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# Suicide Prevention

**IF YOU NEED HELP**

If you are having suicidal thoughts or you know someone who is, the National Suicide Prevention Lifeline is free and available 24/7 at **1 (800) 273-8255 (TALK)**. You can also access the Lifeline Crisis Chat system via the internet. Help and hope are available. The Community Guidance Center’s Wellness Office provides services locally, contact them at **(670) 236-8752**. If you have a plan to commit suicide, go to the emergency room for immediate treatment.

Suicide is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior. A suicide attempt is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. Suicidal ideation refers to thinking about, considering or planning suicide. A suicidal person may not ask for help, but that doesn’t mean that help isn’t wanted. People who take their lives don’t want to die – they just want to stop hurting. Suicide prevention starts with recognizing the signs and taking them seriously. Among the leading causes of death in the United States, suicide is a major public health concern. In 2015, the Centers for Disease Control reported suicide as the 10th leading cause of death in the United States claiming more than 44,000 lives. Suicide was the 2nd leading cause of death among people between the ages of 15 and 34, with numbers rising in various age

brackets. In 2015 there were more than twice as many suicides (44,193) in the U.S. as there were homicides (17,793). If you think a friend or family member is considering suicide, you might be afraid to bring up the subject but talking openly about suicidal thoughts and feelings can save a life.

- RISK FACTORS FOR SUICIDE:** Risk factors are characteristics that make it more likely that someone will consider, attempt or die by suicide. They can’t cause or predict a suicide attempt but they’re important to be aware of.
- o Mental disorders, particularly mood disorders (e.g. depression, bipolar disorder) schizophrenia, anxiety disorders and certain personality disorders
  - o Alcohol and other substance use

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disorders

- o Hopelessness
- o Impulsive and/or aggressive tendencies
- o History of trauma or abuse
- o Major physical illnesses
- o Previous suicide attempt(s)
- o Family history of suicide
- o Job or financial loss
- o Loss of relationship(s)
- o Social withdrawal from friends, family and the community
- o Easy access to lethal means (e.g. pills, knives, razors, firearms, belts, rope)
- o Local clusters of suicide
- o Lack of social support and sense of isolation
- o Stigma associated with asking for help
- o Lack of healthcare, especially mental health and substance abuse treatment
- o Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- o Exposure to others who have died by suicide (in real life or via the media and internet)
- o Aggressive behavior or threatening to hurt someone
- o Recent tragedy or loss
- o Prolonged Stress

### WARNING SIGNS FOR SUICIDE:

- ▶ Talking, writing or thinking about suicide, wanting to die or killing one's self
- ▶ Looking for a way to kill one's self, like searching online or buying a gun
- ▶ Clinical depression – deep sadness, loss of interest in things one used to care about, trouble sleeping and eating – that gets worse
- ▶ Talking about feeling hopeless, helpless, worthless or having no reason to live
- ▶ Talking about feeling trapped or in unbearable pain
- ▶ Talking about being a burden to others, saying things like “it would be better if I wasn't here” or “I want out”
- ▶ Increasing the use of alcohol or drugs



- ▶ Acting anxious or agitated; behaving recklessly like having a “death wish,” tempting fate by taking risks that could lead to death, such as driving fast or running red lights
- ▶ Sleeping too little or too much
- ▶ Withdrawing or isolating one's self
- ▶ Showing rage or talking about seeking revenge
- ▶ Extreme mood swings – sudden, unexpected switch from being very sad to being very calm or appearing to be happy
- ▶ Putting affairs in order, tying up loose ends, changing a will
- ▶ Visiting or calling people to say goodbye

Suicide is not inevitable for anyone. By starting the conversation, providing support and directing help to those who need it, we can prevent suicides and save lives. Evidence shows that providing support services, talking about suicide, reducing access to means of self-harm and following up with loved ones are just some of the actions we can all take to help others.

### COMMON MISCONCEPTIONS ABOUT SUICIDE

- Myth:** People who talk about suicide won't really do it.
- Fact:** Almost everyone who attempts suicide has given some clue or

warning. Don't ignore even indirect references to death or suicide. Statements like “You'll be sorry when I'm gone,” “I can't see any way out,” – no matter how casually or jokingly said, may indicate serious suicidal feelings. **Myth:** Anyone who tries to kill him/herself must be crazy. **Fact:** Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness. **Myth:** If a person is determined to kill him/herself, nothing is going to stop them.

**Fact:** Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

**Myth:** People who die by suicide are people who were unwilling to seek help.

**Fact:** Studies of suicide victims have shown that more than half had sought medical help in the six (6) months prior to their deaths.

**Myth:** Talking about suicide may give someone the idea.

**Fact:** You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true – bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

**Source:** SAVE - Suicide Awareness Voices of Education

### HELPING A SUICIDAL PERSON:

**Get professional help.** Do everything in your power to get a suicidal person the help he or she needs. Call a crisis line for advice and referrals. Encourage the person to see a mental health professional, help locate a treatment facility or take them to a doctor's appointment.

**Follow-up on treatment.** If the doctor prescribes medication, make sure your friend or loved one takes it as directed. Be aware of possible side effects and be sure to notify the physician if the person seems to be getting worse. It often takes time and persistence to find the medication or therapy that's right for a particular person.

**Be proactive.** Those contemplating suicide often don't believe they can be helped, so you may have to be more proactive at offering assistance. Saying, "Call me if you need anything" is too vague. Don't wait for the person to call you or even to return your calls. Drop by, call again, invite the person out. Encourage positive lifestyle changes, such as a healthy diet, plenty of sleep, and getting out in the sun or into nature for at least 30 minutes each day. Exercise is also extremely important as it releases endorphins, relieves stress and promotes emotional well-being.

**Make a safety plan.** Help the person develop a set of steps he or she promises to follow during a suicidal crisis. It should identify any triggers that may lead to a suicidal crisis, such as an anniversary of a loss, alcohol or stress from relationships. Also include contact numbers for the person's doctor or therapist, as well as friends and family members who will help in an emergency.

**Remove potential means of suicide, such as pills, knives, razors or firearms.** If the person is likely to take an overdose, keep medications locked away or give out only as the person needs them.

**Continue your support over the long haul.** Even after the immediate suicidal crisis has passed, stay in touch with the person, periodically checking in or dropping by. Your support is vital to ensure your friend or loved one remains on the recovery track.

Information in this article was taken from the following sites:  
<https://www.nimh.nih.gov/health/statistics/suicide/index.shtml>  
<https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/>  
<https://www.webmd.com/depression/guide/depression-recognizing-signs-of-suicide#1>  
<https://www.helpguide.org/articles/suicide-prevention/suicide-prevention.htm>

# Diabetes Awareness Month

For those of you who did not know that November is Diabetes Awareness Month in the CNMI, now you are aware. Diabetes is the high glucose in your blood. This means insulin is not being used by the cells because they cannot absorb sugar, which is needed to produce energy. Type 2 Diabetes, can



develop at any age. I have been dealing with this non communicable disease since 2004. It has been difficult and slow. I have had to change my lifestyle to better live with my diabetes. This change is sometimes very difficult for some of us to do. But, change is crucial, however, if we are to survive diabetes. Small steps, like just a 10 minute walk after dinner, can help with your type 2 Diabetes.

The CNMI has some of the highest numbers of diabetes in the world. We also have people who get dialysis and have to sit for 4 hours as machines clean their blood through a needle in their arm. This lifestyle is difficult to change, but if you don't, it may take you down to the point where you will need others to care for you, or worse, a heart attack.

Three things that you can do to better live with your diabetes are: One, I like to take the time to enjoy my walks. No rush, stay calm and speed walk. It will keep you strong and happy. I walk with my wife and we enjoy the strolls we have around island. Also keep changing the location of your walks. It will keep you from getting bored.

Two, get friends who have Type 2 Diabetes, so you can exchange notes with them. Also if possible, join an online community to share all we know about diabetes. The American Diabetes Association is a good one.

Finally, the big one, food! We need to curb our appetites for food. Eat less, and eat nutritiously. Eat in a bowl if necessary. No Corned Beef in a can, or SPAM. Try to eat everything as fresh as possible. My favorite is fish. I eat all kinds of seafood and keep each meal as small as possible.

I know Diabetes Awareness Month has passed, but I believe that this is something we can talk about all year long. Thank you for listening, and if you have diabetes, you can beat it. It takes small steps, but eventually, they lead to bigger milestones, which you can celebrate with your family!

For more information & referrals on diabetes, contact NMPASI at 235-7273/4 or, for TTY & Fax call 235-7278, or visit us online at [www.nmpasi.org](http://www.nmpasi.org).  
Thomas M. Thornburgh - Type 2 Diabetic

# CNMI's Disability Network Partners Complete American Sign Language Course



Saipan, CNMI – November 30, 2017 – The University Center for Excellence in Developmental Disabilities (UCEDD) at the Northern Marianas College (NMC) offered a two-day training course in Basic American Sign Language (ASL) and Deaf Culture to member of the CNMI's Disability Network Partners (DNP) on November 17-18, 2017, at the Latte Stone Room of Kanoa Resort.

Participants of the DNP included representatives from the Northern Marianas College, Center for Living Independently (CLI), Office of Vocational Rehabilitation (OVR), Maternal Child and Child Health Bureau (MCHB), Commonwealth Transit Authority (CoTA), CNMI UCEDD, and the Public School System (PSS). Participants who completed all

training requirements will receive certificates from NMC's Community Development Institute (CDI) and UCEDD. There were 23 people who attended the training workshop.

Taught by Iyanne Ealy, an ASL instructor at the NMC Community Development Institute, the purpose of the ASL Training was to help service providers and members of the CNMI's Disability Network Partners (DNP) develop skills to effectively engage and communicate with Deaf and hard-of-hearing individuals. Along



with the basics such as the manual alphabet and numbers; general vocabulary and signs largely associated with the workplace of service providers (e.g., medical and social work-related) were learned. An overview of Deaf culture and resources for communicating and advocating for the Deaf was also included in the training.

Some comments from the training evaluations include:

"The instructor provided information that I know will be beneficial and useful in my work place. Personally and professionally a gain for me. Activities that instructor provided for the whole group of attendees allowed everyone to fully engaged and participate."

"What I like about this training is that not only was I able to learn sign language, but also meet people who are experienced in doing sign language. The people I've met have support my learning. In addition, the training was super enjoyable !!" (Jefferson Mateo, CNMI UCEDD Office Trainee).

Jennifer-Eilleen E. Castro, UCEDD Program Manager at the Northern Marianas College, said, "I was thrilled at the overwhelming response we got from the disability network during the registration process. So many people continue to request for more ASL and Developmental Disability training, and we will do our best to continue building capacity in the CNMI through trainings and workshops like these."



## Disability Training for NMC Faculty and Staff

A similar Basic ASL Training Workshop was offered to NMC Faculty and Staff at the Northern Marianas College (NMC) Campus, September 22-23, 2017. Participants included NMC faculty and staff, as well as student trainees and interns at NMC this fall semester. Upon completion of the course, participants received certificates from NMC's Community Development Institute (CDI) and UCEDD. There were 14 people who attended the training workshop.

### Thoughts from participants about the ASL Training:

Samuel J. Crawford, NMC Academic Librarian and one of the participants, says, "I was so glad to participate in the basic American Sign Language (ASL) training at NMC. I registered for the course because I wanted to start learning how the NMC Library can better serve our Deaf students, and how we can help foster a spirit of inclusion and support both within our campus and among the wider island community. It so happens that my partner is Deaf, as well, so I have a personal and a professional interest in improving my ASL abilities and being a better advocate for the Deaf

community, in the CNMI and beyond."

Dawn S. Sablan, Office Assistant at International Student Services at NMC says, "...as a former Disability Support Services note taker, and a student in the field of Rehabilitation and Human Services, taking the Basic American Sign Language certification training definitely helped open my eyes to the boundaries facing students who are deaf or deaf-mute and students who do not speak English. The English language in its written form is different from the way it is spoken and it also true for when it is signed. Students who are deaf or deaf-mute will have a hard time in their English courses because in Sign Language you do not sign in complete sentences, rather sign and use facial expressions to get your message across. For example, to sign "I am a college student and I want to become a counselor," I would have to sign "College, Student, Me, To Be, Counseling, Person." American Sign Language is a [completely separate and unique] language in itself; we cannot just assume students who sign will also know how to write and comprehend the English language the same way we are taught, because English is their second language, not their first."

Jennifer Eileen E. Castro, UCEDD

Program Manager at the NMC, shares that "One of the goals of the University Center for Excellence in Developmental Disabilities is to help bring our programs up to speed and in line with technology. This includes assisting NMC update its website to be more user-friendly for those with developmental disabilities, and to make the registration and evaluation processes for UCEDD-sponsored trainings and workshops more efficient by using online forms and registration. According to participants of this particular ASL course, 85% of the participants preferred the online process, citing "easier access" and "online forms are easier to fill and compile," and it is better for the environment by wasting less paper.

#### Contact:

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# OVR and SRC begin Comprehensive Statewide Needs Assessment Project

Every three years, the Office of Vocational Rehabilitation and the State Rehabilitation Council, through the San Diego State University Research Foundation's Interwork Institute, conducts the Comprehensive Statewide Needs Assessment Project.

Dr. Chaz Compton, Ed.D., CRC of SDSURF-II initiated the project with individual interviews and focus group meetings conducted on October 23-27, 2017 in Saipan, Tinian, and Rota.

Preliminary activities prior to the focus group meetings included compiling OVR consumer data for fiscal years 2014, 2015, and 2016 for Dr. Compton and his team to review and analyze.

The next phase of the project, which is ongoing, is the individual survey that asks former, current, or potential consumers of OVR services their input into the needs assessment that will help OVR to more effectively meet the needs of people with disabilities in the CNMI. Individuals are encouraged to take the survey, which is anonymous and will require no more than 20-25

minutes of their time, before the deadline of November 17, 2017. The survey may be accessed at the following link:

[https://sdsu.co1.qualtrics.com/jfe/form/SV\\_dfYTycK3KGdRhtml](https://sdsu.co1.qualtrics.com/jfe/form/SV_dfYTycK3KGdRhtml)

For those without internet access, they may request for a paper survey by contacting **OVR at 322-6537/8**.

Another activity related to the needs assessment is the fiscal forecasting for Pre-Employment Transition Services. OVR's leadership is to articulate the process for determining when the VR agency can move from required pre-employment transition services to authorized services using the Title I 15% reserve funds.



The purpose of the CSNA project is to inform VR policy development and the State Plan. SDSURF-II will consult with OVR and the SRC to identify the agency's priority for the accomplishment of the recommendations contained in the final report, which OVR expects to release sometime in February, 2018.

## *iCanConnect Program*

If you know of anyone in the CNMI who has both vision and hearing impairments, please let them know about the iCanConnect program offering free technology to help folks stay connected with their family, friends, and loved ones. For the first time in the summer of 2017, the Federal Communications Commission included the CNM in the National Deaf-Blind Equipment Distribution Program, commonly known as iCanConnect. For now, the grant funds are being administered by Cathy Kirscher of the Helen Keller National Center in San Diego, California.



In September of 2017, Ms. Kirscher visited Saipan and met with OVR and other partner agencies to share program information including assistance with referrals to the iCanConnect program. Some of the free technology include smartphones, tablets, computers,

screen readers, Braille displays, and more.

In 2016, Ms. Kirscher reached out to OVR director Arlene Yamagata, M.S., CRC to solicit support so the FCC may consider expanding the program to the CNMI and its residents.

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*For more information about iCanConnect, please contact:*  
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# Reporting and Writing About Disabilities

The following guidelines are suggestions for using language in a more sensitive manner that avoids reducing individuals to a series of labels, symptoms, or medical terms. Please consider the following when writing about people with disabilities:

**DO NOT FOCUS ON DISABILITY** unless it is crucial to a story. Avoid tear-jerking human interest stories about incurable diseases, congenital impairments, or severe injury. Focus instead on issues that affect the quality of life for those same individuals, such as accessible transportation, housing, affordable health care, employment opportunities, and discrimination.

**SHOW PEOPLE WITH DISABILITIES AS ACTIVE** participants of society. Portraying persons with disabilities interacting with those without disabilities in social and work environments helps break down barriers and open lines of communications.

## ATTITUDES

adapted from "Think Ability," President's Committee on Employment of People with Disabilities (1999)

Perhaps even more than language, attitudes can influence interactions with people with disabilities. Even if you personally do not have any of the following attitudes, your readers may, and people with disabilities

will have experienced them from others, and may thus be wary. Some of the attitudinal barriers are:

**Pity:** People feel sorry for the person with a disability, which tends to lead to patronizing attitudes. People with disabilities generally do not want pity and charity, just equal opportunity.

**Ignorance:** People with disabilities are often dismissed as incapable of accomplishing a task without the opportunity to display their skills. In fact, people with quadriplegia can drive cars and have children. People who are blind can tell time on a watch and visit museums. People who are deaf can enjoy music. People with developmental disabilities can be creative and maintain strong work ethics.

**The Spread Effect:** People assume that an individual's disability negatively affects other senses, abilities, or personality traits. For example, many people shout at people who are blind or do not expect people using wheelchairs to have the intelligence to speak for themselves. Focusing on the person's abilities rather than his or her disability counters this type of prejudice.

**Stereotypes:** The other side of the spread effect is the positive and negative generalizations people form about disabilities. For example, many believe that

all people who are blind are great musicians or have a keener sense of smell and hearing; that all people who use wheelchairs are docile or compete in paralympics; that all people with developmental disabilities are innocent and sweet-natured; that all people with disabilities are sad and bitter. Aside from diminishing the individual and his or her abilities, such prejudice can set too high or too low a standard for individuals who are merely human.

**Backlash:** Many people believe individuals with disabilities are given unfair advantages, such as easier work requirements. Employers need to hold people with disabilities to the same job standards as co-workers, though the means of accomplishing the tasks may differ from person to person. The ADA does not require special privileges for people with disabilities, just equal opportunities.

**Denial:** Many disabilities are "hidden," such as learning disabilities, psychiatric disabilities, epilepsy, cancer, arthritis, and heart conditions. People tend to believe these are not bona fide disabilities needing accommodation. The ADA defines "disability" as an impairment that "substantially limits one or more of the major life activities." Whether a condition is visible or not, it still can result in substantial limitations.

## Terminology

**able-bodied:** The term able-bodied should be avoided and is not accurate to describe a person who does not have a disability. Accessible environments and adaptive equipment allow many individuals with disabilities to be able-bodied. Use the term non-disabled or the phrase does not experience a disability when it is necessary to distinguish that a person does not have a disability. Avoid using the term able-bodied.

**accessible, accessibility:** Use accessible when describing a space, location or event that is modified to comply with the Americans with Disabilities Act of 1990. Accessible modifications allow unrestricted admittance to accommodate individuals who may or may not use a wheelchair as a result of mobility impairments as well as individuals who may have sensory impairments. The term accessibility also includes modifications for individuals who communicate in different languages, have hearing or vision impairments, and other cognitive and learning disabilities.

**ADA:** Americans with Disabilities Act.

**autism:** Autism is characterized by indicators

such as significant language dysfunction, difficulty interacting socially, and repetitive behavior. Use the phrase individual with autism. Avoid the term autistic.

**congenital disability:** Congenital disability describes a disability that has existed since birth but is not necessarily hereditary.

**deaf/hard of hearing:** The D/deaf community prefers the term deaf or hard of hearing; "hearing impaired" implies a medical/pathological view. People who are Deaf (big "D" connoting cultural view) view themselves as a linguistic minority.

**deinstitutionalization:** A movement that strives to relocate individuals with disabilities from segregated institutional environments to supportive and inclusive community settings.

**developmental disability:** Any mental and/or physical disability starting before the age of 22 and continuing indefinitely. It limits one or more major life activities

such as self-care, language, learning, mobility, self-direction, independent living, and economic self-sufficiency.

**disability:** A term used to define factor(s) that limit significant life activities or experiences considered to be typical among individuals who do not experience a disability. Such restrictions may be permanent or temporary, and may fluctuate depending upon the disability and the resources available.

**Down syndrome:** Not Down's syndrome.

**inclusion:** A term that implies that all individuals with a disability, regardless of their ability, are part of typical classrooms, schools, local and world communities. The federal Individuals with Disabilities Education Act (IDEA) and its 1997 amendments make it clear that schools have a duty to educate children with disabilities in general education classrooms.

**mental disability:** The Federal Rehabilitation Act (Section 504) lists four categories under mental disability: psychiatric disability; retardation; learning

disability; or cognitive impairment.

**person-first language:** person-first language seeks to avoid reducing people to a set of labels. When writing about disability or health-related issues, this effort avoids placing a disability or condition before an individual. We are all people first, no matter what labels we have acquired.

**Seeing Eye Dog:** A trademark for a guide dog trained by Seeing Eye Inc. of Morristown, N.J. Use companion animal or service animal.

**special education:** Educational services including instruction, as well as related services such as occupational therapy, physical therapy, psychology, and speech and language therapy that are designed to ensure students with disabilities receive the supports and services needed to meet educational goals.

**wheelchair:** Avoid the phrases confined to a wheelchair or wheelchair user. Instead, use phrases such as uses a wheelchair, and other person-first configurations that focus on ability rather than limitations.



# What is Autism?

Autism spectrum disorder (ASD) is a complex developmental disability; signs typically appear during early childhood and affect a person's ability to communicate, and interact with others. ASD is defined by a certain set of behaviors and is a "spectrum condition" that affects individuals differently and to varying degrees. There is no known single cause of autism, but increased awareness and early diagnosis/intervention and access to appropriate services/supports lead to significantly improved outcomes. Some of the behaviors associated with autism include delayed learning of language;

difficulty making eye contact or holding a conversation; difficulty with executive functioning, which relates to reasoning and planning; narrow, intense interests; poor motor skills' and sensory sensitivities. Again, a person on the spectrum might follow many of these behaviors or just a few, or many others besides. The diagnosis of autism spectrum disorder is applied based on analysis of all behaviors and their severity.

In 2016, the Centers for Disease Control and Prevention issued their ADDM autism prevalence report. The report concluded that the prevalence of autism had risen to 1 in every 68 births in the United States – nearly twice as great as the 2004 rate of 1 in 125 – and almost 1 in 54 boys. The spotlight shining on autism as a result has opened opportunities for the nation to consider how to serve families facing a lifetime of supports for their children. In June 2014, researchers estimated the lifetime cost of caring for a child with autism is as great as \$2.4 million. The Autism Society estimates that the United States is facing almost \$90 billion annually in costs for autism. (This figure includes research, insurance costs and non-covered expenses, Medicaid waivers for autism, educational spending, housing, transportation, employment, related therapeutic services and caregiver costs.)

Know the signs: Early identification can change lives Autism is treatable. Children do not "outgrow" autism, but studies show that early diagnosis and intervention lead to significantly improved outcomes. For more information on developmental milestones, visit the CDC's "Know the Signs. Act Early" site.

## HERE ARE SOME SIGNS TO LOOK FOR IN THE CHILDREN IN YOUR LIFE:

- Lack of or delay in spoken language
- Repetitive use of language and/or motor mannerisms (e.g., hand-flapping, twirling objects)
- Little or no eye contact
- Lack of interest in peer relationships
- Lack of spontaneous or make-believe play
- Persistent fixation on parts of objects

