

Discovery in Child Welfare Cases – What do you need? How do you get it?

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What information do you need?

- CPS/Foster Care Records
- Medical Records
- Criminal History (convictions, police reports)
- School Records
- Mental Health Records
- Substance Abuse Treatment Records
- Videotaped interviews of children
- Information from other service providers (parenting classes, domestic violence programs, wraparound services)

Formal Discovery – do this in every case

- MCR 3.922
 - Need to make the request. File a copy with the court
 - Sets forth specific items that must be disclosed
 - Court can permit discovery of any other materials and evidence
 - Court may authorize depositions
- What should you request (in addition to required disclosures)?
 - Entire child protective and foster care file
 - Prior investigative reports involving the children and your client's other children
 - All exhibits the agency is planning to introduce into evidence
- Set deadline in request. Follow up with motion to compel and sanctions if necessary. MCR 3.922(A)(2)(4)

Obligation to provide information to L-GAL

- MCL 712A.17d
 - “The supervising agency shall provide documentation of progress relating to all aspects of the last court ordered treatment plan, including copies of evaluations and therapy reports and verification of parenting time not later than 5 business days before the scheduled hearing.”
 - If agency is not complying, ask for court order.
 - If you represent a parent, ask for an order imposing a similar obligation.

“Informal” Discovery

- Make requests directly with the service provider via phone and/or letter and request information
- Prior to doing so, you need to understand the confidentiality laws that govern the release of that information
 - See DHS Service Requirements Manual – 131 available at <http://www.mfia.state.mi.us/olmweb/ex/srm/srm.pdf>
- Three principles to remember
 - If you don't ask, they have no obligation to give
 - Get a release signed by the parent
 - If you don't have a release, seek a court order

CPS/Foster Care Records

- File written request with the Dep't
- Alleged perpetrator and L-GAL are permitted to access the records of the children. MCL 722.627(2)(f)(j)
- If you represent the perpetrator, have your client sign a release. Use DHS standard form
- Identity of the reporter will remain confidential unless the court orders that that information be released. MCL 722.625

Mental Health Records/Medical Records

- If the treatment is mandated by a court order, did the client waive confidentiality? (e.g. court-ordered evaluation)
- Confidentiality governed by Health Insurance and Portability Accountability Act (HIPAA), 42 USC 1320d et seq. and 45 CFR Part 164.502 et seq., and the Michigan Mental Health Code, MCL 330.1748 and 330.1748a .
- Bottom line. If confidentiality is not waived:
 - Need release signed by the parent . Service providers may have specific release forms to meet HIPAA requirements
 - Need court order or judicial subpoena. An attorney-signed subpoena is not sufficient.

Substance Abuse Treatment Records

- 42 CFR Part 2 et seq.
- Need release signed by parents. Very specific requirements set forth in 42 CFR 2.31
- If no release, then need a court order and subpoena. Very specific requirements set forth in 42 CFR 2.64

School Records

- Governed by Family Education Rights and Privacy Act (FERPA) – 20 U.S.C. 1232g ; 34 CFR 99
- Access records via court order or subpoena
- Access records via release signed by parent
 - Specify the records that may be released.
 - State the purpose of the disclosure.
 - Identify to whom the release may be made

Criminal History

- How to get criminal history?
 - Offender Tracking Information System (OTIS) – information about offenders who have been under the jurisdiction and supervision of the Dep't of Corrections within the last three years.
<http://www.state.mi.us/mdoc/asp/otis2.html>
 - Internet Criminal History Access Tool (ICHAT) – information about all state felonies and serious misdemeanors.
<http://apps.michigan.gov/ICHAT/Home.aspx>
 - FOIA police reports. Note that under MCL 722.627(8), DHS is not permitted to forward police reports of ongoing investigations related to allegations of child abuse or neglect
 - Once you ascertain criminal history, you can learn more by looking at the file in the case.

Video recorded statement of child witness

- Release of videorecorded statement of child governed by MCL 712A.17b
- MCL 712A.17b(7) – each respondent and attorney has a right to view and hear videorecorded statement at a reasonable time before it is offered into evidence. Court may order that a copy be given to the defense under protective conditions.
- If no tape, get a copy of the transcript.
- Make the request during formal discovery. Follow up with a written letter to prosecutor, CPS worker and police officer.

Other types of records

Court records from the following types of cases.

- Custody
- Domestic Violence
- Guardianship
- Landlord-Tenant

Summary

Three main principles

- You've got to ask
- Get a release
- Get a court order

QUESTIONS?

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
Michigan Department of Human Services

Client Name				
Case Number			Client ID Number	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Client's Date of Birth		
County	District	Section	Unit	Worker
Worker Name				
Telephone Number/ext.				

TO:

SECTION 1:

I authorized you to release the named adult and/or minor child's information as described below. The type and amount of information to be released is as follows:

<p>REQUESTED INFORMATION</p> <p><input type="checkbox"/> MEDICAL RECORDS OF: <u>(insert names here)</u></p> <hr/> <p>Physical examinations and clinical evaluations including any information relative to HIV, ARC or AIDS if applicable. Treatment for any physical illness. Medical records, including admitting histories, discharge summaries, laboratory reports, test results, diagnosis, complications, progress notes, medications, workshop evaluations, training reports, treatment plans, prognosis, recommendations and current status.</p> <p><input type="checkbox"/> MENTAL HEALTH RECORDS OF: <u>(insert names here)</u></p> <hr/> <p>Treatment for any emotional illness, psychiatric or psychological reports, IQ scores, diagnosis, progress notes, medications, treatment plans, prognosis, recommendations and current status.</p> <p><input type="checkbox"/> SUBSTANCE/ALCOHOL ABUSE RECORDS OF: <u>(insert names here)</u></p> <hr/> <p>Treatment for any drug or alcohol abuse, laboratory reports, test results, diagnosis, complications, progress notes, medications, treatment plans, prognosis, and current status.</p> <p><input type="checkbox"/> EDUCATIONAL RECORDS OF: <u>(insert names here)</u></p> <hr/> <p>School records including progress reports, attendance, special education and other evaluations.</p> <p><input type="checkbox"/> OTHER (Specify) OF: <u>(insert names here)</u></p> <hr/> <p><input type="checkbox"/> OTHER (Specify) OF: <u>(insert names here)</u></p> <hr/>
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I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

This information may be released during the course of business to organizations that regularly review child welfare cases including Office of Children's Ombudsman, Foster Care Review Board, Citizen's Review Panel, Friend of the Court, County Medical Examiner, law enforcement, and Child Fatality Review Team.

SECTION 2:

This information may be released to and used by the following:

- | | |
|--|---|
| <input type="checkbox"/> _____ County Department of Human Services | <input type="checkbox"/> Attorney Representing Mother |
| Address (Street) _____ | <input type="checkbox"/> Attorney Representing Father |
| Address (City, State, Zip Code) _____ | <input type="checkbox"/> Lawyer – Guardian Ad Litem Representing Child(ren) |
| () _____ | <input type="checkbox"/> Service Provider (specify) _____ |
| Phone Number _____ Fax Number _____ | <input type="checkbox"/> Service Provider (specify) _____ |
| <input type="checkbox"/> _____ County Family Division of Circuit Court | <input type="checkbox"/> Service Provider (specify) _____ |
| <input type="checkbox"/> _____ County Prosecuting Attorney | <input type="checkbox"/> Court Appointed Special Advocate (CASA) |
| | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> Other (specify) _____ |

SECTION 3:

This release and use is for the following purpose(s): To assist the Department of Human Services in conducting child and family assessments for the purpose of providing case planning and treatment services.

- Other (Specify) _____

(NOTE: The statement “at the request of the individual” is sufficient when the individual initiates an authorization and does not, or chooses not to, state the purpose.)

I understand that if I give DHS permission I have the right to change my mind and **revoke** it. This must be in writing to :
 _____ County Department of Human Services. I also understand that DHS cannot take back any uses or releases already made with my permission.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date):

- | | |
|---|--|
| <input type="checkbox"/> Court jurisdiction dismissed | <input type="checkbox"/> Children’s services case closed |
| <input type="checkbox"/> Other (specify) _____ | |

I understand that release of this information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

By signing this Authorization, I understand that any release of information carries with it the potential for an unauthorized release and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

Printed Name of Client (or Legal Representative)	Printed Name of Witness (Worker)
Signature of Client (or Legal Representative) Date	Signature of Witness (Worker) Date
If signed by Legal Representative, Relationship to Client: (A letter of authority may be requested)	

DHS USE ONLY	
This authorization was revoked:	
_____ Signature	_____ Date

AUTHORIZATION:

This authorization is valid only for the purpose, information, agencies and persons cited above. This information release authorization has been prepared in accordance with the authority specified below:

- 42 CFR, part 2, subpart C, Section 2.31, as revised August 10, 1987
- 1978 PA 368
- 1978 PA 238
- 1974 PA 258

This authorization form is acceptable to the Michigan Department of Human Services as compliant with HIPAA privacy regulations 45 CFR Parts 160 and 164.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Court Improvement Program- Match In-kind Resources

Time Estimate/Duties and Functional Responsibilities

On _____, you participated in a _____ Meeting.
The meeting started at _____ and ended at _____.

This is a CIP initiative; therefore, the time you spent both at the meeting and in preparation for the meeting qualifies as an in-kind match for the State Court Administrative Office (SCAO). We appreciate the following information relative to the costs of your attendance. Please, if at all possible, provide us with your hourly rate, including your best estimate of your fringe benefit rate. (If you cannot provide a best estimate of your fringe rate, please let us know it is not included). If you are paid with federal funds, please DO NOT fill out this form as we cannot use your time for our match.

My title is _____ and my primary job responsibilities are _____.

My total time spent in the above activity is worth _____.
(dollar amount= hourly pay+fringe x # of hours)

Fringe benefits **are** included Fringe benefits are **not** included

I certify that my participation was consistent with the tasks necessary to accomplish the goals of the Court Improvement Program Grant.

DATE _____

Signature

Name (Printed)

E-Mail Address

Phone

Mail completed form to:
SCAO-Child Welfare Services
P.O. Box 30048
Lansing, MI 48909