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We are pleased to support the vision incorporated in the Strategic Plan, "Advancing Understanding, Care, and Support for Deaf, Hard of Hearing and Deaf-Blind Individuals in Wisconsin" that outlines a framework to address providing mental health and substance use services across the lifespan. We recognize the importance of serving the deaf and hard of hearing communities. The unique language, communication, and service approaches defined in the Americans with Disabilities Act provide opportunities to ensure more equitable mental health and substance use service provision. This includes identifying a shared vision of access to and the delivery of services and prevention efforts.

We recognize that commitment and real partnership are needed to successfully engage in meaningful dialogue and action. This Strategic Plan offers positive change and guides policy to create an ongoing process for measuring services, quality, and evaluation of health outcomes for optimal quality of life for all persons who are deaf, deaf-blind, and hard of hearing. As the lead agency addressing mental health and substance use issues for children, youth and adults, we are aware these problems exert a negative impact on employment, education, and health care. Persons who are deaf, deaf-blind, or hard of hearing and their families face tremendous challenges in finding services, that include access to qualified, skilled interpreters within the mental health and substance use systems.

The vision, goals, recommendations and engagement with partners to implement this plan are part of an ongoing process that will occur within a climate with diminishing federal, state and local resources. We need to work together to develop innovative, culturally and linguistically-competent approaches to ensure recovery with optimal health outcomes and the ability to fully participate in our communities.

We look forward to working with you as partners in the promotion of needed change, which fosters prevention and aligns equitable service delivery across Wisconsin. We urge you to give thoughtful consideration and to participate fully in bringing this Strategic Plan successfully to life.

Sincerely,

Linda Harris, Administrator
Division of Mental Health and Substance Abuse Services

Pris Boroniec, Administrator
Division of Long Term Care

EXECUTIVE SUMMARY OF THE STRATEGIC PLAN ADDRESSING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES "Advancing Understanding, Care and Support for Deaf, Hard of Hearing, and Deaf-Blind Individuals in Wisconsin"

In 2010 a Steering Committee was formed to identify how to improve the delivery of mental health and substance abuse services, and enhance education and increase outreach to individuals who are deaf, hard of hearing, and deaf-blind and their families across the lifespan. This strategic planning initiative identified goals and strategies to support effective delivery of mental health and substance abuse services which are culturally affirmative and linguistically accessible. Additionally a Summit was planned for early 2012 to involve key stakeholders with an opportunity for dialogue, commitment, and input into implementing this Strategic Plan.

The Steering Committee adopted a Vision Statement:

"wherein people of all ages who are deaf, deaf-blind or hard of hearing receive needed mental health and substance abuse services that result in recovery and optimal individual quality of life."

People who are deaf, hard of hearing, and deaf-blind are an underserved cultural and linguistic population within Wisconsin's mental health and substance abuse systems for a variety of reasons. There is a lack of both state and national data regarding the prevalence of individuals who are deaf, hard of hearing and deaf-blind who have mental health and substance abuse issues across the life span, and a current needs/gap assessment. Access to an integrated continuum of mental health and substance abuse services needs to be made available in a way that is appropriate to each deaf, deaf-blind, and hard of hearing person's culture and language. Access to the continuum of services and supports for which both professionals are fluent in their preferred language and qualified interpreters who have received specialized mental health training. The plan identifies recommendations to impact positive systems change.

This Strategic Plan provides five Goals areas:

1. Increase understanding among Wisconsinites who are deaf, deaf-blind, or hard of hearing and their families /social supports about mental health and AODA and recovery. This is essential to achieve appropriate service seeking, effective relationships with service professionals, and improved outcomes.
2. a) Increase understanding within MH and AODA systems to achieve communication competency and trustworthiness, provide materials to meet health literacy, and provide effective mental health and substance abuse services which foster recovery and wellness planning to meet the needs of each individual who is deaf, deaf-blind or hard of hearing.
   b) Provide resource information to typical referral networks (e.g. crisis response teams, educational system, emergency rooms, workplaces, police and criminal justice systems, etc.) to enable them to rapidly and effectively link people who are deaf, deaf-blind and hard of hearing to appropriate mental health/ substance abuse services.
3. Expand access to communication and peer / family supports by identifying, coordinating, and developing sustainable resources and funding so that people of all ages who are deaf,

deaf blind or hard of hearing receive mental health and AODA services that foster recovery to meet the needs of each individual and his or her families.

4. Develop long-term collaborative partnerships between people who are deaf, deaf-blind and hard of hearing, and representatives of the mental health and AODA systems and relevant others. The purpose is to advance this plan and achieve mental health/ substance abuse prevention and services that foster recovery to meet the needs of individuals who are deaf, deaf-blind and hard of hearing and his or her families.
5. Collect meaningful, current data regarding prevalence, gaps/needs of services to address the mental / AODA and health care needs of individuals who are deaf, deaf-blind and hard of hearing.

The Committee views this strategic plan as a beginning rather than an end of the work to be accomplished. It will take the energy and involvement of many "change makers" which include consumers who are deaf, hard of hearing, and deaf-blind and their families, providers, staff, community leaders, policy and decision-makers to create the relationships, communication access, and systems refinements to improve access to an integrated continuum of services. Altogether, we share in an exciting opportunity to improve people's health access and wellbeing, and to make recovery possible.

A list of the participants who served on the Steering Committee who developed this plan can be found in the appendix.

STRATEGIC PLAN for
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES for
PEOPLE WHO ARE DEAF, DEAF-BLIND, HARD OF HEARING

Vision for Wisconsin: People of all ages who are deaf, deaf blind or hard of hearing receive needed mental health and substance abuse services that result in recovery and optimal individual quality of life.

Project objective: Develop a strategic plan defining state-level goals that lead to sustained, aligned and collaborative cross-system partnerships, leadership and action among people who are deaf, deaf-blind and hard of hearing and multiple partners in the mental health and alcohol and substance abuse systems.

Seven critical facts:

1. Many people in the deaf, deaf-blind and hard of hearing community do not receive mental health and / or substance abuse services that meet his or her needs. The term 'services' includes prevention, active treatment, supported transition and after-care.

2. People who are deaf, deaf-blind and hard of hearing and their families often do not have an understanding of mental health, mental illness and AODA including co-occurring disorders/problems and the related impact with physical health.

3. Society lacks a meaningful understanding and sensitivity about the experiences and needs of people who are deaf, deaf-blind or hard of hearing.

4. People working in mental health/ substance abuse and related systems often do not meaningfully understand the experiences and culture of deafness.

5. There is a lack of thorough, accurate epidemiological data at the state and federal levels regarding mental health and AODA needs and treatment by persons who are deaf, hard of hearing or deaf-blind.

6. Sustainable resources and funding are needed to create the capacity to implement this plan and achieve the vision.

7. It will be neither quick nor easy to create change so that people of all ages who are deaf, deaf blind or hard of hearing receive mental health and substance abuse AODA services that meet the unique needs of each individual.

Background:

Society lacks a meaningful understanding and sensitivity about the experiences and needs of people who are deaf, deaf-blind or hard of hearing:

- National data estimates the need for MH services among the deaf, deaf-blind and hard of hearing populations to be 3-5 times higher than in the hearing community (1)
- Add bullet here with some data on AODA / SA needs for this population. (5-11-11 e-mail to Brad for fact and cite.)
- Estimates indicate that as many as 85% of deaf adolescents living in residential treatment centers have confirmed or suspected histories of sexual abuse. Deaf children may be re-traumatized by health care providers and MH/AODA treatment staff who are not trained in working with deaf individuals. (Need a cite)
- Many deaf, deaf-blind or hard of hearing individuals have experienced some degree of trauma or emotional neglect as a result of their hearing loss which can impact his or her emotional development. Children experiencing a lack of effective communication can develop long-term lack of self-value, depression and lack of trust in others.
- The deaf, deaf blind and hard of hearing communities are relatively small and extremely diverse and tend to be overlooked within larger society
- Many different communication techniques and language preferences are used within the deaf, deaf blind and hard of hearing communities which complicate effective planning and capacity for effectively communicating with each individual as there can be no one-size fits all approach. It takes effort to learn the communication preferences and needs of each person.
- When a deaf person presents for MH/AODA services, his or her needs related to communication and hearing limitation may receive primary attention while their MH / AODA problems go unaddressed.
- Due to communication challenges, typical referral sources (e.g. schools, workplaces, disability agencies) may not pick up or accurately identify MH or AODA problems.
- Providers of MH/AODA services and others may not understand the required federal ADA requirements for interpretation in medical and other related settings.

Goal 1

Increase understanding among Wisconsinites who are deaf, deaf-blind, or hard of hearing and their families /social supports about mental health and AODA and recovery. This is essential to achieve appropriate service seeking, effective relationships with service professionals, and improved outcomes.

Examples of things to be understood include:

- Provide general understanding of key facts about mental health, mental illnesses, Alcohol and Other Drug Abuse (AODA), addiction, trauma, recovery, stigma
- Provide formal and informal resources available; how to access and use resources and services
- Reinforce confidentiality and HIPPA issues
- Include minority communities that may have unique cultural or communication considerations
- Include parents of children with hearing loss
- Promote the responsibility of each individual to express his or her personal and family member's communication preferences and needs

Key fact supporting the importance of Goal 1:

People who are deaf, deaf-blind and hard of hearing often do not have an understanding of mental health, mental illness and AODA including co-occurring disorders/problems and the related impact with physical health.

- general understanding of mental health, mental illnesses, trauma, and AODA
- the myths and stigma of mental illness and / or AODA lessen the likelihood of seeking mental health/ AODA services
- many don't know that mental health and AODA services exist or how to acquire help from service systems
- previous negative experiences have created a sense of distrust with the MH / AODA and other service systems.
- need to promote communication integration with individuals and their families beginning at very young ages to improve social inclusion and life outcomes

Goal 2

a) **Increase understanding within MH and AODA systems to achieve communication competency and trustworthiness, provide materials to meet health literacy, and provide effective mental health and substance abuse services which foster recovery and wellness planning to meet the needs of each individual who is deaf, deaf-blind or hard of hearing.**

Examples of things to be understood include:

- The concept of culture
- The concept of "language" both spoken and gestural, and communication differences
- The culture of deafness (deaf, deaf-blind and hard of hearing),the unique life developmental and societal challenges, and the broad scope of individual issues
- Parameters of stigma, discrimination, and bias
- Trauma and recovery oriented informed care,
- Person/family-centered, self direction that fosters self-choice in their care
- Approaches to successfully evaluate and identify the communication preferences and needs of each individual
- An identified process on how to access and effectively use communication resources and meet ADA compliance requirements
- Serving ethnic populations with additional unique cultural service challenges

b) **Provide resource information to typical referral networks (e.g. crisis response teams, educational system, emergency rooms, workplaces, police and criminal justice systems, etc.) to enable them to rapidly and effectively link people who are deaf, deaf-blind and hard of hearing to appropriate mental health/ substance abuse services.**

Example of things to be understood include:

- lack of knowledge in educational and other systems on how to promote communication and inclusion plus professional understanding of potential for and signs of mental health concerns

Key fact supporting the importance of Goal 2:

People working in mental health/ substance abuse systems often do not meaningfully understand the experiences and culture of deafness.

- the unique developmental and societal challenges of this population due to limited interactive communication and life encompassing impact on physical, emotional, social, and intellectual development
- the difference between communication (access), and language (meaningful exchange), with the attendant impact? on how language use impacts effective therapy
- communication differences - to discern how to best communicate with each individual who is deaf, deaf-blind, or hard of hearing
- the high risk of making erroneous and biased assumptions based on factors such a person's response to sound or quality of speech or past experiences with a person who is deaf, hard of hearing or deaf-blind.
- how to hire certified interpreters with training in mental health; how to access and effectively use communication technology
- creating trusting relationships with individuals who are deaf, deaf-blind, and hard of hearing
- the history of typical family dynamics related to inconsistent communication with the child

Goal 3

Expand access to communication and peer / family supports by identifying, coordinating, and developing sustainable resources and funding so that people of all ages who are deaf, deaf blind or hard of hearing receive mental health and AODA services that foster recovery to meet the needs of each individual and his or her families.

Specific things to be done include:

- Seek out federal ADA compliance language and require all MH/AODA providers statewide to become aware of the requirements for interpretation and need for persons who are deaf, HH and deaf-blind to have access to interpreters
- Improve the language assessment capacity and technology access within the MH and AODA and related systems.
- Increase the number of certified interpreters throughout the state with expertise in MH / AODA / DV & SA communication. Spell out.
- Increase quantity and use of computer and video technologies for communication between people who are deaf, deaf-blind and hard for hearing and mental health / AODA systems.
- Develop recommendations to address barriers related to technological compatibility for emergency/crisis response system communication access.
- Develop capacity for resource specialists / navigators to provide assistance in the deaf, deaf-blind and hard of hearing communities to access needed services
- Establish or designate a website as a clearinghouse with state and national linkages that provide information to individuals who are deaf, deaf-blind or hard of hearing and his or her families about MH / ADOA and related needs, resources, and services.
- Develop Peer Specialist capacity in WI specifically for people who are deaf and deaf-blind and hard of hearing
- Develop family- to- family support capacity for families of persons who are deaf, deaf-blind, and hard of hearing.
- Work to ensure a "no wrong door" approach so people have seamless entry for having service needs met regardless of entry portal.

Key fact supporting the importance of Goal 3:

Sustainable resources and funding are needed to create the capacity to implement this plan and achieve the vision. Examples of current gaps include:

- sufficient certified interpreters with mental health/ substance abuse training
- computer and video technologies to facilitate communication, especially challenging in rural areas
- resources and funding to create events and opportunities to educate, collaboratively plan and act to implement this plan
- technological improvements so patients/clients/consumers, families, and health care providers can more effectively access emergency and other services
- resource navigators to provide technical assistance (TA) and support in navigating the system for individuals who are deaf, deaf-blind and hard of hearing and his or her families

Goal 4

Develop long-term collaborative partnerships between people who are deaf, deaf-blind and hard of hearing, and representatives of the mental health and AODA systems and relevant others. The purpose is to advance this plan and achieve mental health/ substance abuse prevention and services that foster recovery to meet the needs of individuals who are deaf, deaf-blind and hard of hearing and his or her families.

Specific things to be done include:

- Regularly convene leaders in MH and AODA and related systems to meet with consumers/ individuals who are deaf, deaf-blind and hard of hearing and family members to:
  - acknowledge and determine now to address unique MH / AODA needs of people of all ages who are deaf, deaf-blind or hard of hearing
  - align efforts among existing and new organizations for the deaf, deaf-blind and hard of hearing
  - engage in ongoing multiple-partner collaborative information sharing and problem solving to implement this plan with measurable outcomes or recommendations
  - work toward state-wide consistency in best practice, systems access, effective policies and protocols to have communication that works well for each person with hearing loss and his or her family members
  - engage in ongoing collaborative sharing of knowledge and resources.

- Educate and establish relationships with legislators, advocates, policy makers and other public leaders to advance needed system, policy and resource/funding changes.

- Educate and establish relationships with foundations or other funders who might have interest in supporting and funding elements/recommendations of this plan.

- Identify and disseminate information about initiating and facilitating partnership development between service systems and people who are deaf, deaf-blind and hard of hearing and their families.

Key fact supporting the importance of Goal 4:

It will be neither quick nor easy to create change so that people of all ages who are deaf, deaf blind or hard of hearing receive mental health and substance abuse AODA services that meet the unique needs of each individual.

- Achieving the vision will require many people in many organizations and entities to jointly "own" this issue and work collaboratively to create the needed changes and improved outcomes.
- There is room for improved communication and collaboration among current groups and associations that represent the deaf, deaf-blind and hard of hearing populations.
- The scope of education, health care, and other systems' changes needed are broad as they cover mental health needs over the life-span (e.g. day care, schools, assisted living facilities, jails, workplaces, therapy settings, etc.)

Goal 5

Collect meaningful, current data regarding prevalence, gaps/needs of services to address the mental / AODA and health care needs of individuals who are deaf, deaf-blind and hard of hearing.

Examples of things to be done include:

- Develop data capacity to measure and track outcome change and improvements in access to effective mental health/ AODA services by people of the deaf, deaf-blind and hard of hearing communities.
- Collect empirical information and identify an data base and website location to compile and provide access to information on best practices, current research, and other related knowledge on effective mental health/ substance abuse services for deaf, deaf-blind, and hard of hearing individuals.
- Enhance existing data systems through partnership or provide new data systems with resources, policies, and procedural requirements to collect specific datasets on the needs of, services received, individual and family evaluation regarding treatment, services or supports received, and outcomes (including quality, satisfaction and timeliness measures) for individuals who are deaf, deaf-blind or hard of hearing and their families.

Key fact supporting the importance of Goal 5:

There is a lack of thorough, accurate epidemiological data at the state and federal levels.

- Census data does not provide information broken out by deaf, deaf-blind of hard of hearing – it has two categories a) have difficulty hearing normal conversation or b) unable to hear normal conversation. Estimated numbers are rounded off to the nearest thousand.
- There is currently no national database of deaf and hard of hearing persons.
- State service reporting systems do not capture data on deaf, deaf-blind or hard of hearing. Most data is captured under the label of "disability".
- There is a lack of a standardized definition of hearing loss and culture in the United States
- Some data may currently exist in educational or other systems, which could possibly be useful for preparing adult populations projections but research of this potential is lacking.

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Mental Health Directory Maintained by Gallaudet research.gallaudet.edu/publications/mental.health/listings-php

Position Statement Supplement: Culturally Affirmative and Linguistically Accessible Mental Health Services (2008)

Various Resources:

Wisconsin Children's Mental Health Action Plan November 2011 (draft as of 12-12-11): This Children's Action Plan may be considered a companion document to this strategic plan. http://deafaodawi.org/DMHS.aspx

Alternative Solutions Center (ASC): http://www.ascdeaf.com/about.html

Alternative Solutions Center is a Deaf-owned and operated psychotherapy and consulting practice staffed by Deaf licensed professional therapists. They specialize in work with Deaf people and their families.

Bureau of Mental Health & Substance Abuse Services, WI Department of Health & Family Services: http://www.dhs.wisconsin.gov/substabuse/

Disability Rights Education & Defense Fund (DREDF): http://dredf.org/mail-enews/2011/october/DREDF-documents-the-health-disparities-exhibited-by-people-with-disabilities-from-minority-populations.html

Gallaudet: http://www.gallaudet.edu/

Hands & Voices: http://www.handsandvoices.org/

Hearing Loss Association of America (HLAA): http://www.hearingloss.org/

Hearing Loss Association of America (HLAA), Wisconsin: http://hlaa-wi.org/

National Alliance on Mental Illness (NAMI): http://www.nami.org/

National Association of the Deaf (NAD): http://www.nad.org/issues/health-care/mental-health-services

National Association of the Deaf (NAD): http://www.nad.org/

Wisconsin Association of the Deaf (WAD): http://www.wisdeaf.org/wp/

Mid-west Regional Resources:

Illinois:

COD: Center on Deafness (Illinois): http://www.centerondeafness.org/

Centerview Therapeutic School: http://www.centerondeafness.org/therapeutic.htm

National Thresholds Bridge Program for the Deaf:
http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/Deaf.pdf

National Technical Assistance center for Children's Mental Health (NTAC):
http://gucchd.georgetown.edu/67211.html

Mental Health and Deafness Resources, Inc.: http://mentalhealthanddeafness.org/

Project Reach: http://project-reach-illinois.org/

State of Illinois Deaf and Hard of Hearing Commission: www.idhhc.state.il.us

Iowa:

Deaf Services Commission of Iowa (DSCI): http://www.deafservices.iowa.gov/

Minnesota:

Deaf/Hard of Hearing Intensive Mental Health Program for Adolescents and Child Treatment (DHH IMPACT):
http://www.voamn.org/Services/MentalHealthServices/DHHIMPACT/tabid/8384/Default.aspx

> The mission of Volunteers of America of Minnesota is to provide opportunities which will make a significant, lasting impact in the lives of our program participants, and to elicit community support for our program participants.

Deaf and Hard of Hearing Services Division (DHHSD):
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_139373&RevisionSelectionMethod=LatestReleased

> In response to this, a statewide mental health response team has been created to ensure that deaf adults are able to acquire accessible mental health services within their community. This mental health response team is composed of professional staff, fluent in

American Sign Language (ASL) and experienced in providing direct mental health services to persons with hearing loss.

Lifetrack Resources, Inc.: http://www.lifetrackresources.org/

Lifetrack Resources is a nonprofit human services organization with a mission to work together to develop the strengths within children, families and adults facing the greatest life challenges so that all families and individuals are strong, healthy and productive members of the community.

People Incorporated: http://www.peopleincorporated.org/programs-services/community-support-services/deaf-mental-health-services-2/

People Incorporated Deaf Mental Health Services (DMHS) offers a variety of coordinated services for adults who are Deaf or Hard of Hearing or Deaf-blind, use or want to use sign language as their primary mode of communication and who experience a mental illness. This program is culturally and linguistically accessible to this population. There are two components of this program: Drop-In Center and Outreach Services.

Regions Hospital: http://www.regionshospital.com/rh/doctors-specialties/mental-health/

Our comprehensive program offers a wide range of services in numerous locations to people of every age and background. We provide assessment, stabilization and treatment of mental and chemical health problems through a variety of specialized programs

2011 Mental Health/ Substance Use Glossary

The following definitions and key terms based on revisions from staff in the WI DHS/Division of Mental Health and Substance Abuse Services/Bureau of Prevention Treatment and Recovery with external partner input.

Accommodation: Changes or adjustments in a work or school site, program, or job that makes it possible for an otherwise qualified employee or student with a disability to perform the duties or tasks required.

Addiction: Is a health condition in which an individual manifests a pathological pattern of use of alcohol, tobacco or other drugs that interact with brain systems of reward. Genetic, psychological, environmental, and cultural factors influence its onset and progression. Persons with addiction have altered motivational hierarchies so that they are preoccupied with procuring supplies of using substances that early in the illness can produce euphoria, and substance use persists despite a range of medical, family, occupational, legal, and other consequences. Individuals, families, and communities suffer when addiction is prevalent and not adequately treated. *Adapted from definitions of the American Society of Addiction Medicine*

Affective (also referred to as Mood Disorders): A group of mental disorders (*e.g.,* manic episode, major depressive episode, bipolar disorders, & depressive disorder) involving a disturbance of mood, accompanied by either a full or partial manic or depressive syndrome that is not due to any other mental disorder. *Mental Health America of WI*

After Care: Following psychiatric hospitalization, a continuing program of rehabilitation designed to reinforce the effects of the therapy in a care plan or wellness plan; may include partial hospitalization, day hospital, or outpatient treatment or other community-based settings.

Antipsychotic medication (conventional) Available in the 1950s, conventional antipsychotic medications have proven effective in treating positive symptoms of schizophrenia such as hallucinations and delusions. *National Institute of Mental Health*

Antipsychotic medications (atypical) Introduced in the 1990s, atypical antipsychotics alleviate the positive symptoms of schizophrenia. *National Institute of Mental Health*

Anxiety disorders Mental disorders marked by physiological arousal, feelings of tension, and intense apprehension without apparent reason. *American Psychological Association*
AODA: means alcohol and other drug abuse.

Behavioral Health: refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used to describe the services encompassed in

systems that promote of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support. *National Framework for Quality Improvement in Behavioral Health Care SAMHSA June 2011 draft*

Best Practices: These are the best clinical or administrative practices available at the moment, given a certain situation, the consumer's or family's needs and desires, and resources available. A number of consumer-operated services fall into this category (e.g. WRAP, peer support). There is typically a strong research backing for these practices and they have been replicated in a variety of settings. This is one step down from EBPs and may sometimes be referred to as "exemplary practices." *Science to service SAMHSA*

Bipolar disorder: A mood disorder characterized by alternating periods of depression and mania. A person with bipolar disorder experiences alternating feelings of depression and feelings of intense energy or mania. Symptoms of the depressive stage include loss of interest in once enjoyed activities, changes in sleeping patterns, weight or appetite and fatigue or loss of energy. Symptoms of the manic stage include extreme happiness, rapid and often uncontrollable ideas, and poor judgment like extreme spending. *American Psychological Association*

***Chronic mental illness:** Wisconsin statutes define chronic mental illness as, "a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support which may be of lifelong duration." *Carabell *This definition does not include conditions from aging, alcohol or substance dependence or diagnosis of mental retardation.*

Community-based services and supports: are situated within and draws on the strengths, resilience, and resources of the community, including professional and non-professional organizations and groups, such as community-based service agencies, recovery community organizations, faith-based organizations, schools, civic groups, and others. *Onaje M. Salim Public Health Advisor, CSAT/DSCA/Co-Occurring and Homelessness Activities Branch*

Comprehensive, Continuous, Integrated System of Care Model: CCISC is both a framework and a process for designing a whole system of care around the complex needs of the individuals and families being served. In CCISC, all programs and providers of service in the system engage in partnership with other programs, along with the leadership of the system, and consumer and family stakeholders, to become welcoming, recovery-oriented, and co-occurring capable. *Minkoff & Cline 2004, 2005*

Consumer: Individuals who are receiving or have received mental health services either voluntarily or involuntarily and in that context, "consumer" is intended to include those who refer to themselves as survivors, ex-patients, ex-inmates, clients, users or other similar terms. Mental health services includes those services, including vocational rehabilitation, employment services, housing services, social security and other services that are designed

to be supportive of a person living their life to the fullest in the community of their choice. *National Mental Health's Consumers' Self-Help Clearing House*

Continuing Care: often referred to as aftercare, are substance abuse and other services that occur after primary treatment and are designed to be less intensive as the client progresses in treatment and establishes greater duration of abstinence. Continuing Care is essential for women since, even though they may have successfully completed a course of treatment, women who are recovering from substance abuse are more likely to be poor, with fewer job opportunities, and be the primary or only person caring for children or other family members while juggling multiple roles without the support from a partner (Forth-Finnegan, 1991; Lisansky-Gomberg, et al, 1984; Wilsnack & Cheloha, 1987; Miller, 1987; Van Den Bergh, 1991; Boyd, 1993; Goldberg, 1995; Lex, 1991). Women also generally begin the treatment process in far more psychological distress, with much lower self-esteem than men and little belief in their own self-efficacy (Colletti, 1998). They are also more likely to have a co-occurring mental health disorder. (Kessler, et al, 1997). Data indicates that women are more likely to stay in treatment during transitions to less intensive levels of care if the care is provided by the same treatment agency (Scott-Lennox et al. 2000). Women appear more likely to engage in continuing care if the primary treatment they received involved specialized programming for women (Claus et al.2007). *TIP 51 Substance Abuse Treatment: Addressing the Specific Needs of Women p. 181*

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Co-Occurring/Dual Diagnosis- Also Co-occurring Conditions, Co-occurring Disorders and Dual Diagnosis or Dually Diagnosed, IDDT, MISA: Clients with co-occurring disorders (COD) have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. A person who meets the diagnostic criteria for a major Axis I Mental Disorder or Axis II Personality

Disorder (List A) **AND** a major Substance-Related Disorder (List B) per the current version of the DSM. COSIG *SAMHSA's 2002 report to Congress*

Culture: The shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, language, nationality, or religion.

Culturally Appropriate: Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message.

Cultural Competence: A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community.

Cultural Competence: Definition and Conceptual Framework: Cultural competence is the ongoing practice of integrating information about individuals, families and communities into service delivery. This is accomplished by transforming that information into specific clinical standards and practices, skills, services approaches, policies, and outreach strategies that match the service population and increase the quality and appropriateness of care. Cultural competence is also acknowledging the impact of oppressive histories, life experiences, language, values, beliefs and customs, including traditional healing approaches, on an individual's recovery process. *Davis, King (1998). Cave, Cathy. (2005)*
Cultural competence requires that organizations:
-- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
---have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
---incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities
Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Adapted from Cross et al., 1989) *National Center for Cultural Competence Georgetown University Center for Child & Human Development*

Cultural Diversity: Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A Community is said to be culturally diverse if its residents include members of different groups.

Cultural Groups: A group of people who consciously or unconsciously share identifiable values, norms, symbols, and some ways of living that are repeated and transmitted from one generation to another.

Cultural Sensitivity: An awareness of the nuances of one's own and other cultures.

Dual Recovery: is an individualized process of moving forward in your life and community while balancing your journey towards integrated healing from mental illness and substance use. *The Dual Recovery Committee of Wisconsin Recovery Implementation Task Force*

Emerging Practices: This term is often used interchangeably with promising practices. The New Freedom Commission defines these practices as treatments and services that are promising yet less thoroughly documented. These practices often include programs that run on a more local level, have had positive outcomes with people in the community but have not been replicated on a large scale or gathered significant data. *Science to Service SAMHSA*

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions including the allocation of resources that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers collectively to speak effectively for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his/her own destiny and influences the organizational and societal structures in his/her life.

Ethnic: Belonging to a common group -- often linked by race, nationality and language-- with common cultural heritage and/or derivation.

Evidence-Based Practice - A practice which, based on research findings and expert or consensus opinion about available evidence, is expected to produce a specific clinical outcome (measurable change in client status). *SAMHSA COCE overview 5*

Evidence-Based Thinking: A process by which diverse sources of information (research, theory, practice principles, practice guidelines, and clinical experience) are synthesized by a clinician, expert, or group of experts in order to identify or choose the optimal clinical approach for a given clinical situation. *SAMHSA COCE overview 5*

Family: A family is a grouping of individuals who are nurturing each other intellectually, emotionally, spiritually, physically, and psychologically. Family is not limited to nuclear family. Family may include family of origin, extended families, blended families, and "adopted" families. Not all women have children.

Family-Centered Treatment: Family-Centered Treatment is a very comprehensive combination of principles, philosophy and services that have been shown to enhance the transformation of both individuals and families into healthy, functioning entities that can raise children, reach economic goals, and support the wellbeing of all members. *Family-Centered Treatment for Women With Substance Use Disorders -History, Key Elements, and Challenges Submitted by: JBS International, Inc., and The Center for Children and Family Futures, Inc. Submitted to: Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment 2007*

FAS: Fetal Alcohol Syndrome is a *specific* birth defect caused by alcohol use while pregnant. **FAS** *is* a diagnosis: It is medical diagnosis Q86.0 in the International Classification of Diseases (ICD-10).

FASD: Fetal Alcohol Spectrum Disorders is a term referring to individuals who have more than one of the features associated with FAS but do not exhibit sufficient features to make a clear FAS diagnosis. Included within this terminology is alcohol-related neurodevelopmental disorder (ARND).*CDC's Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice.*

FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD refers to a spectrum of conditions that include fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD). Although disorders within the spectrum can be diagnosed, the term FASD itself is not intended for use as a clinical diagnosis. *FASD Center of Excellence*

Gender Responsive: A created environment through site selection, staff selection, policy and program development, content, and material that reflects an understanding of the realities of the lives of women & girls, and their families that addresses and responds to their strengths and challenges. *S. Covington and Bloom*

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports. *National Consensus Statement on Mental Health Recovery US Department of HHS, SAMHSA.gov*

Insurance Parity: Refers to federal and state laws requiring mental health and alcohol and other substance use and addiction coverage which is no more restrictive than coverage for other illnesses, that is, making coverage equivalent to the coverage for all other disorders.

Integration/integrated Services: is the creation of linkages between traditionally separate systems, services, resources, people, or processes making connections. Ideally, there would be a team based approach and a single plan with the input individual and family and from representatives of all systems involved with the individual and her family.
Language: The form or pattern of speech -- spoken or written -- used by residents or descendants of a particular nation or geographic area or by any large body of people. Language can be formal or informal and includes dialect, idiomatic speech, and slang.

Linguistic competence/ Linguistic proficiency: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations

served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.
Developed by Tawara D. Goode and Wendy Jones, 8/00, Revised 8/03, 9/08, 3/09. National Center for Cultural Competence, Georgetown University Center for Child & Human Development

Major Depressive Disorder (MDD): A mood disorder characterized by intense feelings of depression over an extended time, without the manic high phase of bipolar disorder. Major depressive disorder involves feelings of irritability and sadness, as well as feelings of guilt, hopelessness and fatigue that could lead to thoughts of suicide and death. *American Psychological Association*

Mania/ Manic Episode: A component of bipolar disorder characterized by periods of extreme elation, unbounded euphoria without sufficient reason, and grandiose thoughts or feelings about personal abilities. *American Psychological Association*

Mental Disorder: Health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. *American Psychiatric Association*

Mental Health: State of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. *US Surgeon General*

Mental Illness (es): Term that refers collectively to all diagnosable mental disorders. *US Surgeon General*

Mental Health Problems: Signs and symptoms of insufficient intensity or duration to meet criteria for any mental disorder. *US Surgeon General*

Mood Disorders: See affective disorders.

Affective (mood) Disorder: To diagnose schizoaffective disorder, a person needs to have primary symptoms of schizophrenia such as delusions, hallucinations, disorganized speech, or disorganized behavior along with a period of time when he or she also has symptoms of major depression or a manic episode. See definitions for major depressive disorder and manic episode for more information on these symptoms. *National Alliance on Mental Illness*

Multicultural: Designed for or pertaining to two or more distinctive cultures.

Obsessive Compulsive Disorder (OCD): A mental disorder characterized by obsessions—recurrent thoughts, images, or impulses that recur or persist despite efforts to suppress them—and compulsions—repetitive, purposeful acts performed according to certain rules or in a ritualized manner. *American Psychological Association*

Panic Disorder: An anxiety disorder in which individuals experience unexpected, severe panic attacks that begin with a feeling of intense apprehension, fear, or terror. *American Psychological Association*

Person Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health. *National Consensus Statement on Mental Health Recovery US Department of HHS, Samhsa.gov*

Prevention: The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has produced effective strategies for the mental health and substance abuse fields. The system must have three levels of prevention practice: Universal which addresses populations at-large, selective prevention, which targets groups or individuals who are at higher risk of developing a substance abuse problem or mental illness; and indicated prevention, which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable. Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. Prevention science tells us that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavioral or normative change. Health reform recognizes that prevention is a critical element in bending the cost curve and in improving the overall health of all Americans. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being.

Promising Practices: Clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in achieving client outcomes but are not yet supported by rigorous scientific evidence. NREPP defines these practices as those that score at least a 3.33 on its rating scale.16 (See *NREPP Rating System).Science to Service SAMHSA*

Program: A designed plan for carrying out the applicant's proposal.

Public Health Model: Considers that mental health and substance abuse (use/misuse) problems arise (or worsen) when individuals at risk of problems interact with agents (such as substances or stressors) in environments that encourage problems. Services may include reducing risk and promoting resiliency factors within the environment. Addressing environmental risk factors can effectively reduce the incidence and severity of substance use, trauma, and mental health problems. Sex/gender and cultural factors lead to differences in socialization, expectations, and lifestyle, as well as differences in the way women and men experience risk and resiliency factors, stress, and access to resources. *Brittle, c, Bird CE. Literature review on effective sex- and gender –based systems/models of care. Arlington, VA: us department of HHS, 2007. retrieved June 23, 2011*
http://www.womenshealth.gov/archive/owh/multidisciplinary/reports/genderbasedmedicine/

Psychotherapy: Any of a group of therapies, used to treat psychological disorders that focus on changing faulty behaviors, thoughts, perceptions, and emotions that may be associated with specific disorders. *American Psychological Association*

Psychosocial Treatment: Treatment option for those with mental health disorders emphasizing a positive consumer- therapist relationship. The consumer learns skills to communicate effectively, maintain self-care and their relationships with others, and improve functioning in their daily lives. Consumers who receive psychosocial therapy are known to adhere more strictly to their medication schedule. *National Institute of Mental Health*
Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.

Recovery: Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential. *SAMHSA 5/20/11*

Recovery Coaches: have an ongoing professional relationship that offers help to persons who are in or who are considering recovery from addiction to produce extraordinary results in their lives, careers, businesses, or organizations—while advancing their recovery from addiction.
Recovery coaches affirm that there is innate health and wellness in clients. They do not promote or endorse any single or particular way of achieving or maintaining sobriety, abstinence, or serenity or of reducing suffering from addiction. They focus on coaching of clients to create and sustain great and meaningful lives. Through the process of recovery coaching, clients deepen their learning, improve their performance, and enhance their quality of life. Coaching accelerates the client's progress in recovery by providing greater focus and awareness of choices, actions, and responsibility. Coaching concentrates on where clients are now and what they are willing to do to enjoy a better tomorrow. The recovery coaching process recognizes that results are a matter of the client's intentions, choices, and actions taken toward building a strong foundation and creating a life worth staying healthy for, supported by the coach's efforts and application of the coaching process. *Adapted from ICF Definition of Coaching*

Recovery Principles: Person-driven; Occurs via many pathways; is holistic; is supported by peers; is supported through relationships; is culturally-based and influenced; is supported by addressing trauma; involves individual, family, and community strengths and responsibility; is based on respect; and emerges from hope.

Recovery-Oriented System of Care: A recovery-oriented systems approach supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustain health, wellness, and recovery from alcohol and drug problems. Allows coordination of multiple systems, providing responsive, outcomes-driven approaches to care.

Recovery support services: Essential service definition -Relapse Prevention/Wellness Recovery Support Services are designed to address the further needs of people who are working to develop or who have developed a plan for recovery. Relapse Prevention and Wellness Recovery Support Services include activities to develop and implement strategies or treatments applied in advance to (a) prevent future symptoms of mental illness and/or substance abuse, (b) reduce the adverse behavioral health and health impacts related to mental illness, substance abuse, and related traumatic experiences, (c) build on, and/or maintain wellness skills learned in medical, behavioral

health, and related trauma treatment and allied recovery support services, and (d) provide linkages to other clinical and non-clinical services that promote recovery and wellness, which are considered relapse prevention and wellness recovery support activities. *SAMHSA Financing Center of Excellence 9/3/2010 draft*

Rehabilitation: Program option designed to help consumers interact more effectively in their communities and daily lives. *National Institute of Mental Health*

Resiliency: Encompasses the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and open. *The President's New Freedom Commission on Mental Health, 2003*

Risk Factor: The precise cause of mental illness isn't known, certain factors (*e.g.,* genetics, stressful life situations, a traumatic experience) may increase the risk of developing mental health problems. *Mayo Clinic staff*

Respite Care: Temporary relief for caregivers and families and is a service in which care is provided to: individuals with disabilities and other special needs; individuals with chronic or terminal illnesses; individuals at risk of abuse or neglect.

Schizoaffective disorder: Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses, characterized by a combination of symptoms of schizophrenia and an **Schizophrenia / Schizophrenic disorder:** Chronic, severe mental disorder with symptoms broken down into three categories: positive, disorganized, and negative symptoms. Positive symptoms refer to mental experiences "added to" a person when they are ill, including hallucinations and delusions. Disorganized symptoms include: confused thinking and speech, behaviors that do not make sense, altered senses to everyday sights, sounds and language, and misunderstanding feelings such as joy or anger. Negative symptoms refer to attributes that are "taken away" from the person by illness, including: emotional flatness, lack of expression, and an inability to start and follow through with daily activities. *National Alliance on Mental Illness*

Self-directed: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his/her own life goals and designs a unique path towards those goals. *National Consensus Statement on Mental Health Recovery US Department of HHS, Samhsa.gov*

Serious Emotional Disturbance (SED): Applies to persons from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria and that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. *Substance Abuse and Mental Health Services Administration*

Serious Mental Illness (SMI): A mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and may be of lifelong duration. *Substance Abuse and Mental Health Services Administration*

Spiritual Health: Is a positive perception of meaning and purpose of life. *Paraphrased as defined by the World Health Organization [WHO]*

Stigma: Refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan and Penn, 1999) *Mental Health: Culture, Race, and Ethnicity, 2001 A Supplement to Mental Health: A Report of the Surgeon General U.S. Department of Health and Human Services*

Strength-based: Identifies and builds on the assets, strengths, resources, and resiliencies of the individual, family, and community – rather than emphasizing the needs, deficits, and pathologies. *SAMHSA website retrieved June 23, 2011* Onaje M. Salim, Public Health Advisor CSAT/DSCA/Co-Occurring and *Homelessness Activities Branch 9/2010*

Stress: is the state in which a person perceives an event as threatening or endangering to their well-being and/or the body's reaction to a positive or negative change that requires a physical, cognitive, behavioral, or emotional adjustment or response. Stressors are external life circumstances, triggers, or events, which may be at the root cause. *Adapted from Mental Health America of Wisconsin*

Substance Use: Refers to the risky, chronic, problematic or harmful use of alcohol, tobacco, prescription drugs, and controlled substances. *Healthiest Wisconsin 2010*

Trauma: A traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss. It includes responses to powerful one-time incidents like accidents, natural disasters, crimes, surgeries, deaths, and other violent events. It also includes responses to chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation. This definition intentionally does not allow us to determine whether a particular event is traumatic; that is up to each survivor. *Sidran Institute*

Trauma-informed care: Care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans. Includes basic training training/education to all staff—from secretaries to high level administrators—understanding of trauma permeates every aspect of treatment milieu and interventions. *Institute for Health and Recovery*

Trauma-specific treatment: Educating fewer, carefully selected staff/clinicians to conduct actual trauma treatment. Services are designed, reconsidered and evaluated with the

understanding of the role that violence and highly adverse experiences play in the lives of people seeking health and human services. Health and human service staff are knowledgeable about the prevalence of trauma histories in the lives of individuals who seek and receive services. Services are delivered in a way that avoids inadvertent traumatization and retraumatization and facilitates consumer participation. Programs, policies, and services are designed to work respectfully and collaboratively with the person who has experienced trauma to promote healing and recovery.

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. *SAMHSA.gov*

Wellness: a proactive, preventive lifestyle approach, which emphasizes daily lifestyle choices; Wellness involves recognition of social, occupational, spiritual, physical, intellectual and emotional needs, with each dimension being necessary for optimal health. A person's overall state of health (mental and physical) is closely linked with their lifestyle choices.

Woman-centered treatment: uses bio-psycho-sociocultural frameworks based on knowledge and research centered on women; the knowledge and models are grounded in women's experiences, are built on women's strengths, and recognize the realities of women's lives, including the barriers and constraints they face. Woman-centered care must recognize the **Centrality of Connections and Relationships:** in women's lives and embed treatment in relational contexts. Woman-centered care must be **Holistic, Comprehensive, Coordinated, and available through a Continuum** that addresses all stages and severities of use. Holistic services are based on the understanding that there are connections among the biological, psychological, sociocultural, and political spheres of life. Comprehensive and coordinated services include at least two major components: (1) the breadth of life areas included and (2) the continuity of assistance over time (including different levels and types of care at different times). Comprehensive approaches attend to the major areas of women's lives, all of which are affected by their use of alcohol, drugs, and tobacco and are required for a healthy recovery, continuing wellness, and constantly improving quality of life. *Draft TIP 51*

Wraparound services: The term "wraparound" came into use in 1986, in an article by Lenore Behar, who defined it as a way to "surround multi-problem youngsters and families with services rather than with institutional walls, and to customize these services" (Behar 1986). The wraparound approach is more a process than a service, in which a child's or family's individual needs are addressed by the full range of services they need, with maximum flexibility in funding. *TIP 51 Substance Abuse Treatment: Addressing the Specific Needs of Women*

GLOSSARY of Terms- Deaf, DeafBlind, and Hard of Hearing
(*alphabetized)*

American Sign Language (ASL) – manual (hand, facial expression, body language) language with its own syntax and grammar used primarily by persons who are deaf. Each country has its own sign language, as with spoken language, and there are regional differences in signs within the United States.

Assistive Listening Devices – Refers to hard-wired or wireless transmitting/receiving devices that transmit sound from the microphone directly to the listener, minimizing the negative effects of distance, noise, and reverberation on clarity. The devices transmit sound directly to the ear, but also can employ "teleloop" attachment accessed by the telephone switch in some hearing aids and cochlear implants.

Braille – is a system of writing using a series of raised dots to be read with the fingers by people who are blind or whose eyesight is not sufficient for reading printed material.

Brailler – is an all-purpose Braille writer enclosed in a grey enamel aluminum case. It is operated by six keys.

Cane – The type of cane a blind person uses is different from the type of cane a person with a mobility disability or the elderly use. This type of cane is longer and assists the people who are blind with locating objects on the floor and in his/her pathway that he/she will need to step around.

Captioned Telephone (CapTel): You dial the other person's number, exactly the same way as with any other telephone. While you dial, the CapTel phone automatically connects to the captioning service. When the other party answers, you hear everything they say, just like a traditional call. At the same time, the captioning service transcribes everything they say into captions, which appear on the CapTel display window. You hear what you can, and read what you need to. When people call you, they need to dial the captioning service first and enter your telephone number in order for you to see captions during the call. {From CapTel Website: http://www.captel.com/how-it-works.php }

CART (Communication Access Real-Time Translation) – CART Reporters are trained court stenographers who use a computer program which translates steno into written English using a steno machine and a laptop computer. A person who is deaf or hard of hearing will read what is being said by others from a laptop, word for word, as it is being said. This service is used primarily if a person does not sign, uses cued speech, or has no other way to receive what is being said by the speakers.

Closed Captioning – is a method of embedding subtitles within the video signal. The subtitles can be descrambled and viewed on the television screen with the use of special decoding equipment, or if a TV was built in 1993 to present, it is required by the FCC to have a built-in decoder for closed captions.

Companion Animal – is a service animal, while not legally defined may provide emotional or physical support to persons with disabilities.

- Never pet or playfully taunt a service animal. They are working and should not be distracted at any time.

- Under the American's with Disabilities Act (ADA) service animals are permitted to go almost anywhere with their owner, including on planes, buses, trains, in restaurants, parks, malls, and any other place where a regular animal "pet" might be prohibited.

Please note: service animals are not always dogs.

Cued Speech – Some Deaf and Hard of Hearing people have been educated in a system which uses 12 specific hand signals representing the sounds of the English Language. The cues, when used along with lip movements, help a deaf or hard of hearing person to more clearly understand the numerous words which look alike on the lips.

Deaf: used to denote individuals who, in addition to having a significant hearing loss, function by choice as members of the Deaf community, subscribing to the unique cultural norms, values, and traditions of that group. A label of pride and solidarity for those who have similar experiences use a shared form of communication and who subscribe to Deaf cultural values, norms, and traditions. {(P. 435). From: Humphrey, J., Alcorn, B. (2007). *So you want to be an interpreter? An introduction to Sign Language Interpreting.* H & H Publishing: Renton, WA.}

deaf: "refers to the inability to hear as compared to "normal" hearing, generally seen as a deficit or an impairment; measured by decibels (p. 435)." This particular group typically doesn't include themselves in the Deaf community or see themselves as a part of Deaf culture. {From: Humphrey, J., Alcorn, B. (2007). *So you want to be an interpreter? An introduction to Sign Language Interpreting.* H & H Publishing: Renton, WA. }

Deaf-Blind – Refers to people who have significant, but not necessarily total, loss of both vision and hearing (dual sensory loss). Deaf-Blind people may be culturally Deaf, oral deaf, late deafened, or hard of hearing and his/her mode of communication varies accordingly.

Deaf Community: A group of people who have shared experiences, common interests, shared norms of behavior, and shared survival techniques – coming together to form a community. Such a group seeks each other out for social interaction, emotional support and physical safety (P 2.3). {From: Humphrey, J., Alcorn, B. (2001). *So you want to be an interpreter? An introduction to Sign Language Interpreting.* H & H Publishing: Seattle, WA. }

Deaf Culture: a set of learned behaviors of a group of people who have their own language values, rules of behavior, and traditions. {(P 2.3). From: Humphrey, J., Alcorn, B. (2001). *So you want to be an interpreter? An introduction to Sign Language Interpreting.* H & H Publishing: Seattle, WA. }

Descriptive Video (sometimes called **Descriptive Captioning)** –designed for people who are Blind, the videos provide an additional narration that describes the visual elements of the film, such as the action of the characters, locations, and costumes, without interfering with the actual dialogue and sound effects. Some videos are now being made with Description caption. If ordering new materials from any agency, always inquire about to whether the video is available in descriptive captioning.

FM and Infrared Loop Systems – FM System or Infra red Loop System cuts out background noises and allows a hard of hearing person to receive a spoken message sent directly to the telecoil in their hearing aid or to their ear. Used often in a group setting, where there are one – two speakers. The speaker wears the microphone that allows the hard of hearing person to pick up the signal in his/her hearing aid. This signal is not broadcast beyond the user.

Hard of Hearing (HOH): term applied to persons whose hearing is impaired but who have enough hearing left for practical use. {From: http://medical-dictionary.thefreedictionary.com/hard+of+hearing }

Hoyer, hydraulic lift or **barrier free lift** – A mechanical aid that assists with transferring a person from a wheelchair to a bed, a ***sling*** is NEEDED WITH THE LIFT: See Sling below.

Late Deafened – Refers to people who became deaf post-lingually (after learning to speak), and were raised in the hearing community. *Most* late-deafened people do *not* learn sign language.

Oral Deaf – This term refers to people who are born deaf or become deaf prelingually, but are taught to speak and do not typically use American Sign Language for communication.

Oral Interpreting – Oral interpreting is rendered by highly trained professionals. It involves the interpreter mouthing everything being said by whoever is speaking. The interpreter is trained to clarify words that may look similar on the lips and may include some natural gestures if necessary, to ensure comprehension.

Quad cane – usually a metal cane with four prongs instead of one, usually giving greater stability than a single leg cane

Reacher – an Assistive device used to reach far away objects. A reacher usually looks like a long stick with a hook on the far end and a trigger mechanism on the handle end. Persons with limited reach use a reacher to grab far away objects, bringing t hem closer within their grasps (e.g. picking papers, coins or reaching into cabinets, refrigerator, and etc.)

Screen Reader – Also called **Voice Output Technology**. Hardware and software produce synthesized voice output for the text that is being displayed on the computer screen, as well as for keystrokes entered on the keyboard. Examples of product names: JAWS for Windows, OutSpoken for Macintosh, and Screen Reader 2.

Service Animal – A service animal is any animal that has been trained to provide assistance to a person with a disability. Specific types of service animals are defined below:

(I)"**Guide Animal**" means an animal has been or is being specially trained to aid a particular person who is blind or has low vision.
(II) "**Hearing Animal**" means an animal has been or is being specially trained to aid a particular person who is deaf or hard of hearing.
(III) "**Service Animal**" means an animal has been or is being specially trained to aid a particular person with a physically disability other than sight or hearing.

Please note: service animals are not always dogs.

- Never pet or playfully taunt a service animal. They are working and should not be distracted at any time.

- Under the American's with Disabilities Act (ADA) service animals are permitted to go almost anywhere with their owner, including on planes, buses, trains, in restaurants, parks, malls, and any other place where a regular animal "pet" might be prohibited.

Signed English - Sign systems exist in which persons who are deaf use sign language and mouth movements, which follow the syntax of English. Persons who utilize this service rely on qualified professionals.

Slate – Slates are made of metal or plastic frames and used as a guide as the person who is blind punches dots onto the paper with a stylus. The paper fits into the slate between the top and bottom of the frame and is held in place by small pins. The Braille dots are punched downward into the paper.

Sling – This is a device used often in conjunction with a Hoyer lift (also called a hydraulic or barrier-free lift). It is made of a strong, durable mesh netting material and is used for a person with a mobility disability to sit in. The sling has hooks usually at four corners which hook on to the lift so that the person can be lifted and transferred.

Speech Reading – also known as **lip reading**, through this method and depending on a person's accent, individual speech pattern, this may be a method of communicating with a Deaf or Hard of Hearing person. If the persons who are deaf or hard of hearing aren't accustomed to speech reading, having pen and paper on hand is often helpful to write down words.

Stylus –A pointed steel tool with a handle used to punch Braille dots.

Tactile ASL – refers to the signing of ASL into the palms of a deaf-blind person's hands, done by a skilled interpreter.

Teletypewriter (TTY): a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate, by allowing them to type text messages. A TTY is required at both ends of the conversation in order to communicate. It can be used with both land lines and cell phones. Unlike text messaging, it is designed for synchronous conversation, like a text version of a phone call. {From: http://www.phonescoop.com/glossary/term.php?gid=259 }

Transfer – means moving from one place to another, in this case, from wheelchair to bed, wheelchair to the commode, etc. Persons with mobility disabilities may require assistance with transferring.

Video Phone: a telephone that can transmit video as well as audio signals so that users can see each other. {From: http://www.merriam-webster.com/dictionary/videophone }

Video relay service (VRS): allows deaf and hard of hearing individuals to have telephone conversations with hearing people. Using a videophone with real-time video connection, an

interpreter relays the conversation between the two parties. {From website: http://www.zvrs.com/z-services/video-relay-service-vrs }

Video Remote Interpreting (VRI): fee-based interpreting service conveyed via videoconferencing where at least one person, typically the interpreter, is at a separate location. As a fee based service, VRI may be arranged through service contracts, rate plans based on per minute or per hour fees, or charges based on individual usage. VRI can be provided as an on-demand service and/or by appointment. Unlike video relay service (VRS), video remote interpreting is not regulated by the Federal Communications Commission (FCC) or other telecommunications legislation. Video remote interpreting is currently used in a variety of settings. {From RID, Standard Practice Paper: Video Remote Interpreting: http://www.rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/VRI_SPP.pdf }

Acronyms for Deaf, Hard of Hearing, and Deaf-Blind

AADB	American Association of Deaf-Blind
ACT	Assistive Communication Technology
ADA	Americans with Disabilities Act
ADARA	American Deafness and Rehabilitation Association
AGB	Alexander Graham Bell Association for the Deaf
ALDA	Association of Late Deafened Adults
ALS	Assistive Listening System
ASDC	American Society for Deaf children
ASLHA	American Speech, Language and Hearing Association
C/KODA	Child/Kid of Deaf Adult
CBC	Certified Broadcast Captionist
CC	Closed Captioning
CCHD	Center for Communication, Hearing & Deafness
CCP	Certified CART Provider (have knowledge about Deaf culture)
CDI	Certified Deaf Interpreter
CI	Certified Interpreter
CRR	Certified Realtime Reporter
CSI	Communication Specialties, Inc. (Interpreter Referral Agency)
D	Deaf
DB	Deaf-Blind
dB	Decibel
DHH	Deaf/Hard of Hearing
DOJ	Department of Justice
EEOC	Equal Employment Opportunity Commission
EI	Early Intervention
ESL	English as a Second Language
FCC	Federal Communication Commission
GU	Gallaudet University
H & V	Hands and Voices
HA	Hearing Aid
HH	Hard of Hearing
HKNC	Helen Keller Nation Center
HLAA	Hearing Loss Association of America
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IFSP	Individual Family Service Plan
ITP	Interpreter Training Program
LEP	Limited English Proficiency
NAD	National Association of the Deaf
NAOBI	National Alliance of Black Interpreters
NASADHH	National Association of State Agencies of the Deaf and Hard of Hearing
NCLD	National Center for Law and the Deaf
NCOD	National Center on Deafness

NTID	National Technical Institute for the Deaf
OBVI	Office for the Blind and Visually Impaired
OC	Open Captioned
ODHH	Office for the Deaf and Hard of Hearing
OSERS	Office of Special Education and Rehabilitation Services
PEPNet	Postsecondary Education Programs Network
PIE	Professional Interpreting Enterprise, Inc. (Interpreter Referral Agency)
PSE	Pidgin Signed English
RID	Registry of Interpreters for the Deaf
RSA	Rehabilitation Services Administration
SEE	Signed Exact English
SLP	Speech Language Pathologist
SLT	Speech Language Therapist
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SWITS	Southern Wisconsin Interpreting & Translation Services, Ltd. (Interpreter Referral Agency)
TDD	Telecommunication Device for the Deaf
TRS	Telecommunication Relay Service
TSS	The Speech Source, Inc. (Interpreter Referral Agency)
V	Voice
VCO	Voice Carry Over
VI	Video Interpreter
VR	Vocational Rehabilitation
VRI	Video Remote Interpreting
WAD	Wisconsin Association of the Deaf
WCBVI	Wisconsin Center for the Blind and Visually Impaired
WESP-DHH	Wisconsin Educational Services Program Deaf and Hard of Hearing
WisRID	Wisconsin Registry of Interpreters for the Deaf

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