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QUALITY IN FAMILY, FRIEND, AND NEIGHBOR CHILD CARE SETTINGS

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The Reviews of Research series synthesizes research on selected topics in child care and early education. For each topic, Reviews of Research provides an in-depth Literature Review, a summary Research Brief, and a companion Table of Methods and Findings from the literature reviewed. Each of these are available on the *Research Connections* web site: www.researchconnections.org.

Acknowledgements

What We Know

FFN caregiver characteristics

► Education: Family, friend, and neighbor (FFN) providers generally have lower levels of education than licensed providers (a high school education compared to some college or a college degree).

► Experience: FFN providers exhibit a range of experience caring for children, some gained by virtue of their own parenting experiences, and some by caring for children who were not their own.

► Motivation: FFN providers cite consistent, similar reasons for providing care including: wanting to help the child's parent; wanting to help the child grow and learn; fostering intergenerational ties; and staying home with their own child.

► Stability: the extent to which caregiver turnover is a problem in the license-exempt sector is unclear; however, relative providers self-report a remarkable degree of stability of FFN care arrangements – ranging from 12 months or more.

Quality in FFN care

► Quality ratings in FFN care tend to vary by the assessment tool used. For example, studies using the Family Day Care Rating Scale (FDCRS) to assess quality consistently show that the quality of FFN care was rated as inadequate to minimal. Studies using the QUEST – a new quality assessment tool designed for home-based child care – found that caregiving settings received at least adequate ratings for space and comfort, outdoor materials and safety, supervision and monitoring, and caregiver warmth and responsiveness.

► Research findings consistently show low adult:child ratios (for example, 1:2) in FFN care; lower than ratios generally found in licensed caregiving settings.

► Overall, the quality of caregiver-child interactions is a strength of FFN care. Most FFN studies found acceptable levels of warmth and support for children.

► Studies were mixed on whether the development of children in license-exempt settings lags behind that of children in licensed settings. The Three City Study suggests that child care quality rather than child care setting affects child development (Li-Grining & Coley, 2006). The Growing Up in Poverty Study however, found that children in centers showed significantly higher cognitive and school readiness skills than children in FFN settings. At the same time, children in family child care had higher rates of behavioral problems than children cared for in FFN settings (Fuller, et al., 2004).

► Findings on the quality in FFN care should be viewed cautiously however, as researchers are wrestling with whether the concept of quality and the measurement of quality should be the same in license-exempt settings as it is in licensed settings.

► FFN providers reported wanting to learn how best to support children's development. They also expressed interest in health/safety, child development, and business and financial information, as well as in community resources and activities particularly low-cost ones. At the same time, the majority of FFN providers did not express interest in becoming licensed. More research is needed to understand the most effective strategies for educating and supporting FFN providers.

Parental satisfaction

► Research findings were mixed on parents' satisfaction with their FFN care arrangements, but further research is needed to clarify the factors affecting parental satisfaction and decisions about choosing care.

Parent-FFN provider relationships

► Parents' and providers' reports about their relationships and/or their communication with each other were strikingly positive (which may in part be due to the social desirability of good relations).

INTRODUCTION

Currently, more than 60 percent of children in the United States under the age of 5 are in some type of non-parental child care on a regular basis (Johnson, 2005) and care by family, friends, and neighbors (FFN care) is the most common form of non-parental child care in the nation (Maher & Joesch, 2005; Sonenstein, Gates, Schmidt, & Bolshun, 2002; Snyder, Adelman & Dore, 2005). Infants and toddlers, regardless of family income or household structure, are predominantly cared for by family, friends, and neighbors. One state study in Minnesota, for example, found that 78 percent of children under the age of 3 were in FFN care (Chase, 2005). National studies show that nearly half of all children (under the age of 6) spend time in family, friend, and neighbor care (Boushey & Wright, 2004), and nearly a quarter of school-age children are cared for by FFN caregivers (Capizzano, Tout, & Adams, 2000; Snyder & Adelman, 2004).

Recognizing the widespread use of FFN care, a number of national and state agencies have invested public funds to support the use and strengthening of family, friend, and neighbor care. For instance, since 1988 parents can use federal child care subsidies (through the Child Care and Development Fund) to pay for care by a FFN caregiver, and currently nearly a quarter (22 percent) of all children who receive federal child care subsidies use FFN care (U.S. Child Care Bureau, 2009). Additionally, more than 25 percent of states now fund quality improvement initiatives specifically aimed at family, friend, and neighbor child care (Porter & Rivera, 2005).

New understanding of how the quality of various early childhood settings affects child outcomes has led to increased attention regarding quality at the state and federal levels and prompted policymakers, researchers, and parents to ask more careful questions about the quality of care across settings, including FFN care. To date, much of the research on the quality of child care has explored the quality of care offered in licensed child care settings (that is child care centers and family child care homes). Given

that FFN caregivers are generally exempt from state regulation (depending on the state), only need to meet basic health and safety requirements to receive CCDF payments for providing care, and therefore not required to meet defined program standards, the quality of the care children are receiving in FFN care is of primary importance.

This review examines the current research on the quality of family, friend, and neighbor care. Specifically, it looks at the following questions:

▸ What are some of the difficulties in defining quality in FFN?

▸ What are the structural characteristics related to quality of FFN care (for example, provider education and training, adult:child ratio, etc.)?

▸ What is the quality of care in FFN settings, including interactions between children and their FFN caregivers?

▸ To what extent do parental perspectives regarding FFN care shape our considerations about quality?

▸ What do we know about FFN care and children's developmental outcomes?

▸ What evidence supports strategies to improve the quality of FFN care?

▸ What are some of the methodological concerns with studying the quality of FFN care?

WHAT IS FAMILY, FRIEND AND NEIGHBOR CARE?

Family, friend, and neighbor care (also referred to as informal care, home-based care, kith and kin care, kin care, relative care, legally unlicensed, and license-exempt care) is one of several types of non-parental child care. Child care is typically categorized according to setting, regulatory status, and the provider-child relationship (see Morgan, Elliott, Beaudette, & Azer, 2001). For example, child care can be based in licensed centers, regulated home-based family child care, in-home nanny care, or license-exempt FFN.

In this review we define family, friend, and neighbor care as home-based care – in the caregiver's or child's home – provided by caregivers who are relatives, friends, neighbors, or babysitters/nannies who are legally exempt from licensing and regulation. While this definition reflects a growing consensus in the field, researchers and policymakers have yet to settle on a consistent term and definition to describe the license-exempt, home-based sector of child care in which so many children spend their time.

Across the literature, FFN caregivers have been categorized differently in various research and administrative datasets, making generalizations across studies difficult.[1]

BACKGROUND ON CHILD CARE QUALITY AND FFN CARE

Researchers and policymakers are actively discussing how most appropriately to define and assess child care quality across the range of child care settings (center care, regulated/licensed family child care, and license-exempt family, friend, and neighbor care) and within settings. At this time, there is no consensus. The first wave of research examining quality in FFN care was guided by two lines of thinking: a structural (regulatory) perspective, and to a lesser extent, a process quality and child-centered, developmental perspective. A structural perspective emphasizes features of the setting that can be affected by state regulation, and is often seen in studies examining quality of care in licensed child care centers and family child care homes (Smolensky & Gootman, 2003). Structural characteristics are tangible aspects of settings – which are most easily regulated and measured- that can support positive early development, such as child:adult ratio, group size, the physical environment, and caregiver education and training.

Process quality refers to the opportunities children have for social and cognitive stimulation and exploration, and includes their interactions with caregivers, other children, and materials and equipment. While not formally considered as structural or process variables, other caregiver characteristics are also widely studied as variables that affect quality, such as caregivers' perceptions and attitudes about children and caregiving and the stability of caregiving arrangements. Like process quality, caregiver characteristics also affect quality but are more difficult to regulate.

A child-centered, developmental perspective focuses on the impact that the quality of care has on children's outcomes. This perspective has generally examined associations among structural characteristics and process quality and children's outcomes, with attention paid to factors that may affect those relations, such as caregiver characteristics.

Multiple studies demonstrate linkages between structural characteristics and process quality (NICHD, 1999a; Kisker, et al., 1991). Studies also show associations between both structural characteristics and process quality and child outcomes (Smolensky & Gootman, 2003). Historically, the samples for these studies have largely been licensed child care settings – centers and family child care homes (the NICHD Study, The Growing Up in Poverty Study, and the Three City Study and the Study of Relative Care are notable exceptions, as they include FFN caregivers and licensed caregivers in their samples) – and they have used measures of quality designed with licensed settings in mind. The findings from the literature with a regulatory perspective, then, are most applicable to understanding the quality of care in licensed child care settings.

When the first wave of work examining quality in FFN care was occurring, there was no clear framework for studying quality in license-exempt settings. Building on the belief that some features of quality transcend setting and using the measures that were available at the time for measuring quality, researchers extended the framework of structural and caregiver characteristics and process quality to the study of quality in unlicensed, home-based settings. This was a reasonable approach at the time, and has helped guide discussion about potential key aspects of care across settings, but with further developments in theory and measurement, researchers are employing other perspectives to approach the study of quality in FFN care as well as licensed care.

More recently, an expanded model for conceptualizing and measuring quality in center-based and home-based settings has emerged to include a family support perspective (Bromer, Paulsell, Porter, Weber, Henly, & Ramsburg, 2011; Kreader & Lawrence, 2006; Morgan, Elliott, Beaudette, & Azer, 2001; Todd, et al., 2005). In contrast to developmental or regulatory frameworks, this perspective supports families' views of FFN care as responsive to the needs of families and reflective of the strengths of families. The recent theoretical formulation of family-sensitive caregiving describes the attitudes, knowledge, and practices of providers that aim to align services to the needs and preferences of families (Bromer, et al., 2011). The rationale for the relationship between quality and family-sensitive caregiving is that when families feel supported – through a positive relationship with providers and care is provided during needed hours – their child's care arrangement is more likely to remain stable and consistent, parental stress is alleviated and competence promoted, thus supporting positive child outcomes. The family-sensitive caregiving model recognizes that family-sensitive caregiving may vary by provider type and family characteristics and needs. For example, home-based providers tend to have stronger relationships with parents than center-based providers, and home-based caregivers – especially relatives – may be more likely to offer family-sensitive care because of their desire to help their kin.

A family-sensitive care perspective may guide the development of new measures of quality in center-based and home-based care, as well as the development of new interventions, education or support programs appropriate to and/or welcomed by FFN providers. For example, use of a parent education model of support may better suit the needs of the FFN population than the traditional professional development models (Susman-Stillman, 2003). A family perspective is also likely to guide the next phase of research on FFN care.

In an effort to include findings from the older and newer theoretical frameworks, this review organizes the literature to-date on quality in FFN care around the frameworks of structural and process quality

and child development. Summaries of findings in each of these areas are presented. Relevant findings from the family-sensitive caregiving perspectives (e.g., parental perceptions of care) are also included. Throughout, the review raises questions about the methodological adequacy of measures used in both licensed and FFN care settings, and the extent to which the different frameworks appropriately capture the important conceptual and practical dimensions of FFN care. It also offers suggestions for conceptual and methodological consideration.

CRITERIA FOR SELECTION OF STUDIES FOR REVIEW

In combing the literature for relevant research, the authors considered a wide range of sources, including peer-reviewed journals; published reports from government agencies and reputable research organizations; presentations at established research conferences; and recently completed unpublished studies.

Twenty-seven studies, with a specific focus on quality of FFN care, were included in this review (see Table 1). All were judged as methodologically sound (for example using validated observation measures) and drew evidence-based conclusions, using what is understood as best theory and practice based on the current state of the field. Recently completed studies that have not yet been published were included based on the use of questions or methods that broke new methodological ground or yielded new information. A table on the methods and findings of the 27 studies focusing on quality accompanies this review (see *Quality in Family, Friend, and Neighbor Child Care –Table of Methods and Findings* at www.researchconnections.org/childcare/resources/14342).[2]

Table 1: Methodology of Studies Reviewed and Topics Examined

Types of Studies	Methodology/Datasets	Studies Reviewed	Topics Examined
National survey studies	National Survey of Families and Households Waves 1 and 2 (NSHF)	Guzman, 1999	Caregiver characteristics
Multi-site studies	Parent and provider interviews/ questionnaire; quality observations	Li-Grining & Coley, 2006; Votruba-Drzal, et al., 2004; Fuller, et al., 2004; Loeb, et al., 2004; Layzer & Goodson, 2006; NICHD, 1996; Paulsell, Mekos, DelGrosso, Rowand, & Banghart, 2006	Parental perceptions of FFN care, Structural characteristics, Caregiver characteristics, Process quality, and FFN care and children's development
State survey studies	Illinois – linked surveys of parents and their license-exempt providers participating in the state subsidy system. Longitudinal analysis of statewide subsidy administrative data.	Anderson, Ramsburg, & Scott, 2005	Parental perceptions of FFN care, Structural characteristics, Caregiver characteristics, and FFN provider interest in quality improvement
	Washington – telephone survey of families and FFN caregivers	Brandon, Maher, Joesch, & Doyle, 2002	
	Minnesota – telephone survey with randomly selected households acrossthe state	Chase, 2005; and Chase, Arnold, & Schauben, 2006b	
Smaller-scale studies	Focus groups, interviews, and/or surveys with providers and/or parents; and/or quality observations	Bromer, 2006; Jaeger & Funk, 2001; Porter, 1998; Porter, Rice, &Mabon 2003; Porter & Vuong, 2008; Reschke & Walker, 2006; Maxwell, 2005; Shivers, 2005; Shivers & Kim, unpublished; Todd, Robinson & McGraw, 2005; Tout & Zaslow, 2006; Whitebook, et al., 2003; Whitebook, et al., 2004; Maher, Kelly, & Scarpa, 2009; McCabe & Cochran, 2008	Parental perceptions of FFN care, Structural characteristics, Caregiver characteristics, Process quality, FFN care and children's development, and FFN provider interest in quality improvement

DESCRIPTION OF STUDIES

Methods

The literature reviewed here uses a variety of methods, including observations and child assessments, to measure quality and child outcomes of care settings as well as interviews and focus groups with parents and providers to understand parent satisfaction of care and provider perceptions of care and interest in formal professional development or informal education and support. Some studies (multi-site and smaller-scale) have conducted observations and assessments across child care settings (Li-Grining & Coley, 2006; Votruba-Drzal, et al., 2004, Fuller, et al., 2004; Jaeger & Funk, 2001; Loeb, et al., 2004; McCabe & Cochran, 2008; NICHD, 1996; 2000), while others have exclusively examined FFN care (Anderson, et al., 2005; Brandon, et al., 2002; Bromer, 2006; Chase, et al., 2005; Maher, et al.., 2008; Maxwell, 2005; Paulsell, et al., 2006; Porter & Vuong, 2008; Shivers, 2005; Shivers & Kim, unpublished; Todd, Robinson, & McGraw, 2005; Tout & Zaslow, 2006; Whitebook, et al., 2003; Whitebook et al., 2004).

Measures

Much of the research examining quality of FFN care relies on the research of quality in licensed child care – using the same (or adapted) observational measures and definitions of quality across settings. In the literature reviewed, researchers used a variety of observational tools for assessing child care quality and child outcomes across settings, including: the Family Day Care Rating Scales (FDCRS), the Arnett Caregiver Interaction Scale (CIS), the Child Caregiver Observational System (C-COS), the Observational Record of the Caregiving Environment (ORCE), and the Child Care HOME.

The FDCRS was used in the majority of the reviewed studies to observe quality in FFN child care (Li-Grining & Coley, 2006; Fuller, et al., 2004; Loeb et al., 2004; Jaeger & Funk, 2001; Maxwell, 2005; McCabe & Cochran, 2008; Shivers, 2005; Shivers & Kim, unpublished). It is designed for use in licensed family child care settings and adapted from the original Early Childhood Environmental Rating Scales (ECERS), used in center-based settings. The FDCRS assesses quality – both structural and process – on seven aspects of care: space and furnishings, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children. Despite its wide use in evaluating FFN care, there are questions about how accurately the FDCRS can measure the quality of FFN caregiving considering how certain scales favor licensed settings with more resources.[3] The FDCRS developers explicitly distinguish between family child care settings and the child's home environment, which may be more aligned with family, friend, and neighbor care. Therefore, there has been some concern that the FDCRS will automatically produce higher quality ratings in licensed settings (Maher, 2007).

The Child Care HOME Inventories (CC-HOME) was also used to observe home-based care (NICHD, 1996; Whitebook et al., 2004). The CC-HOME is based on the Home Observation Measurement of the Environment (HOME), which evaluates the quality of the family environment. The CC-HOME, which can be used across licensed and licensed-exempt home-based care settings, assesses the quality of home-based child care environments through subscales used to observe caregiver-child interactions along with structural, organizational, and educational aspects of the environment. There are separate versions for infant/toddler care (under age 3) and early childhood (age 3 to 6). The Infant/Toddler version of the CC-HOME is composed of 43 binary-choice items organized into six subscales: Caregiver Responsivity, Acceptance, Organization, Learning Materials, Caregiver Involvement, and Variety of Stimulation. For children age 3-6, the CC-HOME includes 58 items clustered into eight subscales: Learning Materials, Language Stimulation, Physical Environment, Caregiver Responsivity, Academic Stimulation, Modeling of Social Maturity, Variety in Experience, and Acceptance of Child.

The Arnett Caregiver Interaction Scale (CIS); the Child Caregiver Observational System (C-COS); the Observational Record of the Caregiving Environment (ORCE), and the Attachment Q-Sort (AQS) were also used in different studies to observe process quality – the child-provider interactions. In contrast to the FDCRS and the CC-Home, each of these measures can be used in studies examining both center and home-based settings. The C-COS and the ORCE track the experiences of a particular child, while the Arnett rates interactions between providers and all the children in their care. The AQS measures the security of caregiver-child attachment. Currently, there's no consensus on the best measures to use for examining quality in these settings, nor are researchers satisfied with them for studying the quality of FFN care.

The literature reviewed here also includes newer instruments developed specifically for FFN settings to address the concern that the instruments used in many of these studies were designed for use in licensed settings and are missing key aspects of quality in FFN settings. Porter and colleagues (Porter, Rice & Rivera, 2006) at Bank Street College of Education designed an assessment instrument specifically for measuring quality in relative care – the Child Care Assessment Tool for Relatives (CCAT-R). This instrument assesses the frequency of caregiver-

child interactions and includes checklists for materials and health and safety and a provider interview (Porter et al., 2006). Abt Associates created the Quality of Early Childhood Care Settings: Caregiver Rating Scale (QUEST) for the National Study of Child Care for Low Income Families to be used across child care settings – including FFN care – for comparability (Layzer & Goodson, 2006). The instrument includes an Environment Checklist which assesses health and safety issues and the adequacy of resources in the care environment, and the QUEST also includes the Provider Rating which assesses caregiver interactions and behaviors. The Environment Checklist was also then modified by Tout & Zaslow for the purpose of observing quality in license-exempt settings (Tout & Zaslow, 2006).[4, 5]

EMERGING THEMES

FFN care, like all forms of child care, has strengths and weaknesses.

While there is a limited literature describing structural characteristics, caregiver characteristics, and process quality in FFN care, a picture emerges of a form of care with strengths and weaknesses – strengths and weaknesses that differ in important respects from licensed care.

Structural Features

Adult: Child Ratio

Despite the common perception that FFN caregivers often care for many children at the same time, findings consistently show low adult:child ratios (e.g., 1:2), ratios lower than those generally required of or found in licensed settings (Chase, et al., 2005; Fuller, et al., 2004; Layzer & Goodson, 2006; Li-Grining & Coley, 2006; NICHD, 1996; Tout & Zaslow, 2006). Furthermore, when looking across all settings, small adult:child ratios and group sizes were related to higher levels of positive caregiving in FFN settings (NICHD 1996; 2000).

Education of FFN Providers

Educational attainment of child care providers, namely possessing a bachelor's degree, is among a number of factors loosely linked to the quality of child care in formal settings (Tout, Zaslow, & Berry, 2005). FFN providers tend to have lower levels of education than licensed providers (a high school degree compared to some college or a bachelor's degree) (Fuller, et al., 2004; Jaeger & Funk, 2001; Layzer & Goodson, 2006; Li-Grining & Coley, 2006; Maxwell, 2005; Todd, Robinson, & McGraw, 2005). Lower education levels of FFN providers were also found for FFN providers with lower social and economic status (SES) of particular samples (Shivers, 2005; Tout & Zaslow, 2006; Whitebook, et al., 2003). Some studies show FFN providers have less education than the parents of the children for whom they care (e.g., Anderson, et al., 2005).

Training and Experiences Caring for Children

FFN providers exhibit a range of experience caring for children. Some providers have limited experience (Maxwell, 2005; Whitebook, et al., 2004), others have some experience (that is have worked in other child care settings or have had several years of experience providing home-based care) (Brandon, et al., 2002; Paulsell, et al., 2006; Porter & Vuong, 2008; Shivers, 2005), and still others have many years of experience, such as grandparents caring for their grandchildren. FFN providers have gained experience caring for children by virtue of their own parenting experiences and/or by caring for children who were not their own, in some cases working in a Head Start classroom, child care center, or child care home (Paulsell, et al., 2006, Porter and Vuong, 2008). The research literature does not consistently define experience of FFN providers, but most of these experiences are considered to be informal. The large majority of FFN providers, however, have minimal educational or formal training in child care or child development (Chase, 2005).[6]

Caregiver Characteristics

Motivation for Caregiving

A caregiver's motivation for providing care – intentionality – is a pivotal variable in understanding the quality of care children receive in home-based care (Doherty, Forer, Lero, Goelman, LaGrange, 2006; Galinsky, Howes, Kontos & Shinn, 1995). Across different surveys and interviews, FFN providers consistently offer similar reasons they provide care, including wanting to help the child's parents; not wanting the child to be in another child care setting; wanting to help the child grow and learn; fostering intergenerational ties; and staying home with their own children (Anderson, et al., 2005; Brandon, et al., 2002; Bromer, 2006; Chase, et al., 2005b; Guzman, 1999; Paulsell, et al., 2006; Porter, 1998).

Within the heterogeneous group of FFN providers, relative and non-relative caregivers differ in their reasons for providing care. In particular, relative caregivers are less likely than non-relative caregiverss to provide care as a source of income Relative providers also most commonly report that they provide care to help out the child's family, and in-depth interviews with caregivers reveal the deep importance FFN caregivers, particularly relatives/grandmothers, ascribe to their responsibility (Bromer, 2006; Porter, 1998). Many report that caring for the child is the best part of their day (Chase, et al., 2005), that their love for the child is their reason for caring for the child (Porter & Vuong, 2008), that they want to promote the child's emotional and intellectual development (Bromer, 2006), and that they provide the child with a safe, secure environment (Anderson, et al., 2005; Paulsell, et al., 2006). While they enjoy caring for children, non-relative providers are more likely to say that they want to stay home with their own children.

Stability of FFN Caregiving

The stability of the caregiving arrangement is an important feature of quality caregiving. While caregiver turnover is a significant problem in the licensed sector, the extent to which it is a problem in the

licensed-exempt sector is unclear. Relative providers self-report a remarkable degree of stability of FFN care arrangements – a range between 12 months or more (Anderson, et al., 2005; Brandon, 2002; Li-Grining & Coley, 2006; Layzer & Goodson, 2006; Maher, et al., 2008; Maxwell, 2005; Paulsell, et al., 2006). However, a single measure may not be sufficient to capture caregiver stability (Weber, 2005). In addition to caregiver self-reports, few data are available to confirm the stability of the relative and non-relative FFN caregiving population. Estimating the overall stability of FFN caregivers requires an accurate estimation of the baseline number of FFN caregivers. However, it is hard to define when a caregiving relationship begins and ends, hard to define the population of FFN caregivers, and hard to locate them. FFN providers are not recognized as part of the formal child care workforce, and no central repository exists for information about FFN providers (Whitebook, et al., 2003).

Administrative data studies present a mixed picture of the stability of subsidized FFN arrangements. One five-state study found the average length of subsidy receipt for families using relative and in-home non-relative care was comparable to the length of receipt for families using center and regulated family child care (Meyers, et al., 2002); another study in one county, using a different methodology, found high percentages of FFN providers leaving the subsidy rolls (Whitebook, et al., 2003).

Different data sources and definitions of turnover may help to explain the inconsistent findings. The administrative data currently available from subsidy systems may not pick up the stability of the arrangement. No longer receiving subsidy defines the end of the caregiving relationship from an administrative standpoint; however, the length of subsidy receipt does not necessarily equal the length of the caregiving arrangement, because the child-adult relationship and even the caregiving may continue. Self-report data from relative caregivers suggest this is the case (Anderson, et al., 2005). FFN providers will often continue to provide care when family income drops, and even if there are changes in the amount of time an FFN provider is caring for a child, the relationship

continues. In contrast, in the licensed or regulated sector, caregiver turnover generally results in the end of the caregiving relationship.

Greater consistency of the caregiving relationship appears to be a difference between FFN care and licensed or regulated care. However, further research is needed to more fully understand stability of FFN caregiving and the factors that affect it.

Physical Environment

The child care physical environment includes elements such as the amount of space, access to the outdoors, arrangement of rooms, availability of a variety of materials, air quality, equipment, and lighting. These elements impact health and safety as well as children's well-being and opportunities to promote cognitive and social development. Elements of the physical environment are the most easily measured and regulated aspects of care. Studies investigating FFN homes caring for low-income children and that used structured observational ratings, namely the FDCRS, found inadequate to minimal quality scores on space and furnishings (Li-Grining & Coley, 2006; Jaeger & Funk, 2001). The two studies using the QUEST found caregiving settings received at least adequate ratings for space and comfort, opportunities to play, and outdoor materials; there was note of safety hazards observed such as lack of outlet covers and accessibility of hazardous materials, but the homes were generally considered to be safe for children (Layzer & Goodson, 2007; Tout & Zaslow, 2006). The degree of difference in these findings may be methodological; they may demonstrate potential differences in standards for rating the quality of the physical environment, but they also may illustrate variation in resources available to enhance the quality of the physical environment.

Process Quality

Process Quality in FFN Studies

Process quality is recognized as an important aspect of quality across both regulated and unregulated settings, since research directly links process quality (e.g., caregiver-child interactions) to children's outcomes

(Helburn & Howes, 1996). It includes the quality of the content of learning activities and routines, as well as about the nature and kinds of adult-child interaction. Across the limited number of studies examining quality in FFN settings, findings vary as a function of the observational tool used. Studies using the FDCRS find the overall quality of care as inadequate to minimal (Fuller, et al., 2004; Jaeger & Funk, 2001; Li-Grining & Coley, 2006; Maxwell, 2005; McCabe & Cochran, 2008; Shivers, 2005), while the two studies using the QUEST (Layzer & Goodson, 2006; Tout & Zaslow, 2006) portray quality as varying more on some aspects than others. In general, FFN caregiving settings received at least adequate ratings supervision and monitoring, and caregiver warmth and responsiveness. Areas of concern included provision of learning opportunities, support of socioemotional development, and use of television. The Early Head Start home visiting and the Tutu and Me evaluations using the CCAT-R found FFN caregiver and child language interactions in a large proportion of the observation periods, as well as a high degree of engagement of FFN caregivers and children (Paulsell, et al., 2006; Porter & Vuong, 2008).[7]

Quality of Caregiver-Child Interactions

Overall, across the different measures used to examine the quality of caregiver-child interactions, these descriptive studies demonstrate that caregiver-child interactions are a strength of FFN care. Most FFN studies found an acceptable level of warmth and support for children (Layzer & Goodson, 2006; Shivers & Kim, unpublished; Tout & Zaslow, 2006) or no differences in levels of warmth between licensed and FFN caregivers (Li-Grining & Coley, 2006). In one multisite study, positive caregiving was more likely with home-based informal settings (with grandparent, fathers, nannies or sitters) than other home-based settings or centers as the adult:child ratio and group sizes were lower (NICHD, 1996; 2000). One study (Shivers & Kim, unpublished), which assessed the quality of the attachment between African-American providers and African-American children using the Attachment Q-Sort (AQS), found 80 percent of children in the sample were classified as "secure." The authors note the higher-than-expected rate of security, which could

be an artifact of the particular sample or an example of the benefits of caregiving by close relatives. Likewise, in the Early Head Start study the CCAT-R observations found that during half the observation periods, on average, FFN caregivers engaged the Early Head Start child in nurturing behaviors, such as kissing or hugging the child, touching or patting the child, or comforting the child (Paulsell et al., 2006).

Although a couple of studies found a range of sensitivity levels (Fuller, et al., 2004; Whitebook, et al., 2004), generally reasonable levels of warmth and sensitivity were common. Furthermore, the literature indicates that provider sensitivity is somewhat independent of provider education levels, as there are some studies with FFN providers who have at least acceptable ratings of sensitivity but low levels of education (Fuller, et al., 2004; Shivers, 2005). In FFN settings, this aspect of quality may be more prevalent than other aspects of quality such as provider education or training. In the NICHD study, positive caregiving was more likely in in-home settings despite lower levels of specialized caregiver training (NICHD, 1996).

Child-Caregiver Activities and Interactions and Quality

Observations of child-caregiver activities and interactions link some aspects of child-caregiver interactions (process variables) to ratings of overall quality. Using the FDCRS, frequent television watching was negatively related to overall quality, and provider sensitivity and frequent caregiver invitations to children to talk were positively related to overall quality (Fuller, et al., 2004; Shivers, 2005). Using the CCAT-R, which measures the frequency of caregiver-child interactions, the EHS study found that FFN caregivers in the Enhanced Home Visiting program were verbally engaged with children (for example inviting children to talk or repeating and building on what children said) in nearly 70 percent of the observation periods, on average, and that they were engaged in an activity with children in approximately 80 percent of the observation periods (Paulsell, et al., 2006), suggesting there were very positive relationships between caregivers and the children.

Quality and Parental Perceptions of FFN Care

Parents' Reasons for Choosing FFN Care Largely Reflect Parent and Family Needs

Parents choose FFN care arrangements based on trust, safety, parent flexibility, accessibility, cost, a desire to maintain and strengthen family connections, and a belief that children receive more personal attention in FFN care (Anderson, et al., 2005; Brandon, et al., 2002; Bromer, 2006; Brown-Lyons, et al., 2001; Li-Grining & Coley, 2006; Paulsell, et al., 2006; Porter, et al., 2010; Porter, 1998). For families choosing relative care, the parent's relationship with the provider is key (Drake, et al., 2004; Layzer & Goodson, 2006), as is the fact that parents are less likely to pay relatives for care (Brandon, et al., 2002; Chase, et al., 2006; Maher, et al., 2008).

Caregiver knowledge or training in child development – a structural factor – is less likely to be a primary consideration for parents who choose FFN care. When caregiver knowledge or training is an important consideration, parents of children between the ages of 0-5 are less likely to choose FFN (Brandon, et al., 2002).

Learning activities – a component of process quality – are also less likely to be a primary consideration. While important to parents with low incomes (Anderson, et al., 2005; Layzer & Goodson, 2006), learning activities tend to be secondary to their concerns about health and safety.

Parents Report Satisfaction with FFN Care

Several studies find a great deal of parental satisfaction with FFN care (Anderson, et al., 2005; Layzer & Goodson, 2006), and one study found that mothers reported higher levels of satisfaction than those using center care (Li-Grining & Coley, 2006). Parents using FFN care generally appreciate its flexibility, accessibility, and dependability, as well as the language and cultural similarities between the family and caregiver (Kreader & Lawrence, 2006).

The quality of parent-provider relationships may also contribute to parents' satisfaction. Reports from

parents and providers about their relationships and/or their communication with each other are strikingly positive across settings – although the ratings may be strong in part due to the social desirability of good relations (Anderson, et. al, 2005; Chase, et al., 2005b; Li-Grining & Coley, 2006; Layzer & Goodson, 2006). Parents and their FFN providers report good communication and satisfaction, and greater communication about the individual child than parents with center providers. While parents and relative providers report both stronger positive and negative feelings than parents and non-relative providers, parents and providers generally feel positively about each other. FFN providers (90 percent in the EHS study and 85 percent in the Tutu and Me evaluation) said they valued their relationship with parents, and 75 percent of FFN providers thought that parents listened to their advice about caring for the child (Paulsell, et al., 2006; Porter & Vuong, 2008). Another study demonstrated that grandparents who provide care have better relationships with their daughters and daughters-in-law and more contact with them than grandparents who do not provide care (Guzman, 1999).

Satisfaction is not universal, however. Data from some low-income mothers using relative care indicate that they would be interested in switching to center-based care if changing were a realistic option (Brown-Lyons, et al., 2001; Fuller, Chang, Suzuki, & Kagan, 2001). In-depth interviews and focus groups with low-income FFN providers reveal boundary issues and tension-provoking conflicts over child rearing (such as grandparental vs. parental roles) (Bromer, 2006; Porter, 1998; Reschke & Walker, 2006).

The bases underlying parental determinations about the quality of their FFN care and their satisfaction with it are difficult to clarify. Measuring satisfaction is difficult because of social desirability, the challenge of developing questions that will gauge the concept accurately, and reaching parents. Some parents may render their judgments based on a limited or different set of information or criteria than "experts" in the field, and there is some suggestion that parents' reasons are unrelated to actual standards for quality in the field. For example, in one study, low-income parents participating in the subsidy system reported high levels of satisfaction but also inaccurately reported that their FFN care providers had formal training and educational credentials for child care (Anderson, et al., 2005). Alternatively, parents may value the family-supportive aspects of FFN care, which are not clearly related to traditional quality standards (Bromer, Paulsell, Porter, Henly, Ramsburg, Weber, et al., 2011; Li-Grining & Coley, 2006). More research is needed to clarify the perspectives and factors affecting parental satisfaction and decisions about choosing FFN care, for which parents and under which circumstances.

FFN Care and Children's Development

The findings regarding FFN care and children's development are based on the handful of studies offering data that describe children's experiences in FFN care. Five studies examine children's activities and relationships in FFN care (Fuller, et al., 2004; Layzer & Goodson, 2006; Paulsell et al., 2006; Shivers & Kim, unpublished; Tout & Zaslow, 2006). Two studies directly link quality of care in FFN settings to children's development (Loeb, et al., 2004; Votruba-Drzal, 2004). The following themes emerged from this small number of studies and require further research to solidify them.

FFN Care and Socioemotional Development

The limited number of studies suggests that while FFN providers show support for children's socioemotional development, this is also an area for improvement. In these studies, provider-child interactions were characterized by warmth, affection and responsiveness, but providers missed opportunities to promote social skills such as cooperative play, sharing, and emotional control (Layzer & Goodson, 2006; Tout & Zaslow, 2006). One of those studies noted that both antisocial and prosocial behavior occurred with low frequency, although children in relative care were more likely than children in non-relative care to act pro-socially towards adults and show any prosocial behavior (Layzer & Goodson, 2006). More research is needed.

FFN Care and Cognitive Development

Children's cognitive and language development may be supported differently in relative versus non-relative caregiving settings. In-home observations (Layzer & Goodson, 2006) showed that children in homes with some or all unrelated children had higher rates of object play and goal-oriented play than children in homes of relative caregivers.[8] Children were consistent in their use of language across all home settings. For instance, Early Head Start children engaged in talk or made vocalizations toward the caregiver or other children in nearly 60 percent of the observations (Paulsell et al., 2006). Children in the homes of relative caregivers however, directed more language to both adults and children, while children in homes with some or all unrelated caregivers directed the majority of their language to other children. The latter finding may be due to lower adult:child ratio in relative caregiver homes or may reflect familiar familial communication patterns between children and relative caregivers.

Thoughts about Quality of FFN Care and Children's Development

The question of whether lower process quality observed in studies of FFN care may lead the development of children in unregulated settings to lag behind that of their counterparts cared for in regulated settings is an important one (even though the quality in regulated settings is not consistently of high quality). Two studies located for this review, both of which used samples of mothers and children on welfare, similar definitions for FFN providers, and similar measures of child functioning, offer relevant findings. Analyses from the Three City Study (Votruba-Drzal, et al., 2004) suggest that the quality of care, rather than the setting of care, affected children's socioemotional development and reading achievement. The more time children spent in higher quality care, whatever the setting, the less likely they were to develop socioemotional problems.

In contrast to the Three City Study findings, other studies showed that the children in centers, where the quality observed was higher than the quality of FFN settings, had significantly higher cognitive and school readiness skills than children in FFN settings. Analyses from the Growing Up in Poverty Study (Loeb, et al., 2004) yields comparisons between FFN and center care and FFN and regulated family child care. Positive effects of center-based care on cognition were also evident for children who moved into center-based care from FFN care compared to children who were in FFN care at both waves of data collection for these preschool-aged children. These findings held after controlling for maternal characteristics, ethnicity, and children's previous skill level. Children in family child care were more likely than children cared for in FFN settings to have higher rates of behavioral problems.

Further research on the impact of FFN quality on children's development is clearly needed, but the findings from these two studies raise the critical question of how to insure that children can thrive in whatever care settings their family has chosen for them. Centers may look most advantageous in these initial studies in terms of structural quality and child outcomes, but all families do not choose centers, and children's development may also be well-supported in home-based settings with sufficient resources. The reality, however, is that FFN settings where low income children are spending their time have fewer resources, and a resource-poor environment may be problematic over the long-term for children living in poverty or at-risk for developmental problems. Little is known about the circumstances under which children in FFN care fare at least as well as children in other care settings, and how FFN providers support children's emerging capacities and promote school readiness skills. More research is also needed to understand the development of children by age across settings.

Improving the quality of care offered by FFN providers

There is a growing movement around the nation to offer support and education as one strategy to improve the quality of care offered by FFN providers. This movement is building upon the findings from reports of FFN providers describing their interest in learning how best to support children's development (Brandon, et al., 2002; Chase, et al., 2005; Drake, et al., 2004; Porter, 1998; Stahl, et al., 2003; Todd, Robinson, & McGraw, 2005), as well as public interests in accountability and children's development.

Providers identified a heterogeneous range of information they seek: 1) health/safety/nutrition; 2) child development; 3) business and financial issues, and 4) community resources and activities, particularly low-cost ones. They also expressed the need for training in stress management and in working with parents (Susman-Stillman, 2003; Todd, et al., 2005; Porter, 1998). They expressed a preference for variety in topics and learning that occurs informally, particularly in groups or via a range of delivery methods, rather than via training mechanisms already established for licensed caregivers.

A major difficulty, discussed by Todd, et al. (2005) and Chase, et al. (2005), is to identify the providers who are amenable to education and/or support. Between 10 and 30 percent of FFN caregivers express interest in becoming licensed, but the majority do not; thus education and support must be tailored for the wide range of interests, goals and skills of the FFN population. In particular, the traditionally low level of education of FFN providers is an important consideration in developing effective education and support opportunities (Todd, et al., 2005). Research is needed to determine the most effective strategies for educating and supporting FFN providers.

Support Programs for FFN Caregivers

Newly emerging programs designed to support FFN providers that include an evaluation component are beginning to shed some light on best practices for working with this population of caregivers. Three studies with different designs explored the impacts of home visiting programs to support FFN caregivers: the study of Early Head Start's Enhanced Home Visiting program (Paulsell, et al., 2006), the study of the Promoting First Relationships program (Maher, et al., 2008), and the evaluation of the Caring for Quality Program (McCabe & Cochran, 2008). All interventions focused on supporting caregivers' capacity to promote the positive development of young children through home visits and emphasized improving the quality of care. The Enhanced Home Visiting program provided child development information, developmentally- and age- appropriate materials and activities, health and safety materials, and mentoring during regular home visits and offered group activities. The study also described the implementation of the program. The Promoting First Relationship program used consultation strategies, video-taping, and reflective practice to address identified social and emotional needs of the infant/toddler, improve caregiver qualities and activities, and foster healthy caregiver-parent relationships; and the evaluation used pre and post-interviews with the sample of grandparents participating in the project. Caring for Quality used home visits based on a curriculum for home-based care providers developed by Parents as Teachers, and employed a methodologically rigorous design, randomly assigning FFN and FCC caregivers to an intervention or control group.

In all three studies, caregivers expressed satisfaction with the services they received and all programs demonstrated implementation success. As described in the study, the Enhanced Home Visiting staff reported four main types of implementation success: 1) fostering relationships among caregivers, parents, and home visitors; 2) providing resources to improve the quality of care; 3) delivering services to the caregivers; and 4) effecting changes in caregiver practices (Paulsell, et al., 2006). The qualitative assessment of the Promoting First Relationships program - based on interviews with caregivers - revealed the following perceived program outcomes: 1) grandmothers felt more confident in their caregiving skills, gained new knowledge, and received social supports; 2) caregivers built more responsive and understanding relationships with children and gained better discipline techniques; 3) some caregivers

noted positive changes in children's behaviors; and 4) caregivers thought relationships with parents improved (Maher, et al., 2008). In Caring for Quality, quality measured using the FDCRS, increased significantly for all home-based providers who participated in the home-visiting program compared to the providers who did not (McCabe & Cochran, 2008).

In addition to home visiting programs, other training and support programs have been implemented to support FFN caregivers. A family interaction model called "Tutu and Me" was implemented in 18 counties in Hawaii to support family caregivers and help support children's development prior to entering school. Services included: two-hour sessions twice a week in which adults and children interacted in various activities, lectures/trainings on child development, a caregiver resource center and children's book bags, and child assessments. Pre- and post-test evaluations of the program indicated that there were improvements in the quality of interactions for children under 5 on communication and engagement, as well as slight improvements in nurturing behaviors of parents participating in the program for children under three (Porter & Vuong, 2008). In 2007, Minnesota passed the first legislation of its kind to provide state funding for programs to educate and support FFN providers. After the first two years of program development and implementation, providers who were judged by program staff to be consistent participants reported that they were frequently engaged in learning activities with children; providers also reported positive relationships with parents (Susman-Stillman & Stout, 2010).

All these evaluations demonstrate that support programs for FFN caregivers seem to lead to improved caregiver knowledge about child development, practices with children, and relationships between caregivers and parents, as well as offering social supports to caregivers who may be isolated. More research however, is needed to understand how such support programs, and the knowledge and skills they promote, affect child care quality and child outcomes.

METHODOLOGICAL ISSUES

Across the nation, FFN caregiving is a vital and integral part of families and communities, and the growth in research on the quality of FFN care is both exciting and critical. This young body of literature yields beginning findings as well as a recognition of the kinds of challenges posed by studying caregiving in family and community contexts. Some challenges in studying the quality of FFN care are theoretical, and demonstrate the potential differences in values that shape research on child care. Other challenges are practical, and illustrate the tension between rigorous research designs and the realities of conducting research in home and community contexts.

Interpreting Low Process Quality Ratings

While low ratings of quality are often obtained in regulated settings as well as unregulated settings (with licensed centers generally scoring higher on measures of quality than regulated family day care homes, Li-Grining & Coley, 2006; Fuller, et al., 2004; Jaeger & Funk, 2001), in the studies included here, unregulated homes virtually always received the lowest quality scores on the FDCRS. It may be true that FFN providers are doing a poorer job caring for children than providers in licensed child care centers. However, because the field lacks a clear definition of quality in FFN settings, and across all child care settings, current instruments used to measure quality may miss important attributes of FFN care and be more likely to yield scores favorable to regulated care settings. This suggestion should be given careful consideration in light of the apparently higher scores of observed quality of FFN settings in studies using the QUEST and the CCAT-R (Layzer & Goodson, 2006; Tout & Zaslow, 2006) than using the FDCRS.

Careful interpretation of the findings is critical, particularly because the samples of FFN providers included in most current FFN quality studies are low-income. While some researchers conclude that center-based care is better able to meet children's developmental needs than FFN care (Li-Grining & Coley, 2006; Fuller, et al., 2001), a more accurate reflection of research findings is that FFN providers

from low-income backgrounds with lower levels of education provide lower process quality care as measured by the FDCRS than better educated providers in licensed settings. However, FFN providers with greater financial and educational resources may provide quality of care comparable to or better than licensed providers in home-based settings. The quality of FFN care, as it is a form of home-based care, is rooted in the family and/or neighborhood context and for that matter, depends heavily on socioeconomic factors that affect the caregiver's resources and competence. Further research with FFN providers across the socioeconomic continuum is needed.

Parents' support for FFN caregiving underscores the importance of understanding the relatively low quality ratings FFN care receives using measures traditionally used for licensed care settings. The majority of parents using FFN care report that they are satisfied. They find FFN care to be the most flexible, affordable, accessible and trustworthy (Li-Grining & Coley, 2006). They believe that their caregivers have the necessary training and experience, even if they do not (Anderson, et al., 2005) and feel as though their children are safe and well-cared for and receive individual attention (Layzer & Goodson, 2006; Porter, 1998). Learning opportunities are not a top priority for parents but they would happily support FFN providers in efforts to promote children's learning. (See *Measuring Quality in Family, Friend, and Neighbor Care: Conceptual and Practical Issues* for more information on measuring quality in FFN care at www.researchconnections.org/location/12033)

Defining and Measuring Quality in FFN Settings

One of the difficulties in rating quality of FFN care is that there is currently no consensus about how to define quality in FFN settings, as well as the extent to which a definition of FFN quality is different from an overarching definition of child care quality. Should researchers seek to develop a definition of child care quality that highlights the universals and transcends setting, then based on theory and best practice, select different key indicators for each child care setting?

Key issues need to be addressed, but should all dimensions of quality be given equal weight, or should emphasis be given to unique features of care by setting, such as differences in caregiver-child relationships; and what should be the expectations for quality in FFN settings? For example, caregiving activities with the child that occur during non-traditional child care times such as night and weekends, may support children's development but are not recognized by currently-used measures of child care quality developed for regulated settings. Brandon (2005) argues that caregiver-child interaction time is critical regardless of the timing of care (daytime, nighttime or weekend hours) or the nature of the activity. Another important consideration is time spent in other forms of care, as it is not uncommon for children who spend time in FFN care to also spend time in formal settings (Knox, London & Scott, 2003). The introduction of a family-sensitive/support perspective may be helpful as well, as it can apply to both licensed and licensed-exempt settings (Bromer, et al., 2011). Further definitional clarification is important so that appropriate measures of quality can be developed and used appropriately.

Conducting Research with FFN Caregivers

There are notable challenges in conducting research with FFN caregivers, including sampling and measurement.

Engaging FFN Caregivers in Research

In general, sampling can be a tremendous challenge. Recruiting FFN providers is difficult, time-consuming and expensive, and few researchers are able to muster the necessary resources (see Layzer & Goodson, 2006 for a description of the difficulties encountered in sampling). Recruiting a representative sample of FFN caregivers for research is a challenge because, by definition, they tend to be an invisible, informal, and diverse population; because recruitment is labor-intensive; and because earning their trust is time-consuming (Whitebook, et al., 2003). Gaining access to FFN caregivers in their homes, necessary for observing the quality of care, is especially difficult, even after they have participated in an inter-

view (see Tout & Zaslow, 2006). As a result, samples of convenience are common (Brown-Lyons, et al., 2001), or select populations are studied, and generalizability is limited. For example, Shivers (2005) sampled FFN providers who were taking part in FFN provider training, and Whitebook, et al. (2003) studied FFN providers participating in the Child Care Development Fund (CCDF) subsidy program. While there are legitimate reasons to restrict sampling to the CCDF population, it is also the case that CCDF providers are easier to locate and track. Other sampling strategies in the literature include "snowballing," where initially identified subjects identify other prospective subjects (Whitebook, et al., 2004); "purposeful sampling," where researchers intentionally recruit a sample of interest and ensure that groups are distributed to include a variety of other factors including background and experience (ETR, 2003); and random digit-dial (Chase, et al., 2005 b, c).[9] The reality is that with FFN populations, as compared to licensed caregiving populations, representative samples are harder to achieve.

The difficulty encountered in sampling FFN populations reflects the larger problem of reaching and engaging FFN providers. The heterogeneity of the FFN population necessitates a range of strategies to engage them in research, but there are virtually no comparative data to indicate which strategies are the most effective in engaging the FFN population for research purposes. Researchers are however, starting to have some success with recruiting samples of FFN caregivers and learning strategies for engaging them in research, such as using organizations and staff that caregivers trust. As the field evolves, some of the sampling and recruitment challenges may be less problematic.

Measurement

Measurement problems are also a challenge when studying the quality of FFN caregiving. The FDCRS has been used most frequently in studies of FFN care, but there are concerns over whether that standardized measure is appropriate to use it to rate quality in these settings. Critics offer the following reasons: the FDCRS was designed to assess the formal aspects of

home-based care – for example, the features of home-based care that are more similar to center-based settings than to unregulated settings. It is also easier to identify areas of weakness such as learning opportunities and materials, than to assess and focus on areas of strength unique to FFN care such as the relationship between caregiver and child. The instrument does not measure particular aspects of care that are critical to certain families, such as use of native language or particular cultural strategies. The FDCRS' ability to account for cultural variations in quality given the racial and ethnic diversity in FFN care is unclear. Finally, the instrument only has one section related to parent-provider relationships and does not capture other factors that parents consider important.

Use of different tools, such as the QUEST, the Child Care HOME, and the CCAT-R (Layzer & Goodson, 2006; Tout & Zaslow, 2006; Whitebook, et al., 2004; Porter, et al., 2005), is a step in the right direction. They are more likely to present a better balanced picture of the quality of care in FFN settings, but they do not offer scores that can be compared across different care settings. Only the CCAT-R is designed to capture unique features of FFN care and those which parents and providers value, namely the quality of the relationship between a grandparent and a grandchild and the relationship between the grandparent and the parent.

Furthermore, unmeasured provider and socio-economic factors – such as poverty, mental health problems, and family stresses – affect the caregiving context (Shivers, 2005). While provider and socioeconomic factors are not unique to FFN caregivers, the ways in which these factors shape the caregiving context in licensed-exempt settings may differ from their impact on the caregiving context in licensed homes and centers and have different, potentially stronger effects on low-income children whose homes also lack resources.

Issues Not Adequately Addressed in the Current Set of Studies

Understanding the Impact of FFN Care on Children's Development

While aspects of quality care predict children's development in licensed center and home-based settings, fewer data are available at this point in time to document comparable findings in FFN settings. Overall, the studies to date have been descriptive, not predictive of children's development, and have not focused on implications for unique groups, such as children with special needs, infants, and school-age children. There are data describing FFN use among school-age children; however, no studies located for this review focus on the quality of FFN care for school-age children. Going forward, building on this new and growing area of research, it will be important to more thoroughly describe the experiences and outcomes of children in FFN care, while also acknowledging that FFN care is for many one piece of a patchwork of different care settings (Knox, et al., 2003).

Understanding Factors that Affect the Provision of Quality of FFN Care

Personal, familial and contextual factors are likely to affect the provision of quality care in FFN settings. Little is known about the effect FFN caregiving has on the mental and physical health of the providers, as well as on family relationships and intergenerational and community ties. In one study, grandmothers who provided care were in poorer health than grandmothers who did not provide care (Guzman, 1999). When asked via survey or focus groups, some grandmothers in other studies reported the strains that providing care places on them in their personal lives (Anderson, et al., 2005; Bromer, 2006; Drake, et al., 2004). There is also some indication that family relationships may be strengthened by provision of care, although care by grandmothers was more common when the relationships between the grandmother and her daughter or daughter-in-law were already close (Guzman, 1999). However, studies also suggest that there may be increased conflict between a grandmother and her daughter over childrearing styles (Porter, 1998). Issues of conflict resolution and negotiation are also not well understood.

The receipt of subsidy dollars is another important contextual influence on the quality of FFN care. Some data from the Minnesota survey of FFN providers suggest some differences between subsidy and non-subsidy providers, such as length of time care is provided and motivations for caregiving (Chase, et al., 2006). For example, are subsidy providers more akin to licensed providers (e.g., providing care for longer hours), and thus more likely to seek out professional development and become licensed caregivers? Should there be different expectations for the quality of care provided in subsidized FFN homes as compared to non-subsidized FFN homes? More research is needed to understand the impact of subsidy use on FFN use, FFN caregivers and FFN care.

Developing a Research and Program Evaluation Agenda

Reflection on this developing literature suggests the need for conceptual and methodological refinements to improve the ability to define and study quality; address specific questions about FFN quality and its impact on children's development; and implement and evaluate strategies to best provide education and support to FFN caregivers and their families. Researchers will likely try newer measures, such as the CCAT-R (Porter, et al., 2005) and the QUEST (Layzer & Goodson, 2006), as they gauge caregiver-child interactions and quality. Examples of future questions may include:

▶ Across a broad range of FFN providers, are there differences in the extent to which measures capture quality of care?

▶ How are the unique features of quality in FFN care settings linked to children's development?

▶ How do personal, familial and contextual features of the FFN care provider and setting affect the quality of FFN care?

While there is a range of ongoing efforts to provide education and support to FFN providers across

the nation, future research needs to focus on documenting effective outreach, curricular and program efforts as well as linking programs to improvements in the quality of care. For example:

► Which kinds of outreach strategies are most effective in linking FFN caregivers to education and support?

► Do effective supports differ for relatives and non-relatives, or by cultural group?

► How does participation in support or peer groups improve the quality of care provided by FFN caregivers?

► Does participation in community-based activities or family support programs improve the stability of FFN caregiving arrangements and children's opportunities for learning?

STUDIES TO WATCH FOR

Several FFN intervention studies are underway. The *Caring for Quality Project: Supporting and Connecting Home-Based Child Care Providers* – evaluated the effects of bi-monthly home visits with registered family child care providers and family, friend, and neighbor caregivers in Rochester, NY (McCabe & Cochran, 2008). This pre-, post-test, random assignment study assessed the quality of care (using the FDCRS), provider characteristics, and child outcomes. A process study also examined successes and challenges of program implementation. Publication of the final report of the findings is forthcoming.

Illinois Action for Children created a new model of support for home-based child care through its *Community Connections* project. This mixed-approach model links families, their home-based child care providers, and center-based pre-kindergarten programs (part of Illinois' Pre-K For All state kindergarten program) in caring for and educating preschool-age children. Children already enrolled in licensed or license-exempt home-based care are transported to a state pre-kindergarten program for half-day sessions four days per week. Approximately twice a month, when the child is in the home-based

setting, the pre-kindergarten teachers visits the home-based provider to coordinate the curriculum, bring new resources, and discuss children's progress. Parents and providers also attend monthly meetings and other events at the center, which also serves as a lending library for parents to exchange "Raising a Reader" books and materials. The aim of the program is alignment and communication across all settings involved in the care of the child. Publication of the implementation study, which examines program implementation success and challenges, caregiver gains from participation, and quality assessments of the home-based care arrangements (using the CCATR), is forthcoming. A second phase of the evaluation measuring child outcomes and program impacts is also expected.

CONCLUSION

The literature on the quality of FFN care is growing, and with it, an understanding about the importance of FFN care and the need to appropriately study it. At this early stage of development there are: opportunities to enhance the current conceptual frameworks; lessons learned from conducting research with FFN populations; insights into measures; and interest in implementing and evaluating strategies to improve the quality of care in FFN.

Like studies examining the quality of licensed care, studies of the quality of FFN care offer a profile of care with both strengths and weaknesses and of care that has range of quality within it. Given the prevalence of and public investment in FFN care, researchers and policymakers are challenged with insuring that the quality of FFN care, or any care that children are receiving, is of the highest quality possible. Future research and practice holds promise for supporting FFN caregivers and the children and families for whom they care.

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ENDNOTES

1. For further discussion about the definition of FFN care, as well as definitional issues for licensed family-based care, refer to *Family, Friend, and Neighbor Care in the United States: Demographics* (www.researchconnections.org/childcare/resources/14337) and *A Literature Review of Family Child Care in the United States* (www.researchconnections.org/childcare/resources/11683).

2. Also, for additional information on the quality in home-based care, see *A Review of the Literature on Home-based Child Care: Implications for Future Directions* www.researchconnections.org/childcare/resources/19342.

3. Since the studies above were conducted, a revised version of the FDCRS, the Family Child Care Rating Scale (FCCRS), has been published. We have not located any current studies that have used the FCCRS as the observational measure to study quality in FFN settings.

4. For further discussion on quality measurement issues in FFN care see below as well as *Measuring Quality in Family, Friend, and Neighbor Care: Conceptual and Practical issues* by Erin Maher www.researchconnections.org/location/12033.

5. For profiles of many quality measures targeted to Family, Friend, and Neighbor as well as other care settings, see *Quality in Early Childhood Care and Education Settings: A Compendium of Measures* www.researchconnections.org/location/13403.

6. FFN caregivers in Minnesota may be an exception, with at least half of a random sample of FFN providers reporting taking parent education and more than one-third having child care training. This may be an example of state variations, as Minnesota has offered a statewide parenting education program for over 25 years.

7. The CCAT-R measures the frequency of specific types of adult-child interactions during an observation period. Ratings of poor, adequate and good are based on factor scores that include a group of specific items (Porter, Rice, & Rivera, 2006; Porter & Vuong, 2008). The Early Head Start Enhanced Home Visiting Pilot (Paulsell et al., 2006) reported the CCAT-R findings as a percentage of the total observation periods (up to 60 20-second observation periods) in which child-caregiver interactions were observed. The greater the number of interactions and the proportion of interactions recorded the higher the quality of care.

8. This is likely due in part to the ages of children in homes of relative caregivers (more likely to be infants and toddlers and school age).

9. Random digit dial was used to obtain the first representative sample of FFN providers to date (Chase, et al, 2005), and eligible subjects obtained via the random digit dial were recruited for an observational study (Tout & Zaslow, 2006).

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