An Attorney Advocacy Guide for Reducing Reliance on Institutional Placements

Research, best practices, and federal law point to a common understanding that most youth in foster care experience better outcomes when they grow up in family settings. Services to support and strengthen individuals and families are best provided in the home and in their community, whenever that is safely possible. If a youth is removed from the home, federal and state statutes require placement in the least restrictive, most family-like setting to meet their needs.[1] Yet, statistics reveal reality is not consistent with the law, policy, and best practices.[2] Attorneys play a critical role in changing this practice and improving outcomes for youth and families.

This guide was created to provide a framework for attorneys' advocacy efforts to keep youth in families and family settings. It is based on multi-disciplinary research, as well as other resources and guidelines, and draws on best practices for professionals within the child welfare field.[3] Attorneys are encouraged to familiarize themselves with the cited references, as well as the resources and research on the *Every Kid Needs a Family* site, to further strengthen their legal advocacy.

The guide starts with the premise that every kid needs a family. A young person should grow up in a family unless there is a well-documented, professionally recommended clinical and/or behavioral need that is beyond the ability of a family to meet, even with appropriate community services in place. Youth engagement and voice is also critical; although not dispositive, youth preferences and opinions should guide the determination of whether institutional care is appropriate in a particular case. The cornerstone question is whether institutional care[4] is necessary and appropriate to meet the youth's needs.

---

[1] *See, e.g.,* 42 USC § 657 (5) (A).

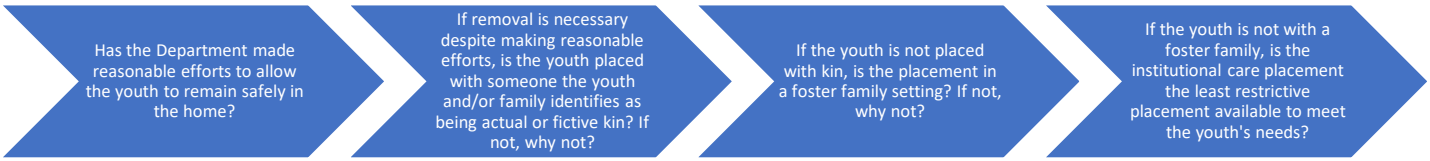
[2] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, A National Look at the Use of Congregate Care in Child Welfare (2015)

[3] *See, e.g.,* Annie E Casey Foundation, Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance for Success, Kids Count Policy Report (May 2015); Building Bridges Initiative, Best Practices for Residential Interventions for Youth and their Families: A Resource Guide for Judges and Legal Partners with Involvement in the Children's Dependency Court System (February 2017).

[4] For purposes of this toolkit "institutional care" includes group homes, institutions, emergency shelters, residential treatment facilities, or other congregate care settings.

I. Guiding Questions for Attorneys Regarding Placement Advocacy

The four questions below guide inquiry and analysis of placement at any stage of the case. After a thorough, independent investigation of the facts, attorneys should gather applicable laws and social science research to prepare to assert arguments to the court.[5]



1. Has the Department made reasonable efforts to allow the youth to remain safely in the home?[6]

A. Did the Department make reasonable efforts to prevent the removal of the youth from the home? Did the Department provide services and support that would have allowed the youth to remain safely in the home and eliminate the need for placement? Were there such services and supports that could/should have been explored? Why/why not?
B. Did the Department offer services that were appropriately tailored to the family? Especially if Title IV-E funding was used to fund such prevention services, were the services trauma-informed, evidence-based, and rendered by a qualified clinician?
C. What efforts did the Department make to engage the family in services? How many engagement attempts did the Department make? How were services offered/delivered?
D. What protective factors were explored/recommended to the family? Were family supports considered (as respite, temporary placement, caregiving support, etc.)?
E. Did the Department provide/offer/design services with the family's preferred language and culture in mind?
F. Did the Department make efforts to address any economic barriers (assistance with public benefit applications; referrals to job placement programs; exploration of childcare options; referrals to housing programs and services)?

---

[5] Relevant statutes, statistics, data, social science, and other research can be found throughout the *Every Kid Needs a Family* site.

[6] For resources regarding the harm of removal and preventing removal, see Vivek Sankaran. "A Cure Worse Than the Disease? The Impact of Removal on Children and Their Families." Christopher Church and Monique Mitchell, co-authors. *Marq. L. Rev.* 102, no. 4 (2019): 1163-94; Shanta Trivedi, The Harm of Child Removal, 43 NEW YORK UNIVERSITY REVIEW OF LAW & SOCIAL CHANGE 523 (2019); Judge Mary Tabor, Transformation in Child Welfare, *The Iowa Lawyer* (June 2020): 10-12.

G. Did the Department refer the family to a civil legal aid provider to help prevent removal, for example through advocacy in housing, family law, domestic violence, or public benefits matters?
H. Did the Department ask the youth whether they wanted to remain in the home? Does the youth want to remain in the home? Why/why not? Does the youth feel safe in the home? Why/why not?

2. If removal is necessary despite making reasonable efforts, is the youth placed with someone the youth and/or family identifies as being actual or fictive kin? If not, why not?

A. Has the Department asked the youth and parents to identify close relatives?
B. Has the Department explained who can qualify as a relative under local law/Department policy, and asked the youth and parents about non-relatives they consider to be kin (step-family members, godparents, friends, neighbors, community members, church members, etc.)?
C. If no kin were identified, has the Department conducted a diligent search, and if so, how recently? What steps did the diligent search include? Has the diligent search been comprehensive, to include public records, social media, etc.? Was the diligent search tailored to this particular family or did the Department follow the steps it does for every family?
D. Have maternal AND paternal relatives been identified and contacted (even if either parent is absent)?
E. If there are identified kin, but none are currently serving as a placement, what are the barriers? Can those barriers be addressed and ameliorated by the court and/or Department (e.g., licensing waivers, services for the kinship provider and/or youth, assistance with school transportation)?
F. Are there services or supports that might support or accelerate the youth's placement with kin (e.g. kinship navigator services)?
G. Did the Department ask the youth where they would like to be placed? Does the youth want to be placed with kin? Why/why not?
H. Has the Department re-explored kinship placement possibilities throughout the case, particularly when a placement disrupts, and considered the changing circumstances of the youth, family, and kinship options?

3. If the youth is not placed with kin, is the placement in a foster family setting? If not, why not?

A. Is there a foster family available and willing to serve as a placement?
B. How was the foster family identified? Was a matching process completed? What was the process? What factors were used to determine that the placement would be a good match for the youth?

C. Has the Department shared appropriate, relevant background information about the youth with the foster family? Is the foster family willing and able to meet the youth's needs and foster their strengths?
D. Did the Department ask the youth their opinions about placement with the foster family? Were those opinions factored into the placement decision?
E. Did the youth have the opportunity to attend pre-placement visits with the family?
F. Does the available foster family support the youth's culture and identity?
G. Does the available foster family support and encourage the youth's connection to their biological family? Is the foster family willing to facilitate family time, phone calls, relationships, etc.?
H. Where is the foster home in relation to the youth's community, school, family, activities, services, etc.? Are there any transportation barriers to be addressed?
I. Are there supports that might allow the youth to live in a family setting?
J. Does the youth need a therapeutic foster home which can address identified needs, and what efforts have been made to identify one?

4. If the youth is not with a foster family, is the institutional care placement the least restrictive placement available to meet the youth's needs?[7]

Note: many of the questions in this section invoke the attorney's independent duty to investigate the proposed placements.

A. What is the basis of the determination?

i. Is the institutional care decision based on a qualified, independent assessor's recommendation?[8]

1. Did the assessor use a functional, age-appropriate, evidence-based, and validated assessment tool?
2. Were all parties provided with a copy of that assessment tool and the recommendations?
3. Did the assessor consult with the youth, family, permanency team, and all relevant professionals?[9]
4. What behaviors or needs did the assessor identify that cannot be met within a family setting?
5. What short and long term mental and behavioral health goals did the assessor identify?

[7] *See* Section II for more guiding questions tailored to institutional care facilities.

[8] The term "independent assessor" comes from the Family First Prevention Services Act (FFPSA). An attorney's state may not have opted into FFPSA provisions concerning institutional care. Although it is important to know whether FFPSA applies in your jurisdiction, the relevant language in this guide can still provide a useful framework to attorneys in institutional care advocacy.

[9] FFPSA defines this to include "all appropriate family, relatives, and fictive kin of the child, as well as relevant professionals (ex. teachers, medical or mental health providers, clergy)" and requires that the input is solicited "at a time and place convenient for family." Pub. L. 115-123.

6. Was there an opportunity to cross-examine the professional who conducted the evaluation on the record?

ii. What is the youth's opinion on being placed in an institutional care placement? Was the opinion considered in the determination? Why/why not?[10]

iii. Have all community-based services been utilized before considering an institutional care setting? If not, why not? What services will the youth receive in an institutional care setting that they cannot receive in the community?

iv. What is driving the decision to place the youth in an institutional placement – safety concerns? Lack of available/willing foster homes? Mental health needs? Educational needs?

B. What type of institutional placement is proposed and what does it provide?[11]

i. How does this placement meet the federal standard for the least-restrictive, most family-like setting, and how is it appropriate to meet the youth's needs?

ii. Is there a child-specific, best interest reason to support this placement?

iii. Is the placement able to offer the type and frequency of treatment recommended by the independent assessor?

iv. Does the placement utilize a trauma-informed model?

v. What treatment modalities does the placement offer? How do they choose what modality to use with each youth? Are decisions regarding treatment modalities individualized based on the youth's needs?

vi. What assessments or evaluations are conducted during the placement?

vii. What tools is used to determine the youth's baseline functioning at admission, during treatment, and at discharge?

viii. How is a youth's progress gauged during the placement? Is it a level system (based on behavioral modification) or are there other assessments or tools that are used?

ix. What is the average length of stay in the placement?

x. How far away from the youth's home, family, and school is the placement being considered? How will the youth's family be able to visit and/or be meaningfully involved in the treatment team?

[10] Under FFPSA, if a Qualified Residential Treatment Program (QRTP) is recommended over the objection of the child or parent, the reasons why must be documented in the case plan. Pub. L. 115-123.

[11] Some of the language in this section comes from FFPSA and its requirements for qualified residential treatment programs (QRTPs). An attorney's state may not have opted into FFPSA provisions concerning institutional care. Although it is important to know whether FFPSA applies in your jurisdiction, the relevant language in this guide can still provide a useful framework to attorneys in institutional care advocacy.

xi. What is the peer group like? What are the ages and needs of the other youth at the placement? How many youth are placed at the facility?
xii. What is the ratio of staff to youth?
xiii. What staff members will be working with the youth and what are their qualifications? Who is responsible for ensuring that the youth's treatment objectives are being met?
xiv. Does the placement provide regular and consistent training and supervision to staff?
xv. What are the placement's disciplinary policies and procedures?
xvi. Does the placement implement standards and procedures to hold itself accountable? Does the placement have operating principles that are publicly available?
xvii. Is the placement licensed by the state? Is it accredited by an approved organization, per FFPSA? How does the state or other licensing body monitor the facility?
xviii. Have there been any complaints lodged concerning the placement? Is there any disciplinary history regarding the placement? What concerns have been cited? How have they been resolved?

II. GUIDING QUESTIONS FOR ATTORNEYS REGARDING INSTITUTIONAL CARE PLACEMENTS

Suppose that after the attorney's thorough and independent investigation, they determine that institutional care is necessary, or despite arguments to the contrary, the youth is placed in institutional care. What now? It is crucial to determine and advocate for the best possible placement, given the youth's needs, for the shortest period of time to meet those needs. Below are questions the attorney can ask to ensure the institutional care placement is safe, effective, and appropriate to meet the youth's needs, as well as compliant with federal law, and if not, argue for a different placement.

1) Does the program provide high-quality treatment?

a. Has the program drafted a treatment plan for the youth? Does the attorney have a copy of it? How often it is updated/by whom?
b. Has the program set long- and short-term goals for the youth's treatment? What are those goals? How does the treatment plan promote those goals? What is the expected timeline for achieving them?
c. How often are treatment team meetings held? Who participates?
d. What services is the youth receiving? Are they evidence-based? Trauma-informed? Are expressive therapies (art, music, dance, etc.) provided? How often are services provided? What are the qualifications of the service/treatment providers?
e. Where will the youth receive medical care? Does the program have medical staff onsite? How often are medical staff available?

f. Are trauma assessments completed for the youth? Are trauma assessments completed by the parents and other family members involved in the youth's transition home?
g. Does the staff receive regular training on trauma and evidence-based strategies?
h. Is there a protocol for using evidence-based strategies related to trauma?

2) Does the program authentically engage/involve youth?

a. How does the program engage/involve youth in their treatment plan and goals?
b. Does the program provide youth with the opportunity to connect with peers? What activities, sports, and/or recreational opportunities are provided? Are youth taken into the community? How often?
c. Does the program ensure the youth can attend their court hearings?
d. Has the youth's attorney been provided with a way to contact the youth?
e. Does the program facilitate communication with the youth's attorney and other members of the youth's professional team? How and how often?
f. If the program is far from the youth's home, is the youth provided with meaningful opportunities to engage with family and others in their support network? How often?

3) Does the program authentically engage parents and families?

a. Does the program involve/engage family and parents in treatment team meetings, treatment planning, and treatment? What efforts does the Department make to engage the family in treatment at the program?
b. Is family therapy offered? Who is included in family therapy?
c. Are all important people in the youth's life allowed contact with the youth at the program? Has the family been provided all contact information for the program and key staff? How often are phone calls? How often are visits?
d. How does the program engage/involve parents in all key decisions at the program?
e. Does the program communicate with the youth's family and family members? How and how often?
f. Does the Department provide financial support for families to travel to the program? How often?

4) Does the program focus on permanency?

a. Does the program have a commitment to every youth having a permanent family?
b. What efforts will the program make to identify and engage a family placement if the youth does not already have one identified?
c. Does the program/Department have a plan for pre-discharge visits to the identified family placement/permanency option?

5) Does the program provide the youth with a quality education?

a. Where will the youth attend school? Their home school? Another public school? At the program?
b. Is the school accredited/approved/recognized/certified by the state?

c. What is their academic curriculum?
d. What is their student-to-teacher ratio?
e. Does the school have the youth's transcript, credits, IEP, 504 plan, etc.?
f. If the youth has an IEP, is the school implementing it?
g. Is the youth earning credits towards high school graduation? If the youth is in an out-of-state placement, will those credits transfer?
h. Does the program provide access to and support with SAT preparation and test-taking, college applications, financial aid, college preparation, etc.?

6) Does the program provide culturally humble and linguistically appropriate services?

a. Does the youth have an opportunity to engage in religious and/or cultural traditions?
b. Is the program able to meet the cultural and linguistic needs of the youth?
c. What are the demographics of the staff? Does the staff reflect the racial, cultural, and linguistic identity of the youth?
d. What are the demographics of the other youth at the program? Do the residents reflect the racial, cultural, and linguistic identify of the youth?
e. Are all programs and services provided in the youth's preferred language?
f. Does the staff engage in cultural humility, implicit bias, and racial equity trainings? How often?

7) Does the program ban seclusion and restraint?

a. Does the program have a policy regarding the use of seclusion and restraints? Have all parties and relevant family members been given a copy?
b. What restraints are used? Under what conditions? Who performs them? What is their training?
c. Is physical restraint banned? If it is used, under what circumstances? What types?
d. Is chemical restraint banned? If it is used, under what circumstances? What types?
e. Is seclusion banned? If it is used, under what circumstances? Under what conditions? For how long?
f. Does the program use debriefing techniques after seclusion and restraint?
g. What documentation is required after the use of seclusion or restraint? Is there a policy requiring the youth's team/family to be notified?
h. Is the staff required to undergo regular training on seclusion and restraint? How often?
i. Does the program collect, monitor, and track data on seclusion and restraint usage?
j. Does the program create an environment grounded in knowledge of trauma and apply it to policies concerning seclusion and restraint?
k. Has the youth been subjected to seclusion or restraint and if so, why? What was tried to de-escalate the situation prior to the use of seclusion or restraint? How long did the seclusion or restraint last and was that the least amount of time necessary to safely reduce the threat? Was a de-briefing conducted with the youth (and staff) after the seclusion or restraint? Was the youth's team/family notified? Provided documentation?

8) **Does the program have an informed practice on the use of psychotropic medication?**
    a. Is the youth currently on any psychotropic medication? What kind? What dosage? What is the medication prescribed for? Is that consistent with the youth's diagnoses? How many medications is the youth prescribed?
    b. Does the program have a psychiatrist on staff or as a regular part of the treatment team? How often does the youth meet with the psychiatrist for a medication assessment?
    c. Does the prescribing psychiatrist weigh the risks and benefits of medications and explain those to the youth and parents/medical decision maker?
    d. Does the psychiatrist conduct on-going reassessments of medication? How often?
    e. Does the program engage the parent in all medication decisions? Does the program ensure the parent consents to medication (unless the parent is no longer the medical decision maker)?
    f. Does the program know who the medical decision maker is? Does the program have a process for obtaining informed consent for medication? Does the program have copies of any relevant court orders regarding the administration of psychotropic medication to the youth?
    g. Is the youth informed about the medication/engaged in decisions about what medications are prescribed?
    h. What amount of medication does the program provide upon discharge? Does the program help ensure a smooth transition to ensure the prescriptions are maintained appropriately?

9) **Does the program support youth in transition to adulthood?**
    a. Does the youth have a transition plan?
    b. Does the program teach youth the skills needed to be successful in adulthood?
    c. Has an adult connection or connection to a support network been established for the youth?
    d. Is there a mechanism at the program for the youth to learn budgeting, open a bank account, save money, etc.?
    e. Does the program utilize peer mentors to teach and model skills?
    f. Does the program connect youth to post-transition resources?
    g. Does the program facilitate job-training, resume writing, interviewing skills training, etc.?
    h. Does the youth have a place to live and a means of financial support in place upon discharge?

10) **Does the program focus on outcomes?**
    a. Does the program have a process by which it tracks data to measure and improve outcomes?
    b. In addition to tracking systemic outcomes, how does the program measure and ensure outcomes for the individual youth?
    c. Has the program determined what outcome data is critical to collect and implemented a method for data collection and benchmarking its performance?

d. Does the program ensure that practice and process indicators are measured?
e. Does the program collect functional outcome data and uses it to inform on-going performance?
f. Does the program share its data with external constituents?

11) Does the program engage in robust discharge planning?

a. Does discharge planning begin as soon as the youth enters the program?
b. Is there a discharge plan that identifies anticipated duration of intervention and the treatment targets?
c. Is there a plan to transition the youth from institutional care to their home or to another family setting?
d. What are the steps to transition the youth from institutional care to a permanent living arrangement? Is that Department's work sufficient to meet the reasonable efforts requirement?
e. How are the youth and parents involved in the transition plan?
f. Is there an aftercare or step-down program associated with the program? Does the program provide discharge services?[12]
g. Does the Department and/or program ensure the youth has what they need once discharged (medication, therapeutic services, school placement, in-home supports, etc.)?

[12] Under FFPSA, QRTPs are required to provide six months of post-discharge services. Pub. L. 115-123.