Child Welfare News #26—Summer 2005

Table of Contents

Leave No Adolescent Behind: Issues in the Transition to Adulthood

Adolescents aging out of the child welfare system often face considerable challenges as they navigate early adulthood without the supports provided to most young people by their families. On June 3, CASCW, along with the Children, Youth and Families Consortium (CYFC) and the Institute on Community Integration (ICI) hosted an all-day conference dealing with adolescents and their transition to adulthood. The objective for the conference was to present perspectives of researchers, practitioners, and policymakers and discuss strategies for how these diverse professionals can work together more cohesively to impact the lives of adolescents in and around the child welfare and juvenile justice systems.

Diane Benjamin of Kids Count provided a context for the day's discussion. Young adults between the ages 18-34 who have never been removed from their homes receive on average $38,000 from their parents during this time for things such as food, housing, education and cash. These data demonstrate the need for supportive services and advocacy well beyond the traditionally labeled "adolescent years," especially in the context of foster care youth. In 2001, there were 3,130 young adults ages 15-19 in the Minnesota foster care system on the brink of "aging out." While Minnesota does provide some supports, the high rate of former child welfare system participants in the homeless population suggests that more supports are needed by many young people.

Research

Mark Courtney, Director of Chapin Hall Center for Children at the University of Chicago, presented a research perspective and outlined the report on adolescents who had aged out of foster care, The Midwest Evaluation of the Adult Functioning of Former Foster Youth. This research concluded that foster youth at age 18 had not been adequately prepared for independence, and that they often faced major challenges such as educational deficits, limited employment experience, and significant psychosocial problems. His research examined the well-being of youth in states that allowed foster care youth to elect to stay in foster care to age 21. Youth who maintained their foster

family connection were much more likely to access health care, have medical conditions receive needed attention, and, generally, be better off.

Courtney stressed to policymakers and practitioners that youth in the system, like most non-system youth, want to remain connected to parents and siblings and that many return to their families for support after aging out. The practice and policy implications for the research findings suggest that service providers and courts must take into account the reality that many foster youth are not prepared to make the transition to independence at 18, that most young people appear to benefit from their connections with the child welfare system, and that connections with family are important to the transition process for this population.

Policy

Robin Nixon of the National Foster Care Coalition presented a policy perspective and gave recommendations on how to best advocate for adolescents. Nixon highlighted the importance of Mark Courtney's and Chapin Hall's research and its impact on policy making. She urged practitioners and policy advocates to use both research based data as well as personal stories of challenges faced by adolescents when working with policymakers. Nixon used the example of the Chafee Act to make this point and stated that its passage would not have been realized if it weren't for the youth who came and shared their stories with members of Congress.

Practice

Mark Kroner, of Lighthouse Youth Services, presented a practice perspective and explained the innovative work he and his organization have been doing for more than twenty years in Ohio. The Lighthouse Transition System is a personalized and needs-based housing system that provides services through their Youth Crisis Center, Street Outreach Program, Independent Living Program, Transitional Youth Program, the Emancipated Youth Program, and Shelter Plus Care Program. Kroner described their Continuum of Living Arrangement Options and demonstrated the possibility of successful outcomes that come from a flexible and comprehensive system able to provide services that match the needs of youth coming from diverse situations. Youth are able to move from less restrictive to more restrictive residential settings depending on how well they are functioning. Program staff have other options than removing youth from the program when problems develop.

Adolescents and Brain Development

New brain research on adolescents was presented by the keynote speaker, Dr. David Walsh from the National Institute on Media and the Family, and author of, Why Do They Act That Way: A Survival Guide to the Adolescent Brain for You and Your Teen. Dr. Walsh described the latest understanding of brain functioning in adolescents, which has revealed that adolescent brains do not fully develop until about age 25, presenting major implications for both practitioners and parents. This research supports the need for continued assistance to young adults aging out of foster care who cannot rely on family members to help them mature. Dr. Walsh also explained how negative implicit

and explicit memories in a young child, such as neglect or abuse, can be harmful and damaging to a child's brain development.

Local Experts
In the afternoon session, several local experts from the community presented overviews of the services and programs within their organizations and identified key issues on which policy, practice or research should focus in the next year. Speakers included Richard Wayman of Streetworks, Laura Kadwell of Minnesota Housing Finance Agency, Teresa Toguchi Swartz of the University of Minnesota, Richard Farland of Ain Dah Yung Center, Weida Allen of the Children's Law Center, and Carole Coffey-Hannah and Joan Riebel of Family Alternatives. There were also opportunities to dialogue with the national experts during the panel discussion. Steve Vondherharr from the Department of Human Services described the initiatives the state is pursuing in this area, and Gary Decramer, a former state legislator summarized the day with his comments about the importance of policymakers, practitioners and researchers collaborating in efforts to address the issues raised in the conference.

The audience for the day's conference was made up of social workers, probation officers, administrators, researchers, legislators, and others. The Center for Advanced Studies in Child Welfare plans to continue to learn and promote effective strategies for collaboration among researchers, practitioners and policymakers through forums and dialogues in 2005-06.

Child Well Being in Substance-Abusing Families: A Model of Harm Reduction

Esther Wattenberg, the Center's Special Projects Coordinator, organized county and Department of Human Services supervisors' two forums on the issue of providing safety and well-being for children in substance-abusing families through a harm reduction model. Because of the level of interest in harm reduction, January's Twin Cities forum was provided regionally in April to county supervisors in northern (Walker) Minnesota. Gayle Thomas, M.S.W., M.H.P., was the guest speaker at both forums and has expertise in harm reduction management and supervision, chemical health, and dually diagnosed populations. She is a Certified Harm Reduction Trainer and is currently the lead case manager at Cabrini House, working with residents who are dually diagnosed with mental illness and chemical dependency. Professor Ronald Rooney teaches graduate courses in social work methods, child welfare, and involuntary clients at the University of Minnesota's School of Social Work. He presented additional information on stages of change and motivational interviewing at the April forum.

Framing the discussion for these meetings was the key question of, "Is achieving sobriety and abstinence the only condition that can assure the safety and well-being of children of substance-abusing parents?" Within this context, the fact that drug and alcohol use, both illicit and regulated, is widespread was not contested. It is part of our culture, part of our world. And, while the twelve-step program has been a widely accepted approach to chemical dependency treatment, caseworkers must be cognizant of alternative models. The rate of relapse or failure for abstinence-only programs requires us to examine other options. The CASCW forums provided the opportunity to

raise critical questions on implementing a harm reduction perspective. The extent to which the interests of child protection, the chemical health system, the courts, and federal and state guidelines can be reconciled is the challenge.

Two concepts integral to harm reduction are familiar to social work practice - stages of change and motivational interviewing. One aspect of motivational interviewing that requires discussion is that child protection has to balance what the parent determines as the plan for a reduction in substance abuse with the safety and well-being of the vulnerable child. Yet, the parent's response may not always be acceptable to the case manager (i.e., improvement in parental skills may be uncertain or inadequate). Appropriate judgment in such cases can only be derived from skilled social work experience.

Stages of change, as discussed in these forums, is especially relevant for involuntary clients who often can be substance-abusing parents who are required to participate in a treatment plan. Forum participants recognized that most parents are still in the pre-contemplation stage and, therefore, may be ambivalent or resistant. This stage signals that parents are not yet ready for treatment. Recognition of a pre-contemplation stage prepares practitioners to distinguish the intensity of parental resistance. Recovery is an extremely hard process. Therefore, reflective listening and empathy on the part of the social worker is crucial.

The proportion of child welfare caseloads with connections to substance abuse issues is generating nationwide philosophical debate with regard to current policies, practices and timelines. Incomplete treatment plans resulting from failed abstinence, which complicate family reunification efforts, have led to a consideration of harm reduction models. However, human services specialists are divided on the approach toward harm reduction. Forum participants agreed that family and community involvement may be needed in order to formulate and implement appropriate harm reduction policies and practices.

Executive Summary: A Survey of Minnesota County Service Agencies Regarding Children's Mental Health Screening Procedures

In 2003, the Minnesota legislature passed legislation directing county boards to conduct mental health screenings for specific child welfare populations beginning July 1, 2004. The Center for Advanced Studies in Child Welfare (CASCW) coordinated a study to investigate the preliminary effects of this law.

Nation-wide studies have shown that children in the child welfare system are more than twice as likely as other children to have mental health issues (Burns et al., 2004; Garland, Hough, Landsverk & Brown, 2001). The intent of the mental health screening legislation in Minnesota is to ensure that children with mental health concerns in the child welfare system are identified early and receive services to address their mental health needs.

The child welfare target population includes children 3 months to 18 years of age who are receiving child protective or alternative response case management services, children for whom parental rights have been terminated or those who receive adoption case management, children who are in out-of-home placements for 30 days or more and are not involved in a children's mental health work group, i.e., receiving mental health services (DHS Bulletin, 2004).

Children who meet these requirements must be screened using one of two approved mental health screening instruments unless they satisfy one of the exemption categories or the parent declines the screening. The instrument is then scored by a social service professional. If a child has a score that is higher than a pre-determined cut-off score, this indicates a "positive screen." Children with positive screens should be referred for a diagnostic assessment.

CASCW, in consultation with DHS Children's Mental Health Division staff, created an online, ten question survey to determine counties' progress in conducting mental health screening. Sixty-eight percent of county social service departments responded to the survey. The counties that responded to the survey were representative of the state geographically and by county size.

Approximately 90% of counties that responded stated that they were conducting children's mental health screenings; however 44% of respondents stated that under half of their eligible caseloads had been screened while 56% stated that over half of their caseloads had been screened. Although the survey instructions directed respondents to base their answers on the caseload of children required to be screened (not those exempt from screening), DHS staff note that data on the rate of screening exemptions were not captured in the survey and may be contributing to the low rate, if respondents did not exclude exempt children in their estimate. Another factor that may have influenced the number of children being screened is worker training. Over 70% of respondents indicated that additional training in the following areas would be helpful: parent consent and family involvement, cultural competence, diagnostic assessments, children's mental health treatment and children's mental health disorders.

Almost half of respondents indicated that 0-9% of children who had been screened had a positive screen. This figure is substantially lower than anticipated, based on national estimates that as many as 49% of children in the child welfare system may have mental health service needs (Burns, et al., 2004). An understanding of incidence and prevalence of mental health needs among Minnesota children will require larger data sets for analysis, which will be available through SSIS reporting later in 2005.

In this survey, fifty-five percent of respondents stated that under half of the children in their caseloads who had positive screens actually received services. We do not know all of the factors that are contributing to this finding. One likely factor is likely insurance coverage. In the survey, of those children receiving services, 26% had private insurance, 61% were enrolled in Medical Assistance or MinnesotaCare and 19% had no insurance.

Because these findings are based on workers' perceptions of the screenings, they may not reflect actual results once SSIS data become available. The findings do suggest areas where additional review may be helpful to full implementation of the screening requirement. Additional data will also be needed to determine whether children with positive screens receive the diagnostic assessments and subsequent services they need.

Recommendations to increase screening and referrals include providing additional training as described above, and continued monitoring of implementation issues.

Additional information on the screening requirement and related issues can be found in the Practice Notes #17. The complete results from the survey of Minnesota county service agencies will be posted to CASCW's Publications - Papers & Reports website.

References

Bulletin (2004). DHS implements child welfare and juvenile justice mental health screening (Minnesota DHS Publication No. 04-68-05). St. Paul, MN.

Burns, B.J., Phillips, S., Wagner, H., Barth, R., Kolko, D., Campbell, Y. & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. Child and Adolescent Psychiatry, 4 (8), 960-970.

Garland, A. F., Hough, R.L., Landsverk, J.A. & Brown, S.A. (2001). Multi-sector complexity of systems of care for youth with mental health needs. Children's Servcies: Social Policy, Research and Practice, 4(3), 123- 140.

Recognizing Childhood Anxiety and Depression: CASCW's Annual ITV Conference

Implementation of the Children's Mental Health (CMH) Screening Statute expands the range of expertise required of child welfare professionals. Although the age-specific mental health assessment tools bear the responsibility of determining appropriate screening questions and scoring methods, child welfare workers should be knowledgeable of child development and related emotional, cognitive and behavioral characteristics to ensure that children with mental health concerns are identified and receive services that address their mental health needs. For this reason, CASCW chose children's mental health as the subject of its sixth annual ITV child welfare conference.

Thirty-six Minnesota counties, as well as tribal social services and professionals from non-profit agencies and schools, participated in our April broadcast via interactive television (ITV). Audience members were able to phone or fax their questions during the broadcast. The conference was designed to supplement existing Department of Human Services' (DHS) training that had been created in response to the passage of the Children's Mental Health Screening Statute. Because DHS' training focuses on policies and procedures, CASCW provided the opportunity to learn more about child and adolescent mental health disorders and treatments.

L. Read Sulik, M.D. - Medical Director of Child and Adolescent Psychiatry at (Minnesota's) St Cloud Hospital - was our presenter. As a psychiatrist and pediatrician, Dr. Sulik has worked extensively with schools and social services to help them develop expertise in child and adolescent mental health issues. In our two-hour seminar, he

focused on recognition of depression and anxiety disorders. He also provided information on his clinical experience with medications and mental health treatment of children and adolescents.

According to Dr. Sulik, depression is more prevalent among adolescents (20%) than pre-school or school age children (1-2%). However, the condition was an important one to recognize in young children, as an untreated childhood onset generally continued into adolescence and adulthood. Teens may be reluctant to disclose personal information and do not have a clear understanding of depression and its symptoms. Therefore, Dr. Sulik advised case managers to pose questions that may reveal the common, interconnected symptoms of the condition - such as mood changes (e.g., sadness, irritability), cognitive changes (e.g., daydreaming, easily distracted) and behavioral changes (e.g. loss of appetite, sleep disruptions). If the symptoms seem to indicate depression, it is especially important to be direct in asking if the child or teen has experienced suicidal thoughts.

While medication is generally part of the treatment for children and adolescents with depression, there are important considerations to note. One issue is that clinical trials on antidepressants are performed on adults. So, the faster metabolic rate in children and teens can lead to problems with administering an appropriate dosage of the drug and a higher risk of such side effects as increased restlessness, anxiety, irritability and impulsiveness. The Federal Drug Administration (FDA) released a warning, after conducting 24 studies on children and teens taking some of the more commonly prescribed antidepressants (e.g. Celexa, Prozac, Luvox, Paxil and Zoloft), because they found that 4% of those taking the drugs experienced suicidal thoughts as compared to 2% who received a placebo. The FDA warning included a call for close monitoring - at weekly intervals throughout the first month of medication - for an assessment on patient safety, adverse drug reactions, behavioral changes, and compliance with prescribed dosage levels. A National Institute of Mental Health (NIMH) Treatment of Adolescent Depression Study has found that antidepressants alone, when properly administered, are more effective than cognitive behavioral therapy alone. In tandem with mental health treatment for depression, Dr. Sulik advised social workers to establish a relationship with the child's primary care provider and psychiatrist for triage assessment and consultation around appropriate client/parent discussions and child self-care training.

Anxiety, to varying degrees, is developmentally appropriate and common in young children. It ranges from the body's natural fight or flight response to a real or imagined threat, to separation and general anxiety disorders, to post-traumatic stress. Separation anxiety occurs in connection with social phobias, which a child may manifest through extreme distress at being left at daycare or school. General anxiety disorder includes separation or social anxiety, but also exhibits ongoing worry about events that are beyond the child's control. Post-traumatic stress occurs after the child or teen has experienced or witnessed an unusually traumatic event that threatened injury or death. Children with anxiety disorders may exhibit the fight or flight response by behaving in combative or aggressive ways. Depending upon the severity of the child's anxiety,

treatment can be found through various modalities - individually or in combination - such as psychotherapy, medication, and relaxation or other alternative therapies. Indications for medical treatment and referral include: the child's anxiety symptoms exceed the norms for that developmental stage, the child appears to be suffering, or the child's general functioning seems impaired.

Dr. Sulik commented that, "anxiety begets anxiety." Therefore, he advised professionals to monitor their own thoughts and emotions when working with anxious children. He also stressed the importance of asking questions and giving clear answers, as children tend to fill in their own information gaps, which may compound their anxiety level. And, because children lack "self-soothing" skills, it is important that case managers monitor their own words and behaviors and provide children with a safe, nurturing environment and relationships, so that the child can develop those skills in order to better tolerate stress in later life.

Overall, participant evaluations found Dr. Sulik's presentation interesting and useful and felt the knowledge they received would impact positively on their work. Others commented on the value of training that could simultaneously be broadcast to many sites throughout the state, presenting issues and knowledge not contained in the other child welfare trainings.

As always, CASCW is open to suggestions from counties and child welfare workers on topics for future ITV broadcasts. Comments can be emailed to the conference's coordinator, Nancy Johnston (njohnsto@umn.edu).

Chronic Neglect: Patterns, Effects, and Successful Case Management

Dee Wilson, Executive Director of the Northwest Institute for Children and Families at the School of Social Work, University of Washington (Seattle), presented three regional trainings for county child welfare professionals in Bemidji, St. Cloud and Mankato, Minnesota, entitled, "Improving Child Welfare Interventions in Chronic Neglect for Child Welfare Workers." The trainings were also broadcast via interactive television statewide. Mr. Wilson has worked in social services for approximately 30 years in both Colorado and Washington. He is considered an expert in the area of chronic neglect. A summary of his presentation and some of the discussion is below.

Defining Neglect

The behavior of a parent or caregiver is considered neglectful when he or she fails or refuses to provide basic, necessary care for a child's safety, health or well-being (e.g., medical or physical care, nurturance, protection, etc.). While some reports of neglect received by child protection services are situational and specific (i.e., limited to one form of neglect), according to Wilson, chronic neglect is frequently across all child care domains. It is the pervasiveness of neglect that causes a great impact on child development.

Patterns vs. Incidents in Child Protection Assessments

There is a danger in viewing only individual incidents of neglect. When a report is received, it can be very easy to overlook an ongoing pattern of neglect, especially when each neglect report may be screened by a different intake worker. It is imperative to look at the history of neglect reports and not just focus on whether an individual report would be "screened in" for assessment based on the specifics of the incident. Early pattern identification is vital for multiple reasons, including:

- to address the cumulative emotional and developmental effect on children, corresponding to the length of the chronic neglect history;
- to establish appropriate, long-term case management (i.e., plans and services).

Reponses to chronic neglect cases need to be very different from those used to address an individual neglect incident. Attempts to approach these two very different types of cases in the same manner will lead to failure to provide chronically neglecting families with the services, support, and time needed to make a lasting change.

Typology of Neglect

Wilson's Typology of Neglect breaks down categories of chronically neglecting caregivers and the multiple parental impairments that set the stage for the neglect. Wilson states that chronic neglect is almost always related to serious parental functioning impairments and extreme poverty.

Wilson highlighted seven significant categories of chronically neglecting families:

- substance abuse with anti-social features
- substance abuse with depressive features
- substance abuse as a form of self-destruction
- intergenerational transmission of chronic maltreatment which is congruent with the family's values
- mentally ill parent with periodic breakdowns
- developmentally delayed parent with profound cognitive impairment
- emotionally desperate parent (failure to protect)

It is important that social workers understand these categories and the effect that the issues will have on case planning for a chronically neglecting family. Working with chronically negligent parents can be a long term and frustrating process. Chronic neglect is an identifiable outcome of the multiple issues that parents/families face; social workers need to increase their understanding and training to help them address the multitude of issues in an effective manner.

Assessment Guidelines

Throughout Minnesota, as well as other areas of the country, guidelines or practices for assessment of reports or case management of chronically neglecting families lack consistency. County attorneys also differ in how they interpret statutes. Two areas that reflect these differences are in the initial screening process:

- whether a report is screened in or not – which is often dependent upon how aggressive a county's policy is regarding neglect reports;

- whether a case is screened in based on immediate specifics only, or if the history is taken into consideration.

Chronically negligent families are commonly transient and move between counties. Families will, therefore, continue to "fall between the cracks" - by accident or by choice - when there is inconsistency between counties' response to neglect reports.

Issues in Case Planning

Pattern recognition based on careful review of child protection case histories is extremely important and necessary when deciding on investigative strategies, and safety and service plans. Yet, the specifics of case planning, services offered, and the decision to close a neglect case also appear to vary widely by county in Minnesota. When comparing Minnesota's services (administered at the county level) against Washington's services (administered at the state level), Wilson described a shift in policy and practice that Washington implemented in regard to chronic neglect. The shift was heavily influenced by successful litigation against the state and review of extreme chronically neglecting families. One example of a policy change is:

- Washington implemented a guideline for chronic neglect reports of: three in one year, four in two years, and five in three years. If the number of reports for a particular family is above the guidelines, then the case cannot be closed by a social worker or his/her supervisor. The case closing must be approved following a group staffing. An issue they encountered (and were forced to deal with) was that due to a larger than expected number of cases with reports beyond the guidelines, many staffings then became "token."

It is important for social workers and supervisors to collaboratively develop and review case planning strategies as a way to be receptive to the special needs of the chronically neglecting family and to learn from the collective experience of agency staff.

Emotional/Developmental Effects on Children of Chronic Neglect

Wilson discussed a literature review of cumulative emotional and developmental harm to children associated with chronic neglect and the use of resiliency-based strategies to increase positive outcomes. He explained that seriously detrimental effects can result from chronic neglect, for example:

- cognitive delays
- attachment issues
- affective regulation, and
- social withdrawal.

He explained that further research is increasingly pointing to child maltreatment's negative effects on early brain development and connections between early maltreatment and juvenile delinquency.

Promising Programs

Wilson stated that programs for chronically negligent parents take at least one of the following approaches:

- enhanced social support (i.e., emotional support and coaching)
- enhancing parenting skills (i.e. coaching parents during parent-child interactions)
- improved substance abuse assessment, treatment and aftercare (i.e. comprehensive programming to deal with a wide range of family problems)
- employment and job skills training (i.e. job training specific to substance abusing or depressed parents)
- "teaming" (i.e. teams of a social worker, chemical dependency counselor, therapist, family advocate, etc.)
- decision-making models (e.g., family group decision making)
- services for children (e.g., early childhood education).

Washington was able to propose and implement a number of promising practices and programs with the potential for improving interventions in chronically neglecting families. Through the allocation of small amounts of funding, and a great deal of support for the idea of "trying something new," staff in Washington were able to develop models that eventually became long-term programs/practices. Two such programs are: Project Safe Care (that provides emotional support and coaching through a therapeutic relationship) and Project 12 Ways (hands on, behavior-oriented strategies for teaching parenting skills). The success of programs that were funded with small amounts of start-up capital and became self-sustaining entities supports the idea that, with support and commitment, making a change can be done even with limited resources.

Overall, it seems imperative that counties set policies and develop practices that help combat chronic neglect. The following should be taken into consideration when making changes to policy/practice:

- staff at all levels are active stakeholders in the process
- ensure early identification of a chronic neglect pattern
- set standards for engaging in appropriate long-term services
- counties (social service departments, social workers, and supervisors) set realistic expectations for chronically negligent families — changing the pattern is a long term process
- "baby steps" should be expected and supported
- and establish hope in negligent parents – a family's level of hope usually corresponds to that of their social worker.

In addition, social workers should increase their skills by consulting with others and seeking out resiliency/strength- based strategies to incorporate into case planning.

The future for chronically negligent families can be improved with early identification of a pattern, strong policies/practices that work in the best interest of these families, and a commitment to work with the family for the long term.

Dee Wilson also presented a July 1 CASCW county supervisors' forum on the subject of integrated treatment planning for the co-occurring conditions of mental illness and substance abuse. For a summary of that event, visit URL.

Alumni News

Molli White (MSW ' 02), who has worked as a child protection social worker in the Ho-Chunk Nation's Department of Health and Social Services since 2001 has been promoted to Director of Child and Family Services.

On April 13, Valandra (MSW '96) provided a musical presentation to 200 sex offenders at Lino Lakes state prison as part of Crime Victim's Rights Week (April 10 - 16, 2005). Through her music, Valandra spoke of breaking the silence around child sexual abuse, promoting healing and recovery, and adult accountability and responsibility for ending child abuse. On April 29, she provided a keynote address on the effects of domestic violence on children at the Take Back the Night rally in St. Cloud. Currently, Valandra is an adjunct assistant professor in the College of St. Benedict's/Saint John's University's Department of Social Work.

We would like to thank Kevin Merritt (MSW '98) and Charissa Bryant (MSW '96), both of whom are Senior Social Workers at Hennepin County's Human Services Public Health Department, for sharing information on their jobs as well as current issues in foster care for CASCW's (May) National Foster Care Month display.

Recruitment

This summer, we sent letters and flyers describing the Title IV-E MSW and PhD program to Directors of Undergraduate Studies in social work and human services-relevant departments at nearly 200 public and private colleges and universities in Minnesota, North Dakota and Wisconsin. Out-of-state schools were chosen based on their proximity to our distance education sites in Fargo and Rochester, Minnesota. CASCW administers a scholarship available to students who are committed to improving the quality of public (county or state) services to children and families. If you or someone you know wishes to apply to the University of Minnesota's School of Social Work MSW or PhD program and are interested in obtaining more information on the scholarship, the application process, the child welfare curriculum, or post-graduation employment requirements, please contact Karen Moon by email at kmoon@che.umn.edu or by phone at (612)625-8121 or visit our prospective student area of the website.