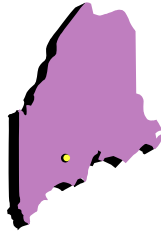


**State of Maine  
Child Welfare/Substance Abuse Committee**

*A collaboration between the  
Department of Health and Human Services,  
Offices of Child and Family Services and Substance Abuse,  
and the Maine State District Court*



**Universal Substance Abuse Screening for Families  
in the Child Welfare System:**

*Policy and Practice for Family Assessments and Alternative Response*

*July 2007*

**Introduction**

Maine has a system for universal screening for substance abuse of families who have been referred to the child welfare system. Considered the first state to implement such universal screening, a group of dedicated policy makers, administrators, and professionals developed and implemented a system of screening policies and procedures that use the UNCOPE screening tool for identifying substance abuse issues in its child welfare family assessments. In addition, contract agencies providing alternative response services to low-to-moderate at-risk families also utilize the UNCOPE. For the first time, a uniform screening tool is part of the safety assessment completed for every case that is investigated or referred for alternative response.

But Maine's road to developing this system was filled with twists and turns that required careful navigation and constant collaboration. The purpose of this paper is two-fold:

1. To provide a description of the process, policy, and practice requirements for implementing universal screening for substance abuse in all families referred to the child welfare system; and
2. To offer some “*lessons learned*” that may assist other jurisdictions in their own planning effort to improve outcomes for children and families.

**Background and History**

In January 2001, a five-year old girl came into custody of the Department of Health and Human Services (DHHS) because of substantiated child welfare allegations involving substance abuse by a parent. Tragically, she died while living in a DHHS foster home. At the same time, a study commissioned by the state's Office of Substance Abuse (OSA) showed early detection and

intervention resulted in better substance abuse treatment outcomes. This prompted OSA to engage the Muskie School's Institute of Child and Family Policy to undertake the Substance Abuse and Protocols Project. In March 2001, the project issued a preliminary report<sup>1</sup> that concluded *“one of the key factors in effective and efficient substance abuse services is found in appropriate and reliable screening and evaluation...and the project could not find a common standard or process of substance abuse screening and evaluation.”* The report recommended that *“As part of developing practice protocols, the two departments should develop a system that provides reliable, clear and uniform methods for screening and evaluating substance abuse.”*

The report was presented to the Legislature's Joint Standing Committee on Health and Human Services who endorsed the recommendations, particularly the ones emphasizing the relationship between child welfare situations and substance abuse. The Committee encouraged OSA to work with DHHS on developing a uniform screening and evaluation system. In November 2001, the Child Welfare and Substance Abuse Committee, comprised of child welfare and substance abuse policy makers and professionals, was established by both the Bureau of Child and Family Services and OSA for the purpose of developing this system.

### **Leadership from the Beginning**

In November 2001, the Office of Substance Abuse (OSA) and the Department of the Human Services (DHS) established the Child Welfare and Substance Abuse Committee. The creation of this committee represented a commitment from the top administrators responsible for substance abuse and child welfare to develop a uniform system of screening and assessment. In addition to their support, this initiative was endorsed by the Legislature's Health and Human Services Committee. The commitment of elected officials and top administrators, combined with the participation of leading professionals in substance abuse and child welfare, simultaneously gave the committee credibility and access to decision-makers. Since this Committee was established, DHS and OSA have been merged into one agency called the Department of Health and Human Services (DHHS). Since 2006, Committee membership has expanded to include the Courts, providers, training institutes, and tribal representatives.

### **Developing Screening Policies and Procedures**

Through the course of examining various screening tools and models for systems collaboration, the Committee undertook various initiatives either directly or indirectly. Prior to implementing these screening procedures, a Family Treatment Drug Court initiative was begun in one site, and funding for an additional two sites was also obtained. The State also piloted an out-stationed substance abuse worker in the Ellsworth/Machias District Office of DHHS, located in a district where opiate abuse had increased dramatically during recent years. These sites helped inform the committee during the screening development process.

Making a timely and informed decision when adopting a screening tool can save a significant amount of effort and time. Maine discovered:

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<sup>1</sup> Child Welfare, Domestic Violence, and Substance Abuse: A Report on Protocols and Practices, Preliminary Report. March 2001. (Brennan, M. and St. Onge, A., et. al.) Edmund Muskie School of Public Service. Portland, Maine.

- There is not a perfect tool and that endless analysis can lead to needless work.
- Early on, the Committee established criteria that reflected the necessary components of a screening tool. DHHS staff supported a uniform screening process, but insisted the tool be brief, reliable, and require minimal training.
- The Committee decided to adopt the UNCOPE, a six question tool developed by Norman Hoffman, PHD of Evince Clinical Assessments. The instrument, while not having been used extensively in child welfare situations, met the committee's objective of using a tool that was short and easy to administer yet valid and reliable.
- Once a screening tool was agreed upon, the Committee developed a plan to "field test" it in three counties. The counties were selected based the receptivity of the DHHS staff and geographical considerations related to training and management.

Pilot testing the UNCOPE screening tool occurred at three child welfare offices (Washington, Kennebec, and Somerset Counties). The demonstration project using the UNCOPE as a screening tool revealed:

- Training staff members is crucial to the successful implementation of a screening and assessment system. Along with training, instilling a sense of “buy-in” to the system is essential. If staff members are not invested in the tool or do not see it as having a purpose, it can quickly become a meaningless exercise.
- On-going training and orientation of new staff needs to be built into the system with an emphasis not only on the technical aspects of the tool but also on the dynamics of substance abuse, particularly related to denial or the pre-contemplation stage of change. Initially, UNCOPE scores were low. This was considered to be due, in part, to the reluctance of clients to reveal any problems with alcohol or drugs. Moreover, staff members may also over-estimate their understanding of substance abuse issues.
- The screening tool should not be the only indicator of a substance abuse problem. Screening was modified to include the use of “collateral” information such as criminal justice reports or previous DHHS reports.

Five months of data revealed that all sites were not buying into the project at the same level. Despite uneven reporting among the pilot sites, UNCOPE screening was seen as an essential first step in engaging families with substance abuse problems in the family assessment process. In April 2005, DHHS made the decision to incorporate screening for substance abuse as a universal element of their Family Assessment, and the UNCOPE screening tool was identified as the instrument for conducting such screening.

### **Implementing Universal Screening in Child Welfare Family Safety Assessments**

As a means for creating more buy-in for this decision, the Committee commissioned development of a cross-training curriculum for child welfare and substance abuse staff. This curriculum includes training in UNCOPE, substance abuse assessment; and practice standards; child safety risk assessment; motivational interviewing; substance abuse service planning for child welfare clients; parenting skills assessment; and guidelines for report writing. In addition to these training and implementation initiatives, Committee members played a role in a statewide

child welfare conference titled *“I’m Using...So What?!” – Exploring the Relationship Between Substance Abuse and Child Maltreatment*.

The decision by DHHS to implement universal screening for substance abuse in its child welfare family assessments dramatically shaped the future of these efforts. Statewide implementation of the UNCOPE screening instrument in child welfare family assessments consisted of the following elements:

- A. Training child welfare staff through the following means:
  - 1. Substance abuse experts were identified in each of the regions that will team with child welfare trainers.
  - 2. A professional trainer and member of the CW/SA Committee conducted a Train-the-Trainers session for the Child Welfare/Substance Abuse (CW/SA) training team from each region.
  - 3. CW/SA training teams conducted UNCOPE training in all 13 offices within the 8 regions served by DHHS.
  - 4. For new hires, UNCOPE was incorporated into the Child Welfare Training Institute pre-service training.
- B. OCFS issued a policy statement regarding UNCOPE implementation and procedures.
- C. As creating a data field in MACWIS (IS) was not feasible, UNCOPE is documented in the assessment narrative. Per policy, assessments are not to be signed off without a completed UNCOPE.
- D. Compliance is monitored through Quality Assurance. This involves random reviews of 8 cases per month in each of the child welfare district regions (64 total in all 8 regional districts).
- E. Statewide implementation began June 30, 2006.

Full implementation of the new policies and procedures for incorporating UNCOPE screening into child welfare substance abuse assessments did occur as scheduled. Screening consistency has not been determined, but six months after the policies were enacted, but after three quarters, preliminary quality assurance data indicated that approximately 50% of families assessed were screened positively for substance abuse using the UNCOPE screening tool.

### **A Gap in Screening Opportunities: Alternative Response Referrals**

The State of Maine was invited to attend the Cross Site Meeting sponsored by the National Center on Substance Abuse and Child Welfare held in Sacramento, CA in March 2006. A subsequent request for technical assistance included mapping the first 30 days of a child welfare referral to identify specific linkage points between the child welfare, substance abuse, and court systems. In mapping the flow of families referred to the child welfare system, two significant gaps were revealed:

1. First, of the total number of families deemed appropriate for some level of response, ***almost a third (32.9%)***<sup>2</sup> were referred directly to Community Intervention Program (CIP) providers, community-based agencies contracted to respond to families at low to moderate risk of child abuse and neglect.
2. Secondly, ***almost two-thirds (64%)***<sup>3</sup> of families with substantiated findings had had prior referrals to CIPs, and often multiple referrals. These data gaps are shown in the figures below.

The Community Intervention Program providers were not included in the original implementation plan for universal substance abuse screening in child welfare family assessments. The implications for this became obvious. A significant number of families were not being screened. In addition, CIP agencies had an opportunity to work with families over a longer period of time, with an opportunity for greater engagement and motivational enhancements for treatment.

Working with leadership and through the network of CIP providers, the Committee developed a plan to address this missed opportunity. Policy and practice changes were developed and actions required for closing this gap included:

1. Amending DHHS policy to ensure consistency in family assessment guidelines for families referred to CIP providers.
2. Amending CIP contracts to reflect these changes and expectations to become effective July 1, 2007.
3. Develop and implement training for CIP Supervisors that included motivational interviewing, conducting substance abuse screening using the UNCOPE tool, an overview of substance abuse treatment levels of care, and an orientation of local treatment resources.

Full implementation of the revised screening policies and procedures was targeted for July 1, 2007. By that date, with new contracts in place for FY 07-08, an estimated 75 CIP supervisors and staff would be trained through the delivery of four regional training conducted throughout the state. All training targets were accomplished, and the plan was fully operational on schedule. Maine now has a comprehensive system for universal substance abuse screening of every family that is touched by the child welfare system, either through direct assessment or through an alternative response referral.

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<sup>2</sup> “The Flow of Referrals Into the Child Welfare System” Data analysis conducted by the Maine State Committee on Substance Abuse and Child Welfare. Augusta, ME. September 2006.

<sup>3</sup> Data analysis conducted by the Muskie School of Public Policy, Cutler Institute of Child and Family Policy. The Muskie analysis indicated families with substantiated findings with prior DHHS referrals. In 2002, 65.7% had prior referrals; in 2003, 62.86% had prior referrals. Two year aggregate rate of prior referrals is rounded to 64%. Muskie School of Public Policy, Cutler Institute on Child and Family Policy. Portland, ME. 2004.

## **Lessons Learned**

Effective July 1, 2007, Maine has developed and implemented a system for universal screening for substance abuse among its child welfare referrals. By design, every family touched by the child welfare system will be screened for substance abuse, utilizing the same screening instrument and procedural guidelines.

During the Committee's work there were a number of lessons learned about how to develop a uniform screening system. Obviously, circumstances in Maine would not be the same for other states that are addressing substance abuse and child welfare issues, though many of these steps are essential regardless of the jurisdiction. However, there are also an equal number of pitfalls that can be avoided, and these are offered that other may benefit from Maine's experience:

### Leadership from the Beginning

A sustained commitment from the top administrators is responsible and required to develop a uniform system of screening and assessment. Committee meetings are typically attended by the top administrators in the systems. In addition to their support, this initiative was endorsed by the Legislature's Health and Human Services Committee. The commitment of elected officials and top administrators, combined with the participation of leading professionals in substance abuse and child welfare, simultaneously gave the committee creditability and access to decision-makers.

### Selecting a Screening Instrument

Maine discovered there is no perfect tool. Trying to accomplish too much can result in needless work. Staff from DHHS, while supporting a uniform screening tool, insisted the tool be brief and require minimal training. The UNCOPE instrument, while not having been used extensively in child welfare situations, met the Committee's desire for a tool that was valid, reliable, short and easy to administer.

### Field Testing the UNCOPE Instrument

The Committee developed a plan to "field test" the UNCOPE screening tool in three counties. The counties were selected based the receptivity of the DHHS staff and geographical considerations related to training and management. The demonstration project revealed:

- Training staff is crucial to the successful implementation of a screening and assessment system.
- On-going training and orientation of new staff should be built into the system with an emphasis not only on the technical aspects of the tool, but also on the dynamics of substance abuse particularly related to denial.
- Instilling a sense of "buy-in" to the system is essential. If staff is not invested in the tool or do not see it as having a purpose, it can quickly become a meaningless exercise.
- The screening tool should not be the only indicator of a substance abuse problem. In addition to the UNCOPE, include the use of "collateral" information such as criminal justice reports or previous DHHS reports.

### Supervision Makes a Difference

The single most significant lesson learned from the demonstration project was the importance of administrative supervision. In one county, where the supervisor was part of the Committee and very committed to the screening system, the UNCOPE was consistently used by the staff, leading to an increase in referrals for substance abuse treatment. In the two other counties, supervision was inconsistent, resulting in mixed response to the UNCOPE. Consequently, when the system was put into effect, it was incorporated into an overall policy on safety assessment, elevating it to a level that requires consistent supervisory attention. The field tests led to making the UNCOPE mandatory training for new staff members, and is included in DHHS's on-going quality assurance program.

### **Next steps**

Maine's Child Welfare/Substance Abuse Committee has narrowed its focus by developing a "shared outcomes" statement that is targeted at improving the length of time it takes to achieve permanency for Maine's at-risk children. Specific data collection efforts will be conducted to determine those families who are experiencing substance abuse issues as a barrier to permanency for their children. With the screening system in place, Maine will focus upon developing a uniform referral and substance abuse assessment system for child welfare clients. A survey of substance abuse providers showed that at least 15 different assessment tools or procedures were used across the state. Many of the assessments were not child welfare specific and most providers did not have training in child welfare and substance abuse related cases. In addition to the referral, assessment, and communication protocols, Maine will be developing a network of substance abuse treatment providers who can better serve the needs of child welfare-involved families.

### **Conclusion**

Maine's effort in this collaboration is based on the premise that early identification, assessment and treatment of drug and alcohol problems in child abuse and neglect cases will lead to less family disruption, increase reunification, and decrease the length of time required for a child to achieve permanency. While it is too early to offer data to support this assumption, there is reason for optimism. Equally if not more important, though, has been the emergence of a more collaborative child welfare, substance abuse, and court system. Prior to these efforts, there were noticeable differences between child welfare and substance abuse professionals, with each believing the other did not fully appreciate their roles and responsibilities. This project has helped bridge those philosophical differences and increase program coordination.

*This document has been prepared in part with technical assistance provided by the National Center on Substance Abuse and Child Welfare.*

## The UNCOPE Screening Instrument for Substance Abuse

The UNCOPE consists of six questions found in existing instruments and assorted research reports. Variations in wording are noted for several of the items. The more concrete wording of the revised versions were found to be slightly better as a generic screen. Either version of the six questions may be used free of charge for oral administration in any medical, psychosocial, or clinical interview. They provide a simple and quick means of identifying risk for abuse and dependence for alcohol and other drugs.

**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 CAUTION REGARDING ALL SCREENS

Screens merely provide an indication of whether or not an individual appears at risk for a given condition. Screens are inappropriate for use as treatment intake tools and insufficient for supporting diagnoses.

For further information on the UNCOPE, contact:

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