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Service Transformation Toolkit and Guide

PROVIDER AMABASSADOR PROGRAM

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Provider Ambassador Program

Service Transformation Toolkit and Guide:
ASAM LOC 3.2-WM (3rd Ed.) to Crisis Stabilization Unit

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Provider Ambassador Program

Introduction

The release of the ASAM Criteria, Fourth Edition includes significant updates that have been made to how levels of care are defined and delivered- notably, Level 3.2-WM (Clinically Managed Residential Withdrawal Management) has been removed as a distinct service category. In alignment with this national shift, the State of Colorado is actively updating its behavioral health service delivery system to reflect these evidence-based standards. This transition is part of a broader commitment to improving quality of care, individual outcomes, and system alignment with best practice models.

Colorado is not losing a level of care. Rather, the state is advancing toward a more integrated, person-centered model where withdrawal management is no longer isolated but instead embedded across the continuum of behavioral health services. Current personnel offering services under the former ASAM 3.2-WM level of care have an opportunity to evolve their programs to meet critical community needs by transitioning to the delivery of crisis services, specifically through an opportunity to transition 3.2-WM programs to becoming Crisis Stabilization Units (CSUs).

CSUs serve as the third branch of the integrated services within a connected and integrated crisis system as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA):[1]

1. Someone to Contact: 988 Suicide & Crisis Lifeline (988 Lifeline) and Other Behavioral Health Lines;

2. Someone to Respond: Mobile Crisis and Outreach Services; and

3. A Safe Place for Help: Emergency and Crisis Stabilization Services.

CSUs serve individuals experiencing acute behavioral health crises- including mental health and substance use-related emergencies- who require short-term, intensive services but do not meet the criteria for inpatient hospitalization and would be better served in a community setting. These units are designed to offer a safe, structured, and trauma-informed environment where individuals can be stabilized, assessed, and connected to appropriate follow-up care.

Populations typically served include individuals with co-occurring disorders, those experiencing suicidal ideation or severe distress. Some of these individuals will need

[1] https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf

intoxication or withdrawal management services that can be safely delivered in a 24-hour personnel- monitored setting.

Importantly, expedient access to withdrawal management must be fully integrated into CSU service delivery to ensure continuity of care and to reduce risk of harm for individuals presenting with acute intoxication or withdrawal symptoms. Incorporating withdrawal management as a component of CSU programming not only aligns with best practices but also enhances the system's capacity to provide equitable, whole-person care across the crisis continuum and reduce overreliance on more restrictive and higher cost services.

This document is intended to support agency personnel in navigating this transition. It outlines what a shift from 3.2-WM to CSU entails and provides tools and guidance to help agencies align with Colorado's evolving system of care- while continuing to meet the needs of the communities they serve.

To effectively use this tool, start with the Service Type Comparison tool and the Implementation Workflow to identify the areas with the most urgent gaps in compliance. From here, based on your agency's identified needs, prioritize the use of the other tools outlined in this guide to ensure your agency is working toward meeting compliance for this level of care.

1. Use the Service Type Comparison Tool to evaluate whether this level of care is right for your agency

When mapping how best to begin planning for a transition to the CSU model, agencies can benefit significantly from using a structured resource that compares the agency's current programming, personnel, and operations in 3.2-WM to best practices for CSUs.

To use the Comparison Tool effectively, agency leaders and multidisciplinary teams should carefully read through each section, to identify areas where the agency is fully aligned, partially aligned, or not aligned at all with the CSU model of care. This process provides a clear understanding of current strengths as well as gaps that need to be addressed to meet the standard.

Agencies must consider the initial feasibility of addressing any gaps identified. For each misalignment, it's important to ask: Do we have the personnel, funding, and infrastructure to meet this expectation? Would this shift be sustainable with our current resources? Are we prepared to make operational or philosophical changes to support this level of care?

Equally important is evaluating the community's needs. A Crisis Stabilization Unit is a structured and moderately resource-intensive level of care. Agencies must examine whether there is a need for this service in the communities they serve in comparison to other service types offered in this transition. This includes understanding referral volume, community needs, and existing personnel capacity.

Review of this Comparison Tool is the first step in an agency's strategic planning process. It provides the foundation for identifying gaps and related needs. In some cases, the crosswalk may reveal that transitioning to become a CSU is the right next step. In others, it may point toward strengthening existing services or pursuing a different level or type of care that better fits the agency's mission and capacity while partnering with a CSU provider.

- Agency Service Type Comparison tool: 3.2-WM to CSU

2. Ensure A Comprehensive Understanding of All Aspects of the Crisis Stabilization Unit Model

Crisis stabilization services serve as a vital no-wrong-door entry point for individuals experiencing mental health or substance use crises- similar to how hospital emergency departments accept all walk-ins and drop-offs by ambulance, fire, or police. These programs are designed to say "yes" to all behavioral health crisis referrals, regardless of a person's age (within the scope of facility licensure) or clinical condition, including individuals with serious emotional disturbance, serious mental illness, or intellectual and developmental disabilities.

This commitment influences the facility's personnel model, physical layout private rooms with beds, and creating a trauma-informed and recovery-oriented environment- to maximize capacity and responsiveness. CSUs should be able to accept walk-ins and first responder referrals, ultimately achieving true diversion from emergency departments and the legal system. Similarly, expedient access to withdrawal management and medications for addiction treatment (MAT) is a requirement of this model in Colorado.

When an individual requires medical care in a hospital or medical withdrawal management services, the crisis facility-not the referring party- bears the responsibility for coordinating the appropriate transfer. It is also important that the facility communicates a clear expectation that they are responsible for triage, not emergency responders and Law Enforcement.

SAMHSA outlines clear expectations regarding the CSU model:[2]

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

- Accept all referrals;
- Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
- Design their services to address mental health and substance use crisis issues;
- Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically equipped personnel services if needed;
- On-site personnel at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    - Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
    - Nurses
    - Licensed and/or credentialed clinicians capable of completing assessments in the region; and
    - Peer support professionals with lived experience similar to the experience of the population served.
- Offer walk-in and first responder drop-off options;
- Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no rejection policy for first responders;
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; and
- Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

[2] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

- Offer a dedicated first responder drop-off area;
- Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
- Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; and
- Coordinate connection to ongoing care.

Here are some tools that your agency can use to get started:

- Crisis Stabilization Unit Compliance Workflow
- Crisis Stabilization Unit Trainings
- National Guidelines for Behavioral Health Crisis Services [https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf]

3. Conduct a Thorough Agency Assessment and Gap Analysis and Implementation Plan with Reasonable Timelines

Before an agency can effectively transition from ASAM 3.2-WM to a Crisis Stabilization model of care, your organization must have a clear and realistic understanding of its current capabilities, infrastructure, and service delivery model. An agency assessment and gap analysis is more than a checklist- it's a strategic opportunity to uncover strengths, identify limitations, and prioritize areas for investment and improvement.

Key Areas for Evaluation Include:

Personnel Structure

Each agency will need to complete a comprehensive assessment of its current personnel structure in comparison to CSU to identify any gaps that will need to be met prior to implementation. The tool below can help agencies begin this process:

- Personnel Crosswalk

Why it matters: Crisis Stabilization Units require a team of qualified professionals available 24/7 to address the clinical needs of individuals, not just basic support or observation.

Physical Environment

Designing the physical space of a Crisis Stabilization Unit is pivotal in ensuring effective care for individuals experiencing behavioral health crises. The Facility Guidelines Institute (FGI)[3] emphasizes that CSUs should provide a calming, non-institutional environment to facilitate rapid stabilization and recovery. This includes incorporating natural lighting, comfortable furnishings, and minimizing barriers such as Plexiglas partitions, which can hinder therapeutic engagement. Additionally, spaces should be anti-ligature and designed with safety in mind to prevent self-harm and ensure the well-being of both individuals and personnel.

The Substance Abuse and Mental Health Services Administration (SAMHSA) advocates for trauma-informed design principles in CSUs.[4] This involves creating spaces that are welcoming and free from elements that may re-traumatize individuals, such as locked doors or seclusion rooms. Instead, open layouts that promote autonomy and dignity are recommended. Furthermore, incorporating areas for group therapy, quiet reflection, and family engagement can support holistic recovery processes. By adhering to these best practices, CSUs can offer a therapeutic environment conducive to healing and crisis resolution.[5]

To evaluate your agency's compliance with CSU physical plant requirements, please refer to the tool below:

- CSU Physical Plant Tracking Tool

Why it matters: A CSU must go beyond basic shelter. The setting should reflect a structured, therapeutic, and professional care environment, including adequate space for clinical services and supervision.

Policies and Procedures

Clear alignment of policies and procedures with the national best practice standards are a cornerstone of successful implementation. While clinical skills, strong leadership, and a well-designed environment are essential, they must be underpinned

[3] https://fgiguidelines.org/wp-content/uploads/2022/06/FGI-Design-of-BHCUs_2022-06.pdf

[4] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services- executive-summary-02242020.pdf

[5] https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf

by clear, intentional documentation that reflects both the spirit and structure of the crisis service delivery. Without this alignment, agencies risk inconsistencies in care delivery, confusion among personnel, and non-compliance with licensing, accreditation, and payer requirements.

Why Policy Alignment Matters

1. Alignment Operationalizes Crisis Stabilization Standards

Crisis Stabilization Units (CSUs) are expected to provide timely, person-centered, recovery-oriented care through specific requirements related to personnel, environment, integration with other crisis services, and rapid access to assessment and stabilization. Policies and procedures bring these expectations to life by specifying how services are delivered, who is responsible, and how fidelity to best practices is monitored. Operational alignment ensures that the unit's daily practices reflect its mission and regulatory expectations

2. Alignment Supports Personnel Consistency and Accountability

CSUs operate 24/7/365 and rely on interdisciplinary teams to function effectively. Clear, standardized policies minimize variation in crisis response, triage, de-escalation, assessment, care coordination, and discharge planning. This consistency supports personnel onboarding, clinical supervision, and performance management while also reinforcing trauma-informed and culturally responsive care practices across all shifts and disciplines.

3. Alignment Protects the Rights of Individuals Serves and Ensures Equity

CSUs must safeguard the dignity, rights, and autonomy of individuals in acute distress. Policies should explicitly include mechanisms for person-centered care, shared decision-making, protection of rights, and access to culturally and linguistically appropriate services. Embedding these values into policies ensures that equity, inclusion, and recovery principles are upheld, rather than relying on individual discretion.

4. Alignment Demonstrates Readiness for Licensure, Reimbursement and Accountability

Crisis services are increasingly subject to regulation, quality review, and funding compliance. Well-developed, standards-aligned policies help agencies demonstrate readiness for licensure, certification, accreditation, and participation in Medicaid or other public funding streams. Clear documentation of scope, personnel models, care

protocols, and safety measures improves the ability to meet audit and reporting requirements.

5. Alignment Guides Implementation and Change Management

The shift to high-quality, standards-based crisis care requires coordinated change across people, processes, and systems. Strong policies act as guideposts during transformation- clarifying expectations, reducing ambiguity, and anchoring practice in shared values and evidence-informed care models.

To evaluate where your agency is regarding policies and procedures, please utilize the tool below:

- CSU Policy Alignment Tool

4. Ensure Programming is Co-occurring Capable

Crisis Stabilization Units (CSUs) play a pivotal role in addressing the immediate needs of individuals experiencing behavioral health crises. Given the high prevalence of co-occurring mental health and substance use disorders, CSUs must be equipped to manage both simultaneously. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the coexistence of mental health disorders and substance use disorders- referred to as co-occurring disorders- is common, necessitating integrated treatment approaches.[6]

Timely access to medications for addiction treatment (MAT), such as buprenorphine, methadone, and naltrexone, is a critical component of effective crisis intervention. Initiating MAT during a crisis not only addresses the immediate physiological needs of individuals but also serves as a gateway to longer-term recovery efforts. SAMHSA's Treatment Improvement Protocol 42 emphasizes the importance of integrating substance use treatment within mental health services to ensure comprehensive care for individuals with co-occurring disorders.[7]

Furthermore, SAMHSA's National Guidelines for Behavioral Health Crisis Care advocate for crisis systems that are designed to be co-occurring capable. These guidelines stress the importance of providing services that are trauma-informed, recovery-oriented, and person-centered, ensuring that individuals receive holistic care during crises. By adopting such integrated approaches, CSUs can significantly improve

[6] https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders

[7] https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf

outcomes for individuals in crisis, reducing the likelihood of repeated emergency interventions and fostering pathways to sustained recovery.[8]

To take a deeper dive into whether your agency is co-occurring capable, consider using the following tools:

- Dual Diagnosis Capability in Addiction Treatment Toolkit [https://case.edu/socialwork/centerforebp/sites/default/files/2021-03/ddcattoolkit.pdf]
- Dual Diagnosis Capability in Mental Health Treatment Toolkit [https://med.stanford.edu/content/dam/sm/cdi/documents/ddcmhttoolkit4.0.pdf]

Why it matters: It is well-established that the presence of co-occurring conditions are an expectation, not the exception in individuals with SUD. For individuals seeking crisis stabilization, addressing mental health and SUD needs in the same place at the same time, by the same team is more effective.

5. Embed Trauma-Sensitive Practices[9]

Trauma-informed care is essential in Crisis Stabilization Units (CSUs), where individuals often present in acute distress with complex, layered histories, frequently including abuse, neglect, incarceration, homelessness, and systemic oppression. Trauma is a nearly universal experience among individuals in behavioral health crises. Programs that are not operationally trauma-informed can contribute to disengagement from services, re-traumatization, and poor outcomes.

Implementing trauma-informed care in CSUs involves intentionally integrating trauma responsiveness into physical environments, policies, personnel practices, and every point of individual interaction. Individuals may exhibit hypervigilance, withdrawal, emotional dysregulation, or mistrust, behaviors that, without a trauma-informed lens, are too often misinterpreted as noncompliance or resistance. Recognizing these as trauma responses is crucial for effective de-escalation and engagement.

All personnel- including clinicians, peers, administrative personnel, and security- must receive ongoing training in trauma-informed care and be supported through supervision structures that reinforce compassionate, culturally responsive practices. Without this grounding, CSUs risk re-traumatizing individuals through punitive rules,

[8] https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf
[9] https://library.samhsa.gov/sites/default/files/sma14-4884.pdf

chaotic environments, or a lack of choice in care. In contrast, trauma-informed CSUs foster safety, empowerment, and trust, creating the conditions necessary for stabilization and recovery.

Six Key Principles of Trauma-Informed Care:

1. **Safety** – Individuals and personnel must always feel physically and emotionally safe. CSU environments should be calm, predictable, and non-threatening.
2. **Trustworthiness and Transparency** – Policies and procedures should be clearly communicated and consistently applied to build trust, especially for individuals with histories of betrayal or coercion.
3. **Peer Support** – The inclusion of peer specialists with lived experience promotes hope, connection, and validation.
4. **Collaboration and Mutuality** – Power differentials are minimized, and care is co-created with individuals to support shared decision-making.
5. **Empowerment, Voice, and Choice** – Individuals are encouraged to define their goals, express preferences, and make informed decisions about their care.
6. **Cultural, Historical, and Gender Responsiveness** – Programs must address the impact of systemic inequities such as racism, sexism, and homophobia by embedding cultural responsiveness into practice.

Integrating these principles into CSU operations both enhances crisis response and supports long-term recovery and system-wide transformation.

To evaluate your agency's current alignment with trauma-informed care standards, please refer to the tool below. This tool includes key information regarding screening tools, services, and program evaluation:

- SAMHSA TIP 57: Trauma-Informed Care [https://library.samhsa.gov/product/tip-57-trauma-informed-care-behavioral-health-services/sma14-4816]

Why it matters: As mentioned above, trauma is pervasive for individuals being served by the behavioral health system. Programs that are trauma-informed promote and facilitate recovery more effectively than those who do not.

6. Promote Cultural Humility

Cultural humility is a foundational component of high-quality, person-centered care within Crisis Stabilization Units (CSUs). Unlike the concept of cultural competence,

which implies an endpoint of mastery, cultural humility is an ongoing commitment to self-reflection, lifelong learning, and respectful partnership with individuals whose cultural backgrounds, values, and lived experiences may differ from those of the provider or majority groups in the area.

In CSUs- where individuals often enter care at a time of heightened vulnerability- practicing cultural humility is essential for creating a safe, welcoming, and trauma-informed environment. Crisis settings must recognize and respond to the complex interplay of race, ethnicity, gender identity, sexual orientation, disability, language, faith, immigration status, and historical trauma that can impact how individuals perceive and engage with services. Without this lens, CSUs risk retraumatizing individuals or failing to build the trust needed for stabilization and recovery.

Culturally humble crisis care requires not only adapting service content but also transforming the structure, personnel attitudes, and institutional practices that have historically excluded or harmed marginalized communities. To meet this imperative, CSUs must integrate the following strategies:[10] [11] [12]

- **Conduct regular community needs assessments** to understand the cultural identities, needs, and preferences of the populations served and to tailor services accordingly.
- **Provide comprehensive training and supervision** to all personnel—clinical and non-clinical—on cultural humility, implicit bias, and the impact of provider identity and power dynamics on care delivery.
- **Encourage self-awareness and reflective practice** among personnel to explore how their own experiences and assumptions shape their perceptions and interactions with individuals in crisis.
- **Utilize culturally responsive screening and assessment tools** that help providers understand the cultural context of presenting symptoms and treatment preferences.
- **Engage individuals served in culturally collaborative decision-making**, ensuring that treatment goals reflect not only clinical needs but also cultural values, family roles, and community connections.

[10] https://thinkculturalhealth.hhs.gov/clas/standards

[11] https://library.samhsa.gov/product/tip-59-improving-cultural-competence/sma15-4849

[12] https://library.samhsa.gov/sites/default/files/sma14-4884.pdf

Importantly, cultural humility is a core element of trauma-informed care. Individuals in crisis often bring with them histories of trauma related to racism, sexism, homophobia, xenophobia, and other forms of systemic harm. A CSU cannot claim to be trauma-informed without a deep and active commitment to cultural humility.

The link below contains information from SAMHSA regarding culturally responsive care. This resource includes agency and clinician self-assessments, tools that are culturally responsive or culturally neutral, and more:

- SAMHSA TIP 59: Improving Cultural Competence [https://library.samhsa.gov/product/tip-59-improving-cultural-competence/sma15-4849]

Why it matters: Behavioral health issues can be exacerbated by harmful experiences related to one's identity. Therein lies an opportunity to promote healing through the trauma-informed tenet of cultural humility.

Social Determinants of Health

Crisis Stabilization Units serve individuals experiencing acute behavioral health crises-many of whom also face significant barriers related to social determinants of health (SDOH). Factors such as housing instability, poverty, food insecurity, lack of access to healthcare, transportation challenges, and systemic discrimination can profoundly impact an individual's mental health and their ability to stabilize and recover.

To deliver effective, high-quality, person-centered care, CSUs must routinely assess and respond to these social factors. A behavioral health crisis is often exacerbated or triggered by unmet social needs. Addressing SDOH in the CSU setting is not only a matter of health equity but also a practical approach to reducing crisis recurrence, hospitalization, and disengagement from follow-up care.

Key elements of SDOH screening in CSUs include:

- Safe and stable housing
- Access to reliable transportation
- Financial insecurity
- Food insecurity or malnutrition
- Legal challenges (e.g., probation, immigration, pending court cases)
- Employment or educational barriers
- Childcare or caregiving responsibilities

- Access to culturally and linguistically appropriate services

These assessments should be conducted during intake and revisited throughout crisis stabilization and discharge planning. Identifying these needs early allows CSU personnel to integrate wraparound services into care, make timely referrals to trusted community partners, and establish closed-loop follow-up to ensure support beyond the crisis episode.

When SDOH are unaddressed, individuals are more likely to experience treatment drop-out, repeated crisis episodes, or return to emergency departments- not due to clinical deterioration, but because their basic needs remain unmet. CSU teams including peers, case managers, and discharge planners, play a pivotal role in closing these gaps and setting individuals up for stability and sustained recovery.

Routine screening should occur through the use of standardized tools. Recommended tools include:

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE): https://prapare.org/
- The Centers for Medicare & Medicaid Services Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool (HRSN): https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Why it matters: Focusing solely on the crisis at hand as an individualized problem detracts from true systemic barriers to recovery and ignores community strengths that can be called upon to enhance long-term recovery. Individuals with behavioral health needs face multiple disparities and wraparound services are necessary to address SDOH to achieve long-term recovery.

7. Prioritize Personnel and Training

Operating a Crisis Stabilization Unit requires robust clinical expertise, 24/7/365 personnel availability, and a well-coordinated multidisciplinary team. Agencies should be aware that they cannot effectively "retrofit" other behavioral health models- such as outpatient or short-term residential care- into a CSU framework without substantial adjustments to personnel, service intensity, and operational infrastructure.

CSUs are designed to deliver timely, intensive, and integrated care in a short-term, often sub-acute setting. This requires a licensed, multidisciplinary team capable of managing acute behavioral health crises while simultaneously planning for stabilization and transition. Ensuring adequate primary personnel, contingency planning for vacancies, and strong clinical supervision is essential to operating a safe, effective CSU aligned with national best practices (SAMHSA, 2020).[13]

Key personnel expectations for CSUs include:

- **24/7/365 clinical coverage,** including nights, weekends, and holidays
- **Ongoing recruitment and personnel plans** to prevent gaps in care
- **PRN or as-needed pools** to cover unplanned absences and increase flexibility
- **Multidisciplinary team model** to support comprehensive assessment and crisis response

Tips for evaluating and addressing personnel needs in CSUs:

- Conduct a personnel crosswalk, mapping current positions, credentials, and shift coverage to identify gaps
- Prioritize critical personnel gaps and simultaneously develop long-term workforce strategies
- Offer agency-supported credentialing pathways to upskill existing personnel
- Develop creative personnel partnerships, such as:
    - Telehealth psychiatry and clinical services
    - Behavioral health personnel agencies
    - College and university training programs
    - Internship and fellowship pipelines

Foundational training topics for CSU personnel should include:

- Role-specific understanding of CSU purpose, workflows, and population served
- Evidence-based crisis response interventions (e.g., trauma-informed care, motivational interviewing)

[13] https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf

- Verbal de-escalation and safety planning
- Identifying symptoms of withdrawal and administering evidence-based withdrawal scales such as the Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-AR) and Clinical Institute Withdrawal Assessment- Benzodiazepines (CIWA-B).
- Medications for addiction treatment (MAT) and mental health stabilization
- Agency-specific policies and procedures
- Physical and behavioral health integration
- Medication oversight and administration protocols
- Effective multidisciplinary team collaboration and communication
- Clinical supervision expectations and support structures
- Milieu safety
- Cultural humility and culturally responsive care

Preparing personnel for the specialized demands of CSU care helps ensure that individuals in crisis receive safe, compassionate, and effective support during what may be one of the most vulnerable moments in their lives.

To help plan for personnel, consider using the tool below:

- Personnel Crosswalk- 3.2-WM to CSU

8. Develop An Intentional Clinical Program

Crisis Stabilization Units (CSUs) must deliver short-term, person-centered, recovery-oriented clinical services designed to de-escalate behavioral health crises, stabilize individuals, and support safe transition to appropriate ongoing care. As outlined in SAMHSA's model standards, CSUs are expected to provide trauma-informed, culturally responsive services within a structured, therapeutic environment that is personnel-equipped 24/7 and equipped to meet a wide range of clinical needs- including co-occurring substance use and mental health conditions.

Effective CSU programming must be purposefully designed with clear clinical alignment and continuous quality improvement. This cannot be achieved by simply adding more group sessions or therapy blocks. Instead, every service offering must be

intentionally connected to individual needs, evidence-based practices, and the unit's overall stabilization mission.

Core programming expectations for CSUs include (SAMHSA, 2024[14]):

- **Individualized care planning** driven by comprehensive screening and assessment of mental health, substance use, and social needs
- **Evidence-based therapeutic interventions**, including crisis counseling, psychiatric care, medication management, and peer support. This also includes expedient access to medications for addiction treatment (MAT).
- **A therapeutic milieu** that promotes emotional safety, regulation, and dignity at all times—not just during formal sessions
- **Multidisciplinary team involvement**, with clinical oversight, peer specialists, medical personnel, and case management
- **24/7 availability of services**, including clinical support on nights, weekends, and holidays
- **Immediate access to medications used to treat mental health and substance use disorders** as clinically appropriate
- **Discharge planning, care coordination, and follow-up** to ensure that the stabilization that began in the CSU is supported once a person is transitioned to their next treatment program.

Unlike traditional residential programs, CSUs operate on a shorter stabilization timeframe and must focus services accordingly. The therapeutic structure must balance clinical care, psychosocial support, and discharge planning in a way that maximizes engagement and safety without creating a rigid or repetitive environment.

To ensure clinical integrity, agencies should engage in regular evaluation of CSU programming to assess:

- **Service adequacy**, such as whether core components (psychiatric evaluation, peer support, crisis therapy) are consistently delivered

[14] Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01- 037: Substance Abuse and Mental Health Services Administration, 2025

- **Gaps in co-occurring capability**, including lack of integration between mental health and substance use care
- **Personnel alignment**, ensuring credentialed personnel are available to provide required services at all hours
- **Clinical content quality**, confirming that all therapeutic services are grounded in recognized best practices and documented appropriately

Additionally, curriculum planning and daily schedules should be carefully reviewed to avoid unnecessary duplication and to promote meaningful engagement. While repetition of certain skills (e.g., grounding techniques, coping strategies) may reinforce learning, programming must remain dynamic, individualized, and responsive to the needs of those in crisis.

Deliberate planning and service mapping can help CSU leadership ensure that every aspect of the program is contributing to stabilization, safety, and transition readiness. To ensure your program meets CSU service requirements and recommendations, please utilize the tool below.

- CSU Comprehensive Service Element Planning Tool

Why it matters: In contrast to the supportive, low-intensity environment of 3.2-WM, a CSU is of higher acuity, requiring intentional and dynamic service options.

9. Create Formal Pathways for Enhancing Medical and Psychiatric Support

Integration of medical and psychiatric care is an essential requirement for Crisis Stabilization Units (CSUs), as individuals often present with complex and co-occurring behavioral, medical, and substance use needs. According to SAMHSA[15], CSUs must be part of a comprehensive, coordinated behavioral health crisis system equipped to meet the full scope of an individual's physical and mental health needs during a crisis episode.

CSUs are short-term, 24/7/365 facilities designed to support individuals in acute distress. To be effective, these units must be able to recognize, stabilize, and coordinate care for individuals with medical comorbidities, un-stabilized psychiatric conditions, and co-occurring substance use disorders. The ability to offer or facilitate timely access to psychiatric assessment, intoxication and withdrawal management,

[15] https://library.samhsa.gov/sites/default/files/model-definitions-pep24-01-037.pdf

medication initiation (including MAT), and medical consultation is critical to stabilization, safety, and continuity of care.

Core Expectations for Medical and Psychiatric Integration in CSUs Include:

- 24/7 access to licensed medical and psychiatric professionals, including prescribers either on-site or via telehealth
- Real-time collaboration across disciplines, including medical, psychiatric, and behavioral health providers, with shared treatment planning
- Timely access to medications for addiction treatment (MAT) such as buprenorphine, methadone, and naltrexone, alongside psychiatric medications
- Policies and protocols for screening, harm reduction, withdrawal management, and referral to higher levels of care if acuity exceeds CSU capacity
- Training for all CSU personnel on co-occurring conditions, medication support, and reducing stigma related to both physical and behavioral health conditions
- Integrated documentation and care coordination practices that account for the dynamic interaction between psychiatric symptoms, medical needs, and substance use

SAMHSA emphasizes that crisis care should never exclude individuals due to co-occurring physical or substance-related conditions. Instead, providers must be trained to safely assess and manage these needs, ensuring individuals are not turned away due to conditions like intoxication, withdrawal, or unmanaged chronic illness- unless the acuity clearly exceeds the CSU's scope and necessitates a higher level of medical care.

Additionally, integrated services improve outcomes by supporting continuity of care. When CSU services include psychiatric and medical assessment and medication initiation, individuals are less likely to experience treatment disruption after discharge, and more likely to engage in follow-up care. This approach reduces readmissions and supports recovery across all domains- mental health, physical health, and substance use.

- CSU Medical and Psychiatric Integration Tool

Why it matters: Integration of physical and behavioral health care is critical to an individual's recovery process. Programs must demonstrate the ability to respond to physical health and behavioral health needs in a timely and coordinated manner.

10. Develop a Strategic Implementation Plan that Includes Quality Assurance

Successfully launching or enhancing a Crisis Stabilization Unit (CSU) requires a coordinated, agency-wide implementation plan. Because CSUs are expected to operate as 24/7/365, short-term, trauma-informed, and recovery-oriented environments, implementation impacts every aspect of an agency's operations including physical infrastructure, personnel models, clinical workflows, and organizational culture. Without a clearly defined and deliberate strategy, agencies risk failed launches, service fragmentation, and noncompliance with state or federal expectations.

SAMHSA emphasizes that CSU services must meet the needs of individuals in acute behavioral health crises while also supporting safety, dignity, and smooth transitions to ongoing care. A strategic approach to implementation enhances regulatory alignment, clinical excellence, individual satisfaction, and financial sustainability.

Key Activities for CSU Implementation

Establish a Go-Live Date
Agencies should define the target date for when the CSU will be fully operational. From this date, work backward to establish timelines, responsibilities, and milestones. Consider a phased approach to reduce risk. Examples include:

- Pilot a unit or shift cohort to refine workflows before full-scale launch
- Stagger implementation steps, such as finalizing personnel structure before launching the full clinical schedule or testing electronic health record templates before full documentation rollout

Build a Comprehensive Implementation Workplan
A robust workplan ensures alignment with state and federal expectations and may include:

- Facility and infrastructure upgrades (e.g., secure therapeutic space, safety features, IT systems)
- Policy development and revision, including intake, safety, personnel, and medication administration
- Personnel and training plans to meet 24/7/365 CSU coverage expectations, including multidisciplinary team onboarding

- Licensing, certification, and payer engagement to support timely billing and regulatory compliance
- Internal communication strategies to engage all departments and ensure readiness
- Data and documentation systems to support service tracking, quality improvement, and equity measurement

Create a CSU-Aligned Quality Assurance (QA) Plan
QA is essential to early detection of issues and maintaining service excellence. The QA plan should be specific to CSU services and include:

- Internal audits during and after launch, with high frequency in the first 60–90 days
- Review of clinical documentation for alignment with person-centered care, crisis response, and discharge planning
- Personnel pattern analysis to confirm sufficient licensed clinical and peer support coverage on all shifts
- Environmental and safety checks to assess compliance with standards for therapeutic and secure settings
- Monitoring of service satisfaction and outcomes, including tracking readmission, follow-up engagement, and equity indicators
- Defined procedures for addressing deficiencies, including escalation pathways, retraining, and root cause analysis
- Data-driven quality improvement cycles that incorporate process and outcome measures to refine workflows and address emerging gaps

Launching or transitioning a CSU is a complex undertaking that requires sustained focus, leadership commitment, and cross-departmental coordination. However, when implemented strategically, CSUs can provide immediate access to stabilization services that are clinically effective, equitable, and aligned with SAMHSA's national crisis care vision.

11. Navigate Payer Enrollment Requirements and Related Activities Early in the Change Process

When a provider decides to launch or transition to a Crisis Stabilization Unit (CSU), administrative and financial infrastructure must be in place to ensure that services are reimbursable, sustainable, and accessible to those in need. Without intentional planning around payer enrollment, authorization processes, and documentation standards, even the most clinically sound CSU can experience funding gaps and service delays.

Start Early: Payer Enrollment and Credentialing

CSUs must begin the credentialing and contracting process well in advance of opening. Early engagement with Medicaid, Medicaid Managed Care Entities (MCEs), Behavioral Health Administrative Services Organizations (BHASOs), and commercial payers is essential. Each payer may have distinct requirements related to licensing, facility readiness, documentation protocols, and authorization pathways.

Providers should anticipate needing to demonstrate:

- State licensure or certification aligned with CSU service definitions
- Personnel credentialing and training consistent with crisis stabilization expectations
- Policies that reflect 24/7 availability, trauma-informed care, and rapid admission protocols

Delays in contracting or payer credentialing can directly lead to delays in care or the provision of unreimbursed services. Beginning early allows agencies time to navigate credentialing backlogs, site inspections, and benefit design alignment.

Know the Rules: Authorization and Billing Timelines

Once contracted, CSU providers must clearly understand payer-specific requirements for:

- Admission criteria and documentation expectations
- Prior authorization or notification procedures (including retroactive authorization, where permitted)
- Concurrent review cycles, if applicable for extended stays
- Timely claim submission and encounter data requirements

Crisis care settings are fast-paced, and misalignment between clinical and administrative workflows can lead to claim denials or interruptions in service. Agencies must establish streamlined internal protocols that ensure billing teams receive the information they need in real-time from clinical personnel.

Document with Purpose: Aligning with Medical Necessity Standards

Documentation is essential for demonstrating the need for CSU-level care and for obtaining payer approval. Effective CSU documentation should:

- Clearly establish the presence of a behavioral health crisis, including the nature of risk, urgency, and rationale for CSU admission
- Show evidence of clinical engagement, including psychiatric evaluation, crisis counseling, peer support, and medication services
- Reflect an interdisciplinary approach, with care plans that address behavioral health, medical, substance use, and social needs
- Include proactive transition planning, with confirmed follow-up appointments and referrals that demonstrate closed-loop care coordination
- Demonstrate stabilization and response to intervention, particularly for stays approaching the maximum time permitted by payers

Utilization reviewers increasingly expect documentation to align with medical necessity language and best practice frameworks. When CSU providers use vague, inconsistent, or incomplete documentation, reimbursement can be delayed or denied-even if the care provided was appropriate and effective.

Build the Bridge Between Clinical and Administrative Teams

Successful CSU operations depend on shared accountability across clinical, billing, and administrative functions. This includes:

- Cross-training personnel on documentation expectations
- Holding joint reviews of denied claims to identify trends and retrain as needed
- Routinely updating policies to reflect changing payer guidelines
- Embedding quality assurance checks for claims before submission

By ensuring administrative and clinical alignment, CSUs can increase financial sustainability, improve access, and uphold high-quality, responsive care.

Provider Ambassador Program