

Client and Family-Driven Transformation of the Mental Health System

Background

The 2004 passage of California's Mental Health Services Act (MHSA) was viewed by mental health advocates everywhere as a watershed achievement culminating decades of effort to fundamentally re-design services and supports for people and families affected by mental illnesses.

While the need for such "transformation" had been recognized for some time -- first by advocates and then by public leadership, including the U.S. Surgeon General, the federal Department of Health and Human Services Administration, and the Substance Abuse and Mental Health Services Administration -- the vision of a client-centered and family-focused "recovery-model" system has eluded implementation in most of the country because funding for mental health services and supports has either been lacking, inflexible, or both.

The MHSA addresses and provides for many elements of a transformed mental health system, including significant stakeholder input in planning and service delivery, cultural and linguistic effectiveness, recovery/resiliency focused services and supports, housing, prevention and early intervention services, and resources for workforce education and training to enable these new programs to be realized. Yet, five years on, questions posed by many remain—are these MHSA efforts in themselves effecting transformation? Should that be a goal of the MHSA writ large? And if so how would achievement of this promise be measured?

Facing these challenging questions the MHSOAC Commission directed to its Client and Family Leadership Committee the task of providing analysis and guidance. This is entirely apt since, as envisioned by the MHSA, the most powerful resource for addressing these questions resides in the lived experience of clients, their family members and their communities.

In response to its July 2010 charge, the Client and Family Leadership Committee (CFLC) convened over several months to create the present discussion as a framework for examining, piece by piece, a whole vision of a transformed mental health system as seen by clients and families of people with mental illnesses including those from underserved ethnic and cultural communities.

Introduction

Throughout the past several decades, the United States has made broad progress in advancing mental health policy on a national systemic scale. With the publication of the Surgeon General's Report on Mental Health in 1999, the Supreme Court's decision in Olmstead in 1999, major advances in services and supports, policies, programs and protections for people with mental health issues and their families have been articulated nationwide. In 2003, the President's New Freedom Commission Report, entitled *Achieving the Promise: Transforming*

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*Mental Health Care in America*¹, informed by clients and family members throughout, issued a bold challenge for massive change to the way mental health services are conducted, designed and discussed.

In California parallel efforts and promising programs held out the possibility of realizing such change if they could be implemented across the state. Many of these transformative efforts, spearheaded by Senate President Pro Tem Darrell Steinberg led to mental health initiatives including AB 34, AB 2034, and others. Ultimately, Proposition 63, the Mental Health Services Act (MHSA) was viewed across the nation as the first functional agent of transformation, the way one state would show that the promise *could* be achieved.

California's MHSA, with its resources strategically keyed to the recovery vision, stands out as the first mechanism on a large scale with the capacity to accomplish such massive change. It is seen by many advocates then as the culmination of client and family advocacy to challenge a history of inequitable, insufficient, unjust and, in some cases, abusive practices. The MHSA replaces this legacy with services and supports informed by a recovery model based in dignity and hope in which clients and families access and receive culturally competent services, and are fully empowered in their communities to move beyond the effects of even the most severe mental illnesses.

Still, many questions about "transformation" remain: How will we know, or *can* we know, if California's system has reached a threshold as to be called client-centered and family-focused? How would this transformed system differ from what previously existed and what we see today, especially with many MHSA projects already underway? What would an efficient, responsive and integrated system of recovery-based mental health supports look like?

Over several months, the Client and Family Leadership Committee met to examine these questions and to articulate the crucial changes that would be necessary for a client-centered and family focused network of supports and services, as envisioned by the MHSA, to be realized. To advance more actionable discussions for program and policy-makers the Committee used their process to identify barriers that would need to be overcome if transformation was to occur. This paper discusses the barriers identified and presents a vision of how things would look in a transformed system in several key areas relevant to mental health:

- Community Planning Processes
- Policymaking
- Cultural Competence and Effectiveness
- Mental Health Program and Service Delivery
- Housing
- Employment
- Education

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- Prevention and Early Intervention
- Stigma, Abuse and Discrimination

No discussion of progress in the arena of mental health or social change is meaningful without a focus on role of race, culture and ethnicity. The many cultures and languages of people in the US and California require that broad-scale thinking on mental health transformation address client and family needs in the context of diversity and cultural-effectiveness. Not all cultures see mental health issues, symptoms or recovery in the same way and this, along with history of discrimination and racial injustice, has fostered systems in which disparities of access to and quality of care leave many communities underserved. For transformation to achieve its objectives people must be served in ways that are coherent with and respectful of differing cultural views and traditions. **(Depending on whether we have something from Khatera for the new section on Cultural Competence and Effectiveness we could use the paragraph above for that section's introduction.)**

Transformation, if it is to be real, must be holistic and dynamic: It is not a linear or incremental process, or the result of placing the right building blocks in the right places. The present discussion lays out in brief the major elements of a vision that might easily take up thousands of pages. It points out specifics, none of which, in whole or in part, would be sufficient to effect transformation but all of which would be apparent in this transformed vision.

Transformation can only occur when these many pieces are dynamically interconnected in a truly new "system of care" which, in turn, transforms the social environment around it and creates a new world, or at least a world of vastly different possibilities for people affected by mental illness.

This document, then, is designed not to measure or chart a course towards a destination. Rather it should act as a guidebook for that destination, an atlas that articulates -- with some concrete detail -- how a world successfully transformed by MHSA values might appear, what crucial elements we would expect to see there, and what changes the people of this world would come to expect as natural and dignified supports for human wellness.

The hope of the CFLC committee is that further investigation along the values and items of this document will inspire more action like that the MHSA envisions, more progress and more energy to engage the difficult and critical work of transforming our communities into places in which wellness and support are always there for all.

Eduardo Vega, Commissioner
Chair
Client Family Leadership Committee

Goals for Client and Family-Driven Transformation of the Mental Health System

Goal for Community Planning Processes:

- Clients, families and others involved in served/underserved communities set local mental health goals and resource priorities.

Goals for Policymaking:

- Clients and families including those from underserved ethnic/cultural communities, drive mental health system policymaking.
- Mental health policy is informed by recovery principles, community needs and values and the lived experience of clients and family members including those from underserved ethnic/cultural communities.

*****Insert Goal for Cultural Competence and Effectiveness**

Goals for Mental Health Program and Service Delivery:

- Move all programs toward recovery/resiliency model.
- Clients and family members have access to culturally appropriate services and get what they need to recover in a supportive network of care that is not fragmented.
- Clients and family members are fully empowered in program settings.
- Recovery-focused “client-run programs and family supports” are an integral part of the mental health system.

Goal for Housing :

- Quality, affordable housing is available for persons with mental illness or emotional disturbance and their families in all communities in California.

Goals for the Employment of Clients and Family Members in the Mental Health System:

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- Employment or other productive activity is an expectation and focus of service for clients regardless of their physical setting (i.e., residential or institutional setting) and includes clients being supported to participate fully in the workforce at all stages of recovery.
- Clients and family members are employed in significant roles throughout the mental health system.

Goal for Education:

- The mental health system views education and the necessary supports to advance job skills and return to the workforce as central to recovery and program design.

Goal for Prevention and Early Intervention

- PEI resources that include peer support and/or family support, are sufficient and used effectively to reduce the negative outcomes of mental illness on individuals and communities.

Goals for Reduction in Stigma, Abuse and Discrimination:

- Stigma does not prevent persons from seeking help with mental health issues, family well-being, and personal recovery for the individual.
- Abusive, dehumanizing and demeaning practices are eradicated from the system of mental health care.
- Discrimination against people diagnosed with mental illnesses and their families is eliminated in health care settings, employment, housing, education, and social or civic activities.

Community Planning Process

The community planning process is integral to a mental health system understanding the impact of its various policies and procedures from the perspective of those being served and those not typically served. This includes persons from multiple backgrounds who are receiving services and those from ethnic and cultural populations that are underserved. The MHSA clearly values the voices of clients and families in all aspects of the mental health system and requires that Plans and Updates for MHSA funds shall be developed with adults and seniors with severe mental illness and families of children. As a result of the MHSA, counties in California have developed community planning processes that have involved thousands of stakeholders across the state. Despite this improvement and achievement in involving stakeholders in planning, there are still barriers to maintaining the momentum of this process and the continued interest and investment of stakeholders.

Because multiple planning processes occurred as the various MHSA components rolled out for Community Services and Supports, Prevention and Early Intervention, Workforce, Education and Training, Housing, and Innovation, many stakeholders experienced burnout over time. Continuing to engage and maintain the interest of stakeholders who have previously been part of the process while reaching out to new stakeholders is challenging. Although it becomes more difficult when combined with the fiscal crises currently facing Counties in California, it also becomes more essential for communities to plan in a way that will produce the best outcomes for the persons served which in turn translate to positive system outcomes.

In a Transformed Mental Health System:

- Local mental health departments are successful in continuously engaging stakeholders through the use of timely information and updates, community education, publicity and outreach, planned stakeholder meetings and strategies for motivation and reduced stakeholder burnout.
- Fiscal problems do not translate to less of an investment in community planning and stakeholder involvement.
- Opportunities for stakeholder input are characterized by open two-way communication whereby information is solicited and provided.
- Outreach continues to increase to existing stakeholders and community groups, persons with lived experience, MHSA Advisory/Steering Committees, Mental Health Boards, mental health advocacy groups, law enforcement and the justice system including probation, educators, child welfare organizations, providers and non-profits.
- Improved outreach to underserved cultural and ethnic populations is enhanced by the use of ethnic/cultural community partners in those communities.

MHSA Provision Related to Community Planning Process:

Welfare and Institutions Code (WIC) Section 5848(a) provides, in part, “Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests.”

Policymaking

Too often, in traditional mental health systems, policies and procedures have been developed without significant input from those with lived experience, namely clients and family members² including those from underserved ethnic and cultural communities. As a result they are sometimes developed without a belief in the recovery/resiliency model, without knowledge about the needs of specific ethnic and cultural populations, and generally without information from key informants that could improve overall system outcomes. Frequently clients and family members lack the information and/or education to effectively participate in policymaking and are further discouraged by the tedium of meetings and the use of jargon or other confusing language.

In a transformed mental health system:

1. Clients and family members are offered the information and education necessary to effectively participate in policymaking activities.
2. The system provides opportunities for a continuous dialogue between stakeholders, decision makers and those implementing programs, listens to issues raised by clients and family members and incorporates their voices throughout the system.
3. As a result of a continuous dialogue and the information exchanged between policymakers and clients and family members, learning takes place among all participants and shifts in policy are implemented as appropriate.
4. Policymakers openly disclose themselves as clients and/or family members without fear of stigma and discrimination.
5. System resources are dedicated to policy positions for those with lived experience, advocacy training for clients and family members and mentorship of those leaders seeking to become policymakers.
6. Staff and others are sensitive to the use of jargon and other confusing language that may prevent client and family member participation and input.
7. Translation services are available when policymakers, clients and family members are meeting to discuss policy issues.

² All references to clients and family members include clients and family members from underserved ethnic and cultural communities.

MHSA Provisions Related to Policymaking:

1. WIC Section 5878.1(a) provides, in part, “It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.”
2. WIC Section 5822(h) provides, “The State Department of Mental Health shall include in the five-year plan: (h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).”
3. WIC Section 5846(e) provides, “The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.”
4. WIC Section 5848(a) provides, in part, “Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests.”

*****Insert Section on Cultural Competence and Effectiveness**

Mental Health Program and Service Delivery

How mental health systems organize their programs and deliver mental health services and supports may be most significant in terms of effecting the personal recovery of the individuals and families they serve and overall system transformation.

To be successful a sincere belief in recovery and resiliency must be both obvious and evident in mental health systems. Whether in community mental health and/or inpatient/residential settings, nothing is more obvious than the words and actions of mental health staff; from Directors to administrators, to supervisors and direct line staff. If the words and expectations of those working in the mental health system are not consistent with recovery and resiliency, individuals and families being served by the system are less likely to achieve those outcomes. Actions must include providing services with dignity and respect for the individuals being served such as alternatives to seclusion and restraint and other soft intervention modes. Evidence of recovery is present in mental health systems when large numbers of persons with lived experience are employed in the system, client-run services are readily available and given support, and positive outcomes are experienced by persons served in that system.

Services must also be designed to meet persons and families where they are with regard to personal circumstance, culture and ethnicity. This may require addressing the comprehensive needs of individuals and families such as housing, and/or substance abuse. Frequently the offer of mental health treatment alone may be refused or less than successful. Instead the offer of services and supports that address other essential needs first may lead the individual and/or family to accepting mental health treatment. Whether services and supports are provided by mental health or other types of providers, mental health acting as a single point of responsibility for the service needs of those with the most complex and comprehensive needs results in integrated, more effective services.

In a transformed mental health system:

1. MHSA values, including the focus on recovery and resiliency, are the foundation of all public mental health programs.
2. Each county has a client and family task force or similar body reporting to the county mental health director on all program planning.
3. Programs and services are “integrated” with an identified single point of responsibility for service planning.
4. Programs and services are designed to consider various cultural issues including delivering services where people live, in their own language and with regard to their economic situation.
5. Mental health systems aggressively recruit, train and employ persons with lived experience from underserved populations.
6. System resources are dedicated to supporting client-run services.
7. Fiscal and organizational resources are available to client-run groups and organizations.
8. All mental health systems have eliminated or have a timeline for eliminating seclusion and restraint.
9. All mental health systems have alternatives to crisis services that utilize a “soft intervention” mode.
10. All mental health systems have processes for “whistle-blowing” that ensure no retaliation.

MHSA Provisions Related to Mental Health Program and Service Delivery:

1. Section 2(e) of the Findings and Declarations Section provides, in part, “With effective treatment and support, recovery from mental illness is feasible for most people.”
2. WIC Section 5813.5(d) provides “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
 - (1) To promote concepts key to the recovery for

individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

- (2) To promote consumer-operated services as a way to support recovery.
- (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- (4) To plan for each consumer's individual needs."

Housing

The MHSA suggests that programs that have previously demonstrated their effectiveness in California be expanded with MHSA funds. One of the effective programs cited was the Assembly Bill 34 (AB 34) program that was nationally recognized as a "housing first" program. What became apparent in that program was the therapeutic significance of having a stable place to live and the foundation this provides for individuals' ability and desire to make progress in other aspects of their lives.

Given this understanding, MHSA funds were identified to support various types of housing including Full Service Partnership housing, General System Development Housing, and the MHSA Housing program. Among the housing offered are subsidized rental units, rental units Master Leased by the county, and affordable housing units available as a result of the MHSA Housing projects developed. Even given the MHSA's significant investment in increasing housing resources and supports, barriers remain.

In a transformed mental health system:

1. Typical resistance ((Not in My Back Yard – Nimby-ism) to having clients and families housed in various communities is reduced and when encountered overcome with effective engagement strategies.
2. Different types of housing and the amount of housing available is increased for families and individuals to share.
3. There are increased resources to finance affordable housing for persons with mental illness and/or their families.
4. Rules and regulations do not inappropriately prevent family members without mental health diagnoses from sharing housing with a family member receiving mental health services.
5. Support services are available for persons in all types of housing.
6. The mental health system provides for peer staff, volunteer and paid, in all types of housing, including crisis housing.
7. In-home-support services are widely available.
8. Property management firms working with housing units available to persons with mental illness and/or their family have experience with that population.
9. Property managers and landlords are educated about working with client populations.
10. Understanding of HUD regulations is increased in the community.

11. There are processes in place to protect persons from losing their housing when they are hospitalized.
12. Housing is available for persons with multiple disabilities: physical, substance abuse and/or mental illness.
13. Clients with criminal records or credit issues have less difficulty securing housing because property management firms and others are familiar with waivers or accommodations frequently offered to persons in this situation.
14. Increased numbers of collaborative groups working on housing projects (partnerships) are formed.
15. The mental health system provides for recovery and respite housing as an alternative to hospitalization.
16. Counties and the State collect and track information related to the outcomes of MHSA and other housing for persons with mental illness and their families.

MHSA Related Provisions for Housing:

While there are no MHSA provisions that speak directly about housing services, the Act identifies homelessness as one of the negative outcomes of untreated mental illness and the reduction of homelessness as one of its major goals.

Un-codified Section 2(d) of the MHSA, provides, in part, "The people of the State of California hereby find and declare . . . in a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the street homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives."

WIC Section 5840(d) indicates that the Prevention and Early Intervention program shall identify strategies to reduce the negative outcomes of untreated mental illness including homelessness.

Employment:

Among evidence-based practice programs and other recovery-focused programs, employment has long been recognized as significant to a person's recovery. In turn, this personal achievement is magnified in its effect on the persons and systems surrounding the individual. Expectations from many are still that employment is an unreasonable goal for the majority of persons with mental illness. For the person receiving services the expectation may be that the system has little to offer them in terms of improving their own quality of life outcomes, and their personal recovery. When someone does become successfully employed or involved in other meaningful activity, expectations are raised for everyone, the individual receiving mental health services and the

community around them. As such, employment is a significant factor in reducing stigma in both the eyes of the mental health system and the community.

When one individual with life experience becomes successfully employed in the mental health system the positive results are numerous. The success is positive for the person now employed, for persons receiving services who may now deal with a fellow client, for fellow workers who may raise their expectations for all the persons they serve, and for administrators and policymakers recognizing the value and contribution of the employee.

When there are as many individuals with life experience successfully employed in the mental health system as those without, the result will be transformation.

In a transformed mental health system:

1. Lived experience is highly valued throughout the system and acknowledged as an element of quality improvement when included in service delivery.
2. Training in peer support and peer support standards are standardized across programs and the state.
3. Persons with lived experience are included in hiring processes at all levels.
4. Employment or other productive activity is a standard expectation for persons receiving mental health services.
5. Clients and family members are supported to become employed at all levels in the mental health system.
6. Services include a focus on employment both within and outside the mental health system.

MHSA provisions Related to Employment:

1. WIC Section 5813.5(d) (2) provides, in part: “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: . . . (2) To promote consumer-operated services as a way to support recovery.”
2. WIC Section 5822 provides for what the Department of Mental Health shall include in its 5-Year Education and Training Plan.

Included is the following:

- (g) Promotion of the employment of mental health consumers and family members in the mental health system.”

Education

Education, like employment cannot be underestimated in being significant to recovery and leading to improved life outcomes for individuals and the

community. It may be essential for persons whose goals include employment that will result in earning a living wage and perhaps foregoing Social Security Income (SSI). Although some supported education programs existed prior to the MHSA, most counties did not include a focus on education in their treatment planning. Similar to employment, in the minds of many clients and service providers, education is not considered a realistic goal. Stigma is a frequent barrier for someone seeking an education as a person with mental illness. There is also a lack of information about careers in the mental health system for persons with lived experience and the schooling necessary to be prepared for such a career.

In a transformed mental health system:

1. Mental health programs include a focus on education and/or employment.
2. System resources support working with educational institutions to reduce stigma about mental health clients going to school and to promote positive educational outcomes.
3. Program staff support education goals for clients, including being aware of appropriate accommodations that may be offered for persons going to school.
4. Program services include education about career ladders in the mental health system for persons with lived experience.
5. An assessment tool is available to mental health systems to evaluate "lived experience".
6. Education and employment services establish goals that result in clients earning a living wage.
7. All institutions of higher learning have mental health peer support groups on their campuses.
8. Educational scholarships are available to people with lived experience.

MHSA Provisions Related to Education:

WIC Section 5822 provides for what the Department of Mental Health shall include in its 5-Year Education and Training Plan.

Included are the following:

- a. Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce and reduce stigma associated with mental illness.
- b. Identify strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation

centers and programs, and increasing the number of human service academies.

Prevention and Early Intervention (PEI)

The inclusion of funding and services focused on Prevention and Early Intervention is one factor making the MHSA unique and contributing to the national attention given California's MHSA. The MHSA requires that 20% of MHSA funds be spent on PEI services intended to improve timely access for underserved populations and reduce the negative outcomes that may result from untreated mental illness.

These include:

- Suicide
- Homelessness
- School Drop-out
- Removal of Children from their Homes
- Incarceration
- Unemployment
- Prolonged Suffering

Frequently lack of understanding and education about mental health issues, combined with stigma and discrimination, prevent persons and families from seeking PEI services that could prevent negative life outcomes. If both outreach and service interventions were provided by persons with lived experience, including those from cultural and ethnic communities, then hesitance to accept services may be successfully overcome and negative outcomes avoided.

In a transformed mental health system:

1. Information regarding prevention and early intervention is widely disseminated and available.
2. People are educated and made aware of the full range of PEI remedies.
3. The full range of assistance, including peer support, is available for early intervention when an individual experiences the early signs of potentially severe and disabling mental illness.
4. Support is provided for dignified approaches for early interventions that do not undermine hope for the future.
5. Stigma and discrimination that is cultural, systemic, and personal is significantly reduced.
6. Information is given to at-risk children and transition-age youth so they are better able to understand their own mental health experience.

MHSA Provision Related to Prevention and Early Intervention:

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1. WIC Section 5840 (b) (1) provides, “The [PEI] program shall include...(1) Outreach to families, employers, primary care health providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.”

Stigma, Abuse and Discrimination:

*****Richard is developing narrative paragraph***

In a transformed mental health system:

1. Linguistic barriers are reduced through multilingual supports.
2. Persons with mental illness are accurately portrayed in the media resulting in reduced stigma, abuse, and discrimination.
3. Mental health systems and the media work in partnership to portray the successes experienced by persons with mental illness and the corresponding benefit to the community.
4. There are increased opportunities to reduce stigma by letting the public hear directly from persons with mental illness and their family members.
5. The public are more aware that persons with mental illness are no more violent than the general population and are frequently the victims of violence.
6. The mental health workplace culture values service recipients as whole individuals and not just as clients.
7. Persons with mental illness in residential or institutional care settings are not stigmatized due to their residence.
8. Housing supports are in place to reduce evictions that occur as a result of the behaviors of a family member with mental illness.
9. Physical healthcare policy includes mental health in a systematic way.
10. The rights of individuals while under conservatorship are respected, including the right to vote.
11. Persons with mental health issues and others in their community have the opportunity to interact and discuss mental health issues.
12. Teachers and family members are provided with tools to prevent bullying.
13. Abuse is decreased through an increase in the ratio of patient’s rights advocates to the population they serve in institutional and residential settings.
14. Laws are routinely examined to ensure they are not adding to stigma and discrimination.

MHSA Provision Related to Stigma and Discrimination:

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1. WIC Section 5840(b)(3) and (4) provide, “The [PEI] program shall include the following components: . . . (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. (4) Reduction in discrimination against people with mental illness.”

Conclusion

As stated this document is not intended to be the most comprehensive or universal vision of a transformed mental health system. Instead it presents a picture of a system that is transformed in the way it values, utilizes and promotes the voices and wisdom of clients and family members. This transformation is client-centered, family focused and guided by persons whose life experience may have included negative outcomes of mental illness such as suicide, homelessness, incarceration, unemployment, school drop-out, removal of children from their homes and/or prolonged suffering, and positive experiences of recovery and resiliency. This wisdom is essential to serving others with similar circumstance and critical to achieving positive system outcomes for mental health and communities, all of whom would benefit from informed, coordinated, efficient and effective service delivery.