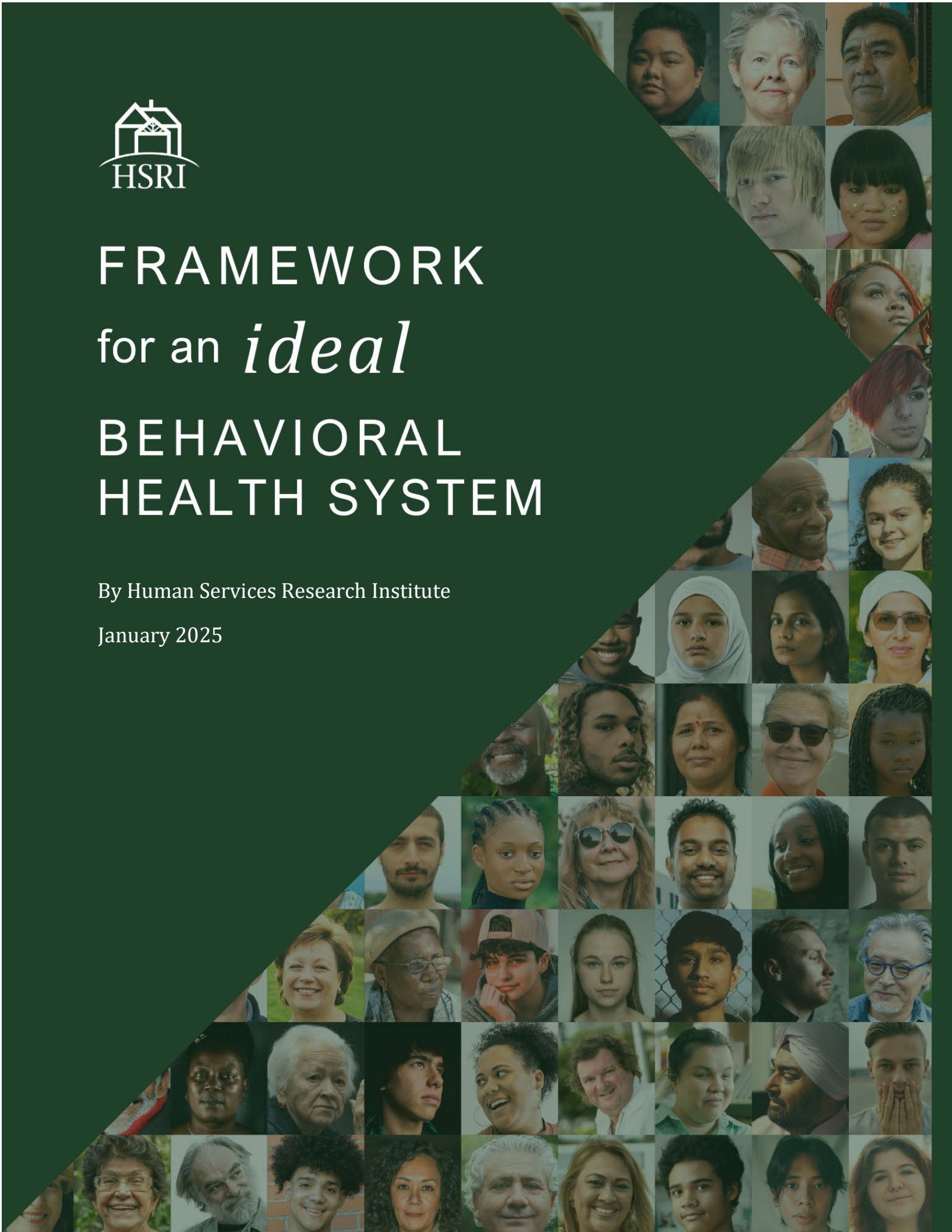


FRAMEWORK for an *ideal* BEHAVIORAL HEALTH SYSTEM

By Human Services Research Institute

January 2025

Summary

This paper outlines HSRI's framework for an ideal behavioral health system. The framework details associated system values, expectations, and practices.

Values

Care for the whole person · Community inclusion · Data-driven · Equity · Honoring culture · Driven by lived experience · Person-centered · Recovery-oriented · Right to care · Self-determination · Transparency · Trauma-informed

Expectations

Promote Access for All	System continuously identifies groups that may be underserved and inappropriately served and rectifies disparities; services are culturally responsive and linguistically accessible for all
Maximize Autonomy	System recognizes that dignity and healing require agency and autonomy; in limited situations where autonomy must be restricted, great care is taken to minimize coercion
Integrated Supports	System sees the person in the context of culture and community; care is integrated, coordinated, individualized, and addresses social drivers of health
Engage Communities as Partners	A wide range of community partnerships drive system performance monitoring and improvement
Management & Operations Aligned with System Values	System uses the latest technologies and best practices to function smoothly and equitably; it is adaptable, sustainable, and continuously improving
Focus on People	All people involved in the system—service users, their loved ones, employees, and leadership—are treated justly, appreciated, and supported to contribute their strengths

System Practices

1. **Education, Outreach, and Engagement: Practices and services that promote an informed and engaged community, empower people who use services to be active participants in the system, and maintain full access to services**
2. **Planning, Coordination, and Decision-Making: Programs, services, and supports that facilitate needs and strengths discovery, identification, and organization of services and supports, navigation of the system, and means to ensure a person's preferences are identified and upheld**
3. **Services and Programs: A full spectrum ranging from prevention and wellness promotion to community supports to clinical treatment. Programs, services, and supports can be delivered at the population, group, or individual levels**
4. **Technical Functions: Activities to ensure the system performs according to its values and expectations. These include financing and sustainability, workforce development and retention, collaboration, and partnership with adjacent systems (e.g., medical, child welfare, education), informatics and data, quality improvement, and innovation**

Introduction

There has never been a more important time to elevate wellbeing in our communities. Across the population, stress, trauma, and feelings of despair are prevalent. Deepening wealth gaps, structural inequality, and other forms of discrimination reinforce existing barriers to wellbeing for communities of color and under-resourced groups.

By **behavioral health system,** we mean the constellation of practices, programs, services, and people that promote the social and emotional wellbeing of the population through wellness promotion and education, prevention, treatment, and recovery supports throughout the lifespan.

Research has established that social and structural factors such as poverty and income inequality, racism and other forms of discrimination, adverse early childhood experiences, lack of affordable housing, and poor access to health care, among others, are associated with poor mental health outcomes. However, health and social service systems often remain ill-equipped to address these drivers of mental health. And too often, carceral and coercive practices become the default when community services are inadequate.

While there is no single definition of an "ideal" behavioral health system, a 2011 SAMHSA paper titled, *Description of a Good and Modern Addictions and Mental Health Service System*,[1] describes a vision, principles, service elements, and core structures and competencies to ensure a behavioral health system meets community needs. For over ten years, the paper has been used by policymakers and by our organization, the Human Services Research Institute (HSRI), in our system assessment and planning work.

Beginning in 2021, HSRI convened an authorship team composed of HSRI staff and partners to draft a description of an "ideal" system—building off the "Good and Modern" paper. **In this paper we describe our approach to developing this framework and define the values, expectations, and practices essential to an ideal behavioral health system.**

In keeping with the values and expectations described in this document, it was critical that our description be collaboratively produced with people with lived experience of the behavioral health system, and that it includes full consideration of issues of equity and social justice. Four of the ten members of the authorship team have personal lived experience as users of publicly funded behavioral health systems and other intersecting social service systems. In addition, we engaged a panel of advisors, a majority of whom have lived experience as system users, to review and provide feedback and guidance on our work at various intervals.

[1] SAMHSA (2011). Description of a Good and Modern Addictions and Mental Health Service System. https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

Background

Efforts to reform or transform the behavioral health system have a long and well-known history in America, from the "moral treatment" movement of the 18th century and "mental hygiene" movement of the early 20th century to the community mental health movement, which was ushered in by the 1963 Community Mental Health Act that sought to replace large state hospitals with community mental health centers. Disability rights and consumer/survivor/ex-patient movement activists have advocated for rights-based approaches in the community since the 1960s, resulting in the establishment of peer services and prioritization of lived experience in policy and practice. In addition to the 2011 "Good and Modern" paper, a number of seminal reports have detailed the shortcomings of the existing system and included comprehensive recommendations for reform. These include, among others:

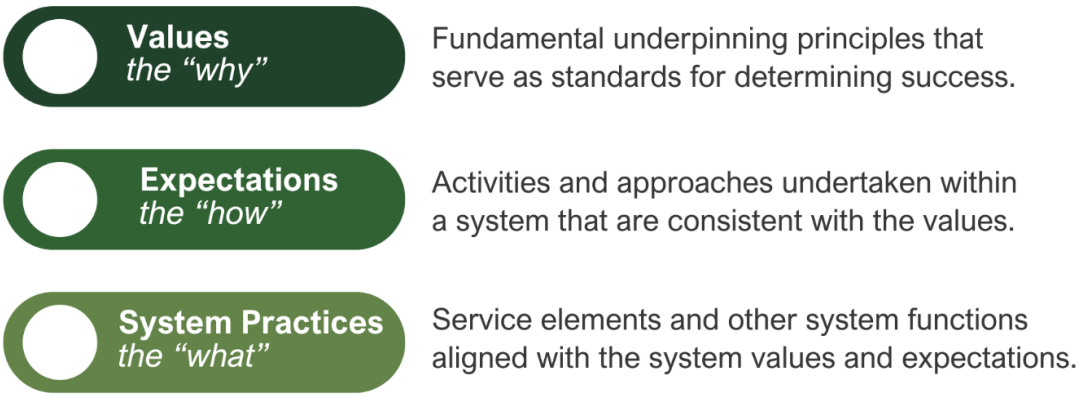
- On Our Own: Patient-Controlled Alternatives to the Mental Health System (1979)
- Mental Health: A Report of the Surgeon General (1999)
- President's New Freedom Commission on Mental Health (2003)
- Institute of Medicine: Improving the Quality of Health Care for Mental and Substance-Use Conditions (2006)
- NAMI: Divert to What? Community Services That Enhance Diversion (2021)
- Center for Law and Social Policy: Core Principles to Reframe Mental and Behavioral Health Policy (2021)
- WHO: Guidance on community mental health services: Promoting person-centered and rights-based approaches (2021)
- Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S. (2021)

Our effort seeks to build on prior work to articulate a framework for an ideal system that can be used for assessment and to guide system planning at the state, county, and local levels.

Three-Level Framework

The framework we developed through this effort, described in this paper, includes three interconnected levels: **values, expectations,** and **system practices.**

Fig 1. Framework for Describing a Behavioral Health System



The first level—**Values**—contains foundational principles underlying the ideal system or the "why" a system exists in the first place. The second level—**Expectations**—describes "how" a value-driven system should operate in a way that demonstrates its values. In a sense, expectations are more concrete and operationalized descriptions of the system's values. The third level—**System Practices**—involves the system structure and implementation or the "what" a system does. The strength of the system is determined by the extent to which its values and expectations are reflected in its practices. The remainder of the report describes each of the levels in detail.

Values

Values play a critical role in any complex system. In the context of behavioral health service systems, values encompass the principles or qualities intrinsically desirable within the system.

In our conceptualization, values serve as the core supporting structure for the framework of the system. They are what inform and drive the expectations for the system, which in turn influence the practices, along with other contextual factors. As such, values play a critical overarching role in driving the behavior and outcomes of a system, as well as what gets evaluated within the system when assessing system performance. To help inform system planning and implementation efforts, systems must be explicitly transparent about the values informing all that they do.

In this spirit, the authorship team—inclusive of authors with lived experience—worked to identify 12 values underpinning our conceptualization of an ideal behavioral health system. For a system to function well, all partners must have shared understanding and commitment to these values.

1. **Care for the whole person**: The person is supported holistically within the context of their life, culture, and community. Physical, emotional, and social needs are all prioritized with a goal of helping people to thrive.
2. **Community inclusion***:* Community inclusion is a human right and means supporting and promoting individuals to participate in economic, educational, political, social, cultural, and recreational activities of their communities.
3. **Data-driven***:* The system uses quantitative and qualitative data to inform all decisions and functions, including the best use of public funds, in alignment with the other system values. The system offers services that are shown to be effective and avoids services that are ineffective. The system values various types of evidence, including data reflecting the experiences of people impacted by the system.
4. **Equity**: Equity is the absence of unfair or avoidable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, race, ethnicity, disability, or sexual orientation). Health equity is achieved when everyone can attain their full potential for health and well-being. In a system that is equitable, everyone has a fair and just opportunity to be healthy. This requires taking accountability for systemic, scientific, structural, and institutional racism and other forms of oppression in all system practices, dismantling these inequities, and making improvements that result in greater health equity.
5. **Honoring culture**: The system is responsive to the person's culture. The system is culturally and linguistically competent, with services that encourage and honor cultural diversity and support connection to the person's culture and cultural conceptualizations of health and wellbeing. Those within the system practice cultural humility using established frameworks that address bias, rebuild trust in service systems, and promote inclusivity. System practices are informed by an understanding of historical and current power imbalances and incorporate frameworks and strategies to dismantle structural inequality.
6. **Driven by lived experience:** In keeping with the disability movement and consumer/survivor/ex-patient movement mantra, "nothing about us without us," people with lived experience using the system should have integral roles in the planning and implementation of strategies, policies, and systems that affect their lives. The idea is based on the belief that lived experience perspectives are vital for system governance and improvement.
7. **Person-centered:** In a person-centered system, people and their chosen caregivers are at the center of service planning and delivery, and all system elements are aligned with a common aim to support people to live a life they choose in the community. Peoples' strengths and contributions are the focus, not their limitations or deficits. The system is consistently warm and welcoming, providing exceptional customer services at all levels.
8. **Recovery-oriented***:* Recovery broadens the focus on wellbeing to encompass a meaningful and self-fulfilling life, which may or may not include the reduction of symptoms or being able to achieve goals defined by society or someone other than the person. A recovery orientation understands everyone is different and should receive support that assists them in

achieving their own hopes, goals, and aspirations. Recovery is accessible to all, and a recovery orientation is essential even in the most restrictive settings.

9. **Right to care:** All people deserve access to quality, accessible, and responsive health care and social services as a basic right.
10. **Self-determination:** Self-determined people freely choose their goals and act to make them happen in their lives. A system that promotes self-determination prioritizes voluntariness and provides interventions that focus on building a person's capacity to act on their own behalf and removes barriers to action and decision-making.
11. **Transparency*:*** Information about policies, planning, services, performance, and outcomes is available to those at all levels, including the community at large. Information is shared in accessible formats and is available in all settings. People know what to expect from the system, including interventions that involve coercion or the use of force.
12. **Trauma-informed*:*** Programs and practices are informed by an understanding of trauma in all its forms – interpersonal, institutional, and intergenerational – and its impacts on health and wellbeing. The system redresses past harms, avoids inflicting further harm, and seeks to promote collective healing for people and communities. Often this healing requires far more than health care but also connection to culture, spirituality, and community.

In some instances, system decisionmakers may find that values conflict with one another. In these instances, decisionmakers must consider the values together to work through ambiguities. For example, the value of "data-driven" may result in de-prioritization of an intervention that has limited research evidence but is a priority for a minoritized group of people with lived experience. In this example, decisionmakers might revisit the values of "equity" and "driven by lived experience" alongside being data-driven and decide to support the intervention and gather additional qualitative and quantitative data to better document its value.

Expectations

Expectations are an extension of values. After identifying 29 different expectations for an ideal system, we grouped the expectations into six areas: 1. Promote Access for All, 2. Maximize Autonomy, 3. Integrated Supports, 4. Engage Community as Partners, 5. Management and Operations Function in Alignment with Values, and 6. Focus on People. Notably, these expectations are aspirational; current behavioral health systems are not fully meeting all of these expectations.

Promote Access for All

An ideal behavioral health system works for all. The system continuously identifies groups that may be underserved and inappropriately served and rectifies disparities in access, quality, and outcomes. The people who work in the system—including its leaders—are representative of the people who use the system in terms of race, culture, and other identity characteristics. The system is responsive to all, including people with complex and intersecting identities, strengths, and needs.

Ease of access – People get services when, where, and how they need them. Access is not just about what has always been available, but consistently learning what is missing and creating access to that.

Cultural responsiveness – Those within system practice cultural humility and strive for cultural competence. Services and programs are culturally responsive and delivered by a workforce that reflects the cultural characteristics of the community. Practice-based evidence is prioritized alongside evidence-based practice. Traditional healing practices, community-defined practices, and cultural adaptations of evidence-based practices are supported and widely accessible.

Linguistic accessibility – Materials are available in languages and formats that reflect the needs of the community using language that is culturally responsive and relevant. Materials are fully accessible for people with a range of cognitive abilities, communication (hearing and vision) needs, and non-English speakers.

Support for people with complex needs – Services and systems are oriented to support people navigating multiple systems (SSI/SSDI, child welfare, criminal legal systems) and those experiencing homelessness, extreme poverty, police involvement, and/or involuntary commitment.

Maximize Autonomy

The system recognizes that dignity and healing require agency and autonomy. The system maximizes autonomy, and those receiving supports provide true informed consent. The system minimizes involuntary interventions in all functions because coercive and forced treatment negatively impact trust and connection. In areas where autonomy must be restricted, those within the system take great care to minimize coercion and intentionally balance health and safety concerns with what is most important to a person. The system is set up to allow for people to take risks, fail, and learn from mistakes.

Voluntariness – The system promotes informed choice and shared understanding while minimizing its reliance on involuntary and coercive approaches. Shared decision-making guides treatment, and supported decision-making is attempted before restrictive conservatorship or representative payee arrangements are considered.

Self-advocacy – People who use the system are encouraged to advocate for their own needs and preferences and are supported to do so with training, information, and resources.

Dignity of risk – All people have the right to take reasonable risks and make choices that may have negative consequences; impeding this right in the name of protection or safety can result in a loss of dignity, self-esteem, or quality of life.

Elimination/minimalization of criminal legal system involvement – Whenever possible, services and programs are geared toward avoiding or minimizing involvement with law enforcement, courts, and carceral settings, and facilitating transition from those settings as quickly as possible. Crisis response programs are transparent about when and how law enforcement personnel will be involved. Interventions that involve the criminal legal system are paired with rights education and supports for self-advocacy.

Integrated Supports

The behavioral health system does not "treat"; rather, it is oriented to support a person holistically and in the context of their culture, community, and society. Care is individualized, integrates paid and natural supports, facilitates shifting between levels of care, and is consistent across the lifespan.

Address social drivers of health – Services, programs, and other practices take into account the fact that health, including mental health, is heavily influenced by social and economic factors such as poverty, education, employment, housing, neighborhood and environment, and social and community contexts. These factors influence not only the health of individuals, but the health of the population as a whole.

Appropriateness – People receive the right service at the right level of care at the right time, in the least restrictive setting. People have access to options and alternatives at every level of the system, including crisis and intensive services.

Consistency and continuity of care – The quality of care is uniform across services and program areas, with consistent information and communication practices to support data-driven and user-preferred transitions between services.

Coordination across systems – There is active coordination and communication between the behavioral health system and related systems including physical health care, justice, education, child welfare, housing, vocational rehabilitation, and other public social service systems.

Integration of services – Behavioral health services are integrated with physical health care and other social services to promote access and a whole-person focus. Those with complex needs receive wrap around services tailored to meet their needs.

Life span approach – Services are organized and delivered with the recognition that people have differing needs across the life span.

Engage Community as Partners

The system invests in developing partnerships with groups that represent the interests of communities, including and especially historically underserved communities and people with lived experience. Communities have the information and the resources they need to engage in fruitful partnerships with the system.

Informed community – The system engages the community to promote awareness of the systems values and practices so that people who use the system know what to expect and can participate as partners in system improvements.

Advocacy partnerships – The system regularly partners with and seeks counsel from organizations that focus on advocacy and the protection of rights, including peer-run organizations operated and led by people with lived experience.

Community partnerships – Community groups and coalitions are seen as key partners in system monitoring, oversight, and improvement activities.

Management and Operations Function in Alignment with Values

Using the latest technologies and guided by best practices, those within the system use strategies to ensure it functions smoothly and efficiently meets the needs of the community through engagement and partnerships with people most impacted by the system.

Adaptability – The system is adaptive to change and de-implements programs and practices that are not aligned with established values.

Continuous quality improvement – System leaders, system users, and other system partners are continuously reviewing outcome and experience data to ensure best practice and quality of care.

Eliminating disparities – The system actively identifies and addresses the root causes of disparities in outcomes, access, quality, or experience. Disparities related to race, ethnicity, culture, language, nationality, gender, gender identity, sexual orientation, disability identity, age, geography, military service history, citizenship status, or other factors will be promptly rectified. There are concerted efforts to improve access to services for populations that are traditionally underserved or "hard to reach."

Outcomes-orientation – Services are effective in producing outcomes valued by each person and by the community, recognizing that these outcomes may differ (e.g., the person's valued outcomes may not be the same as the outcomes valued by the community).

Stewardship – As a public resource, the system makes the most effective use of its funds. Funding is appropriated in alignment with the values of the system and the community.

Sustainability – The system is adequately resourced by funding that is sustainable and flexible to the evolving needs of the community.

Focus on People

All people involved in the system—service users, loved ones of service users, employees, and leadership—are treated justly and are supported to contribute their strengths and abilities to promote the system values.

Representation – System staff, including and especially leadership and decisionmakers, are representative of the community in terms of lived experience, race, language, and culture. This includes ensuring positions designated to represent lived experience at all levels of the system including executive leadership.

Leadership – System leaders understand, embrace, and actively promote system values.

Peer support – Peer support—mutual aid delivered by people with similar life experiences—is incorporated throughout the system, widely available, and delivered in alignment with peer support values and best practice standards.

Sufficient workforce – The workforce is composed of adequate numbers of skilled personnel who are representative of the communities served in terms of lived experience and cultural identities (e.g., race, language, sexual orientation, gender identity).

Supported workforce – The workforce is supported with a livable wage that keeps up with inflation, excellent benefits, opportunities for growth, and working conditions that promote wellbeing.

Community involvement in decision making – People who use services and people working within the system at all levels (e.g., direct service providers, administrators, management) are engaged in and inform system oversight, monitoring, and improvements.

System Practices

The third level of our framework details the core service elements and other functions that make up the system. These are grouped into four areas depicted in the framework: 1. Education, Outreach, and Engagement, 2. Planning, Coordination, and Decision-making, 3. Services and Programs, and 4. Technical Functions.

The following list includes examples of these four areas and presents a wide array of practices that work together in a robust behavioral health system. The list is not intended to suggest that every system must employ every practice. The practices listed can be implemented in any sequence or combination depending on the needs and priorities of the community. Notably, in accordance with system values and expectations, prevention and early intervention should take priority, and coercive or disruptive practices should be used as infrequently as possible or avoided entirely. Finally, the following list is not comprehensive, as different states and systems have unique practices and terminology.

Education, Outreach, and Engagement

- Service directories
- Community education to raise awareness of services and systems
- Self-advocacy skills training
- Translation and interpretation services
- Outreach strategies to reach underserved communities
- Support identifying and enrolling in benefits and social services
- Coalitions and policy councils

Planning, Coordination, and Decision-making

- Screening and referral
- Assessment
- Specialized evaluation
- Person-centered and person-directed planning
- Shared decision-making
- Service and support planning, including crisis planning
- Psychiatric advance directives that are required to be followed by law
- Supported decision-making that is prioritized before conservatorship/guardianship
- Hospital discharge planning and follow-up
- Jail and prison re-entry planning and community follow-up

- Supports for self-direction
- System navigation
- Case management/service coordination
- Intensive case management

Services and Programs

Prevention and Wellness Promotion:

- Social and emotional wellness promotion
- Health education, health literacy support
- Financial literacy support
- Physical health promotion
- Early intervention
- School-based services
- Infant and early childhood mental health programs
- Family support and respite care
- Family skills training/parent training
- Supports for physical health and wellness self-management (e.g. nutrition and exercise)

Community Services and Supports:

- Transition supports (e.g., bridging, stepdown, re-entry)
- Services provided by community health workers/promotores (who work in Spanish-speaking communities)
- Supported employment
- Supported education and vocational training
- Clubhouse
- Skill building (e.g., social, daily living, cognitive)
- Personal care and homemaker services
- Assistive technology
- Recreational and social supports
- Supported housing including Permanent Supportive Housing (PSH)
- Recovery housing
- Culturally specific services, including traditional healing services and religious practices
- Recovery support coaching
- Recovery community centers
- Living room and drop-in centers
- Volunteer and self-help groups (e.g., Alcoholics Anonymous, Hearing Voices)
- Community peer support including family, youth, forensic, and culturally specific peer support

Outpatient Clinical Services:

- Services delivered in primary care settings
- Individual, group, couples, and family therapy
- Team-based intensive treatment and support services (e.g., Assertive Community Treatment)
- Wraparound services

- Individual and family psychoeducation
- Medication services (medication management, pharmacotherapy, laboratory services)
- Medication optimization
- Pharmacy services
- Medication-assisted treatment for substance use disorder
- American Society of Addiction Medicine (ASAM) outpatient (level 1) and intensive outpatient (level 2)
- Intensive in-home treatment
- Intensive outpatient treatment
- Multi-systemic therapy
- Forensic outpatient and team-based services
- Non-emergency health care transportation

Facility-Based and Residential Services:

- Short-term residential services for children, youth, and adults
- Therapeutic foster care
- ASAM medically monitored (level 3) and managed (level 4) intensive inpatient
- Acute inpatient (short-term)
- Partial hospitalization
- Soteria house
- Specialized mental health services for older adults in long-term care settings
- State hospital services
- Supports and services in jails and prisons (full range of clinical and nonclinical services)
- Peer support in jails and prisons
- Peer support in inpatient hospitals

Crisis Services:

- Warm line
- 24/7 crisis hotline and text line services (e.g., 988)
- Peer respite
- Open dialogue
- Mobile crisis services
- Non-law enforcement crisis response services
- In-home family crisis intervention
- Urgent care services 24/7 crisis walk-in centers
- Psychiatric emergency room
- Crisis stabilization/residential/respite services
- Non-law enforcement crisis transportation
- Medical and social detox
- Access to immediate medication-assisted treatment for opioid use disorder
- Overdose response services

Technical Functions

Finance:

- Contracting
- Fiscal / rate setting
- Service authorization and network management
- Revenue generation/pursuing and maximizing funding opportunities
- Self-direction

Workforce:

- Training and professional development
- Recruitment and retention (e.g. loan repayment programs)
- Compensation and benefits
- Pipeline
- Supervision and performance monitoring (including self-assessments)
- Appropriate inclusion of peers in workforce (e.g. adequate supervision, not using certification as an employment initiative)

Collaboration and Partnership:

- Advisory and oversight boards
- Public communications
- Collaboration with advocacy groups
- Processes for gathering community input

Coordination and Technology:

- Coordination and information sharing across programs and areas within the system
- Coordination and information sharing between behavioral health and adjacent systems
- Data systems / health information technology
- Telehealth practices

Quality and Innovation:

- Accountability and performance monitoring
- Performance measurement and improvement
- Continuous quality improvement
- Divesting from services or practices that are not effective in producing valued outcomes

Conclusion

In this paper we have presented a high-level framework of values, expectations, and practices for an ideal behavioral health system. Researchers at HSRI employ this framework when conducting behavioral health system assessments and related projects. This is a living document that will evolve as systems and our understanding of those systems evolve. We are committed to applying principles of continuous learning to our work and welcome feedback and ideas at any time. Reach us at bcroft@hsri.org.

Authorship Team

The authorship team is Giovan Bazan, Ben Cichocki, Bevin Croft, Ebony Flint, Rachael Gerber, David Hughes, Nilufer Isvan, Morgan Pelot, Eric Washington, and Dow Wieman.

Reviewer Acknowledgements

HSRI is grateful to the many collaborators who provided guidance on this process. Martha Barbone, Chyrell Bellamy, Becky Brasfield, John O'Brien, Elliot Pinsly, Morgan Shields, Sandy Steingard, Shawn Terrell, and Kelechi Ubozoh reviewed and provided feedback on the manuscript. Lydia X.Z. Brown, Nev Jones, Ron Manderscheid, David Miller, and Lisa St. George, provided early guidance on the approach and framework.

Suggested Citation

Human Services Research Institute (2025). Framework for an Ideal Behavioral Health System. Cambridge, MA.

Human Services Research Institute

Headquarters:

2336 Massachusetts Avenue,
Cambridge, MA 02140