

Congregate Care, Residential Treatment Rule Update (R501-19A)

Division of Licensing and Background Checks (DLBC) Congregate Care Advisory Committee September 2026 Meeting

Purpose of Rule Update and Next Steps After September 2026 Committee Meeting

The DLBC Rulewriting Team is using the content developed by the DLBC Congregate Care Committee to address updates to the current rule for congregate care, residential treatment ([R501-19A](#)). This rule update will include additional definitions and health and safety requirements for standard residential treatment and intensive residential treatment for congregate care programs. This consultation between the Congregate Care Committee and DLBC to develop and implement health safety standards for these types of settings supports the statutory mandate in [Section 26B-1-436](#).

After presenting a summary of the proposed rule updates to the committee, the DLBC Rulewriting team will capture any additional feedback from the committee. The DLBC Rulewriting team will update the draft and submit for an initial review by the Office of Administrative Rules and then

send the draft rule document to the committee members and other partners in early October 2026 to review and provide additional feedback. The focus on any DLBC rule update is compliance with the Rulewriting Manual for Utah, alignment with the department rule style guide, and clarity and consistency throughout the rule update to support reader clarity and understanding.

After this important partner review, the DLBC Rulewriting team will submit the proposed rule update for internal review, approval, and additional edits to comply with the Rulewriting Manual before publication in the Utah Rules Bulletin and final effective date, likely early 2027.



Summary of Proposed Rule Updates

Proposed Rule Updates from Consultation with Congregate Care Advisory Committee	DLBC Proposed Rule Updates to Rule R501-19A based on Recommendation from the Congregate Care Advisory Committee
Standard Residential Treatment 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. 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. Standard services are already in rule.	Proposed to be added to Definitions Section R501-19A-2 <u>(24)(a) “Standard residential treatment” means a 24-hour group living setting for a client with structured therapeutic or rehabilitative services designed to address a client experiencing any:</u> <u>(i) emotional disorder;</u> <u>(ii) psychological disorder;</u> <u>(iii) developmental disorder;</u> <u>(iv) behavioral disorder; or</u> <u>(v) substance use disorder.</u> <u>(b) This type of treatment setting is specifically indicated for a client who:</u> <u>(i) cannot be treated safely and effectively in a lower level of care program; and</u> <u>(ii) does not require an intensive residential care program.</u>
Intensive Residential Treatment Definition: Intensive Residential Treatment is a sub-acute, highly structured, 24-hour clinical intervention for youth with complex and	Proposed to be added to Definitions Section R501-19A-2 <u>(13)(a) “Intensive residential treatment” means a sub-acute, highly structured, 24-hour clinical intervention for a client with complex and</u>



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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. 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.	<u>treatment-refractory behaviors.</u> <u>(b) This type of treatment setting is specifically indicated for a client who:</u> <u>(i) has a documented high risk of self-harm or suicidality;</u> <u>(ii) exhibits frequent aggression;</u> <u>(iii) has presented with persistent AWOL or absconding behavior ;or</u> <u>(iv) has presented with other behaviors that prevent safe living for the client in less restrictive settings.</u>
1. Training Topics a. Advanced Crisis De-escalation & Co-regulation (can be part of your restraint training) i. Verbal de-escalation under high emotional intensity ii. Tone, body language, pacing, proximity, and nervous-system regulation iii. Managing power struggles, humiliation dynamics, and audience effects iv. Working effectively with teens in rage, panic, dissociation, or shame spiral	Proposed New Section: R501-19A-15. Additional Requirements for Intensive Residential Treatment Programs. <u>(1) Each intensive residential treatment provider shall comply with each requirement in this section.</u> <u>(2) Each provider shall ensure direct care staff conduct and document client checks-in at intervals of at least every 15 minutes during waking hours.</u> <u>(3) Each provider shall maintain a staff-to-client ratio of one direct staff to every four clients.</u> <u>(4) For any client in crisis, within five minutes of program administration making the determination, the provider shall ensure</u>



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v. Mandatory processing protocol after a restraint or other clinical incident vi. Instruction regarding the management of physical violence, restraints, seclusion, and physical separation may be required vii. Training in peer intervention. How to step in if a staff is unsafe or failing to follow procedure viii. Training from a recognized organization b. Suicide Risk Assessment & Acute Safety Management i. Identifying acute vs chronic suicide risk ii. Managing self-harm, suicidal statements, ligature risk, and post-attempt stabilization iii. Safety planning and environmental safety iv. When to escalate to ER/hospitalization vs therapeutic containment v. Documentation and parent communication during crises vi. Taught by a licensed mental health professional or a recognized organization vii. The program's policy, created with a medical professional, will define medical complaint	<u>continuous one-on-one monitoring of the client.</u> <u>(5) The provider shall ensure:</u> <u>(a) any direct care staff is at least 21 years old;</u> <u>(b) the manager is:</u> <u>(i) 25 years old; and</u> <u>(ii) has a bachelor's degree or equivalent training in a human service-related field;</u> <u>(6)(a) Each provider shall maintain a shift manager or crisis responder for any high-risk hours, evenings, and weekends to manage any potential high-acuity event.</u> <u>(b) The staff mentioned in Subsection (6)(a) assigned to support high-acuity events is not counted in the staffing ratio.</u> <u>(7)(a) Each provider shall develop, implement, and comply with a scalable response plan for any code red procedure.</u> <u>(b) The provider shall consider the physical size and layout of the facility when developing and making any update to the response plan.</u> <u>(8) Each provider shall incorporate the use of any fixture and furnishing to limit client self-harm and suicide, including:</u> <u>(a) anti-ligature design features in any bedroom or bathroom space;</u> <u>(b) non-exposed fire sprinkler heads;</u> <u>(c) plexiglass or safety glass;</u> <u>(d) pressure release robe hooks;</u> <u>(e) recessed lighting; and</u> <u>(f) sealed light fixtures.</u>



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escalation triggers and documentation procedures viii. Staff will be trained on policy c. Aggression Management & Safe Physical Intervention (can be part of your restraint training) i. Violence risk recognition and escalation curves ii. Decision-making around holds/restraints and “too early vs too late” intervention timing iii. Team coordination during aggressive episodes iv. Post-restraint processing and repair v. Minimizing injury, liability, and trauma during physical interventions vi. Strong emphasis on least restrictive interventions vii. Taught by a licensed mental health professional or a recognized organization d. AWOL Prevention, Response, & Relational Security i. Predicting AWOL risk and pre-incident indicators	<u>(9) The provider shall install and maintain a system of surveillance cameras in any common area of the facility.</u> <u>(10)(a) Each provider shall develop, implement, and comply with a facility risk mitigation plan.</u> <u>(b) The plan shall be developed in consideration of each program feature:</u> <u>(i) client population;</u> <u>(ii) staff model; and</u> <u>(iii) physical environment.</u> <u>(c) Each provider shall collaborate with program administration staff for the development and adjustment of the plan.</u> <u>(d) Each provider shall submit the plan to OL during initial and renewal licensure.</u> <u>(e) Each provider shall submit any change to plan within 30 days to OL before implementation of the change.</u> <u>(11) Before providing support to any client, each direct care staff shall complete an additional 80 hours of training annually regarding:</u> <u>(a) advanced crisis deescalation and co-regulation, including:</u> <u>(i) verbal deescalation under high emotional intensity;</u> <u>(ii) tone, body language, pacing, proximity, and nervous-system regulation;</u> <u>(iii) managing any power struggle, humiliation dynamic, and audience effect;</u> <u>(iv) working effectively with any client regarding rage, panic, dissociation, or shame spiral;</u>



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ii. Relational engagement strategies that reduce flight behavior iii. Search procedures, law enforcement coordination, and safety response iv. Re-entry processing after return to the facility v. Avoiding shame-based reactions that initiate or reinforce runaway cycles vi. Early intervention and safety planning e. Trauma, Attachment, & Neurodevelopmental Understanding i. How trauma affects behavior, authority responses, emotional regulation, and perception ii. Attachment disruptions and splitting dynamics in residential settings iii. Emphasis on autism, ADHD, mood disorders, substance use, and personality disorders under stress iv. Understanding “survival behavior” without excusing unsafe conduct	<u>(v) mandatory processing protocol after a restraint or other clinical incident;</u> <u>(vi) instruction regarding the management of any physical violence, restraint, seclusion, and physical separation; and</u> <u>(vii) peer intervention if a staff is unsafe or failing to follow procedure;</u> <u>(b) suicide risk assessment and acute safety management:</u> <u>(i) identification of acute suicide risk and chronic suicide risk;</u> <u>(ii) management of self-harm, any suicidal statement, ligature risk, and post suicide attempt stabilization;</u> <u>(iii) safety planning and environmental safety;</u> <u>(iv) escalation to hospitalization or therapeutic containment;</u> <u>(v) importance of accurate documentation;</u> <u>(vi) any client parent or guardian communication during a crisis; and</u> <u>(vii) any client medical complaint escalation trigger and documentation procedure;</u> <u>(c) aggression management and safe physical intervention:</u> <u>(i) violence risk recognition and escalation curves;</u> <u>(ii) management and staff decisions making around any use of a holds or restraints, including the timing of the intervention;</u> <u>(iii) team coordination for any client aggressive episode;</u> <u>(iv) post-restraint processing and repair;</u> <u>(v) minimizing injury, liability, and trauma for any physical intervention; and</u> <u>(vi) use of least restrictive interventions;</u> <u>(d) prevention and response to any AWOL behavior and relational</u>



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v. Taught by a licensed mental health professional or a recognized organization vi. Normal child and adolescent development vii. Relational dynamics viii. Punishment vs safety ix. Power and control x. Dynamics of program's specific population f. Supervisory Leadership During High-Acuity Events i. Command presence without authoritarian escalation ii. Directing staff during emergencies iii. Coaching newer staff in real time iv. Maintaining emotional regulation during chaos v. Debriefing incidents effectively preventing staff splitting, burnout, and reactive culture drift away from Trauma Informed Care vi. Self-care and burnout vii. Maintaining staff, client and visitor safety g. Administrative training (currently in rule but is especially critical for Intensive Residential)	<u>security:</u> <u>(i) prediction of AWOL and absconding risk;</u> <u>(ii) any pre-incident indicator assessment;</u> <u>(iii) relational engagement strategies to reduce flight behavior;</u> <u>(iv) search procedures, law enforcement coordination, and safety response;</u> <u>(v) re-entry processing after return to the program;</u> <u>(vi) management of any shame-based reaction that may initiate or reinforce client runaway cycles; and</u> <u>(vii) early intervention and safety planning;</u> <u>(e) understanding of attachment, neurological developmental, and trauma:</u> <u>(i) impact of trauma on behavior, response to authority, emotional regulation, and perception;</u> <u>(ii) attachment disruptions and splitting dynamics in residential settings;</u> <u>(iii) understanding of mental health disorders and mood disorders, including impact of stress:</u> <u>(A) Autism Spectrum Disorder;</u> <u>(B) Attention Deficit Disorder;</u> <u>(C) Attention Defiant Disorder;</u> <u>(D) common mood disorders;</u> <u>(E) common personality disorders; and</u> <u>(F) substance use disorders;</u> <u>(iv) understanding of survival behavior;</u>



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i. Client rules and rights ii. Client record documentation iii. Documentation and Incident Reporting iv. Mandatory reporter training – abuse, exploitation, neglect, and mistreatment v. Cultural sensitivity 2. Training Standards a. 80 hours of training before being “unsupervised” b. Required documentation of competency in all areas 3. Building Features a. 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	<u>(v) typical child and adolescent development;</u> <u>(vi) relational dynamics;</u> <u>(vii) punishment versus safety;</u> <u>(viii) power dynamics; and</u> <u>(ix) program specific population dynamics.</u> <u>(12) Each provider shall develop, implement, and comply with an internal procedure to determine and document if each direct care is competent in each area of training in Subsection (11)(a).</u> <u>(13) The provider shall ensure any program leader completes annual training for supervisory leadership for addressing any high-acuity event:</u> <u>(a) command presence without authoritarian escalation;</u> <u>(b) providing direction to staff;</u> <u>(c) providing staff ongoing coaching support in real time;</u> <u>(d) maintaining emotional regulation;</u> <u>(e) maintaining client, staff, and visitor safety;</u> <u>(c) debrief of any event effectively to prevent:</u> <u>(i) staff splitting;</u> <u>(ii) staff burnout; and</u> <u>(iii) reactive culture drift away from trauma-informed practices; and</u> <u>(iv) leadership staff self-care; and</u> <u>(v) prevention of leadership staff burnout.</u>



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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. b. Adoption of the standards for intermediate secure: i. Non-exposed fire sprinkler heads ii. Plexiglass or safety glass iii. Pressure release robe hooks iv. Recessed lighting v. Sealed light fixtures c. Required surveillance cameras in all common and permitted areas to accurately document and debrief critical incidents, not to be used for supervision d. Anti-ligature in high risk areas, specifically bedrooms and bathrooms 4. Staffing Requirements a. 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. b. Aged 21 and over	



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c. Exclusion of support staff in ratios who are not actively supervising and have not completed direct care staff training requirements d. Program/Facility Manager e. 25 years old—Current Intermediate Secure rule f. Bachelor’s degree or equivalent experience in human service related field g. Staffing ratio is 1:4 h. 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 i. 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 j. Q15s (15 minute checks) should be documented during waking hours	
Additional Proposed Updates	
• Update statute references for Division of Licensing and Background Checks (DLBC) and Congregate Care Committee. • Add to Section R501-19A-2 or in the rule section the following definitions, sub-acute, treatment-refractory behaviors, AWOL, high-acuity event, peer intervention, code red procedure, and staff splitting.	



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● Add to Section R501-19A-5: ○ “The provider shall develop, implement and comply with a policy, created with a licensed medical professional, to define any medical complaint escalation trigger for the program population”.	

Discussion Questions for Congregate Care Committee

1. Are there other policies that need to be added to the “Policies, Procedures, and Practices” rule section?
2. For the intensive residential treatment training requirements for direct care staff:
 - a. does the training need to be annual;
 - b. does each training area need to be taught by a licensed mental health professional or a recognized organization; and
 - c. how would a program have direct care care staff demonstrate competency?
3. For “Supervisory Leadership During High-Acuity Events” - which level of program staff need to complete this type of training?
4. Other proposed updates?

