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Specialized Foster Care and Group Home Care: Similarities and Differences in the Characteristics of Children in Care

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Until recently, foster children who presented special medical or behavioral problems were largely served in group care environments. Specialized (or "treatment") foster care has recently been developed to serve some of these challenging children. Although growing evidence points to the special needs of children in foster care, much is still unknown about how children placed in various out-of-home care settings differ from one another. The growth of specialized foster care as an alternative placement to group care, calls for examination of how children in these settings compare on demographic, educational, health, and behavioral characteristics. A cross-sectional mailed survey was distributed to all group care and specialized foster care agencies in a large state to address topics related to children's characteristics. Comparisons point to two groups of very difficult children, with unique mental health and health needs.

Many states increasingly enlist family preservation services and kinship care providers to serve abused and neglected children (Wulczyn & Goerge, 1992), yet many children in the child welfare services system have needs that go beyond the abilities of kinship and foster family care providers. Until recently, foster children who presented special medical or

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behavioral problems were largely served in group care environments. Yet in recent years the growing phenomenon of specialized (or "treatment") foster care has developed as an alternative to conventional foster family care and group home care.

Little is known about how children placed in various out-of-home care settings differ from one another on demographic, educational, health, and behavioral characteristics. Given that specialized foster care is less expensive and less restrictive than group home care, children in group home care can be expected to be significantly more difficult to care for than children in specialized foster care. Yet no empirical test of this assumption is available.

Although specialized foster care is called many things by various professionals (e.g., treatment foster care, therapeutic foster care, professional foster care), for purposes here it will be broadly defined as *specialized* because it aims to address the individual needs of challenging children. As an alternative to group care, specialized foster care provides a home-like environment for the child. These homes can be certified to serve up to six children in California (the site of this study), however the majority of providers prefer to place three or fewer children in a home. Some of the features that distinguish specialized foster homes from foster family homes is the additional training and support provided to the family, the involvement of foster parents in case planning, involvement of the birth parents, and individualized service designs for children (Meadowcroft & Trout, 1990; Nutter, Hudson, & Galaway, 1990; Terpstra, 1990; Webb, 1988). Other features include respite care, small caseloads for program staff, and 24-hour on-call availability of social work support (Friedman, 1988; Hudson & Galaway, 1989).

Group home care is also variously described as residential treatment or congregate care. Children in this study served in group care are cared for under the auspices of the child welfare system, although some children are also served under the auspices of the juvenile justice system and the children's mental health care system. The group homes can range in size from six beds to facilities where hundreds of children are housed (groups of 12 or more must be divided into distinctive living arrangements, although these *cottages* may be located on a single *campus*). Children are supervised 24 hours a day, usually by staff who are not residents of the home.

Characteristics of Children In Out-Of-Home Care

Only in the past two decades have large-scale studies been conducted that begin to answer our questions about the characteristics of children in out-of-home care. The great majority of these children have always come from poor, minority homes (Mech, 1983; Shyne & Schroeder, 1978).

African-American children, in particular, have consistently been over-represented in the foster care population (Olsen, 1982; Pelton, 1989) and today's data show no decline in this trend (Barth, Berrick, Courtney & Albert, 1992; Walker, Zangrillo & Smith, in press). Other studies indicate that children in foster care have higher than average rates of emotional disorders and physical disabilities (Maza, 1983; Schor, 1982).

In addition to general information regarding the demographic characteristics of children in out-of-home care, little describes their behavioral characteristics. Anecdotal evidence suggests that the children coming into care are increasingly difficult to care for and challenge foster care providers' abilities to provide stable, loving homes (Rosewater, 1990; Small, Kennedy, & Bender, 1991). Few studies describe the level of behavioral disturbance among foster children. Hulsey and White (1989) studied the behavior of maltreated children placed in group homes and a similar group of children who remained with their families. The maltreated children in group homes showed more problematic behaviors than the children at home, however, the instability of the children's home environment provided better prediction of behavioral disturbances than any other factor.

In California, Fitzharris (1985) conducted a study of nearly 10,000 children served in residential care and examined factors regarding children's family histories, their behavioral problems, and their placement histories. Dependent children exhibited many problems such as impulsivity, aggression, truancy, sexual acting out, lying, and delayed social development. Compared to the general population, Wells and Whittington (1991) also found that children in residential treatment had more behavioral and academic problems, and displayed fewer social competencies than their peers.

Other studies have examined the behaviors of children in foster family care and have found a relationship between children's problematic behaviors and their age, gender, ethnicity, and prior placement history. Younger children have fewer behavioral problems, boys exhibit more problematic behaviors than girls, and African-American children show fewer signs of behavioral problems (Fein, Maluccio, & Kluger, 1990). Fanshel, Finch, and Grundy (1989) noted more severe behavioral problems among children who had seen numerous placements as opposed to their peers with more stable placements. Children in foster care also showed delays in educational attainment. Almost one third of Fanshel and associates' sample were behind their age-appropriate grade level and a significant minority of children and adolescents attend special education classes to meet their challenging educational needs (Whittaker, Fine, & Grasso, 1989).

To contribute to our developing understanding of these children, the present study was conducted to review the demographic, behavioral, health, and educational characteristics of children in group care and

specialized foster care in California--a state that claims more children in out-of-home care than any other state in the nation. In California nearly 18% of children in out-of-home care reside in group homes and approximately 6% of children are cared for in specialized foster homes.

Method

A list of all licensed group care agencies in California including the addresses, telephone numbers, and the name of the agency administrators was provided by the State Department of Social Services. A letter describing the study and an 18 page questionnaire was mailed to the administrator in each agency ($n = 630$). Questions in the survey centered on the types of services provided within the agency, staffing matters, and administrators' general comments about the future of group care. The survey was built upon previous studies in the out-of-home care field (i.e., Cohen, 1986; Fanshel, Finch, & Grundy; 1989; Fitzharris, 1985; Hulsey & White, 1989; Lawder, Poulin, & Andrews, 1986). The survey was also reviewed by four residential treatment providers who are prominent in the two state-wide group care associations. Their comments regarding the content and wording of questions provided additional face validity to the questionnaire.

The administrator was asked to share the survey with the head social worker in the agency for responses regarding the children served in the agency. Approximately five percent of the agencies surveyed were no longer in business, lowering our sample size to 598. In all, following a post card and a reminder telephone call 196 surveys (33%) were returned.

The group care facilities participating in this survey represented a range of service providers. Analyses of returned surveys indicated that the sample was representative of the range of group homes across the state. Following state guidelines regarding rate classification levels (i.e., allowable costs per child), the distribution of this sample mirrored the state population very closely. Analyses of those agencies responding to the survey and those who chose not to respond revealed no differences along the dimensions of agency size, or cost per child. Although the response rate was lower than hoped, these analyses suggest that the sample was representative of the overall state population of group care agencies.

A mailed survey was also distributed to each specialized foster care (SFC) agency in the state using a comprehensive list provided by the State Department of Social Services ($n = 103$ as of Spring, 1990). The SFC surveys were also reviewed by the President of the California Association of Foster Parents and five board members from the Association for readability, comprehension, and content. Based upon their comments, the final

surveys were developed and distributed. This survey mirrored the group care survey and included information regarding agency services, training, and SFC staff. Of the agencies surveyed, seven indicated that their primary service centered on adoption rather than foster care, reducing our population to 96 agencies. Of these, 48 surveys (a 50% return rate) were completed.

We also conducted a survey of SFC homes across the state. A random sample of 569 foster homes received a survey distributed through their parent SFC agency. Each agency director was mailed a number of surveys proportional to the number of foster homes they licensed (20% of all homes in the state). Because it was not feasible to contact specialized foster parents directly, agency directors were asked to distribute these surveys to a random sample of their foster homes. Using this method, we received 123 (22%) returned surveys. In only one case were surveys returned from foster homes when their parent agency did not also complete a survey. This suggests that the foster homes that did not respond to the survey never received a questionnaire from their agency administrators. If SFC agencies that did not return a survey did not distribute the foster home surveys to their families, then our sampling frame is much reduced, and our return rate on foster homes that received surveys increases to about 45%. The representativeness of the sample of SFC agencies and homes could not be determined as no information regarding agency size and cost from our listing of providers was available.

A standard instrument was used to assess children's level of behavioral disturbance. The Behavior Problems Index (*BPI*), developed by Zill and Peterson (1989) was completed by the group home social worker or specialized foster care parent. The *BPI* is designed to measure the frequency and range of several childhood behaviors. Many items were derived from the Achenbach Child Behavior Checklist (Achenbach & Edelbrock, 1981) and other child behavior scales (Graham & Rutter, 1968; Kellam, Branch, Agrawal, & Ensminger, 1975; Peterson & Zill, 1986; Rutter, Tizard, & Whitmore, 1970). The behavioral problems summary score is based on responses to a series of twenty-eight questions dealing with specific problem behaviors that a child may or may not have exhibited in the previous three months. Scores range from zero to 28; higher scores represent a greater level of behavior problems. Three response categories (*often true*, *sometimes true*, and *not true*) are used in the questionnaire, but responses to the individual items are dichotomized and summed to produce an index score for each child. Six behavioral subscales can also be used: antisocial, anxious/depressed, headstrong, hyperactive, immature/dependent, and peer conflict/social withdrawal.

The instrument was used in the National Longitudinal Survey of Youth (NLSY) and was developed for English-speaking and Spanish-speaking

mothers. In that survey, the instrument was normed on a sample of over 3,500 children, over-sampling somewhat for poor and minority children. Norms are available for comparison with boys and girls ages four through 15. NLSY data show internal consistency reliability of the instrument as fairly high with an overall alpha coefficient of .90; test-retest reliability on this scale is somewhat lower at .63. The alpha coefficient for the *BPI* in our sample was .89.

Results

Age and Ethnicity of Children

Figure 1 provides a breakdown of the percentage of children in various age ranges served in group care and in specialized foster care in this sample. Percentages are listed as a proportion of the total number of children in each sample. As the figure indicates, group homes largely serve older children and adolescents, while specialized foster homes provide services to younger children. In our sample of group care providers we found, however, that 296 children between the ages of one week to three years old were being served in group homes. This represents nearly seven percent of the 4,492 children described in the survey. Further, our sample included 125 children (3% of the sample) ages four and five. The shift toward the use of group care for infants and very young children is cause for serious concern. (These findings are consistent with statewide data indicating that the proportion of infants to five-year-olds in group homes in the state increased from 7 percent to 12 percent between 1987 and 1989).

Figures 2 and 3 show the ethnicity of children in our sample of group care and specialized foster care. As the figures demonstrate, proportionately more Caucasian children are in specialized foster care than group care. Mirroring the high overall numbers of African-American children in the foster care system (about 40%), African-American children are highly represented in group care and specialized foster care. African-American children represent almost 30 percent of the children in the group care sample, although their numbers in the general population are much lower (approximately nine percent of the child population in the state). A similar situation is evident among African-American children in specialized foster care with about a quarter of the sample including African-American children. Analyzing this sample in comparison to state-wide data regarding children in group care and specialized foster care shows distinct similarities; this sample of children was representative of the overall population of children in group care and specialized foster care across the state.

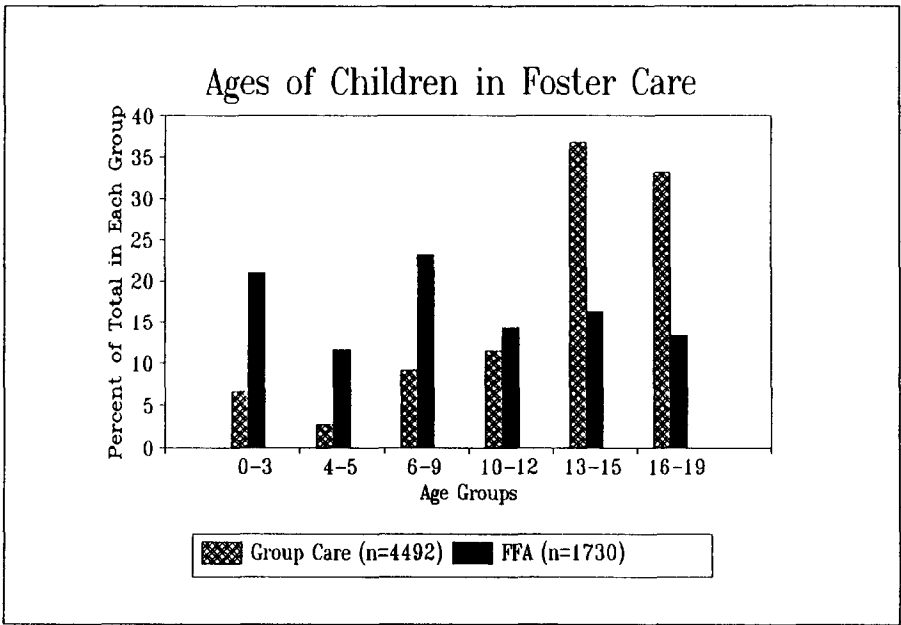


Figure 1.
Ages of Children in Foster Care.

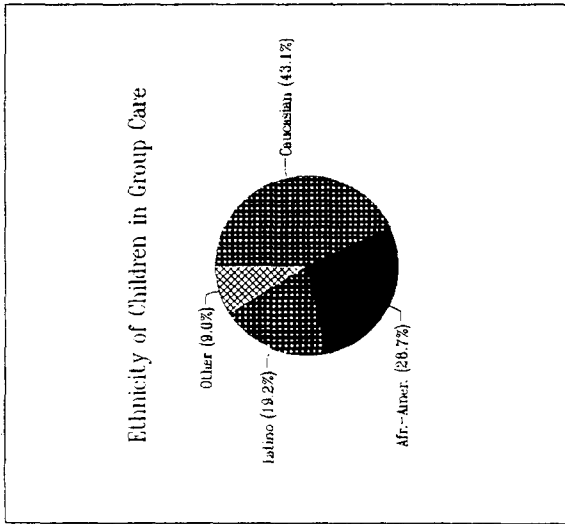


Figure 2.
Ethnicity of Children in Group Care.

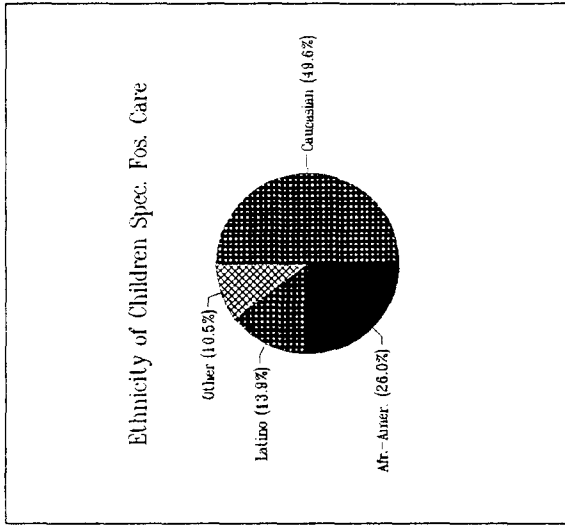


Figure 3.
Ethnicity of Children in Specialized Foster Care.

Behavioral and Medical Problems of Foster Children

Agency administrators in group homes and specialized foster care agencies, as well as specialized foster parents were asked to identify the types of behaviors observed in the children they serve. Results from the survey indicate that children in both types of care exhibit a number of problematic behaviors that contribute to the difficulty in caring for their severe needs. A large majority of these children have a history of sexual abuse or physical abuse. Many show signs of acting out, aggression, sexual promiscuity, and substance abuse. Children served in specialized foster care are also seriously disturbed, although taken as a group, they appear to be less difficult. Figure 4 displays the types of behaviors, problems, or past experiences that children *often* bring to foster care. In most areas, children's problems are noted as more severe by SFC agency administrators than by the actual foster parents caring for children. This may suggest that administrators are not as aware of the real concerns and needs of individual children in their care as are the direct service providers. It may also indicate that administrators (at both the SFC agency level and the group care level) have a tendency to recall children with more problems.

The sample also included children who might be considered *medically complex* or *medically needy*. Figure 5 describes the types of medical issues administrators *often* see among children they serve. In this regard, children in specialized foster care show far more signs of medical problems than do children in group care. In particular, a significant number of children in SFC are prenatally drug- or alcohol exposed. Although HIV+ status or AIDS is a rarity in children in out-of-home care, affected children are more likely to be in group home care as opposed to specialized foster care. In fact, although only two percent of group care administrators noted that they *often* served HIV+ or AIDS children, another three percent indicated that they *sometimes* serve this population. As in earlier figures, we again see a far higher rate of medical need described by SFC administrators than by specialized foster parents.

Children coming into foster care also have special cultural issues. Given the expanding refugee and immigrant population in the Western states it is of little surprise that a significant percentage of the children in group care and specialized foster care evidence areas of special need such as refugee trauma, monolingualism, or as victims of racial violence. Respondents were asked the following question: "Please check any of the cultural characteristics on the list which are qualities of any of the children you have accepted into care." The wording of the question was designed to capture any difficulties administrators may have noted in their children over the years--not to capture the magnitude of the problem among current

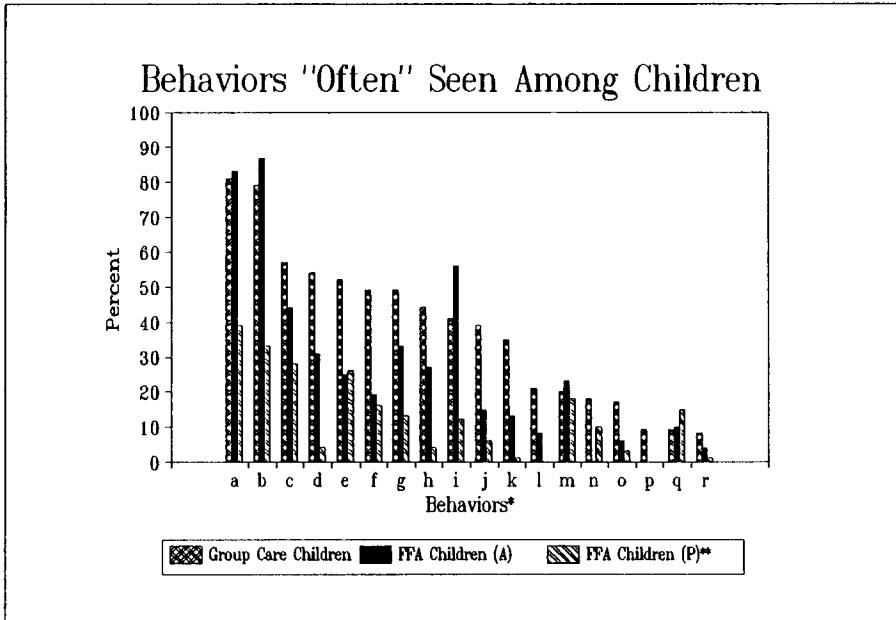


Figure 4.

*Behaviors include the following: (a) history of physical abuse; (b) history of sexual abuse; (c) serious emotional disturbance; (d) truancy; (e) aggressive to people; (f) destroys property; (g) stealing; (h) running away; (i) sexual acting out; (j) substance abuse; (k) misdemeanor crimes; (l) suicidal threats/attempts; (m) developmental disabilities; (n) gang affiliation; (o) self-induced injuries; (p) drug dealing; (q) eating disorders; (r) pregnancy.

**FFA Children (A) indicates responses by specialized foster parent agency administrators regarding the typical child in their care. This is in contrast to FFA Children (P), which indicates the responses given by specialized foster parents.

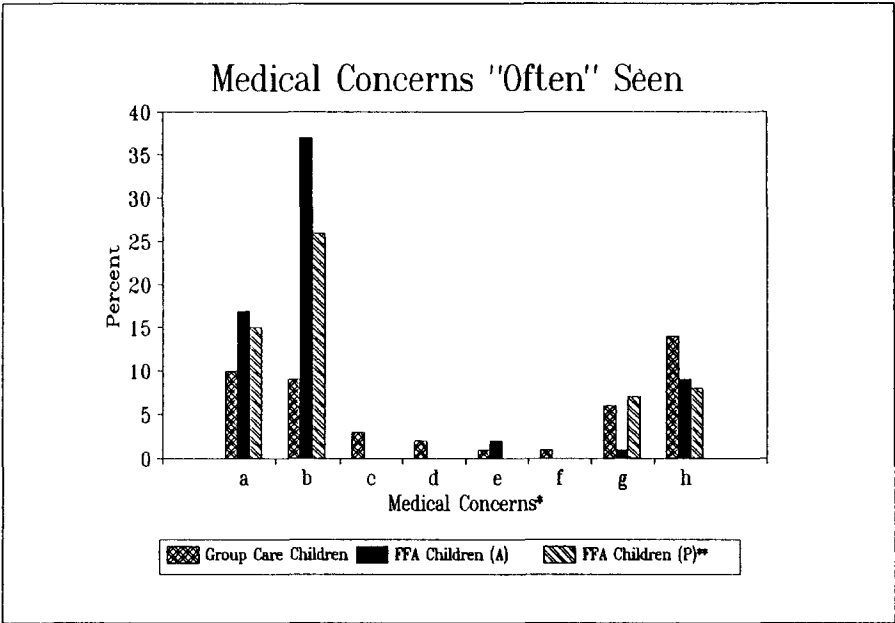


Figure 5.

*Medical concerns include: (a) fetal alcohol syndrome; (b) infant drug addiction; (c) Down's Syndrome; (d) HIV+/AIDS; (e) external feeding tubes; (f) oxygen dependent; (g) other special medical needs; (h) other special medical regimes.

**FFA Children (A) indicates responses by specialized foster parent agency administrators regarding the typical child in their care. This is in contrast to FFA Children (P), which indicates the responses given by specialized foster parents.

foster children. As Figure 6 demonstrates, group home children show far greater need in several areas of acculturation than specialized foster home children.

Portrait of a Typical Child in Out-of-Home Care

To gather more information about the children in specialized foster care and group-home care, survey respondents were asked to provide some general information about one child in care. In the case of group homes, administrators were asked to have a social worker respond to several questions regarding a randomly selected child. Specialized foster parents were asked to respond to a similar group of questions (their agency administrators were not asked these questions). Respondents were instructed to draw one child over the age of two, who had resided in the group home or specialized foster care home for at least six months. If more than one child fit these criteria, social workers or specialized foster care parents were asked to select the child whose first name started with a letter closest to the beginning of the alphabet. This resulted in the random selection of a large group of children. From this portion of the study a profile emerges of the typical child in care.

Group Care Children. Although children's ages ranged from 2 to 19 the average age of the child chosen for study was 13.4 ($n = 167$). The majority of the children were male (66%). Caucasian children were represented in the sample in about 47 percent of the cases, followed by African-Americans (26%), Latinos (17%) and other ethnic groups (10%). Most children had been in group care for just over one year (15 months), although one child had been in his group home for approximately six years. The average cost of providing care to this sample of children was \$2,991 per month (with a range from \$1,365 to \$8,577).

Specialized Foster Care Children. Of the 123 returned surveys, we received valid information on 87 (71%) children. Fifty eight percent of our sample of children were girls (42% boys), about half (51%) were Caucasian, 21 percent were Latino, and 13 percent were African-American (15% were either listed as Asian/Pacific Islander, mixed, or other). Their ages ranged from 1 to 18, with a mean age of 12.1 years, somewhat below the average for group home children. The average monthly rate foster parents received for these children was \$610 per month (ranging from \$250/mo to \$800/mo). This group of children had been living with their foster parents for an average of 14 months, although some children also had been living in their present foster home for up to six years.

Specialized foster parents described these children's health as *excellent* in 54 percent of the cases, and *good* for 41 percent of the children. (This appears in contrast to prior research which suggests that foster children

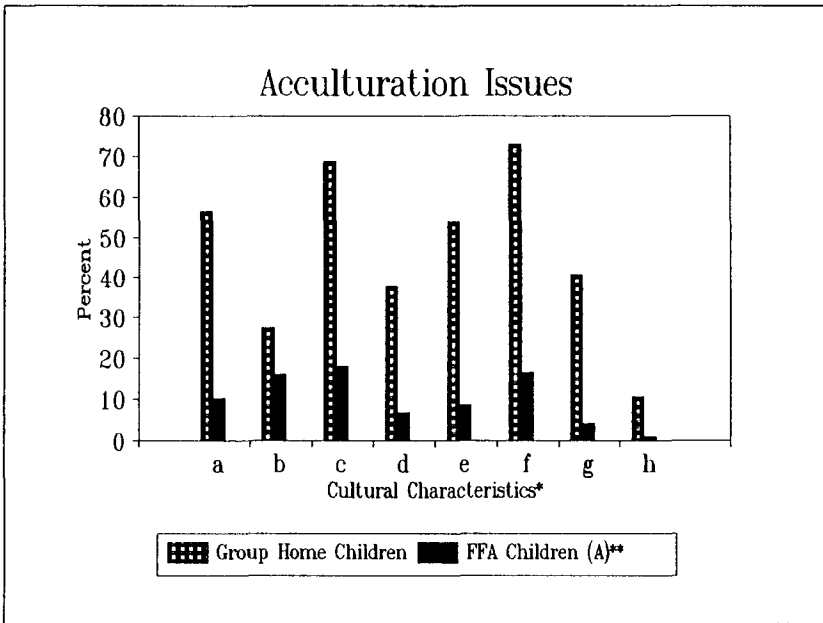


Figure 6.

have numerous health problems (Halfon & Klee, 1991), although the former research also showed that many health problems were undetected by foster parents.) The average child was in sixth grade, and about 30 percent of the sample children had been held back or repeated a grade previously. Children generally received grades in the C+ range and almost 40 percent of children were enrolled in some type of special education class. This included classes for learning disabilities (22%), speech and language (25%), SED (10%), classes for the mentally handicapped (2%), deaf/hearing impaired classes (2%), or classes for the physically handicapped (6%). For the majority (over 80%) of the children in our sample, living with their present foster parents meant a change in their school. Nevertheless, in spite of these difficulties, almost half of the foster parents (47%) indicated that they were *very satisfied* or *satisfied* with the way their child was doing in school. (Questions regarding children's health status and educational status were not asked of group home children).

Behavior Problems. Total scores for the group home sample of children were somewhat higher than total scores for children in specialized foster care. The total sample of group home children had a score of 21.75, whereas the specialized foster care population had a score of 17.14 ($t = 5.85$, $p < .001$). Table 1 provides a breakdown of scores for the two groups.

On the total *BPI* scale and on each of the subscales but one, group home children evidenced significantly greater behavioral problems than

TABLE 1
Behavior Problem Index Scores

<i>BPI</i> Sub-Scale	G.H. Mean Score ($n = 167$)	SFC Mean Score ($n = 87$)	<i>T</i> value
Antisocial	4.48	3.31	4.71**
Anxious/Depressed	4.51	3.19	7.69***
Headstrong	4.31	3.55	4.05**
Hyperactive	3.64	3.23	2.22*
Immature/Dependent	2.50	2.20	1.84
Peer conflict	2.31	1.66	4.63**
Total Score	21.75	17.14	5.85*

* $p < .05$

** $p < .01$

*** $p < .001$

did specialized foster home children. Comparing our sample to the age-based norms established by the NLSY data we find that the group home children in this sample were a highly disturbed group. That is, regardless of the age of the child, children were at least two standard deviations above the norm for a typical group of children the same age. Scores for three of the subscales (anti-social, anxious/depressed, and peer conflict) are very high compared to the national sample. The picture presented of group home children is rather sobering.

Specialized foster care children fare better than group home children. Nevertheless, scores for this group of children are also quite high and point to the extreme difficulties these children face in managing their behavior. Here, we see standard deviations far above the norm, however the SFC children's average standard deviations above the norm hovers just below two (or less) -- lower than the average for group home children. Although it is widely believed that specialized foster care acts as an alternative to group care, these data indicate that SFC children are largely a less disturbed group of children than those children in group care.

For specialized foster care children we found no differences in children's *BPI* score based upon the child's sex, age, months in care, medical needs, or ethnicity. (This is in contrast to Fein and associates' study (1990) which found that older children, boys, and Caucasians were more disturbed than other children in care.) In fact, few factors appear to be related to children's behavioral problems. However, the magnitude of children's behavior problems score is correlated with the need for mental health services, as reported by the SFC agency administrator ($r = .64, p < .05$). We also found an inverse relationship between the behavior problems score and the percentage of children in each agency defined as *adoptable* ($r = -.66, p < .05$) In other words, the more behaviorally disturbed children appeared, the less likely they were to be considered adoptable. Surprisingly, the child's level of disturbance as indicated on the *BPI* and the number of hours seen by the child's social worker or the reimbursement rate the agency received were not related.

A more curious finding from the study is the inverse relationship we discovered between the rate of reimbursement per child and the number of educational disabilities the child exhibited. We used the number of special education classes that the child was enrolled in as a proxy for the severity of the child's educational disabilities (recognizing also that many factors play into the receipt of special education services that go beyond the actual needs of the child). In this analysis we found that the fewer the child's disabilities, the greater the monthly reimbursement rate received by the foster parent ($F = 9.92, p < .01$). Approximately 42 percent of the variance in reimbursement rates could be determined by this variable alone.

As the data seem to indicate that there was little or no relationship between the behavioral disturbance of the child and the rate foster parents received for that child, nor between the child's disturbance and the number of social work services provided by the agency, it may be especially important to follow this issue closely. The *BPI* appears to be a robust test of behavioral problems (as indicated in the NLSY study), and responses to the *BPI* were also closely associated with foster parents' perceptions of the child's future prospects. Foster parents reported how well they expected their foster child to adjust to adulthood; these responses were compared to their responses to children's scores on the *BPI*. Three questions were asked to gauge their perception of the child's future adjustment: (1) "I believe that this child will develop into an adult who... forms close personal relationships easily"; (2) "Can care for self"; (3) "Can provide economically for self". We found that two out of three of these "future prospects" questions explained 60 percent of the variance in children's *BPI* scores ($F = 13.77, p < .0001$).

Among the group home sample, children ages six to 11 had higher scores than the older children in the sample ($F = 5.58, p < .01$) on the *BPI* scale. This was again true for the anti-social subscale ($F = 4.87, p < .01$) although the differences were not significant for other subscales. Caucasian children tested higher (worse) on every scale and subscale. Analysis of variance tests showed Caucasian children to be significantly more behaviorally disturbed than African-American children on the total scale ($F = 2.77, p < .05$). Significant differences were again found between the high scores of Caucasian children and the relatively lower scores of African-American children on the anxious/depressed scale ($F = 3.33, p < .05$), the hyperactive scale ($F = 4.47, p < .01$), and on the peer conflict/social withdrawal scale ($F = 4.60, p < .01$). (Caucasians also had significantly higher scores on the peer conflict scale than children categorized as *other ethnicity*.) Girls scored higher on the immature/dependent subscale than boys ($t = 4.38, p < .0001$), however there were no differences between gender on other scales.

The reimbursement rate each agency received per child was associated with the referral source from which the child had come; a few variables also appear to have an impact on the cost of group care. Analysis of variance tests showed a significant difference between the average rate paid by the Department of Mental Health (\$3,614), the Department of Social Services (\$3,003), and the Probation Department (\$2,777) ($F = 4.33, p < .05$). A few variables (i.e., gender and number of services) taken together explained about 62 percent of the variance in rates ($F = 11.62, p < .0001$). The number of services the agency provided predicted the rate the agency charged for services ($t = 2.30, p < .05$) and boys were more likely to be placed in facilities with higher rates of reimbursement than girls ($t = 2.14,$

$p < .05$). Yet again, we found no relationship between the behavioral disturbance of the child and the rate of reimbursement the agency received to care for that child.

Discussion

The study reported here points to the serious and acute nature of dependent children's problems. A significant number of children in foster care suffer from health problems, educational deficiencies, and are challenged with acculturation issues and racism. Over 80 percent of our sample of parents indicated that the child had changed schools when placed in their foster home. Clearly, this type of change, at a time of great vulnerability, might have a good deal to do with children's abilities to cope well in the school environment. These findings also confirm other studies which point to the educational deficits children bring to foster care (Canning, 1974; Cohen, 1991a,b). Children in foster care also are getting younger each year, and the increasing number of very young children in group care is especially distressing. Young children should not have ever-changing parents. In this sample, most children in group homes were expected to remain in care until emancipation; reunification outlooks for the whole sample were quite poor. The vast majority of children exhibited behavioral problems that were reported to compromise their abilities to get along with others, to form close attachments, and to become responsible adult citizens. These are the costs of abuse and neglect that go undetected or unrecognized.

The findings concerning the relationships (or the lack thereof) between child behavior and placement characteristics should be judged with some caution. The survey measured child behavior *while in placement* for children who had been in these placements for varying lengths of time. There may be a differential *leveling* effect on child behavior resulting from the services provided at various reimbursement rates. For example, programs with higher reimbursement rates and more intensive services might be stabilizing children's behavior at levels close to those observed in less intensive settings, even though they admit into care children who are more disturbed than those admitted to programs with lower reimbursement rates. It may be that there is a threshold of problematic behavior (albeit a high one) under which all programs succeed in managing their residents. Group home programs at different reimbursement levels may be using services of varying intensity to maintain children at similar levels of behavioral disturbance. Research efforts linking behavioral measures prior to placement to level of reimbursement and type of program are necessary to adequately address this issue. Nevertheless, the best possible match

should be made between the needs of children and the ability of various care providers to meet their needs. This is fiscally and developmentally sound. We believe that the findings presented here have implications for social workers in the way that they make placement decisions. These decisions can have serious consequences for children who are inappropriately placed in facilities that can not meet their treatment needs and for children who should be in foster family care where they can develop long-term relationships. The findings also have implications for social workers' time with children. Indeed, we did not find a relationship between the number of hours social workers spend with children and children's behavioral problems. Yet children with intense behavioral issues may need additional time and service from their social worker.

We had expected that higher cost homes would serve either more behaviorally disturbed children or more medically needy children. In fact, we found no relationship between these factors and the cost of care. This also leads one to question the rate structure for care providers. Higher rates should be based upon more resource-rich environments. These intensive service settings should be available and used for children with the greatest needs. This is not to argue for reducing the pay of foster care providers or group home operators, as their job is essential for the care of dependent children. Instead, procedures for more appropriate decision making regarding which children should be served where, and the types of services they should receive once accepted into one or another setting must continue to be developed.

The need for further investigation is great. For example, if extremely disturbed children are being served in relatively low-cost settings, what explains the response of group home staff and specialized foster care staff that the appropriateness of their referrals were generally quite good? One might have expected that staff from relatively low-cost facilities and homes serving extremely difficult children would have been rather disgruntled with the process. Instead, a large majority of respondents were pleased with the appropriateness of the referrals to their agencies. The high level of satisfaction with the placement decision indicates the need for a closer look at this issue. Certainly it would appear there is a group of children in foster care who present special difficulties and who might benefit from additional services if we hope to improve their prospects for adjustment later on in life. These children are not allowed however, to benefit from additional social work support nor more costly (i.e., presumably better trained) foster care placements.

Placement decisions are not well understood (Phillips, Haring, & Shyne, 1971; Wells, 1991); a great deal is left to the discretion of social workers who are acting on their limited knowledge regarding the child and the child's needs. Social workers' knowledge about the children they serve may also be related to the size of their caseload. Evidence suggests

that social workers' working conditions and high caseload sizes are not conducive to knowledgeable decisions regarding children's placements (Hess, Folaron, & Jefferson, 1992). Other factors also play a role in placement decisions such as the availability of bed space and financial considerations. Based upon our data it is fair to suggest that whatever steps that can be taken to improve decision making--be it in the form of training and education or reduced caseload size, or larger systems changes--would be helpful. Other measures may show promise, as well. Efforts to design a mechanism to systematically assess children's needs at the time of placement are needed to make sense out of a complex and sometimes idiosyncratic process of decision making.

Although the need for group care is not likely to diminish for some children, this study points to the possibility of shifting less disturbed children out of group care and into specialized foster care. For example, although our data does not tell us how the medical and behavioral problems of the young and very young children in specialized foster care and group home care compare, we believe that the great majority of younger children could be cared for in specialized foster care. This is fully supported by the analysis indicating that for children younger than five, there are no significant differences in behavior problems of children in specialized foster care and group home care. The impetus for this shift would not be a cost-cutting measure (although this would be an additional outcome). Instead, it would reflect our commitment to serving a group of children in the most appropriate and family-like setting based upon their individual needs.

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