Implementation of the UNCOPE Universal Screen in Oklahoma

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Prepared by

Tom McDonald, Ph.D.

Jody Brook, Ph.D. MSW/LCSW

Yueqi Yan, M.A.

The University of Kansas

School of Social Welfare

Lawrence, Kansas 66044-3184

Prepared for

Oklahoma Department of

Mental Health and Substance Abuse Services

Oklahoma City, OK 73152-3277

Background

As a part of the Oklahoma Partnership Initiative (OPI) project, the State of Oklahoma is implementing the use of a universal screening instrument to help identify families at high risk of substance use disorders in the context of the child welfare system. The UNCOPE is a widely used universal screening instrument that has been used in other states for similar populations and circumstances. The UNCOPE is comprised of the following 6 questions:

U "In the past year, have you ever drank or **used** drugs more than you meant to?" or, as revised, "Have you spent more time drinking or using than you intended to?"

N "Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?"

C "Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?"

O "Has anyone **objected** to your drinking or drug use?" or "Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?"

P "Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?" or, as revised, "Have you found yourself thinking a lot about drinking or using?"

E "Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?"

A positive response to two or more items on the screen indicates increased risk for substance use disorders; and it indicates the need for further assessment of substance use disorders.

In addition to the implementation of the UNCOPE as a part of the OPI project, the State of OK, Department of Human Services (Children and Family Services Division) has concurrently worked with Administration for Children and Families (Children's Bureau) Child and Family Service Review personnel to revise the OK child welfare model and implement a new family

functional assessment (FFA). State personnel from the OPI project were able to collaborate with State personnel in child welfare to embed the UNCOPE screening instrument into the new FFA. As part of the practice model implementation, the new FFA (containing the UNCOPE) began in mid-2009. The OK child welfare supervisors were trained in July 2009, and training of field staff began in October 2009. The use of the FFA is now mandatory practice statewide; however, the FFA has not been incorporated into the OKKIDS child welfare data tracking system, yet. This activity is tentatively planned for this fiscal year.

The presence of the UNCOPE in the new FFA is part of an overall section in the FFA centered on substance use practices and history. It should be noted that the use of the UNCOPE is only indicated for those persons who *do not* have substance abuse as a reason for child removal as identified through the assessment of child safety. This is due to the nature of universal screening: that is, screens are designed to detect risk for those who do not have other indications of high risk—and having a designation of child safety issues or removal due to substance abuse represents high risk designation in and of itself, so further screening would be redundant.

Figure 1, below, is the section of the FFA that contains the UNCOPE. One can see that the UNCOPE is administered in the context of questions about the family's substance use practices and history.

Figure 1: Substance Abuse Section on the OK Family Functional Assessment Tool

Parent's Substance Use	**Assessing the parent's involvement with alcohol and drugs.**
Possible Questions to Engage the Caregiver	◆ How do you get through a bad day? ◆ What is one way that you handle stress? ◆ Do you ever use prescription drugs in ways other than prescribed? ◆ Do you have concerns about the use of alcohol or other drugs by others in the home? ◆ Has your drinking or drug use caused job, family, or legal problems? _____ If substance use/abuse was not identified in *III. Six Key Questions in Gathering Information in the Assessment of Child Safety*, please use the UNCOPE screening tool. Please ask as written: **U** ***In the past year, have you drank or used drugs more than you meant to?*** ☐ Yes ☐ No **N** ***Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?*** ☐ Yes ☐ No **C** ***Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?*** ☐ Yes ☐ No **O** ***Has anyone objected to your drinking or drug use?*** ☐ Yes ☐ No **P** ***Have you found yourself thinking a lot about drinking or using?*** ☐ Yes ☐ No **E** ***Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?*** ☐ Yes ☐ No _____ **NOTE:** If the parent answers yes to 2 or more of the screening questions and, based on critical thinking, a concern is identified that substance use/abuse may be impacting the care of the child, please refer the parent for a formal substance abuse assessment.
Information compiled from family and other individuals who know the family:	
Examples of Protective Capacities on Which You Can Build	☐ Parent can describe their relapse plan. ☐ Parent completed treatment and reports no further abuse of drugs or alcohol. ☐ Parent attends NA, AA, or other support group as recommended by a treatment provider or sponsor.
Examples of Behaviors/ Conditions to Consider	☐ There is a history of substance abuse by the parent. ☐ Parent engages in substance abuse that results in a disruption in the family and reduces the parent's ability to care for the child. ☐ Parent reports no desire to change substance abuse patterns. ☐ Parent appears to be self-medicating through use of prescription drugs, drugs, and/or alcohol. ☐ Parent is using multiple drugs/substances. ☐ Parent is experiencing health problems as a result of substance abuse.
Based on critical thinking, your discussion about Parent's Substance Abuse, and safety threats identified in the Assessment of Child Safety, please rate the family's current functioning in this area:	
☐**Strength** ☐ **Adequate** ☐ **Area of Concern** ☐ **Problem**	
NOTE: **Strength** – Gives no indication of abusing alcohol or drugs; demonstrates ability to deal with life stressors (positive and negative) without the need for alcohol/drugs; displays self-awareness and identifies as past abuser who participated in treatment and has remained in recovery for some time; lack of discomfort in talking about substance abuse issues. **Adequate** – Indicates use of alcohol and/or drugs, but only occasionally in excess; relates some instances of reduction in parenting skills due to alcohol/drugs; identifies as a past abuser of drugs/alcohol, but only recently began treatment. **Area of concern** – Others in household are abusing and not receiving treatment; others express concern of primary caregiver's excessive use of drugs/alcohol; no recognition of the impact of their drug use on other family members. **Problem** – Parent indicates they use alcohol and/or drugs on a regular and consistent basis; displays an inability to parent as a result of alcohol and/or drug use; has no interest in participating in treatment; parent displays discomfort in talking about substance abuse issues (denial) and expresses an inability to deal with life's stressors; denies their need for treatment.	
If rated *Area of Concern* or *Problem*, is there a need for intervention in this area to keep the children safe? ☐ Yes ☐ No **If yes, describe how the behaviors or conditions need to change and identify the To Do(s) to be included in the ISP:**	

In addition to the section on substance abuse (presented in Figure 1, above), the FFA also contains similar sections related to the following domains: kinship and community supports, housing, food and basic needs, medical needs, parental mental and emotional health, violence in the home, parenting skills, child's needs, child's vocational or independent living needs, child's substance abuse, and the family's perspective on child welfare involvement.

Data Source

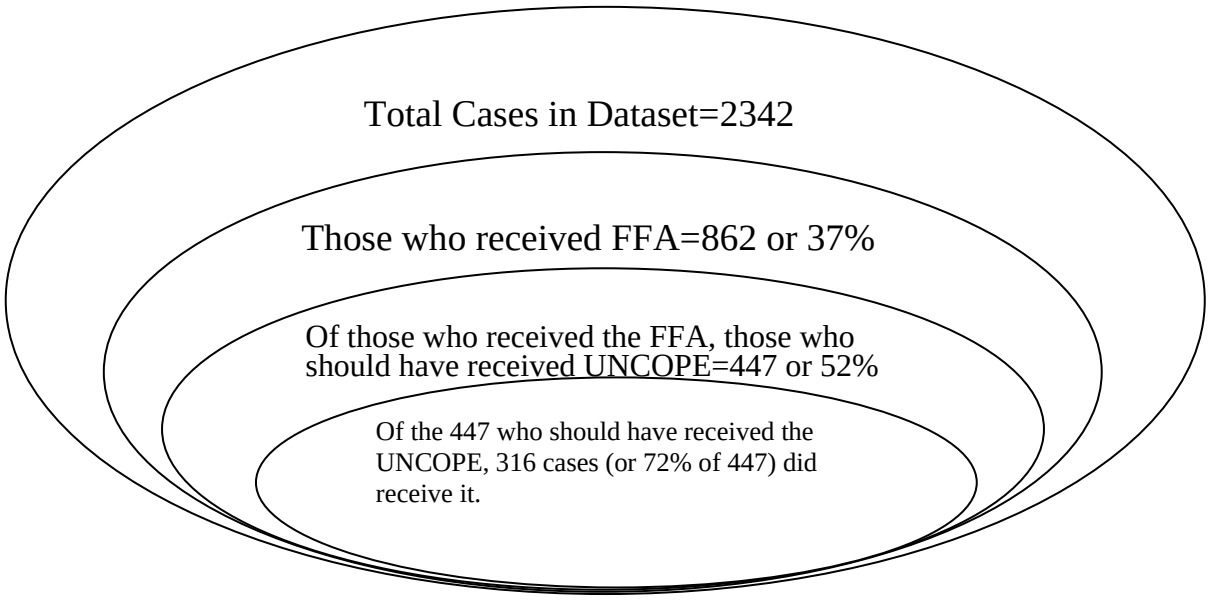
Data for these analyses were provided to researchers at the University of Kansas School of Social Welfare by Oklahoma Dept of Human Services Children and Family services division personnel. The dataset includes information on 2342 child welfare removal cases during the time period April 2009-May 2010 in Oklahoma. For purposes of analysis, the case record on the oldest child removed from the home was chosen to be included in the dataset. The cases represent files from each of the 6 statewide service areas. Information related to the presence or content of the FFA was taken from a scanned paper version of the FFA and was manually entered into an electronic database by Oklahoma Dept of Children and Family Services personnel. It should be noted that the dataset that was generated represents cases of removal during the rollout period of the new FFA—so it was expected that there would be variance in how the form and the UNCOPE screen were being utilized. It is a primary goal of this report, and the report issued in October 2010, to provide OK with introductory information about how this new tool is working, and interpretation of these data should occur with continued understanding and a cautionary note that these findings are preliminary in nature.

Findings

There are the 2342 cases in the UNCOPE dataset in total. A FFA was present in 862 (or 37%) of the cases. Of these 862 cases, 447 (or 52%) did NOT have substance abuse as a removal reason;

therefore, these families should have received the UNCOPE. Of this group (those who should have received), 316 UNCOPE screenings were administered (or 72%). The following figure (2) displays this for the reader.

Figure 2: Completion of the UNCOPE



While 862 persons participated in the FFA, only 447 should have been administered an UNCOPE. Of those who should have been administered the UNCOPE, only 316 or 72% actually received it. There were 415 cases where the UNCOPE should not have been administered (because substance abuse had already been identified in the assessment of child safety): however, in 70% (*n*=290) of those cases it was administered in error. While it may seem fairly innocuous that screens were administered when they did not need to be, in fact, this represents a potential waste of staff and client time.

Table 1, below, shows the number and percentage of cases, by service area, for which there were correctly administered UNCOPE screens—that is, substance abuse was not identified elsewhere in the record and an UNCOPE screening should have been administered.

Table 1. Correct Administration Rate of the UNCOPE by Service Area

Area		UNCOPE Administered Among Cases Having No Identified Substance Abuse
AREA I	Count	43
	% within Area	72%
AREA II	Count	74
	% within Area	78%
AREA III	Count	84
	% within Area	69%
AREA IV	Count	48
	% within Area	70%
AREA V	Count	37
	% within Area	76%
AREA VI	Count	30
	% within Area	67%
Total	Count	316
	% within Area	72%

Chi-square (5, *N*=440) = 3.36, P > .05

No significant differences were found in correct UNCOPE administration rates across different service areas. Table 1 reveals that Area II (78%) and Area V (76%) have the two highest correct administration rates. In the rest of the areas, the rate ranges from 67% to 72%, indicating that about two-thirds of cases should and did complete the UNCOPE.

Table 2, below, displays the distribution of mothers' and fathers' positive UNCOPE screens by service area. The range of positive UNCOPE assessments is 41% to 66% for the mothers' screens and 33% to 54% for the fathers' screens. These differences are statistically significant for mothers, and it is noteworthy that area III has (by far) the lowest percent of positive UNCOPE assessments and that most of the other areas are more similar—ranging from 50% to 66%. Area differences on the fathers' positive UNCOPE are not quite as large but vary substantially, with Areas II and III having the lowest rates at 33% and 34%, respectively. These

differences are not statistically significant given the smaller sample size for fathers compared to mothers.

Table 2. UNCOPE Screening (Positive) Results by Area

		Positive UNCOPE	
		Mothers' UNCOPE Screenings in Total (% Positive)	Fathers' UNCOPE Screenings in Total (% Positive)
Area	AREA I	57 (51%)	39 (49%)
	AREA II	113 (50%)	67 (33%)
	AREA III	129 (41%)	71 (34%)
	AREA IV	105 (55%)	67 (54%)
	AREA V	64 (55%)	48 (42%)
	AREA VI	53 (66%)	30 (43%)
Total		522 (51%)	322 (42%)

For Mothers' UNCOPE: Chi-square(5, *n*=521)=11.0073, p=.05.
For Fathers' UNCOPE: Chi-square(5, *n*=322)=8.80, p=.12.

When analyzing all of the administered UNCOPE screens in the dataset, there are 522 UNCOPE screenings for mothers and 322 screenings for fathers. There are 240 families where both a mother and a father were administered the UNCOPE. There are potentially a variety of reasons that UNCOPE screens are missing for the fathers in the dataset, and this finding should be explored further. In families where there was a correct administration of the UNCOPE, and one parent completed the screen, mothers had positive screens 51% of the time compared to 42% of the time for fathers. In cases where both parents were able to be screened, 42% of the cases resulted in *both of these* parents having a positive screen, while 53% of these cases resulted in *either parent* having a positive screen

The fact that the UNCOPE is embedded into the FFA provides us with the opportunity to gain collateral information about the family at the time of UNCOPE administration. As the FFA is completed, families are assessed in each of the domains on the FFA: kinship and community

supports, housing, food and basic needs, medical needs, parental mental and emotional health, domestic violence, parenting skills, child's needs, child's vocational or independent living needs, child's substance abuse, and the family's perspective on child welfare involvement. The FFA contains a section, in each domain, where the worker and client must designate the overall area to be one of strength or one that is concerning or problematic. For this analysis, these researchers collapsed the choice "strength or adequate" into a single category of "not a problem" and the choice "area of concern or problem" into a single category of "a problem." The reader is referred to page 4 of this document to see an example of these designations in the FFA. For purposes of analysis, we simply collapsed the choice of responses into two categories based on whether they represented a concern or not.

Table 3. Mothers with Positive UNCOPE by Areas of Concern

Positive UNCOPE or Not	% Indicating Area of Concern or Problem
	Kinship/family/community support*
No (*n*=178)	30%
Yes (*n*=73)	44%
	Housing/food/basic needs*
No (*n*=181)	38%
Yes (*n*=72)	53%
	Medical/dental care*
No (*n*=173)	27%
Yes (*n*=74)	39%
	Parents' mental health
No (*n*=174)	51%
Yes (*n*=70)	57%
	Parents' substance abuse***
No (*n*=180)	14%
Yes (*n*=71)	63%
	Domestic violence
No (*n*=175)	40%
Yes (*n*=66)	50%
	Day-to-day parenting
No (*n*=171)	43%
Yes (*n*=67)	40%
	Physical emotional developmental needs
No (*n*=104)	38%
Yes (*n*=42)	41%
	Child education

No (*n*=86)	21%
Yes (*n*=35)	17%
	Child substance abuse
No (*n*=81)	4%
Yes (*n*=25)	8%

* p< .05; ** p<.01; ***p<.001

Table 3 contains only those cases where mothers were correctly administered the UNCOPE. The table examines the relationship between the finding of a positive UNCOPE areas of concern or a problem in the judgment of the caseworker. In other words, the findings displayed in this table answer the question, "Is the presence of a positive UNCOPE (marked as a yes) related to having a functional problem in the family in the other areas of assessment?" Four areas were statistically significantly related to a positive UNCOPE screen for the mother. Not surprisingly, a substantial portion of those who had a positive UNCOPE (63%) also had parental substance abuse identified as an area of concern in the FFA. Three other areas—kinship/family community, housing/food/basic needs, and medical/dental care were also significantly related to having a positive UNCOPE. In each of these areas, if there was a positive UNCOPE, the worker thought there was a problem or concern. From looking at the table, the reader can see that those who identified kinship/family community, housing/food/basic needs, or medical/dental care as an area of concern or problem are 12% to 13% more likely to have a positive UNCOPE than those who did not.

The relationship between a positive UNCOPE and substance abuse as an area of concern is an interesting aspect of this preliminary study. Given that the UNCOPE should inform the worker's rating as to whether substance abuse is an area of concern, one might expect an even higher association between the worker's rating and the UNCOPE score. Another way of looking at this finding is that in 37% of the cases where the mother had a positive UNCOPE, the worker did not indicate that substance abuse was a concern or problem. Further analysis of this relationship

indicates that the mothers needed to score a 5 or 6 on the UNCOPE before workers always indicated that substance abuse was a concern or problem.

Table 4. Areas of Concern for Those with Substance Abuse Problems (Row Percent)

Substance Abuse Identified in AOCS or Positive Maternal UNCOPE or Both	% Indicating Area of Concern or Problem
	Kinship/family/community support
No (*n*=227)	30%
Yes (*n*=351)	36%
	Housing/food/basic needs***
No (*n*=231)	36%
Yes (*n*=342)	52%
	Medical/dental care**
No (*n*=223)	27%
Yes (*n*=340)	38%
	Parents' mental health**
No (*n*=223)	47%
Yes (*n*=338)	58%
	Parents' substance abuse***
No (*n*=227)	22%
Yes (*n*=340)	77%
	Domestic violence
No (*n*=224)	40%
Yes (*n*=324)	48%
	Day-to-day parenting
No (*n*=220)	44%
Yes (*n*=325)	47%
	Physical emotional developmental needs
No (*n*=126)	33%
Yes (*n*=176)	30%
	Child education
No (*n*=104)	19%
Yes (*n*=135)	23%
	Child substance abuse
No (*n*=96)	3%
Yes (*n*=111)	5%

* p< .05; ** p<.01; ***p<.001

A final analysis was conducted to explore the relationship between having substance abuse identified (at any time—either through the assessment of child safety as a removal reason OR a positive UNCOPE or both), and specific concerns in FFA domains. As shown in Table 4, issues of substance abuse either as a removal reason or as indicated by a positive UNCOPE are consistently associated with the rating of a functional area as a concern or problem with one exception—the child's physical, emotional, or developmental needs. Not surprisingly, the

domain of parents' substance use as an area of concern has a statistically significant association with having a substance abuse problem (77% vs. 22%, $\chi^2(1, n = 567) = 165.35$, p<.001). In addition, families with substance abuse problems were significantly more likely to have housing or food basic needs (52% vs. 36%), medical or dental care problems (38% vs. 27%) and parent mental health problems (58% vs. 47%). The findings confirm what has long been documented through the literature: cases that have a substance abuse problem need more supportive services, both for their basic needs and their physical and mental health (Testa and Smith, 2009).

The reader can also see that , overall, the cases represented in Table 4 have a much higher proportion of the cases designated as having a problem or concern than the cases presented in Table 3. Mental Health as an area of concern also became significantly related to the likelihood of a positive UNCOPE finding with this larger sample of cases. This larger sample of cases included those for whom substance abuse was a *reason for child removal* and, perhaps by the time substance abuse rises to the level of severity that it actually becomes a reason for removal, there are greater levels of problems in these other areas for the family.

Discussion

In reviewing the implementation of the UNCOPE in Oklahoma, this evaluation focuses both on characteristics of the implementation process as well as the results from the administration of the UNCOPE universal screen. Implementation of any new activity into child welfare practice is a process, and this is no different. While we found no significantly different completion rates of correctly administered UNCOPE screening among the 6 service areas, none of the areas were administering it correctly over 78% of the time, and most rates ranged around two-thirds correct administration. Further, incorrect administration of a screen can happen in two ways—those who should be administered it can be excluded, and those who need NOT be administered it can be

incorrectly included. Both of these problems are represented in our findings and reflect misunderstanding on the part of the child welfare workforce regarding when the screen is to be utilized. In general, child welfare leadership in the 6 service areas needs to make clear the function of UNCOPE as a screening tool and the requirement of clients' qualification for administration.

Another important finding, revealed from our evaluation to date, is that the workers did not necessarily designate substance abuse to be an area of concern in the FFA, even when there was a positive UNCOPE. Further exploration of this finding is warranted. Perhaps substance abuse has been a concern to this family or this child welfare investigation but is no longer a present condition in the child's life. This is to say that maybe the lack of time frame around parts of the UNCOPE could make the screen positive, when in fact there is no concern overall from the child welfare perspective. Two of the questions contained in the UNCOPE ask the respondent to identify if use has EVER been a concern. Perhaps, it was once a concern but is not currently. It could also be that the worker does not have enough information at the time of designation to consider it "a concern or problem," and would not consider it a concern or a problem unless a full assessment indicated a problem. Interestingly though, further analysis revealed that when there were 5 or 6 of the UNCOPE items marked, the area of concern was always marked "yes." It could be that it simply takes this higher score to get the child welfare worker's level of concern raised.

Our results indicate that there are gender differences among parents in screening results. Mothers are 9% more likely to receive positive UNCOPE screenings than fathers. However, we are not fully aware of how child welfare workers are instructed to administer the screen in the absence of either parent. Therefore, practices such as excluding one parent's screen, completing on behalf of a missing parent, or those factors related to either parent as primary caretaker describing the

other parent's substance use and practices may be inconsistently represented in the dataset and warrant further exploration and clarification. Further, since mothers are often the primary caretaker of children, and many fathers' screens are missing in our dataset, the UNCOPE results for fathers are less reliable than those for mothers.

While we have gained new insights from this analysis of the implementation of the UNCOPE, our data are too limited and not enough time has elapsed for us to draw conclusions regarding the impact of the use of the UNCOPE on service referral and utilization or permanency outcomes. It is our understanding the new FFA will be integrated into the OKKIDS data system within the year and, at that point, we will have much more to work with insofar as meaningful understanding of the process and outcome of this new child welfare practice in Oklahoma.