

An information newsletter about Addiction and Mental Health
Services in Waterloo and Wellington.

The Updater

Winter 2009 / 2010

Crisis Line Numbers

Wellington,
Dufferin

519-821-0140

or toll free

1-877-822-0140

+++++

Waterloo Region

519-744-1813

or toll free

1-866-366-4566

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In this edition of The Updater you will read a lot about what we are doing as a community of service providers to address issues related to suicide – prevention, intervention and postvention support – we are doing good work. I want to talk about what we can do as individuals to effect change, specifically around breaking the stigma attached to suicide. I do a lot of suicide awareness work in the community; no matter who the group is, when I ask the question, “who in this room has had their life touched by suicide in some way” invariably almost every hand in the audience goes up. This tells me that whether or not we encounter suicide in our professional lives, we most certainly encounter it in our personal lives; as friends, family members, co-workers, acquaintances or through our own struggles with thoughts of suicide, it is part of our lives. One of the most pervasive and destructive myths about suicide is that ‘if you talk about it, people will do it’. This simply is not true; in fact, talking about it openly reduces the stigma, reduces the pain and creates opportunities to connect with another human being in a moment of vulnerability and isolation. I have focused my career around mental health and suicide, not only because of a professional interest, but more importantly for me, because of my personal connection to these issues. Many of us have come to ‘helping professions’ as a result of our own experiences. As someone who has lost a family member to suicide, as someone who has attempted suicide, as someone who deals with ongoing cycles of depression – it is my fervent belief and passion that each and every one of us whose lives have been touched, has a responsibility to be part of eliminating the shame that goes along with suicide. How do we do that? By talking about it. By being open and willing to sit with someone in their pain. By not feeding the stigma that exists, even in and sometimes *especially* in, our work world of service provision. Knowing about suicide, working in mental health, crisis, addictions – none of these things make us immune. Suicide is not ‘us and them’. It impacts all of us and thus it is incumbent on all of us to speak out, share our experiences and present ourselves not only as service providers, but as people who care and who are willing to talk openly and honestly about suicide.

Jessie Baynham, Editor

**Invite us to
a team meeting**

Crisis System Orientation

*a one hour inservice on the crisis system
for Waterloo-Wellington*

Learn about:

- ◆ The Crisis Lines
- ◆ Mobile Crisis Teams
- ◆ Crisis Respite Beds
- ◆ Recovery Support Plan (RSP)
- ◆ Includes an informative 10 minute DVD Presentation

Submitted by:
Trieneke Niemeyer, MSW, RSW
Mental Health Coordinator
Upper Grand Family Health Team
Assoc. Prof. Dept. of Family Medicine,
McMaster University

Perspective from a Semi-Rural Family Health Team

“as the main presenting problem in primary care is depression, suicidal ideation is not an uncommon concern of the family physician and often can result in a priority referral”

Mental health therapists working in family health teams deal with mild to moderate mental health problems in family physicians' offices to which they are attached.

If the patient is actively suicidal, crisis intervention services are used and the primary care provider refers patients directly to these services. If during the assessment, the mental health therapist deems the patient to be at risk, then we also use these services. Direct contact is made with the crisis service to ensure that the actively suicidal patient is seen in a timely manner and a treatment plan can be quickly formulated. If the patient has suicidal ideation but is not seen to be in a present crisis, information is given to the patient about the services available in the community that can be used at times when the therapist is not available (such as weekends and evenings).

Mental health therapists' role in primary care is not meant to be a crisis/emergency service, as therapists tend to see patients for regular treatment sessions and are usually booked. However, as therapists are often co-located with physicians or

on joint electronic medical records (EMR) they can triage with the provider to discuss resources, treatment options and shared care issues particularly in suicide prevention and education. An example of this might be giving the patient an appointment for mental health sometime in the near future, making arrangements for 'check-in' times with the physician, and/or taking 15 minutes to briefly meet with the patient to engage them in treatment process and to engender hopefulness. A small but significant part of any therapeutic encounter is patient education, and patients are always made aware of services that are available should their symptoms change or their suicidal thoughts increase.

As therapists we see self-harm as not necessarily reflective of suicidal wishes but perhaps symbolic of a person's self-loathing, difficulty managing intense emotions or reaction to peer behaviour. These problems are of course treated in a different way than when a person has wishes to end his or her life.

One of the challenges of being in a semi-rural location is the lack of transportation options. This means

that patients can sometimes not access programmes that are available in larger centres. Secondly, patients can have concerns about lack of confidentiality and so, psycho-educational, therapeutic or support groups may not always be an option for some. On the positive side, rural communities can have very active community cultures as well as available family supports. Many have lived in the community for years and have well-established connections. For those who are new to the area this may present a challenge and we encourage patients who are isolated to access the Community Information Centre, the Sportsplex, the Seniors Centre, etc. to increase their contacts as this can be very helpful to treating depression and thus lowering suicide risks.

As patients are becoming more familiar with family health teams and the availability of mental health therapists within their family doctor's office this may in itself help with early intervention and assessment of suicide risks.

Youth Talk

Submitted by: Sonia McDonald
Youth Talk Facilitator

Suicide is the second leading cause of death, following motor vehicle accidents, among youth in Canada. Believe it or not, eight of ten young people contemplate suicide before graduating high school. This statistic is startling and almost unbelievable but if you ask a young person, they won't be surprised. They will most likely even be willing to talk with you about their experiences. There continues to be stigma attached to youth suicide that appears to be driven by adults in the world. When we as adults pass along our fears and attitudes about suicide, it perpetuates the taboo and creates further silence. In a perfect and tolerant world, youth would feel free to talk about suicide and their mental health concerns with anyone who would listen. They want to talk about it, and they want it to be acceptable to talk about it.

Why are teens more likely to take their lives? The transition through the teen years can be difficult and unsettling, and often leads to confusion. This can lead to isolation from family and peers. Unfortunately, some may, at one point or another, perceive

suicide as a permanent answer to problems that are, more often than not, temporary. Self-doubts, confusion, and pressures to succeed or conform can come at a high price for some adolescents.

Many troubling and difficult situations can make a teen consider suicide. The same emotional states that make adults vulnerable to considering suicide also apply to youth. Those with good support systems in place are likely to have an outlet to help them deal with their feelings. There are common factors that seem to be especially difficult for youth. Things like divorce, abuse, addictions, substance abuse in the home and domestic violence can be factors in depression and may lead to thoughts of suicide. Symptoms of depression can often be overlooked in youth, therefore keeping silent about feelings can lead many youth down a path of self destruction. Youth who are having thoughts of suicide will exhibit behaviour changes as indicators or invitations for us to respond to their need to talk. They may become withdrawn, neglect their personal appearance, display sadness or hopelessness, may have changes in sleep or eating

patters and will most likely display significant changes in personality. Though many suicidal teens appear depressed or withdrawn, other behaviour changes should be noted. Uncharacteristic changes like elation, risk taking and hyperactivity may also be indicators.

How can we help? It is essential that we take every indicator and mention of suicide seriously. Every youth who is having thoughts of suicide is seeking support and an opportunity to be heard. Providing that support and open communication can save a young person's life. Allowing them to talk about their feelings and asking them directly about suicide will open the discussion and create an opportunity to reduce the risk. Someone who has not considered ending their life will not adopt the idea simply because it has been raised. It is important to be clear when asking about suicide. This will be reassuring and show your concern.

Youth can and will discuss suicide in a very meaningful way if given the opportunity. They are most often respectful of others feelings, very knowledgeable and offer suggestions that prove to be effective when talking with teens.



There are many ways to reach youth and spread awareness about suicide and mental health. At Youth Talk, we have found an exceptionally successful way to reach youth. Through youth engagement, students of all ages have the opportunity to work on peer-led projects that will address suicide awareness in their school community. Many students throughout Wellington and Dufferin have participated in projects and created their own Youth Talk teams. Allowing youth a forum to express their ideas and create meaningful projects has proven to be highly effective in opening communication about suicide among their community as well as with adults in their lives.

**For more information on
Youth Talk
Contact
Youth Project Facilitator at
mcdonalds@cmhagrb.on.ca**

Why I Do What I Do

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- ◆ **Trained crisis line staff.**
 - ◆ **Trained crisis line volunteers.**
 - ◆ **Available 24/7, providing confidential help.**
 - ◆ **Streamlined access to appropriate mental health services.**
 - ◆ **Linkage to mobile crisis response team.**
 - ◆ **Crisis and risk assessment.**
 - ◆ **Linkages to emergency services.**
 - ◆ **Serve Wellington-Dufferin and Waterloo Region.**

See page 1 for crisis line numbers.

I took the opportunity to write this article as a challenge to myself. I began volunteering on the Distress Line in early 2005 and I got hired within the organization as a relief worker for the Crisis Line in February of 2008. Personally, I believe it's crucial for people, whatever the situation that they're in, to check in regularly and ask the following question: **Why do I do what I do?** I find that this question keeps me humble and appreciative of why I'm involved with Community Torchlight and the Crisis Line service.

I challenge you to take a moment to seriously consider these questions;

- Have you ever cried so hard that you've had to sleep the entire next day just to recover? Or maybe the sadness was there but the tears wouldn't come, so you spent many more days wondering how to get rid of that feeling?
- Have you ever stopped in your tracks only to realize that you didn't

have shelter to return to?

- Have you ever struggled financially to the point that you haven't been able to feed your family?
- Have you ever been through a divorce (whether you're the wife, husband, child, or friend)?
- How about trying to live a "normal life" while suffering from a mental illness (schizophrenia, depression, bipolar disorder, Post Traumatic Stress Disorder, etc.) or a physical disability?
- And have you ever had to face any of these challenges without having any supports in place (Doctors, therapists, mentors, friends, and/or family etc)? Maybe you have support, but you require more.

If you answered "no" to the above questions, I dare you to close your eyes and try your best to imagine life under one or all of those circumstances. These are some of the reasons

why I volunteer and work at Community Torchlight. I believe that every individual has the right to be listened to, supported, and provided with all of the resources available that could help. No one has to be alone.

If it were me in one of the situations above, or if I were to face any other difficulty that that comes up in life, I wouldn't want to go through it alone - not without the option of receiving and maintaining supports. My job is not about making things all better. It's not about "saving" people from problems. It's about being human. It's about going home at the end of the day knowing that I've encouraged someone, or many people to feel empowered to deal with whatever challenge they may be facing.

Adopting a National Suicide Strategy

How can it be that on average, 10 Canadians every day of the year will end their life, and yet Canada has not yet adopted a national suicide prevention strategy? Could it be that the government is unaware of the statistics? Could it be that suicide is not seen as a problem in our communities or on a more global scale, throughout the world? Could it be that a blueprint for a strategy is not already made up? No, no and no.

A blueprint for a national strategy does exist!

Throughout the world, this major issue is mirrored with approximately one million people taking their lives every year. That is one death every 2 minutes. Which is why the World Health Organization and the United Nations have called for worldwide initiatives to prevent suicide by creating and implementing national suicide prevention strategies. Many of our industrialized neighbours have responded with aggressive strategies that are already in place. Countries such as the USA, England, Australia, New Zealand and Scotland (who has set a

goal of reducing completed suicides by 20% by the year 2013). In fact, Canada remains one of the few industrialized countries in the world without such a strategy.

But wait...A blueprint for a national strategy does exist! The Canadian Association for Suicide Prevention known as CASP, has spent thousands of hours developing a strategy which has been presented to all levels of government beginning in the fall of 2005. CASP, dedicated to Canadians who want to reduce suicide and its impact in Canada, decided that instead of waiting for government to initiate the strategy, it was their duty to communities across Canada to begin the process. "The Blueprint is also a policy agenda, a national task list, a tool for identifying best practices and a roadmap to an integrated solution."

They are waiting...waiting to have the strategy implemented. Waiting for funding. Waiting for the government to acknowledge that the rate of suicides in this country is much too high.

If you, too, feel that suicide is an issue that needs

to be addressed nationally, then it is important that as Canadians you show your support. A strategy adopted by the government announces that yes, suicide is an issue and as a country we want to address this alarming problem. A strategy means funding for awareness campaigns so that we can educate Canadians on myths surrounding suicide and ensure that all citizens become knowledgeable about warning signs. A strategy means further suicide intervention training for health care workers and community members at large. A strategy means taking a leadership role in helping to bust the stigma surrounding suicide—for those individuals having suicidal thoughts and for the thousands of family members and individuals left bereaved and affected by suicide.

With knowledge comes power; the power to reduce the number of suicides each year in Canada. CASP urges the Government of Canada to take immediate action and move forward on establishing a national suicide prevention strategy.

All Canadians can play a role in suicide prevention.

CASP invites all Canadians to demonstrate their support by participating in an online petition. To register your support for a national suicide prevention strategy and urge the Government of Canada to take action go to: <http://nspscnd.epetitions.net/>

For information about local suicide prevention efforts, contact Waterloo Region Suicide Prevention Council or Suicide Resource group of Wellington/Dufferin

“nearly 4,000 Canadian lives will be lost this year to suicide”.

The Heart & Soul Behind ‘the Numbers’ in Guelph-Wellington

How do we even begin to contemplate the impact of a death by suicide? Across Guelph and Wellington County, service providers must balance the ever present need for services that can respond in the areas of prevention, intervention and postvention, with statistical data that backs up the need for those much needed resources. But, that information does not begin to tell the story of the enormity of loss.

If a picture is worth a thousand words, then the visual of an iceberg to depict the magnitude of suicide in our community is very appropriate. What does that mean locally? In the most recent census, Statistics Canada listed the population of Guelph and Wellington County as 171,406. Their most recent data for suicide rates per 100,000 people in Canada approximates that in our area, 20 people will die by suicide every year. That is the tip of the iceberg. Further evidence estimates another 80 to 200 people will attempt suicide, and live. And even more telling is that just over 10,000 people in our local area will have thoughts of suicide, whether they ever share that experience or not. To com-

plete the bottom of the iceberg, an important consideration is measuring how many people are potentially impacted by even one suicide. The short answer is we will never know statistically, but we see it every day in the voices and on the faces of many.

While the need for actual numbers may be helpful in planning broad, community-based suicide prevention initiatives, it does little to help the person at risk during their time of despair.

When a person you care about *attempts* to take their own life, the only statistic that matters is ‘one’. When a person you care about *thinks* about taking their own life, the only statistic that matters is ‘one’. It is that one person, in that one moment that matters the most. Our challenge is how community services can continue to provide, and in fact strengthen their response to people at risk, when the available statistics do not reflect the reality of all the needs and impacts.

Across Guelph and Wellington County, we respond to the issues of suicide through the strength of collaboration and conviction. This news-

letter provides many examples of that work. I have the privilege of being part of two very important partnerships. **The Suicide Resource Group of Wellington Dufferin** reflects a diverse group of individuals and organizations who believe that through information sharing, education and resource coordination we can make a difference in the reduction of suicidal behavior and the impact on community. **The Living Works Community Training Team**, in partnership with CMHA, offers suicide intervention training (ASIST) facilitated by certified trainers from a number of different community organizations and institutions.

What gives us all hope is believing that while the statistical numbers may be necessary to capture the ear of funders, the real motivation is knowing the choices we make on any given day could save a life...and there is no number that adequately captures that.

Submitted by: Sandra Parkinson
Chair, Suicide Resource Group Wellington-Dufferin; ASIST Trainer; CMHA Community Development & Education Coordinator

“what the numbers don’t tell us is that when a person you care about takes their own life, the only statistic that matters is ‘one’”

Updater article submissions can be forwarded to Karen Guse at kguse@trellis.on.ca. A call for article submission outlining the theme as determined by the Waterloo Wellington Crisis Communication Working Group will be sent 2-3 weeks prior to the email distribution target date. Suitable material such as articles of interest, new issues, important notices, changes in service, current research initiatives, coming events/conferences, etc, will be identified and submitted to the editor(s) for inclusion. The editor(s) will edit for spelling, grammar and format but will not be ultimately responsible for content errors and will not significantly alter submissions unless otherwise notified.

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A Suicide Safer Community ASIST: Applied Suicide Intervention Skills Training

Submitted by:
Jessie Baynham
Community Torchlight Inc.
o/a Distress Centre
Wellington/Dufferin

For many years, the Canadian Mental Health Association - Grand River Branch has been fostering and developing a team of suicide intervention trainers, supporting them to deliver a schedule of ASIST (Applied Suicide Intervention Skills Training Workshops) every year across Waterloo Region, Wellington and Dufferin Counties. CMHA not only handles the registration, marketing and administration of these workshops, but the organization also subsidizes the cost of the two-day ASIST training for individuals, staff, students etc. from our community, making it as accessible as possible for anyone and everyone.

This team has grown substantially over the past few years, both in the number of active Living Works trainers, but also the diversity of where the trainers are coming from in the community and the diversity of Living Works curriculum now available throughout the year to participants. We now have 13 Living Works trainers and offer a menu of suicide prevention/ intervention workshops

including SafeTalk, ASIST and SuicideCare (visit www.cmhagrb.on.ca for workshop schedules and details).

The past year has been an exciting one, as CMHA successfully applied for a three-year Ontario Trillium Foundation Grant to support the important work of consistent suicide intervention training in our community. The purpose of the grant is to expand the training team's capacity to offer ASIST workshops, increase the number of individuals trained in ASIST, and involve a variety of community organizations in sponsoring and supporting the work of new ASIST trainers as part of the Living Works Community Training team. The steering committee for this grant is composed of community partners who have a vested interest in broadening the reach of ASIST training in our region, including representatives from Mosaic Counselling and Family Services, Waterloo Region Public Health Department, Lutherwood, Community Torchlight and the W-W Regional Crisis System.

Suicide is a serious social issue that needs to be addressed on a community level. The community training team approach incorporates trainers from different organizations across our region. Each certified facilitator has undergone extensive training to deliver workshops that help caregivers of all types respond to someone at risk of suicide. Our community training team includes trainers from the following organizations:

- ◆ Canadian Mental Health Association - Grand River Branch
- ◆ Community Torchlight / Distress Centre of Wellington-Dufferin
- ◆ Grand River Hospital
- ◆ Lutherwood
- ◆ Special Education Teacher / Social Worker
- ◆ University of Guelph
- ◆ Wilfrid Laurier University

ASIST Dates & Locations:

Jan 13, 14, 2010—Guelph

Feb 16, 17, 2010—Waterloo

*March 30, 31, 2010—
Orangeville*

*April 13, 14, 2010—
Kitchener*

May 18, 19, 2010—Waterloo

July 7, 8, 2010—Fergus

Sept 8, 9, 2010—Kitchener

*To register contact
CMHA, Grand River Branch
workshops@cmhagrb.on.ca
or call 519-766-4450*

Costs: \$135.00 per person



Waterloo Region Suicide Prevention Council 2009 Annual Report

Waterloo Region Suicide
Prevention Council c/o
Canadian Mental Health
Assoc.
171 King Street South,
Waterloo, ON
N2J 1P7

Phone: 519-744-7645 ext. 310
(leave a message)

www.wrspc.ca

*Just as despair can come to one
only from other human beings,
hope, too, can be given to one
only by other human beings.*
- **Elie Weisel**

*To accomplish great things, we
must not only act, but also
dream; not only plan, but also
believe.*
- **Anatole France**

Waterloo Region Suicide Prevention Council continues to grow and has had many accomplishments—with the combined passion of the committee member and supporting agencies. Committee members are from a variety of community agencies and local citizens. An executive committee is made of up five members; working committees tackle education and public awareness, fundraising and special events, conference planning and resource development. An exciting addition to the past year was the hiring of a part time Suicide Prevention Coordinator for Waterloo Region.

Some highlights from the past year includes making connections with local colleges and universities to support their suicide awareness efforts on campus; becoming a member of the Canadian and Ontario Associations for Suicide Prevention; strengthening connections with the Wilmot & Wellesly Suicide Awareness Group; promote awareness through various community displays; development of information resources; hosting the annual Dimensions of Suicide Conference.

Just a few facts.....

- ◆ Nearly 4,000 Canadians die each year by suicide, an average of 10 suicides per day.
- ◆ Suicide is one of the leading causes of premature death in Canada.
- ◆ Canadians are about seven times more likely to die from suicide than to be the victim of a homicide
- ◆ In 1998, suicide was the leading cause of death for men between the ages of 25-29 and 40-44; for women it was the leading cause of death for ages 30-34
- ◆ Suicide is the 2nd leading cause of death among youth
- ◆ One in ten adolescents thinks about suicide before completing high school
- ◆ For each death by suicide there are as many as 100 suicide attempts
- ◆ More than 1000 people in Ontario die by suicide each year (C.I.H.I. 1998-99)
- ◆ On average, 3 people in Ontario die by suicide every day (C.I.H.I.)
- ◆ 3.5% of people in Ontario report thoughts of suicide in the past 12 months (Stats Canada 2002)
- ◆ 9,344 hospitalizations in Ontario due to suicide attempts with an average length of stay of 6.7 days (2001-02 C.I.H.I)
- ◆ Average cost per suicide is \$849,878.00 (New Brunswick Study 1996)
- ◆ 5 of the 10 leading causes of disability are related to mental disorders (World Health Organization)

Source: Waterloo Region Suicide Prevention Council Website

Why I Walk “The Walk”

Submitted by:
Mina McCluskey

I have a confession to make...I never used to be a huge fan of walking. It seemed too boring and slow and ...wimpy! Now, running on the other hand...nothing wimpy about running! Running got me somewhere fast, made me feel like I'd really been productive; walking felt very unproductive. This need for speed and productivity applied to all other areas of my existence as well; I wasn't content unless I was running full tilt through life.

Something happened in the spring of 2005 that brought all that speed and productivity to a standstill. I was suffering from a darkness that made it impossible to even imagine crawling through life, let alone running. And as this darkness of depression closed in on me, I did the unthinkable.

I tried to take my own life.

During my recovery, one of the hardest things I faced was dealing with my own stigma and shame about my suicide attempt. I was convinced that

successful recovery could only happen by hiding my shameful past.

I heard about the “The Walk” for Suicide Awareness & Prevention in the fall of 2006. The Walk was being held for the *express intention* of raising awareness about suicide, making it a part of everyday discussion, and sharing a message that hiding is not going to solve the problem. I decided to participate and what I experienced changed my attitude completely. I started to see how very wrong I had been about the productivity of walking.

People were walking together, out in the open for folks like me and for everyone whose lives are affected by suicide. Once of my closest friends walked with me. One of the members of my toastmaster's club walked with me. My father walked with me.

This year, on September 2, 2009 in Guelph and Orangeville, we walked again to mark World Suicide Prevention Day. I did a rough calculation.

On that night we collectively took somewhere around a *half a million steps*. Whether the steps we took during the long day or short routes, the steps we took to the resource table, or simply the steps we took over to listen to the community concert,- on September 2nd we walked a *half a million steps closer* to making the issue of suicide awareness, prevention and support a subject that is no longer taboo.

It starts with the steps of every single one of us. I am proud and honored to walk for survivors of suicide, as we walk with the memory of those we have lost, and as we walk to *bring* hope to those who, at this very moment, can't find the hope to take even one step.

Mina McCluskey is a Guelph resident who, in addition to being a working professional and volunteer board member, is a public speaker and advocate for people who have experienced mental health issues and whose lives have been touched by suicide.



www.thewalk.ca

The 26th Annual Ontario Crisis Workers Conference is being held on June 9, 10, 11, 2010 at the Delta Guelph. The planning committee of the Waterloo Wellington Dufferin Regional Crisis Committee is excited to have Mina McCluskey a Key Note Speaker. Mina is a powerful speaker who moves and inspires audiences with her passion, humour and sincerity. She believes that society, as a whole, has the power to eradicate the stigma of mental illness with one simple action...that is, the simple act of speech.

Conference information will be posted at www.crisislinks.ca in the

Working Together as a Team Mobile Crisis Team and Police Services

Over the past year, the After Hours Mobile Crisis Team for Wellington-Dufferin has been working to strengthen our connection with local police services. Police are often called out to individuals' homes that are experiencing a mental health crisis. This is frequently the case for individuals who have yet to be connected to any sort of mental health services for both ongoing issues, as well as during an acute situational crisis. When we have responded with police to these situations, it allows support for individuals within their home environment and hopefully deescalates the situation and provides follow up to avoid psychiatric hospitalization.

In one such experience the police contacted the crisis team to connect with an individual at her home apartment. This individual had been in recovery from alcohol addiction but that night had been drinking alcohol as her partner had ended the relationship after five years. As a result of a phone call to a friend voicing her plans for suicide, the friend contacted police. Upon the arrival of police, she became highly agitated due to the police presence.

The Mobile After Hours Crisis Team was called in and attended the home. The worker spent time with this individual sorting through all the various stressors that were occurring within her life, culminating with the break up with her partner. Once safety had been established, the police left with instructions to call dispatch if police needed to come back to the home. At the end of the crisis assessment/intervention, this individual had calmed down significantly and a crisis plan was created with primarily informal community supports. In this situation the individual was able to get the help she needed within her home environment versus the hospital, which allowed for the experience to be more comfortable for this individual. In a conversation with this individual at a later date, she made it known that this intervention had saved her life.

In another situation the police called the Mobile Crisis Team to a home of a woman who was very angry, volatile and had consumed an unknown quantity of alcohol and medication. This woman's hus-

band had left her after ten years of marriage after he had caught her cheating with someone else. This individual was devastated, as the person she was having an affair with had left her as well; she was now all alone with little money and no family supports. After the worker spent some time with her, the concern over her accurate reporting of the amount of alcohol and medication she had consumed was discussed with police and it was decided that she needed to go to the local hospital. Although the individual needed to go to hospital, it was helpful for workers to have a sense of the home environment for the purposes of understanding her situation. This individual did require medical attention. When follow up was provided to this individual the following day, she had calmed down significantly and was thankful for the intervention. She was very thankful to the crisis worker for the time spent with her through the steps of this process. A lot of discussion was had on how to handle this most difficult life situation, given all of the ripple effects in all areas of her life.

At the end of this experience, she was able to be discharged from the local hospital and did not require a psychiatric hospitalization.

Both of these individuals were not involved with mental health services previously; in both cases, the experience of wanting to end their life actually became the turning point in deciding they wanted to live and seeing hope for the future with the right supports. In these kinds of cases it is helpful to work with police in acute situations with individuals that have not had experience with the mental health system. These interventions can help contribute to the prevention of these individuals reaching the same level of desperation and suicidal risk in the future; they now know who to turn to for help within their community before it gets to that point again. The earlier we can intervene as a crisis team with the police on these calls, hopefully the more meaningful the intervention can be within that first experience for individuals and their families.