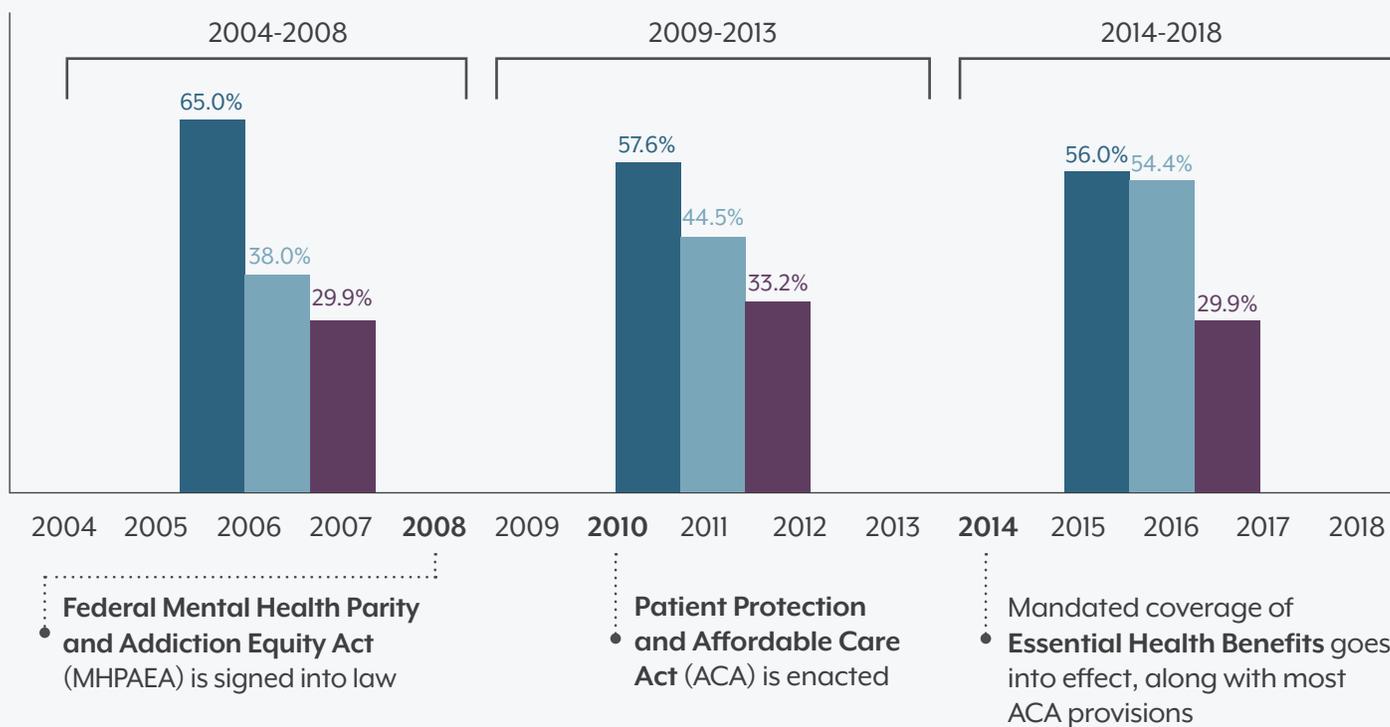
Yet the number of people who died by suicide who were reported as receiving current mental health treatment has remained stubbornly unchanged at less than a third.

The 2019 Colorado Health Access Survey found that cost and coverage were the largest barriers for people who didn't get needed mental health services.⁹ A [survey](#) conducted by Gov. Jared Polis' [Behavioral Health Task Force](#) echoed these findings, with 92% of respondents reporting concerns with access to care.¹⁰



Policymakers are looking for ways to further improve access: The Task Force's recently-released [Blueprint for Behavioral Health Reform](#) outlines steps to build a stronger system of care through addressing workforce shortages, improving affordability, and streamlining the system to ensure Coloradans can get care when they need it.¹¹

Figure 1. Likelihood of Mental Health Treatment Remains Unchanged Over Time



■ **Percentage of suicide deaths** where a current depressed mood was reported
■ **Percentage of suicide deaths** where a current diagnosed mental health problem was reported
■ **Percentage of suicide deaths** where current mental health treatment was reported

Source: Colorado Department of Public Health and Environment

STORY TWO

Structural Racism Perpetuates Worse Health Outcomes Among People of Color

People of color in Colorado who died by suicide were less likely to have mental health treatment than white Coloradans, even though similar percentages of all groups were reported as having a current depressed mood (see Figure 2).

Black, Hispanic/Latinx, Asian, and Native American people experience [higher rates of some mental health conditions](#), and yet they face [disproportionately greater difficulties](#) in accessing care than white people in Colorado.^{12,13} It is not race or ethnicity that inherently causes these disparities or perpetuates inequities, but structural racism and the differential access to services or opportunities by race, such as in the health care system.

The [2018 National Healthcare Quality and Disparities Report](#), which gives an overview of health care received in the U.S., found that compared to white patients, Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander groups received worse care for 40% of the quality measures studied.¹⁴

Exclusion and discrimination can also act as stressors (see: Systemic Racism and Health) and can manifest in the health care system through issues like lack of workforce diversity.

The behavioral health care system is already facing an overall workforce shortage, but even fewer providers offer culturally and linguistically competent care for people of color. The [demand for psychologists](#) among non-white racial and ethnic groups is expected to grow by 24% from 2015 to 2030.¹⁵ While people of color make up about [28% of the nation's population](#), in 2015, only [14% of psychologists](#) in the U.S. workforce were non-white.^{16,17}

Cultural beliefs and stigma related to mental health can also lead people to avoid care. Understanding and addressing this is important to ensuring culturally responsive care. But if there are few providers from diverse backgrounds or a lack of training in these



Black, Hispanic/Latinx, Asian, and Native American people experience higher rates of some mental health conditions, and yet they face **disproportionately greater difficulties** in accessing care than white people in Colorado.

Systemic Racism and Health

There are unique mechanisms by which systemic racism affects different non-white racial and ethnic groups, but there are also similarities across groups, including historical exclusion and intergenerational traumas.²¹

Black and African-American Communities

For many who identify as Black or African American, mistrust in providers and the health care system can be a systemic barrier to care.²² Policies and practices such as the historical segregation of Black people from public accommodations continue to disadvantage Black communities and, in some cases, have led to implicit bias — including stereotypes and negative attitudes — among providers in the health care system. Research has shown the quality of physician-patient communication is lower and that physicians can be more verbally dominant when working with Black or African-American patients compared to white patients. There are also differences in the types of diagnoses and treatments offered, such as for pain.²³ A study of children who had severe acute appendicitis showed that Black children had one-fifth the odds of receiving opioid painkillers compared with white children.²⁴

Hispanic/Latinx Communities

Lack of insurance or inadequate insurance is an issue for many in the Hispanic/Latinx community. The Colorado Health Access Survey has found that Hispanic/Latinx Coloradans have a higher uninsured rate than any other racial or ethnic group in the state.²⁵ Policies that limit enrollment in health care coverage due to immigration status and the overrepresentation of Hispanic/Latinx Coloradans in lower-wage professions that are less likely to offer health insurance are just two reasons for this disparity.²⁶

Asian American and Pacific Islander (AAPI) Communities

The model minority stereotype, in which Asian Americans are perceived as high-achieving and hard-working, can act as a stressor for many AAPI people. It also perpetuates inequalities among all racial and ethnic groups.²⁷ Anti-Asian racism in the U.S. leads to increased stress and poor mental health among members of this community.²⁸ The Chinese Exclusion Act of 1882; the internment of Japanese Americans during World War II; discrimination against Hindu, Muslim, and Sikh individuals after 9/11; and ongoing discrimination against Asians since the start of the coronavirus pandemic are just a few examples.

American Indian and Alaska Native (AI/AN) Communities

Intergenerational historical trauma, such as forced removal from land or government-operated boarding schools that separated AI/AN children from their families and cultures, has been linked to poor mental health outcomes among this population.²⁹ Across the U.S., AI/AN populations have disproportionately higher rates of suicide compared to other racial and ethnic groups.³⁰ However, funding for needed services is limited, and while there are Indian Health Service clinics located on reservations, many AIs/ANs live outside of tribal areas, further increasing difficulty in accessing culturally relevant care.^{31,32}



issues for current providers, inequities in access to care and quality of care will persist (see: Stigma and Protective Factors).

There are national efforts to create a more diverse behavioral health workforce, such as the [Minority Fellowship Program](#) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program aims to improve behavioral health care outcomes across racial and ethnic groups by increasing the number of people with diverse backgrounds in the field, and by improving the cultural competency of existing health care providers.¹⁸ Additionally, many groups have created [mental health provider directories](#) to help people find therapists and support from providers with whom they identify.¹⁹ Colorado's Office of Suicide Prevention recently released a [draft statement and action plan](#) that acknowledges the office's role, commitment, and ability to dismantle racism and apply a racial equity lens to its work.²⁰

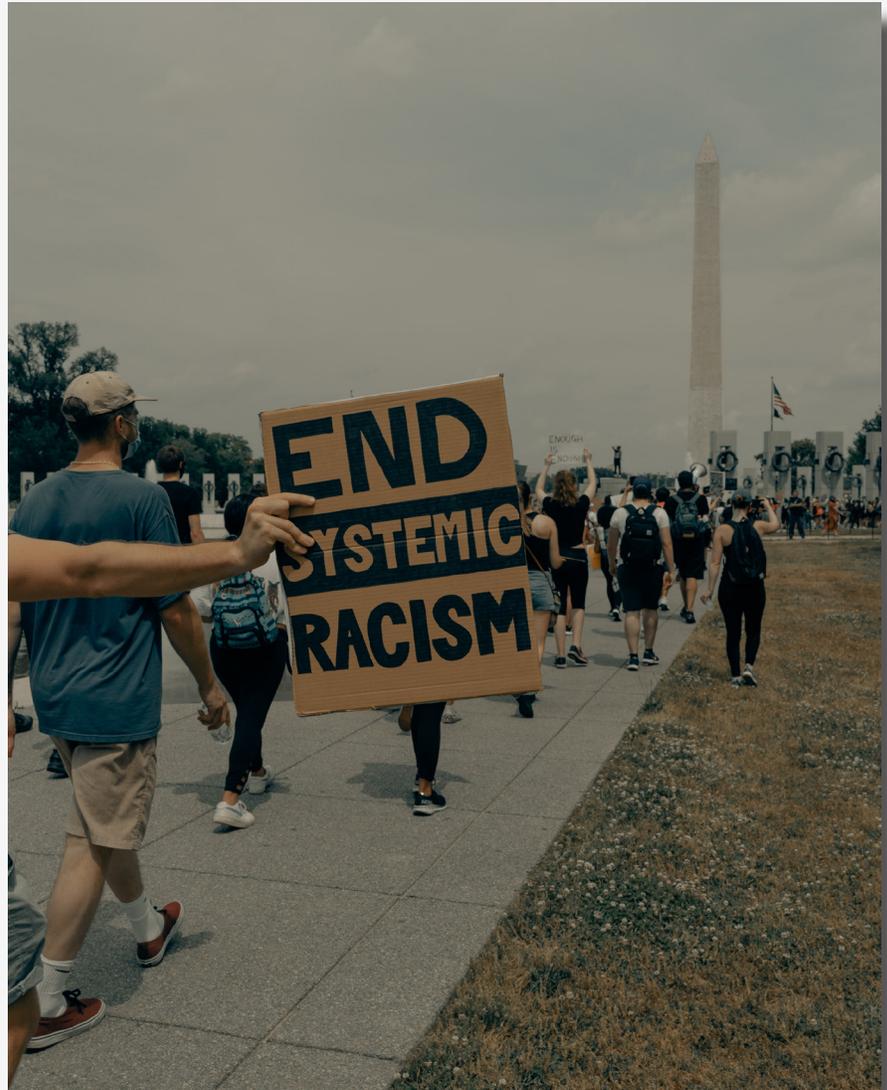
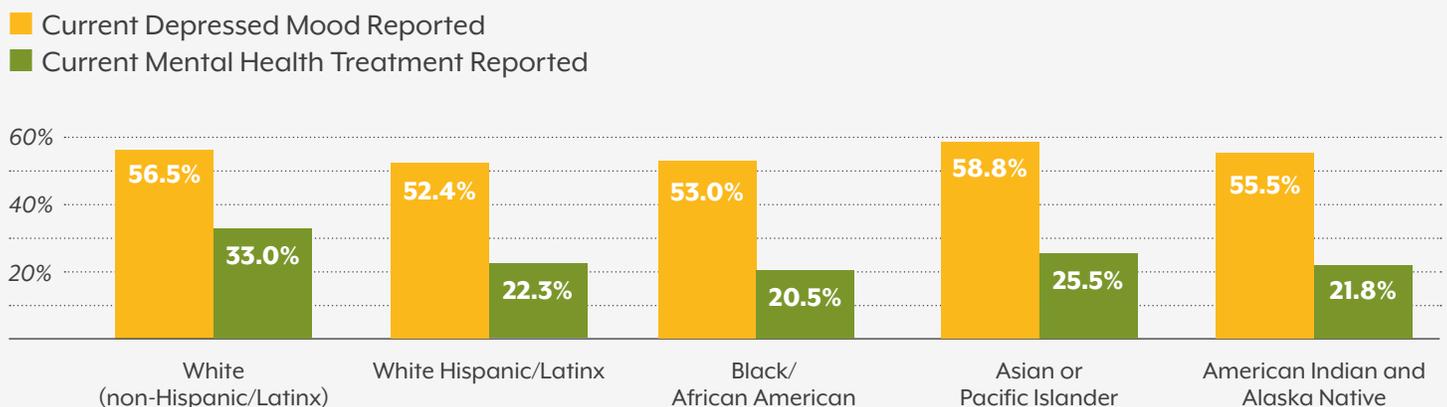


Figure 2. Non-White Coloradans Who Died by Suicide Were As Likely to Be Depressed, Less Likely to Be Receiving Treatment, 2010-2018



Source: Colorado Department of Public Health and Environment

Stigma and Protective Factors

Stigma can play a role in whether a person seeks care. The misconception that mental health is a weakness or other taboos can lead people to avoid seeking care or acknowledging their challenges. But many people and organizations are working actively to change the narrative about mental health. At the same time, some groups of non-white Americans, including Hispanics and Black Americans, have lower rates of suicide compared to white Americans.³³ Protective factors such as faith or strong cultural networks may promote resiliency among these groups. Just a few examples:

Black and African-American Communities

The Omega Psi Phi Fraternity, in collaboration with the National Institute on Minority Health and Health Disparities, launched the Brother, You're on My Mind toolkit to educate fraternity brothers and community members about depression and stress in African-American men. This includes encouraging Omega Chapters to actively participate in mental health discussions and outreach to local organizations in their community.³⁴

Hispanic/Latinx Communities

Groups like Mental Health America have developed numerous resources and screening materials in Spanish to remove language as a barrier when discussing mental health.³⁵ Community health workers, also known as promotores(as) de salud, have become more prevalent and can reduce cultural stigma in communities through their work sharing lived experiences and providing education and outreach.³⁶ Colorado is also home to several initiatives offering care to those who lack health insurance, including La Cocina in Fort Collins.³⁷

Asian American and Pacific Islander (AAPI) Communities

Organizations like the Asian American Health Initiative are working to reduce the taboo around

mental health challenges and to better understand mental health needs among AAPIs.³⁸ Younger AAPIs, who may minimize health problems due to the belief that elders (for example, those who had to flee oppressive regimes like the Khmer Rouge and became refugees or asylum seekers) faced greater obstacles, have built an online community of support through groups like the Asian Mental Health Collective.^{39,40,41}

American Indian and Alaska Native (AI/AN) Communities

Protective factors such as strong identification with culture and family can help decrease stigma around mental health care in AI/AN communities.⁴² Efforts to offer holistic care and to partner with AI/AN communities to develop health care centers, like the Sacramento Native American Health Center, can also lead to increased access and better health outcomes.⁴³ In Colorado, Denver Indian Health and Family Services provides culturally competent services such as primary care, dental



care, and behavioral health to local AI/AN adults, children, and families.⁴⁴ Federal initiatives, such as the Collaborative Hubs to Reduce the Burden of Suicide among American Indian and Alaska Native Youth, have been advancing research on preventive interventions to increase resilience and reduce suicide rates.⁴⁵

STORY THREE

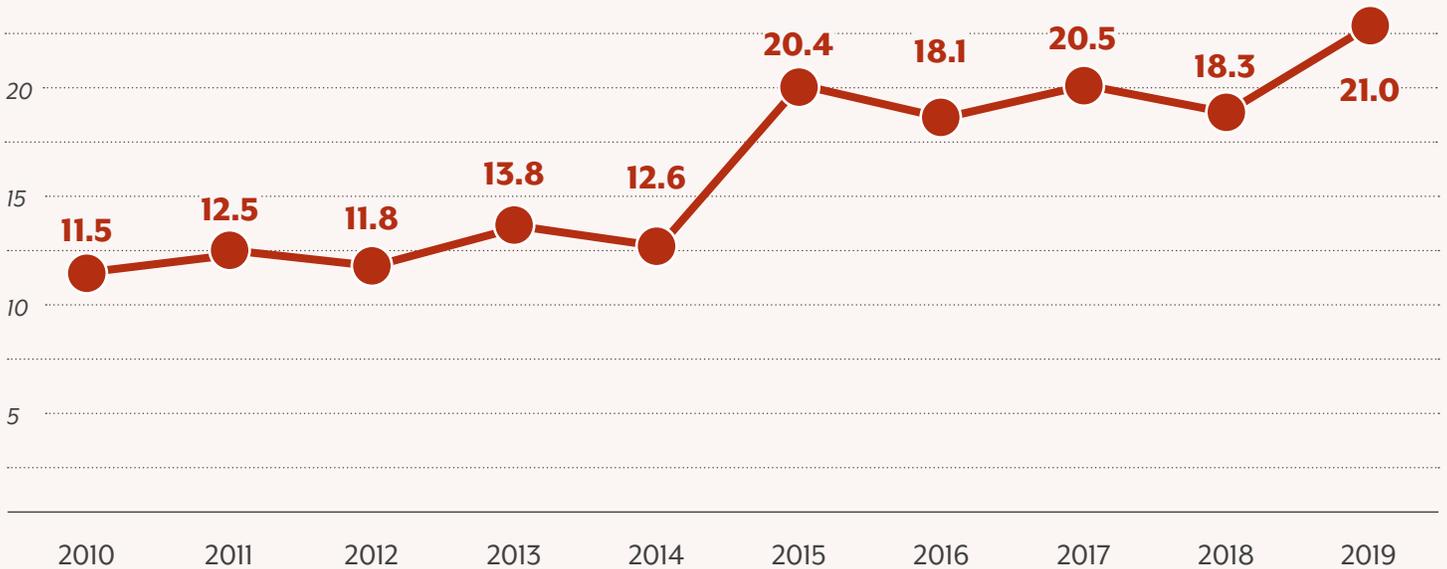
Colorado’s Youth Face Multiple Risk Factors

Over the past 10 years, the number and rate of suicide deaths among Colorado residents ages 15-19 has been increasing (see Figure 3). [Crisis Point](#), a project that examines youth suicide in Colorado, [reports](#) that the ongoing coronavirus pandemic, economic downturn, and racial injustice across the nation will negatively affect the mental health of youth, and that increased anxiety, loss of social connection, and a potential rise in domestic violence will increase the risk for suicide and need for mental health services.^{46,47} For youth, lack of a trusted adult, death of a loved one, pressure to perform well in school, and bullying are also risk factors for suicide.



Lesbian, gay, bisexual, transgender, questioning, intersex, and asexual (LGBTQIA+) youth are also at increased risk for suicide due to discrimination, harassment, and lack of resources. The [2019 Healthy](#)

Figure 3. Rate of Suicide Among Youth Ages 15-19 in Colorado (Deaths Per 100,000)



Source: Colorado Department of Public Health and Environment

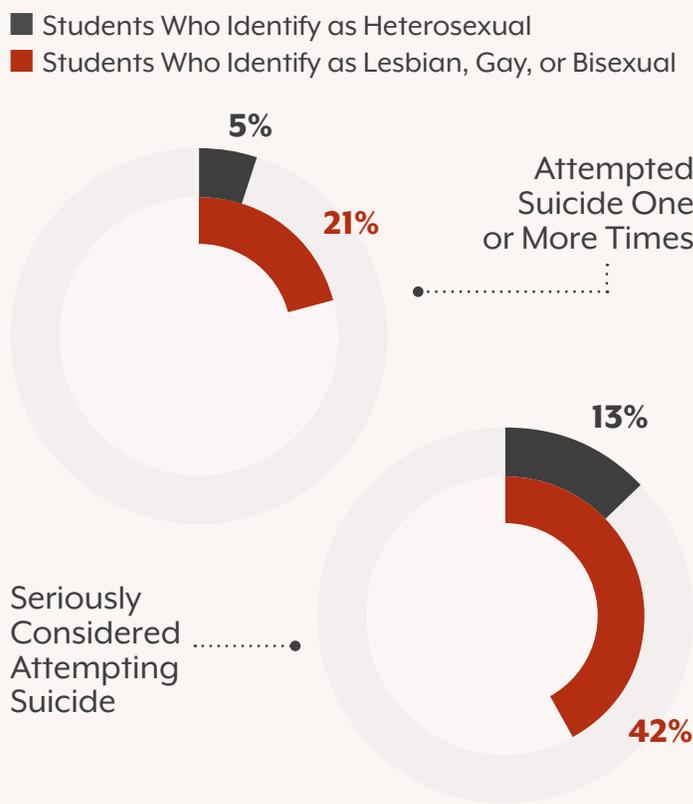


[Kids Colorado Survey](#) found that 42.0% of students who identify as gay, lesbian, or bisexual reported seriously considering attempting suicide during the past year, compared to 13.4% of students who identify as heterosexual. One in five (20.7%) of these students also reported attempting suicide at least once during the past 12 months, compared to 5.4% of heterosexual students (see Figure 4).

All youth can use Colorado Crisis Services if they are having suicidal thoughts or to talk about school, bullying, relationships, or substance use by texting TALK to 38255.⁴⁸ [One Colorado](#) advocates for policies that support the health of all LGBTQ Coloradans, including young people. For LGBTQIA+ youth in Boulder County, the Open and Affirming Sexual Orientation and gender identity Support ([OASOS](#)) program leads peer youth groups and provides other resources to support youth.⁴⁹ [The Trevor Project](#) also provides immediate crisis intervention.⁵⁰ They are available 24/7 at 1.866.488.7386 or by texting START to 678.678.

The 2019 Healthy Kids Colorado Survey found that **42.0% of students who identify as gay, lesbian, or bisexual** reported seriously considering attempting suicide during the past year.

Figure 4. Percent of Students Who Attempted or Considered Attempting Suicide in the Past Year, 2019



Source: *Healthy Kids Colorado Survey*

STORY FOUR

Substance Use Is a Risk Factor — And Numbers Among Colorado’s Young People Are Concerning

Substance use is a risk factor for suicide. Alcohol has consistently been the top substance detected among suicide deaths in Colorado, but over the past five years, marijuana has become the second highest (20.4% of all deaths). Opiates and benzodiazepines are not far behind (18.9% and 16.6%, respectively).

Colorado’s Amendment 64, which passed in November 2012, allows for personal possession and growing of recreational marijuana in the state.⁵¹ Recreational and medical marijuana became fully regulated and commercialized in 2014.

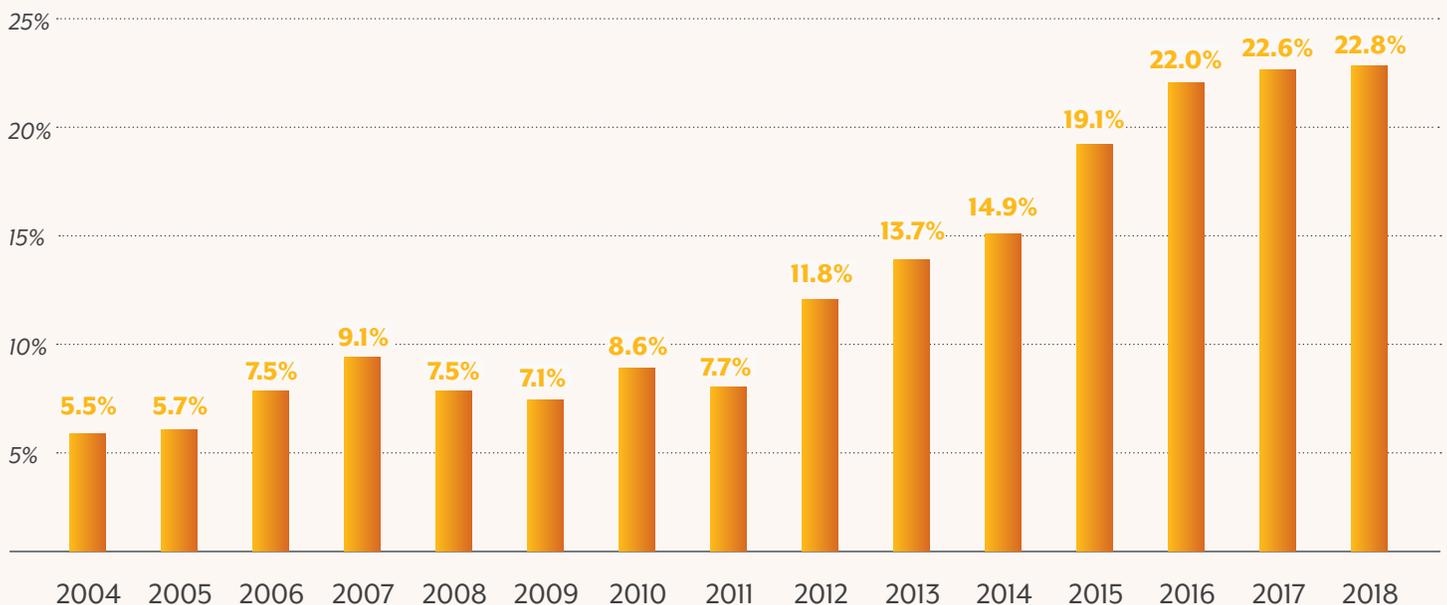
While marijuana presence in suicide deaths in Colorado had been rising since 2011 (see Figure 5), over the five years after commercialization, detection of marijuana in suicides increased for all Coloradans except those ages 10-14 compared to the five years prior (see Figure 6). This includes

a notable increase among youth ages 15-19, who legally should not have access to marijuana.

From 2014-2018, 30% of suicide deaths among youth ages 15-19 had marijuana present, an increase from 19.8% during 2009-2013. Alcohol was present in 12.1% of suicide deaths among 15- to 19-year-olds between 2014-2018, which is similar to past years, but still raises concerns over access to substances among youth (see Figure 7). The 2019 Healthy Kids Colorado Survey found that over half of Colorado students felt it would be easy or very easy to get marijuana and alcohol if they wanted.

Marijuana’s health impacts have been [heavily debated](#) for years.⁵² While usage has been linked to mental illness, such as a higher risk for depression or anxiety, [causation has not been established](#).⁵³ However, the increased [potency](#) of modern-day products raises more concerns about negative health impacts.⁵⁴

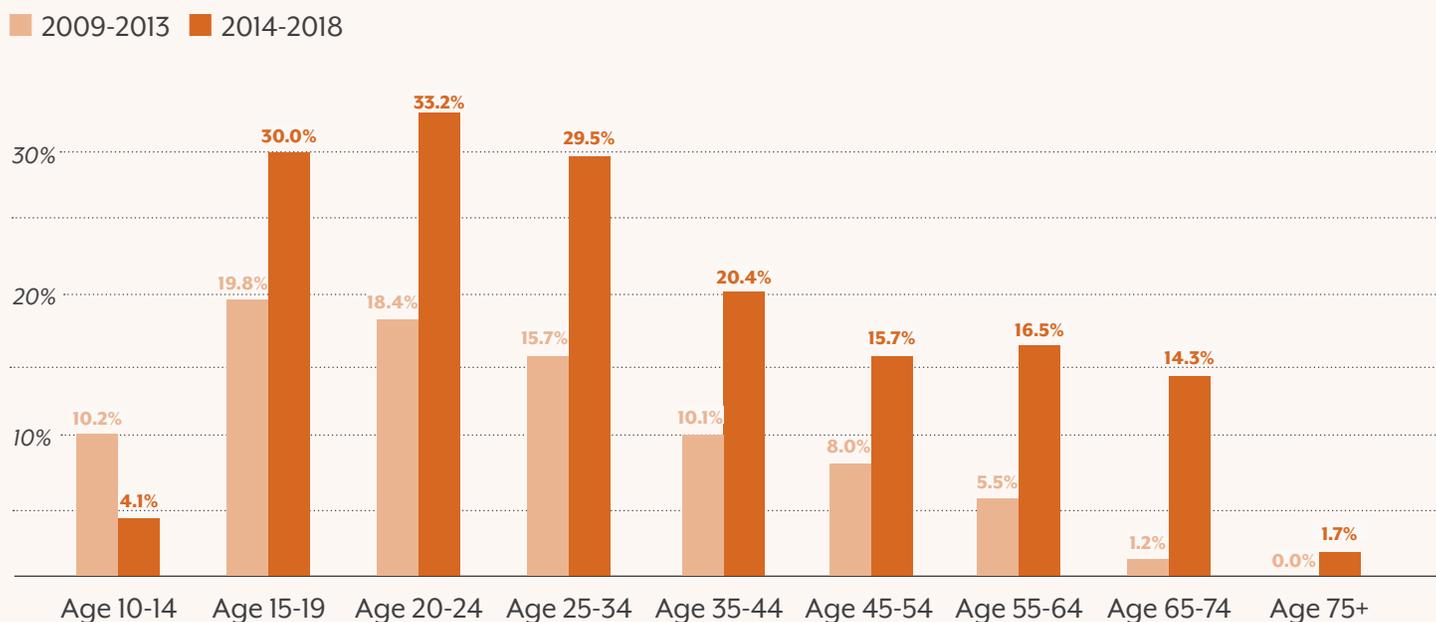
Figure 5. Marijuana Presence in Suicide Deaths in Colorado



Source: Colorado Department of Public Health and Environment

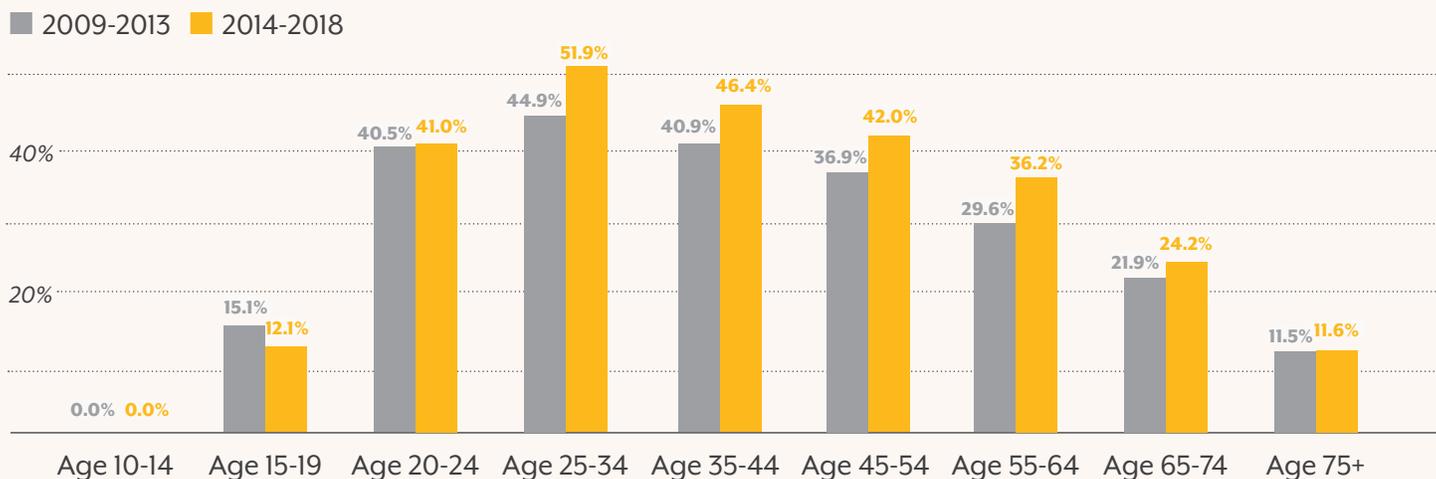
CDPHE has been working with local counties to implement the [Communities That Care model](#) for substance misuse prevention among youth.⁵⁵ For those seeking support for themselves, [Rise Above Colorado](#) is an organization that empowers teens to live healthy lives.⁵⁶

Figure 6. Marijuana Presence in Suicide Deaths by Age



Source: Colorado Department of Public Health and Environment

Figure 7. Alcohol Presence in Suicide Deaths by Age



Source: Colorado Department of Public Health and Environment

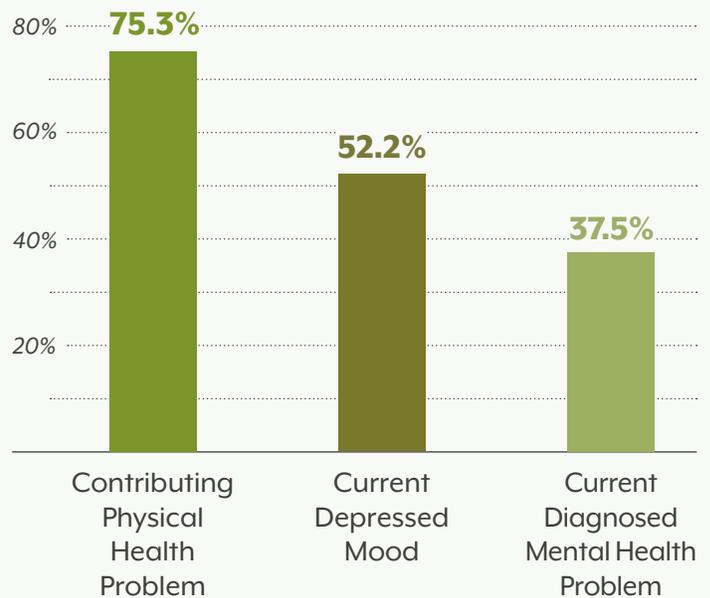
STORY FIVE

Physical Health Challenges Are Linked to Suicide Among Older Adults

About 14% of suicides in Colorado each year are among older adults (those over age 65), which is [higher than the national average](#) and places Colorado [among the top 10 states](#) for suicide among this group in 2020, according to America's Health Rankings.⁵⁷ The most commonly reported circumstance among older adult suicides in Colorado is a contributing physical health problem. The [CDC](#) reports that 80% of older adults have at least one chronic health condition such as arthritis, diabetes, or high blood pressure, and 50% have at least two conditions.⁵⁸ Losing the ability to be physically independent can be a [contributing factor](#) to poor mental health, which is [often undiagnosed](#) among older adults.⁵⁹

In the past decade, only 37.5% of adults age 65 and older who died by suicide in Colorado were reported as having a current diagnosed mental health problem, despite over half being reported as having a current depressed mood. On the other hand, 75.3% had a known contributing physical health problem (see Figure 8).

Figure 8. Percent of Suicides Among Those Age 65+ Where a Contributing Physical Health Problem, Current Mental Health Problem, or Current Depressed Mood Were Reported, 2009-2018



Source: Colorado Department of Public Health and Environment

Screening for mental health concerns should occur in all older adult patients in the same way physical health problems are monitored. When it comes to suicide prevention, older adults are often a [“forgotten population”](#) — a group that is often not thought of when it comes to health promotion and disease prevention efforts.⁶⁰

The American Foundation for Suicide Prevention provides a list of [simple actions](#), such as regularly checking in with loved ones via phone or video chat, to make sure older adults are not forgotten.⁶¹ And the Institute on Aging provides a [24-hour toll-free Friendship Line](#) for adults over 60, including those living with disabilities.⁶² The line may be accessed by calling 800.971.0016. Watching for [warning signs among older adults](#) can help — as can understanding that depression is not an inevitable part of aging.⁶³



STORY SIX

Veterans' Lived Experiences Can Pose Unique Risks

Data show that in Colorado, [suicide among veterans](#) has been increasing.⁶⁴ The U.S. Department of Veterans Affairs' (VA) [2020 National Veteran Suicide Prevention Annual Report](#) found that in 2018, the unadjusted suicide rate among veterans in Colorado was 43.0 per 100,000 people.⁶⁵ After accounting for age differences, the VA determined that Colorado's veteran suicide rate was [significantly higher](#) than both the national veteran suicide rate and the national general population's suicide rate.⁶⁶

Veterans have different lived experiences from civilians. It takes bravery to serve our country, but experiences related to combat and stress can result in poor health outcomes if left unaddressed. In addition to conditions like post-traumatic stress disorder (PTSD), common risk factors for suicide — such as limited independence, homelessness, or chronic health conditions — can be [exacerbated by military service](#).⁶⁷

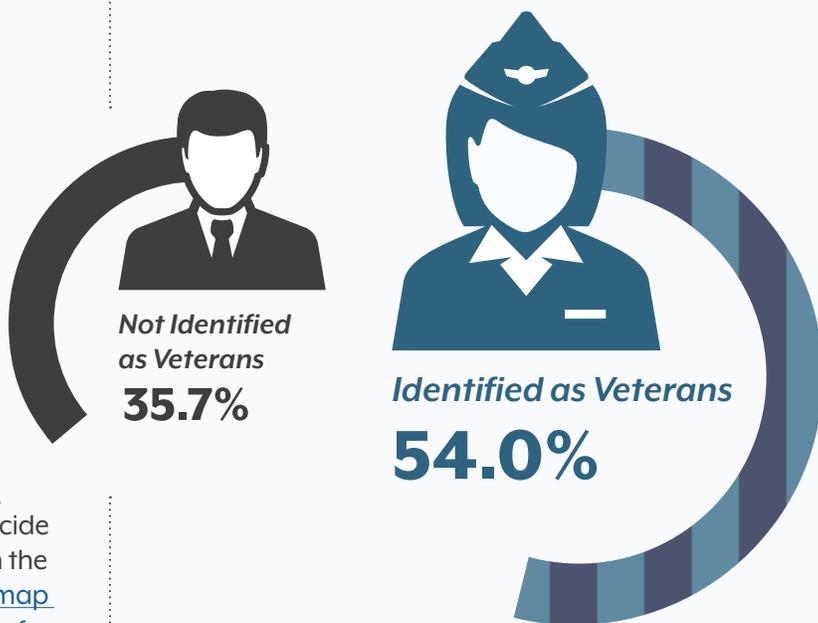
Data from the past five years show that 54.0% of suicides among veterans age 20 and older had a contributing physical health problem, compared to 35.7% of suicides among non-veterans in the same age group (see Figure 9). And although older adults in general are more likely to have a contributing physical health problem, the same discrepancy exists between older adult veterans and non-veterans.

Access to health care services may be an issue. A March 2019 Executive Order known as the [National Roadmap to Empower Veterans and End Suicide](#) noted that 70% of veterans who died by suicide had not recently received health care services from the VA.⁶⁸ This order set in motion [the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide](#) (PREVENTS). One of the priorities of PREVENTS is creating streamlined access to mental health and suicide prevention care.⁶⁹ Given this national initiative and local efforts such as the [Follow-Up Services](#) program through Colorado Crisis Services, there is hope to turn the tide in the coming years.⁷⁰

The National Alliance on Mental Illnesses' [Veterans and Active Duty](#) page focuses on common questions



Figure 9. Percent of Suicides Among Adults 20 and Older With a Contributing Physical Health Problem, by Veteran Status, 2014-2018



Source: Colorado Department of Public Health and Environment

and concerns military personnel have when seeking behavioral health care.⁷¹ The Veterans Crisis Line is also available 24/7 at 1.800.273.TALK (1.800.273.8255), ext. 1. In addition, responders are also available through a text to 838.255 or via [online chat](#).

STORY SEVEN

Men in Colorado Are More at Risk

In our state, the rate of suicide among men is over three times higher than among women (29.2 and 8.8 suicide deaths per 100,000 people, respectively). Yet males who died by suicide were less likely to be reported as having a current diagnosed mental health problem or having ever been treated for a mental health problem. Data show similar trends among youth ages 10-19. (CDPHE's data captures whether a person is identified as male or female on their death certificate. The Department hopes to report data on suicides among transgender people in future releases.)

Mental health is not the only risk factor (see Figure 10). Men and women may also react differently in situations of despair, such as during unemployment, or in reaction to a loss of a loved one or a relationship problem. In Colorado, men were more likely to die by methods that leave little time for intervention and are more likely to be fatal, such as firearms, and hanging/suffocation.

Stigma surrounding mental health or expectations tied to [masculine norms](#) — such as those that encourage men to be self-reliant and hide their emotions — can harm mental health and cause many men not to acknowledge concerns or avoid seeking care when they need it.⁷²

Increasingly, groups are working to tackle this problem. [Efforts](#) to raise awareness among men and normalize behavioral health care include [Man Therapy](#), a campaign that uses humor to encourage men to proactively address their mental health.^{73,74} And with high-profile athletes and celebrities like [Dallas Cowboys' quarterback Dak Prescott](#) openly discussing their own mental health struggles, there is more encouragement for young men to hold open conversations and not shy away from seeking care.⁷⁵

Figure 10. Reported Circumstances and Method of Injury, by Sex, 2004-2018

■ Male ■ Female

Percentage of Suicide Deaths Reported As...

Having a current diagnosed mental health problem (all ages)



Ever having been treated for a mental health problem (all ages)



Having a current diagnosed mental health problem (ages 10-19)



Ever having been treated for a mental health problem (ages 10-19)



Age-adjusted rate* (per 100,000 people) where...

Firearm was method used to inflict injury



Hanging, strangulation, or suffocation was method used to inflict injury



Poisoning was method used to inflict injury



Source: Colorado Department of Public Health and Environment
*Data are from 2004-2019

STORY EIGHT

Construction Has the Highest Suicide Rate of Any Industry in Colorado

Data show that almost every year, construction is associated with the highest number of suicide deaths of any industry in Colorado. This mirrors a national trend: Construction workers are [five times more likely](#) to die by suicide than from a work-related injury.⁷⁶ This highlights the need for better understanding of work-related risk factors for suicide, such as long work hours and physical labor coupled with increased financial incentive to work overtime. Construction is a [male-dominated industry](#), and stigma may also play a role in some construction workers' hesitation to seek mental health treatment.⁷⁷



While more research is needed to better understand prevention strategies and interventions that decrease the suicide rate in the construction industry, there are organizations dedicated to increasing awareness and providing support for these workers. For example, the [Construction Industry Alliance for Suicide](#)

[Prevention](#) provides contractors, unions, associations, industry service providers, and project owners with [suicide prevention resources](#).⁷⁸ The Alliance has also partnered with agencies, such as the Department of Labor and the Occupational Safety and Health Administration (OSHA), to explore how suicide prevention can be promoted through federal programs.

Construction has topped the list of suicide deaths by industry in Colorado **11 of the past 15 years.**

(2004-2018)

Source: Colorado Department of Public Health and Environment



STORY NINE

Firearms Were Involved in More Rural Suicide Deaths

Studies have shown that across the U.S., access to firearms is associated with increased suicide risk.⁷⁹ Half of Colorado’s suicide deaths involved firearms and firearm ownership tends to be higher in rural areas. This is a cause for concern in areas of the state outside the Front Range.

Between 2014 and 2019, deaths by suicide in rural areas were more likely to involve a firearm compared to urban areas (see Figure 11). The county with the highest firearm-involved suicide rate in this timeframe was Custer, a rural-designated county, at 37.1 deaths per 100,000 people. This rate is six times higher than that of the county with the lowest firearm-involved suicide rate: Gilpin, a small county west of Denver with an urban designation, at 5.9 per 100,000. Denver itself has the second-lowest rate at 6.8 per 100,000 people.

Suicide attempts with a firearm are more likely to be fatal, and they leave a smaller window of time to reach out for help.

Although the relationship between rurality and mental health is still being studied, [collaborations](#) between groups like the Colorado Cattlemen’s Agricultural Land Trust, the Colorado Department of Agriculture, and [Colorado Crisis Services](#) are working to tailor and expand mental health resources to people living in rural areas.⁸⁰ And the [Colorado Gun Shop Project](#) promotes suicide prevention at retailers and other organizations in the firearm industry.⁸¹

For immediate needs, Colorado Crisis Services is available 24/7 by calling 1.844.493.8255 or texting TALK to 38255.

Figure 11. Age-Adjusted Rate for Suicide With a Firearm, 2014-2019

Rate per 100,000 people

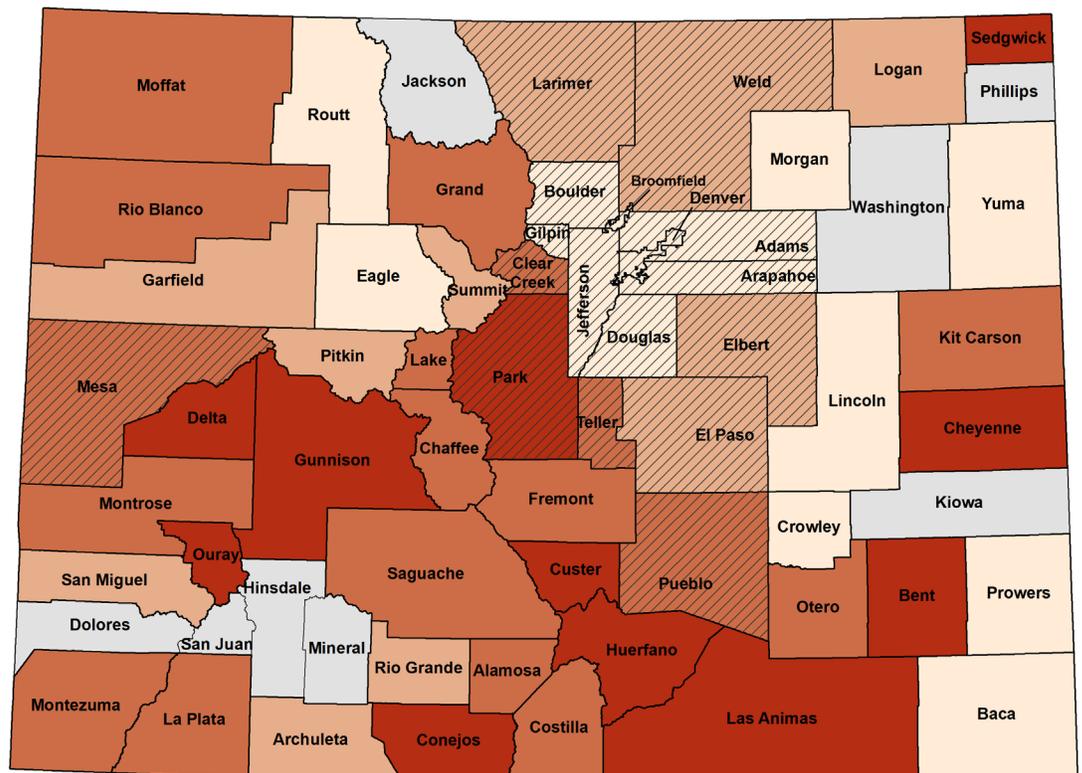
- 5.9-9.5
- 9.6-12.8
- 12.9-18.0
- 18.1-37.1
- Urban counties
- Data are suppressed due to small numbers

RURAL COUNTIES (AVERAGE)

15.5

URBAN COUNTIES (AVERAGE)

11.9



STORY TEN

Suicide Is Preventable

Since 2004, more than one-third (33.6%) of Coloradans who lost their lives to suicide had recently disclosed their intent to someone. In other words, within a month prior to their death, more than 4,500 people had explicitly or indirectly shared their thoughts or intent of suicide.

Prevention is possible. And it can take place long before immediate crisis intervention is ever needed.

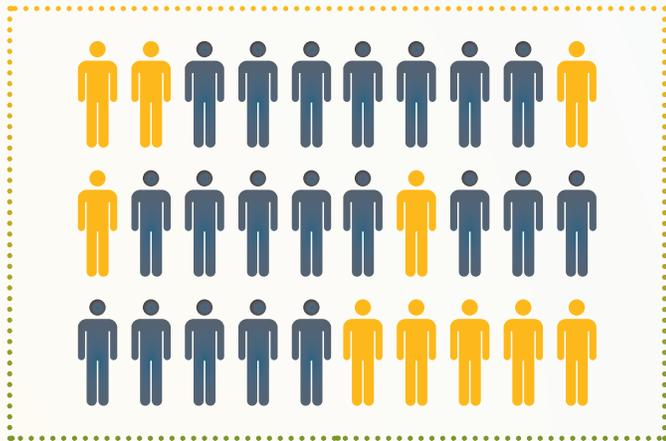
While 2020 was difficult for a multitude of reasons, the need to support Coloradans' mental health and to identify ways to intervene before a crisis existed long before the pandemic began. But we are resilient. [Nine out of 10 people](#) who attempt suicide and survive will not die by suicide later in life⁸² — a reminder that recovering from dark times or suicidal thoughts is possible. And whether through addressing our own mental health challenges or working to improve access to care and society's ability to be responsive to the needs of all people, we can work toward a [new better](#) to strengthen our communities.⁸³

This can happen by staying socially connected and holding open conversations about mental health, so no one has to struggle alone. It requires understanding that people of any age, gender, race, ethnicity, profession, or geography can be at risk for suicide, and that though we all have unique experiences and behaviors, knowing and watching for [warning signs](#) can make an enormous difference.⁸⁴ Even more importantly, we all must support policies and leadership that can improve the [root causes](#) of many mental health stressors.⁸⁵

If you or someone you know needs help, call the National Suicide Prevention Lifeline by calling 9.8.8 or 1.800.273.TALK (8255), or texting HELLO to 741.741.

At this time, more than ever, we must take care of ourselves and each other.

One-third of people who lost their life by suicide in Colorado were reported as having recently disclosed their intent.



But suicides are preventable.



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