MEMORANDUM

Congregate Care Advisory Committee

Date: November 21, 2025

To: Health and Human Services

Division of Licensing and Background Checks

Office of Licensing

From: Congregate Care Advisory Committee

Subject: Congregate Care Advisory Committee Proposal

The Congregate Care Advisory Committee met on July 29, 2026. At the meeting, the committee voted on the following recommendation:

1. **Definition**
    a. Intensive Residential Treatment
        i. Definition: Intensive Residential Treatment is a sub-acute, highly structured, 24-hour clinical intervention for youth with complex and treatment-refractory behaviors. It is specifically indicated for those who demonstrate a high risk of self-harm or suicidality and/or who exhibit frequent aggression or persistent AWOL (absconding), or other behaviors that prevent safe living in less restrictive settings.
        ii. Services: Each residential treatment program shall offer educational support, individual, group, and family counseling or other treatment, including skills development, at least weekly. Changes to services or the frequency of services will be clinically justified and clearly outlined in the individual treatment plan.
    b. Standard Residential Treatment
        i. Definition: Standard residential treatment is a 24-hour group living setting with structured therapeutic or rehabilitative services designed to address emotional, psychological, developmental, behavioral, or substance-related disorders. It is specifically indicated for individuals who cannot be safely or effectively treated in a lower level of care and who do not require intensive residential care.

ii. Services: Each residential treatment program shall offer educational support, individual, group, and family counseling or other treatment, including skills development, at least weekly. Changes to services or the frequency of services will be clinically justified and clearly outlined in the individual treatment plan.

iii. Standard services are already in rule. The committee's recommendations follow the intensive residential treatment.

2. Required Intensive RTC Standards

a. Training Topics

i. Advanced Crisis De-escalation & Co-regulation (can be part of your restraint training)

1. Verbal de-escalation under high emotional intensity
2. Tone, body language, pacing, proximity, and nervous-system regulation
3. Managing power struggles, humiliation dynamics, and audience effects
4. Working effectively with teens in rage, panic, dissociation, or shame spiral
5. Mandatory processing protocol after a restraint or other clinical incident
6. Instruction regarding the management of physical violence, restraints, seclusion, and physical separation may be required
7. Training in peer intervention. How to step in if a staff is unsafe or failing to follow procedure
8. Training from a recognized organization

ii. Suicide Risk Assessment & Acute Safety Management

1. Identifying acute vs chronic suicide risk
2. Managing self-harm, suicidal statements, ligature risk, and post-attempt stabilization
3. Safety planning and environmental safety
4. When to escalate to ER/hospitalization vs therapeutic containment
5. Documentation and parent communication during crises
6. Taught by a licensed mental health professional or a recognized organization
7. The program's policy, created with a medical professional, will define complaint escalation triggers and documentation procedures
8. Staff will be trained on policy

iii. Aggression Management & Safe Physical Intervention (can be part of your restraint training)
    1. Violence risk recognition and escalation curves
    2. Decision-making around holds/restraints and “too early vs too late” intervention timing
    3. Team coordination during aggressive episodes
    4. Post-restraint processing and repair
    5. Minimizing injury, liability, and trauma during physical interventions
    6. Strong emphasis on least restrictive interventions
    7. Taught by a licensed mental health professional or a recognized organization

iv. AWOL Prevention, Response, & Relational Security
    1. Predicting AWOL risk and pre-incident indicators
    2. Relational engagement strategies that reduce flight behavior
    3. Search procedures, law enforcement coordination, and safety response
    4. Re-entry processing after return to the facility
    5. Avoiding shame-based reactions that initiate or reinforce runaway cycles
    6. Early intervention and safety planning

v. Trauma, Attachment, & Neurodevelopmental Understanding
    1. How trauma affects behavior, authority responses, emotional regulation, and perception
    2. Attachment disruptions and splitting dynamics in residential settings
    3. Emphasis on autism, ADHD, mood disorders, substance use, and personality disorders under stress
    4. Understanding “survival behavior” without excusing unsafe conduct
    5. Taught by a licensed mental health professional or a recognized organization
    6. Normal child and adolescent development
    7. Relational dynamics
    8. Punishment vs safety
    9. Power and control
    10. Dynamics of program’s specific population

vi. Supervisory Leadership During High-Acuity Events
    1. Command presence without authoritarian escalation

2. Directing staff during emergencies
3. Coaching newer staff in real time
4. Maintaining emotional regulation during chaos
5. Debriefing incidents effectively preventing staff splitting, burnout, and reactive culture drift away from Trauma Informed Care
6. Self-care and burnout
7. Maintaining staff, client and visitor safety

vii. Administrative training (currently in rule but is especially critical for Intensive Residential)

1. Client rules and rights
2. Client record documentation
3. Documentation and Incident Reporting
4. Mandatory reporter training – abuse, exploitation, neglect, and mistreatment
5. Cultural sensitivity

b. Training Standards

i. 80 hours of training before being "unsupervised"

ii. Required documentation of competency in all areas

c. Building Features

i. To receive an Intensive Residential Treatment endorsement, programs must implement physical facility safety measures that exceed Standard Residential Treatment requirements. These enhanced safeguards must be designed to reduce risk related to suicidality, aggression, AWOL behavior, self-harm, and environmental misuse. The specific safety plan shall be customized based on the program's physical environment, staffing model, and client population, in collaboration with the licensing authority and program administration. Custom facility risk mitigation plan will be submitted to the Department of Health and Human Services Office of Licensing (OL) as part of initial licensing process and changes to the plan will be submitted to OL when they occur.

ii. Adoption of the standards for intermediate secure:

1. Non-exposed fire sprinkler heads
2. Plexiglass or safety glass
3. Pressure release robe hooks
4. Recessed lighting
5. Sealed light fixtures

iii. Required surveillance cameras in all common and permitted areas to accurately document and debrief critical incidents, not to be used for supervision
iv. Anti-ligature in high risk areas, specifically bedrooms and bathrooms

d. Staffing Requirements

i. Programs must be capable of implementing and maintaining continuous 1:1 supervision for a client in crisis within 5 minutes of the determination that such supervision is necessary.
ii. Aged 21 and over
iii. Exclusion of support staff in ratios who are not actively supervising and have not completed direct care staff training requirements
iv. Program/Facility Manager
v. 25 years old—Current Intermediate Secure rule
vi. Bachelor's degree or equivalent experience in human service related field
vii. Staffing ratio is 1:4
viii. Mandated an extra non-ratio shift supervisor or crisis responder on campus during high-risk hours, evenings and weekends to immediately manage acute 1-1 crisis
ix. Program must detail a scalable response plan, for example a calling tree or code red protocols, proportional to the facility's physical size and layout
x. Q15s (15 minute checks) should be documented during waking hours

This recommendation is made pursuant to Utah Code § 26B-1-436. The statute provides that the board may recommend, to the appropriate legislative committee, whether the board supports a change to congregate care advisory recommendations.

If you have any questions about the recommendation, please contact Dustin Penman, the board administrator, at dpenman@utah.gov. While the Department of Health and Human Services (DHHS), Division of Licensing and Background Checks, Office of Licensing provides administrative support to the board, the board's recommendations do not represent the opinions of DHHS.