gatekeepers:

HELPING TO PREVENT SUICIDE IN COLORADO

An Evaluation Report on the Preventing Suicide in Colorado Initiative

GATEKEEPERS:
Community members who have been trained to recognize those contemplating suicide and refer them to appropriate caregivers.

findings at a glance

In suicide prevention, gatekeepers open a gate into potentially beneficial supportive care or treatment services for people they believe are in-need of crisis intervention, but who might not otherwise seek care.

Gatekeeper training has become more common among suicide prevention efforts, yet little is known about whether gatekeepers used the skills after being trained. The intent of this evaluation was to determine if people trained as gatekeepers use the skills they are taught to positively intervene so that potential suicide deaths are avoided and at-risk individuals are referred to professional services.

Ten Colorado communities participated in this initiative, representing 32, or one-half of the state's counties. Over a three year period, about **1,300 gatekeepers were trained across Colorado** through this effort. Of these 1,300 gatekeepers, 570 participated in this evaluation.

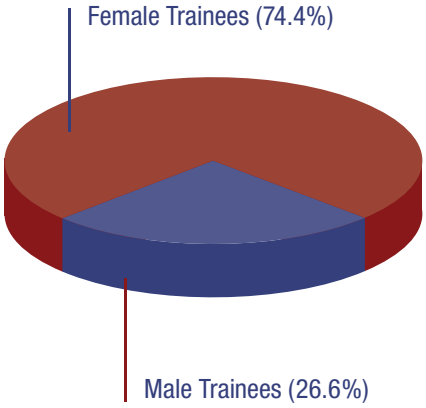
Most of these trainees used their gatekeeper skills to help individuals at-risk of suicide. Forty-four percent intervened at least once; 13% reported they had intervened more than once.

Interventions by Gender

FINDINGS:

- Gatekeeper trainees intervened more often with females (58%) than with males (42%).
- There is a slight tendency for the gatekeeper and at-risk person to be of the same gender, though both male and female gatekeepers indicated a willingness to intervene with persons of the opposite gender.

Gender of Gatekeeper Trainees

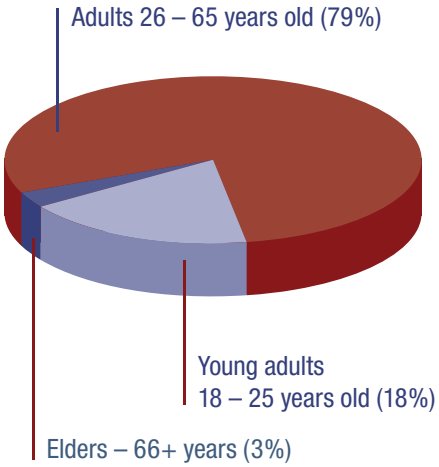


Interventions by Age

FINDINGS:

- The majority of interventions were with adults aged 25-64 (54%). Teens (24%) and young adults (16%) also received a substantial number of interventions. Not surprising is the fact that interventions were rare among children up to 11 years old. Given the fact that the rate of suicide deaths is high among elderly persons, however, it is of note that elders received only 4% of the interventions.

Ages of Gatekeeper Trainees

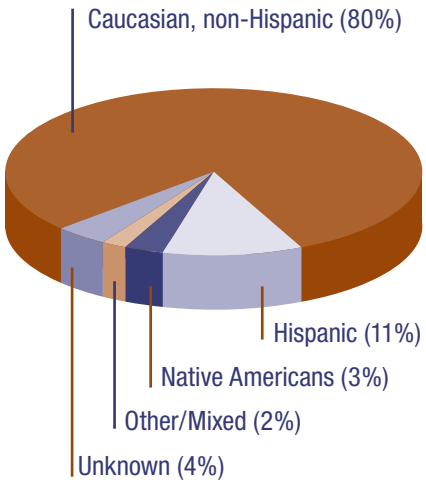


Interventions by Ethnicity

FINDINGS:

- Only about one-quarter of the interventions were with persons of minority ethnic or racial origin. The somewhat small proportion of interventions among persons of minority populations reflects the Caucasian character of the rural locations of many of the adult gatekeeper trainings.
- Among the 55 interventions with Hispanic persons, 38% were conducted by Hispanic gatekeepers. Among the seven interventions with Native Americans, four were conducted by Native American gatekeepers. These data suggest that if at-risk minority persons are to be engaged through gatekeeper behavior, persons of similar ethnic or racial origins should be well represented among trained gatekeepers.

Ethnicity of Gatekeeper Trainees

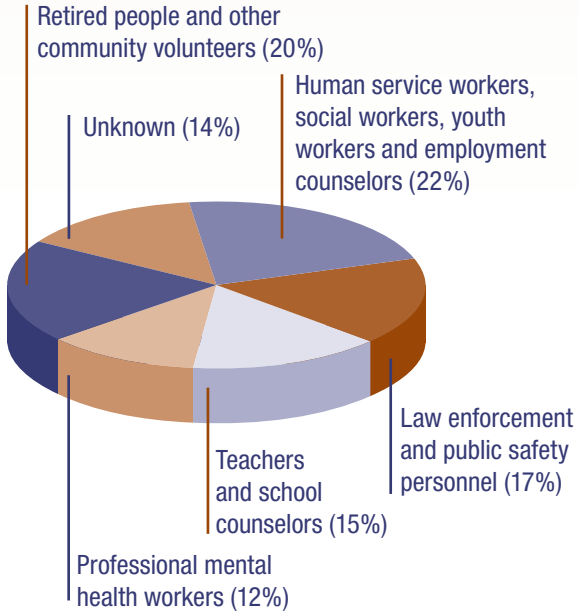


Interventions by Occupation

FINDINGS:

- Almost 40% of the trainees who intervened worked in social services or mental health, 12% of the trainees worked as teachers or school counselors and 14% worked in law enforcement.
- The employment positions of gatekeeper trainees indicate that people who work in front-line social services (51%) and mental health services (64%) are most likely to intervene with individuals at-risk of suicide.

Occupations of Gatekeeper Trainees



The findings indicate that the strategy of gatekeeper training is a successful suicide prevention strategy. In other words, the findings provide hope that the longer-term effect will be to reduce the numbers and rates of suicide deaths and attempts.

introduction

The seriousness and persistence of the problem of suicide in Colorado have long required a sustained public health prevention effort. The Colorado Trust's 2002 report, *Suicide in Colorado,* used data specific to Colorado and the Rocky Mountain region to detail the problem of suicide deaths and attempts in the state, and the lack of sufficient suicide prevention resources. This report echoed the call from the U.S. Surgeon General for comprehensive community-based strategies to attack this public health problem.

The first State of Colorado Plan for Suicide Prevention and Intervention also recommended "the design and implementation of 'community suicide prevention resource plans' that include all community stakeholders interested and involved in suicide prevention and intervention."[1] As documented in *Suicide in Colorado,* however, few financial or technical assistance resources had been available to communities to either begin, or to strengthen this important work.

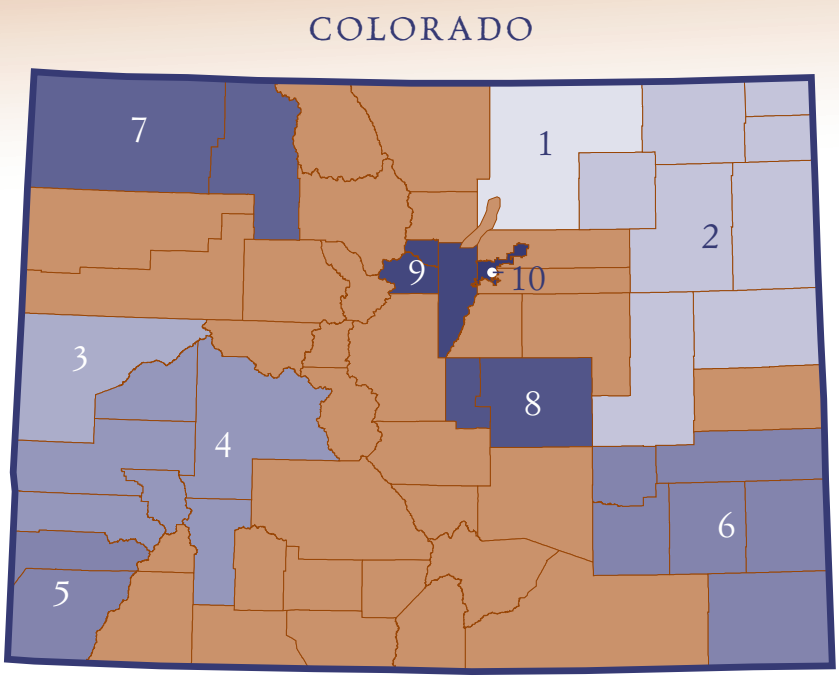
Suicide in Colorado found that at least half of the people at-risk for suicide in Colorado do not seek any type of professional help. The report recommended that communities "respond to this problem by building on existing resources to create a more focused network of formal and informal sources of support that can readily recognize those at risk, ensure that appropriate services are available and used, and link providers to ensure efficient and effective service delivery."[2]

In response, The Colorado Trust developed the Preventing Suicide in Colorado (PSIC) initiative. The initiative provided 10 communities (selected through a Request for Proposals process) with the opportunity to develop and implement comprehensive suicide prevention plans. Seven of these grantees promoted suicide prevention in multiple counties. Their broad geographic reach resulted in an initiative that had prevention efforts in one-half of Colorado's 64 counties (see Figure 1). Seventy-five percent, or 24 of the 32 participating counties had been classified as above the statewide mean either with regard to its rate of suicide deaths or attempts. Five counties – Delta, Dolores, Mesa, Phillips and Sedgwick – were above the mean on both rates. This meant that prevention of suicide deaths and an effort to increase help seeking among at-risk individuals would be especially beneficial in these counties.

Through the planning process, stakeholders in all 10 sites were interested in training community members to become gatekeepers. The logic of this community approach is based on the premise that suicide behavior has signs and symptoms that can be learned and recognized by non-mental health professionals. It follows that if more people know these signs and symptoms, and how to intervene, there would be an increase in identifying people who are at-risk of suicide. These trained individuals become "gatekeepers" into the formal systems of mental health care and suicide prevention efforts.

It was determined that this education and awareness strategy would allow assessment of suicide prevention behavior among community members and, in turn, could be used to assess the potential effect of the overall PSIC initiative.

FIGURE 1: *Geographic Distribution of Preventing Suicide in Colorado Grantees*



1. Hispanic Youth Project of Suicide Education and Support Services of Weld County*
2. The LifeSource Project
3. Link for Life
4. Midwestern Colorado Suicide Prevention/ Intervention Coalition
5. Montelores Suicide Prevention Initiative
6. Project HOPE
7. REPS (Reaching Everyone: Preventing Suicide)
8. Suicide Prevention Education and Advocacy Coalition
9. Tri-County Trust Project: Suicide Prevention
10. Voz y Corazón

**Did not participate in the evaluation; only adults trainees were evaluated.*

about gatekeepers

The definition of 'gatekeeper' used in this evaluation is from the State of Colorado Plan for Suicide Prevention and Intervention:

> "Gatekeeper is a term used in suicide prevention to denote persons in the 'community' that have the opportunity to detect the conditions that lead to suicide and assist in obtaining the help that is required."[1]

In some contexts, a gatekeeper may be thought of as a person who keeps others out of a place; however, in suicide prevention – in which the stigma regarding the use of mental health care continues – the understanding of gatekeeper is precisely the opposite. In this regard, gatekeepers open a gate into potentially beneficial supportive care or treatment services for persons who are in need of care or crisis intervention, but who might not otherwise seek care.

Gatekeepers perform a specific positive role within a community-based effort to prevent suicide deaths and attempts. While some social service agency staff has been trained to perform this role in the course of professional training, the concept of gatekeeper in the context of suicide prevention is not explicitly associated with a specific profession. Gatekeepers are community members who are trained to identify persons at-risk for suicide, encourage help-seeking and know how and where to refer these individuals to appropriate sources of help.

evaluation description

While gatekeeper training has become more common among suicide prevention efforts in Colorado and across the United States, there is little knowledge about whether the gatekeeper trainees really used the skills once they were trained. With this in mind, the intent of this evaluation was to determine if people trained as gatekeepers use the skills they are taught to positively intervene so that potential suicide deaths are avoided and at-risk individuals are referred to professional services.

Evaluations of previous efforts have reported that gatekeeper trainees are grateful for the skills training and have positive opinions about what they learned; however, these findings don't tell us whether such trainings may be successful in helping to identify and intervene with individuals who may be suicidal. This evaluation focused on following up with trainees after the training to find out what they did with the information learned, and if they found it necessary to intervene to prevent a potential suicide attempt. The logic of examining this intermediate outcome is that if gatekeepers use suicide prevention skills, their behavior will potentially have the longer-term aggregate effect of reducing the numbers and rates of suicide deaths and attempts.

The positive nature of the following findings – limited to the PSIC initiative – suggests there is potential for longer-term reductions in the rates of suicide deaths and attempts in Colorado.

gatekeeper curricula

Grantees selected the specific curricula based on the perceived needs and resources of their communities. There are elements of gatekeeper training in suicide prevention programs primarily targeted to youth, however, this evaluation focused specifically on the following three gatekeeper trainings programs for adults:

ASIST is a two-day, practice-oriented training that teaches a model of suicide prevention intervention. The model includes six tasks that begin with helping trainees to recognize when someone is at risk of suicide, to following up on commitments made in a plan to keep the at-risk person safe from suicide. Extensive role-playing among all trainees is used to develop gatekeeper skills intended to prevent immediate risk of suicide.
www.livingworks.net

QPR training is a one- to three-hour suicide prevention gatekeeper training that teaches:

- How to ask the suicide question (examples, specific phraseology)
- How to persuade a suicidal person to accept help
- How to refer a person to local or national resources.

www.qprinstitute.com

SPEAC Intervention Training is a gatekeeper curriculum developed by the Suicide Prevention Education and Advocacy Coalition. The one-half- to one-day training includes:

- Teaching the scope of the problem of suicide
- Identifying persons at risk for suicide
- Intervention techniques
- Resources for information and for mental health treatment.

Because the PSIC evaluation was limited to adults who received training, the Hispanic Youth Project that trained only youth was not included in the evaluation.

methodology

Both program and trainee data were collected. Three program-level data sources described the gatekeeper training in each site during the three-year initiative. Program data were collected:

- As part of the routine progress reports from grantees that documented the number and locations of training sessions
- From curricula material and through observation of selected trainings that documented characteristics of the implemented trainings
- From focus groups and interviews with key informants near the end of the three-year period.

Trainee-level data describe both the population that was trained and the performance of selected trainees once they completed the training.

- Demographic and employment data were collected from trainees as part of the training registration.
- Trainees who agreed to be part of the evaluation were surveyed three months following the training via an on-line survey to determine to what extent they performed a gatekeeper role after the training. Respondents continued to be surveyed in six-month intervals through the end of the grant.

evaluation findings

PEOPLE TRAINED AS GATEKEEPERS

Gatekeeper training is a relatively recent approach to suicide prevention, and this initiative contributed significantly to the pool by training approximately 1,300 gatekeepers across Colorado. Of the 1,300 people trained, 570 participated in the evaluation.

DEMOGRAPHIC CHARACTERISTICS

The typical trainee in the evaluation was a middle-aged Caucasian (non-Hispanic) woman. Women outnumbered men as gatekeeper trainees three to one. For the most part, the gatekeeper trainees were between the ages of 26 and 65 years (79%); however, the trainees also included a small percentage of young adults (college residence hall counselors) (18%), and elders (66+ years) represented a very small proportion of the trainee population (3%).

The large majority of the trainees were Caucasian, non-Hispanic persons (80%), with a smaller representation of persons of color, Hispanic (11%), Native American (3%), mixed origins (2%) and did not identify according to race or ethnicity (4%).

EMPLOYMENT

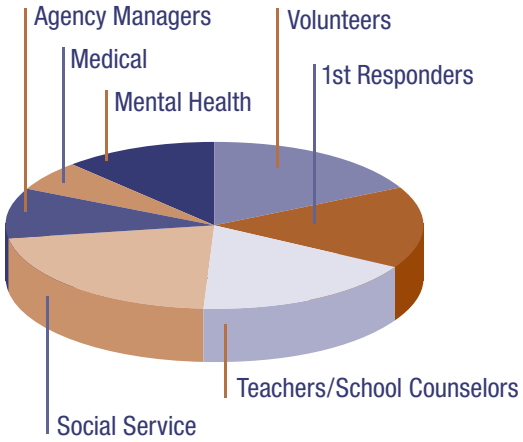
Most of the respondents were currently employed and took the training as a function of their employed position. The largest segment of the trainees included human service workers, social workers, youth workers and employment counselors (22%). Law enforcement and public safety personnel – such as police officers, probation officers, victims' advocates, firefighters and EMTs – also comprised a large proportion of the trainees (17%). Another significant segment of the trainee population worked in the field of education as teachers or school counselors (15%). Professional mental health workers, including clinicians and program managers, participated in gatekeeper trainings (12%) and, as noted above, college-age students who worked as residence hall directors were trained.

While grantees wanted to train the general population as suicide prevention gatekeepers,

the proportion of trainees whose employment was outside health and human services, and the education sector was quite small. Still some business owners, municipal workers and construction employees were among the trainees.

A number of retired persons and other community volunteers learned about the training sessions through stakeholder meetings and advertisements, and participated as trainees (20%). Among these general community members are people who volunteer on local suicide prevention hotlines, serve as mentors for young people or are members of church pastoral care committees. Clergy and other church staff also were trained as gatekeepers. Compared to those who were trained because of their employment positions, however, the "volunteer" trainees were small in number.

FIGURE 2: *Employment Fields of Gatekeeper Trainees*



GATEKEEPER SUICIDE PREVENTION BEHAVIORS

Gatekeepers used what they learned in the trainings both to identify persons who might be suicidal and to intervene to prevent suicide.

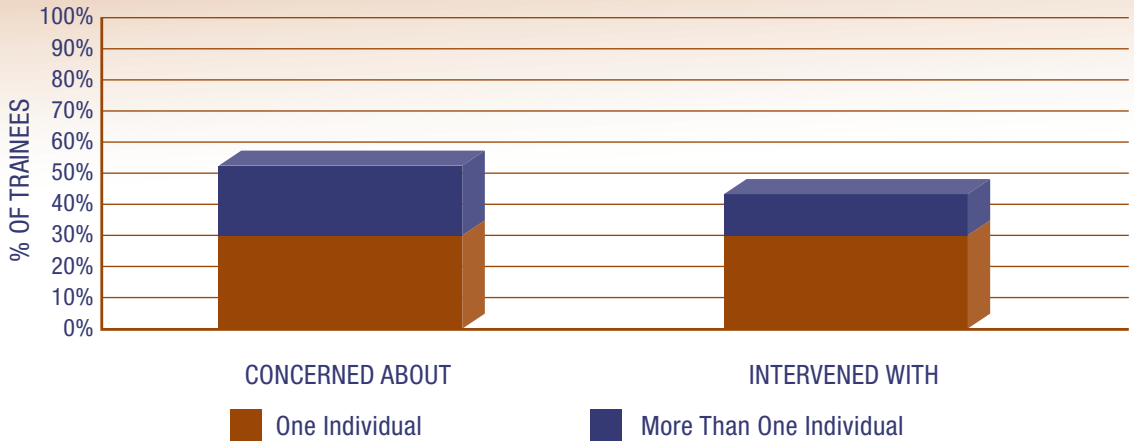
In the survey gatekeeper trainees were asked, *"Since your training… have there been times when you have been concerned that a person was suicidal?"* Thirty-one percent of respondents reported there had been one time since their training when they were concerned a person might be suicidal. Another 21% reported more than one time when they were concerned that someone was at-risk for suicide. Overall, almost 300 trainees (slightly over one-half the respondents, or 52%) reported they had identified at least one person whom they believed was at-risk of suicide.

recommendations

FUTURE TRAINING NEEDS IN COLORADO FOR GATEKEEPERS

- *Target community volunteers, not just people in "helping professions," to become gatekeepers.*
- *Recruit older adult trainees who might be more likely to encounter older adults at-risk of suicide.*
- *Strengthen efforts to train persons of ethnic diversity.*
- *Ensure that training curricula are reviewed and adapted for different trainee populations (i.e., elders, racial and ethnic minorities).*

FIGURE 3: *Percentage of trainees who reported engaging in gatekeeper behavior*



Equally important, most of these respondents also used gatekeeper skills to help individuals they were concerned about. A substantial proportion (44%) of the trainee respondents reported they intervened at least once with a person at-risk of suicide using the knowledge and skills taught in the gatekeeper trainings. And, indeed, 79 gatekeepers reported they had intervened more than once during the initiative.

The findings indicate that a good proportion of the respondents performed one or more gatekeeper interventions once they were trained. Unfortunately, literature in the field of suicide prevention does not yet provide comparative information. Clearly not all trainees can be expected to perform the role of a gatekeeper within two years of training, but what amount of gatekeeper activity would be normal or useful is not yet known.

As there were no pre-training surveys conducted, it is important to be cautious about attributing reported gatekeeper behavior to the training. However, two types of data provide some evidence that it is likely the trainings influenced gatekeeper behavior. The first is from an examination of behavior change among trainees in one site, and the second is from gatekeepers' comments provided on the post-training survey.

In one site, the grantee conducted a small pre-post test among trainees to learn if the training might affect subsequent gatekeeper behavior. Twenty-nine trainees participated in this sub-study by reporting both before and after the training if they had been concerned about someone who might be suicidal and if they had intervened.

A substantial proportion, 45%, of the trainees reported in the pre-test they had been concerned about someone who might be suicidal prior to the training. After the training, a very large proportion, 69%, reported that they had been concerned subsequent to the training that an individual was at-risk of suicide. While this set of trainees reported substantial awareness of at-risk individuals prior to the training, they still reported an increase in the gatekeeper behavior of identifying people at risk of suicide.

These trainees also reported a smaller increase with regard to intervening with an at-risk individual. Eleven trainees (38%) had intervened prior to the training while 14 trainees (48%) reported at least one intervention after the training. The small number of respondents in this pre-post test disallows any confident conclusions, but these findings suggest that behavioral changes both toward increased identification and increased

intervention may be an expected outcome of gatekeeper training.

In the post-training survey, of those trainees who reported at least one intervention (n=252), many directly attributed their suicide prevention activity to be the result of the gatekeeper training. A primary theme of their comments was the usefulness of role playing in the trainings, specifically, in learning the skills of engaging an at-risk person, asking appropriate and useful questions about suicide intent and providing referrals for potential care or support. Trainees also perceived themselves to be more confident to intervene subsequent to the training.

The least positive perceptions were among some individuals professionally trained as mental health workers, law enforcement personnel or firefighters. Professional mental health workers often commented that the training was a "refresher" session for them. For police officers, the situations in which they work don't always allow engagement with the person at-risk of suicide, yet this is taught as necessary to be a successful suicide prevention gatekeeper. For example, a police officer reported he was concerned an individual was at risk for suicide, but was not able to use the skills taught in the training because the suicidal person threw a chair at the officers. Often professional mental health workers and, in some instances, law enforcement officers will be the people to whom gatekeepers refer at-risk individuals for assistance. People in these professions, then, may not be the most appropriate gatekeepers. Even so, some law enforcement officers judged the training to be useful.

Clearly the composition of the gatekeeper trainees in this initiative may have also influenced the size of a training effect. A substantial proportion of the trainees were employed in some type of human services or educational institution in which they might encounter individuals who have mental illness or other risk factors for suicidal behavior among those they serve. Almost 40% of the trainees who intervened worked in social services or mental health, 12% of the trainees worked as teachers or school counselors and 14% worked in law enforcement.

In other words, due to their types of employment, the people who took part in these gatekeeper trainings had some likelihood of encountering persons at-risk of suicide. Indeed, 45% of the trainees indicated on their registration form that they had "met or talked with someone they thought might be suicidal in the three months prior to the training." It is important to understand the positive findings about gatekeeper behavior among these trainees within the context of the type of individuals, primary and mental health, safety, education and social service professionals who were recruited to be trained in this initiative.

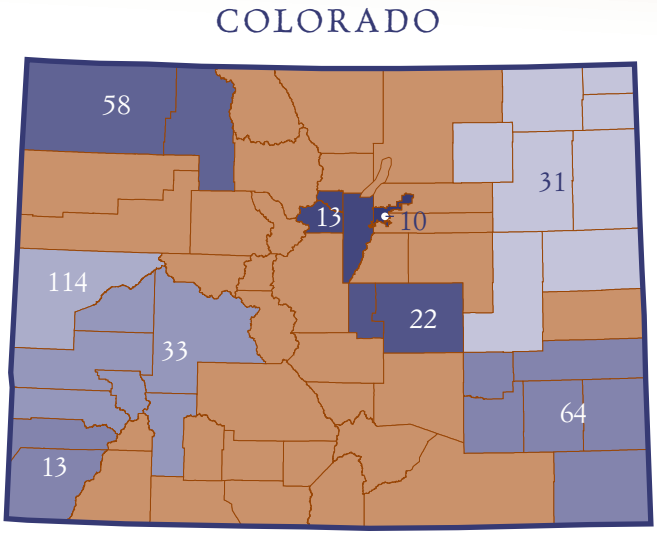
TYPES OF INTERVENTIONS

GENDER

Girls and women received more interventions (58%) in this initiative than did boys and men (42%). These proportions, however, suggest that the interventions among male and female at-risk individuals are more balanced than skewed. While there is a slight tendency in the interventions for the gatekeeper and at-risk person to be of the same gender, there is clearly a willingness on the part of both male and female gatekeepers to intervene with persons of the opposite gender.

Among the 286 interventions conducted by female gatekeepers, 61% were with at-risk females. Among the 69 interventions conducted by male gatekeepers, 46% were interventions with females. Thus, despite both the slight tendency for women to be more likely to intervene with females than males, and the disproportionate number of interventions in this initiative

FIGURE 4: *Trainees from all nine evaluated sites reported they had used gatekeeper skills to try to help someone they believed to be suicidal. The map below shows the numbers of reported interventions.*



performed by women (80% of the interventions were reported by female gatekeepers), the interventions included suicide prevention among a good proportion of at-risk men and male youth.

TEENS AND ADULTS

The majority of the interventions were with adults aged 25 – 64 (54%). Teens (24%) and young adults (16%) also received a substantial number of interventions. Not surprising is the fact that interventions were rare among children up to 11 years old. Given the fact that the rate of suicide deaths is high among elderly persons, it is of note that elders received only 4% of the interventions.

ETHNICITY

Only about one-quarter of the interventions were with persons of minority ethnic or racial origin (65). The somewhat small proportion of interventions among persons of minority populations reflects the Caucasian character of the rural locations of many of the adult gatekeeper trainings. Among the 55 interventions with Hispanic persons, 38% were conducted by Hispanic gatekeepers. Also, among the seven interventions with Native Americans, four were conducted by Native American gatekeepers. Thus, there is a suggestion in these data that if at-risk minority persons are to be engaged through gatekeeper behavior, persons of similar ethnic or racial origins should be well represented among trained gatekeepers.

GATEKEEPER CURRICULA

Differences among the three types of gatekeeper trainings (see page 4) posed the question of potential differences in the amount of gatekeeper behavior that might be expected by trainees. In this evaluation, the two-day ASIST training is compared to the two other trainings (QPR and SPEAC), which are conducted in sessions from one hour to one day in length.

Findings show that gatekeepers trained in the ASIST curriculum more often reported concern that someone might be suicidal on the post-training survey. The ASIST-trained gatekeepers also reported they were more likely to intervene than the gatekeepers trained in the other two types of programs (see Figure 5).

One interpretation for these differences is the amount of time required for the trainings. ASIST requires participants to attend two-full days of stand-alone training, while the other trainings vary from as little as one hour to up to six hours and are often conducted as part of a regularly scheduled staff meeting or gathering. In the

ASIST trainings, trainees were encouraged to engage with each other about their opinions regarding suicide and death, as well as given time to practice skills through role playing; the shorter trainings were more often didactic than interactive. The result was that ASIST trainees were more likely than the other trainees to perform the gatekeeper role subsequent to the training.

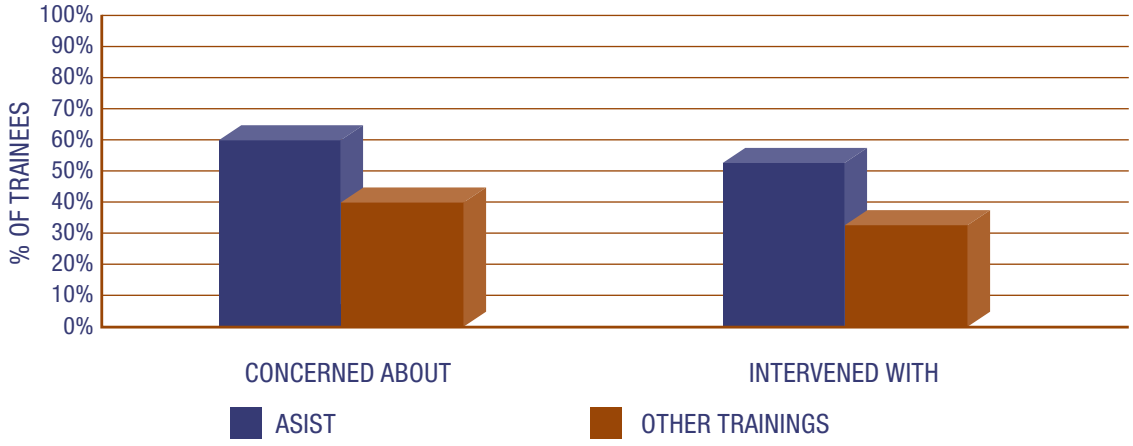
Overall, however, findings show that even the gatekeepers trained in less intensive trainings performed the gatekeeper functions of identifying persons who might be suicidal and engaging the individual in a suicide prevention intervention. Additionally, the QPR training can be customized. For example, in a training conducted at a school, examples of at-risk youth were primarily used by the trainer. Thus, the finding that trainees of all three curriculums report substantial gatekeeper behavior. This suggests that the varying costs of time, trainers and materials of the different curricula, and the ability to customize part of the training to an audience, should be weighed with potential outcomes when determining which gatekeeper training curriculum to select.

TYPES OF EMPLOYMENT

The employment positions of gatekeeper trainees indicate that people who work in front-line social services (51%) and mental health services (64%) are most likely to report an intervention. Office managers or those with an agency are least likely to report an intervention (34%). Trainees who are most likely to encounter a person at-risk among high risk populations (i.e., individuals with multiple social problems or mental illness) appear to have great opportunity to intervene using gatekeeper skills and, in some cases, taking further care by providing therapy or medications. The higher response rate for interventions on the part of these types of trainees is congruent with the responses on the survey to the question, *"How did you become aware of this situation?"* The most commonly reported (34%) reason why the gatekeepers became aware of an at-risk person was *"I evaluated the person for suicidal thoughts as part of my job."*

An important, though less predictable finding is that trainees who might be considered general community members reported a rate of intervention similar to trainees employed in a "helping profession."

FIGURE 5. *The proportion of concerned and intervening respondents who took ASIST training and the two other types of training. The difference in the proportions is statistically significant.*



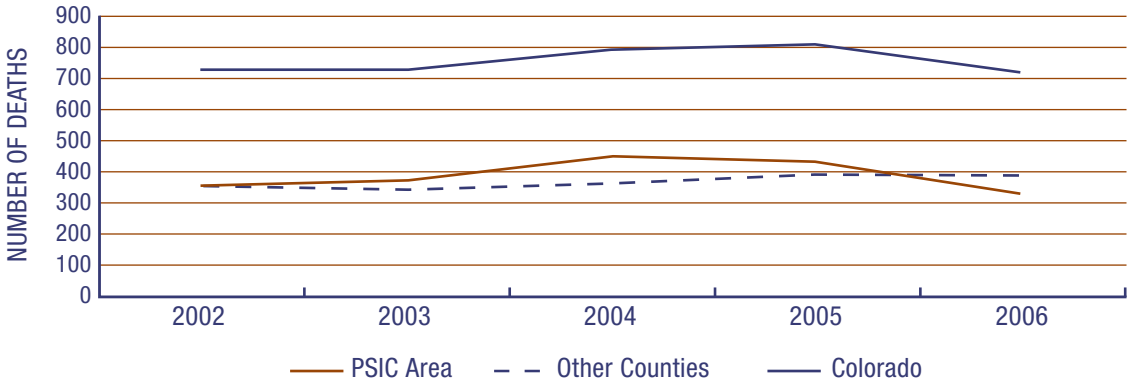
conclusions

The findings indicate that the strategy of gatekeeper training is now a successful part of the majority of community-based suicide prevention strategies within the PSIC communities (see Figure 1); however, the question remains whether this positive outcome will ultimately reduce the number of suicides. While it is premature to adequately measure this, recent Colorado death certificate data suggest a potentially positive outcome. Figure 6 plots the number of suicides from 2002 through 2006 for the participating communities and a comparison area (the remaining counties in which there was no initiative activity). Planning for the projects began in late 2003 and continued into 2004. Implementation of the projects began in the second quarter of 2004.

In six of the 10 participating communities, there was an initial increase in the number of completed suicides during the planning and early implementation phases (2003–2004), with the majority of these deaths (67%) occurring in El Paso and Denver counties. While the reasons for the increase aren't known, it could be due to improvements in reporting suicide deaths at the local level. It also is of note that this increase mirrors a large and surprising national one-year increase of suicide deaths among youth and young adults from 2003 to 2004.[3] In Denver County, for example, the percentage of the 2004 suicide deaths among youth and young adults (16.5%) was about twice that of the 2003 suicide deaths (8.9%).

Just as the reason for the increase in number of suicides between 2003 and 2004 is not fully understood, so the decrease in the number of suicide deaths in the initiative area from 2005 to 2006 is unknown. However, the fact that the increase and decrease trend in the initiative area is so different from the gradual increase in number of suicide deaths for the comparison area suggests there may be partial contribution to the trend by the initiative activity. Until longer trends are known, the sharp decrease in the most recent number of suicide deaths between 2005 and 2006 provokes anticipation of some achievement in this complex area of public health improvement.

FIGURE 6. *Number of Deaths by Suicide*



endnotes

1 Colorado Department of Public Health and Environment, *Suicide Prevention and Intervention Plan, the Report of the Governor's Suicide Prevention Advisory Commission,* Denver: 1998.

2 The Colorado Trust, *Suicide in Colorado,* Denver: The Colorado Trust; 2002.

3 The Center for Disease Control and Prevention. Suicide Trends Among Youths and Young Adults Aged 10 -24 – United States, 1990-2004. *Morbidity and Mortality Weekly Report* [serial online]. September 6, 2007. Available at: http://www.cdc.gov/od/oc/media/mmwrnews/2007/n070999066.htm. Accessed September 9, 2007.

The Colorado Trust is a grantmaking foundation dedicated to advancing the health and well-being of the people of Colorado. To learn more about the foundation and its grantmaking initiatives and evaluations, please visit *www.coloradotrust.org.*

The **Gatekeepers: Helping to Prevent Suicide in Colorado** report was prepared for The Colorado Trust by *Jean Demmler, PhD;* Heartland Network for Social Research.

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The report development was managed by *Nancy B. Csuti, DrPH,* Director of Evaluation, The Colorado Trust, and edited by *Christie McElhinney,* Director of Communications, The Colorado Trust. *Carol Breslau,* Vice President for Initiatives, The Colorado Trust, served as program officer for this initiative.

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THE COLORADO TRUST
1600 Sherman Street • Denver, CO 80203 • 303.837.1200
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