DOCUMENT RESUME

ED 453 903 PS 029 277

AUTHOR	Doherty, Gillian; Lero, Donna S.; Goelman, Hillel; Tougas, Jocelyne; LaGrange, Annette
TITLE	Caring and Learning Environments: Quality in Regulated Family Child Care across Canada. You Bet I Care!
INSTITUTION	Guelph Univ. (Ontario). Centre for Families, Work and Well-Being.
SPONS AGENCY	Human Resources Development Canada, Ottawa (Ontario).
ISBN	ISBN-0-88955-506-0
PUB DATE	2000-00-00
NOTE	213p.; Research funded by the Child Care Visions Program, Social Development Partnerships Division, Human Resources Development Canada. For other reports in this series, see PS 029 278-279.
AVAILABLE FROM	Centre for Families, Work and Well-Being, University of Guelph, Guelph, Ontario N1G 2W1, Canada. Tel: 519-824-4120; Fax: 519-823-1388; e-mail: cfww@uoguelph.ca; Web site: http://www.uoguelph.ca/cfww.
PUB TYPE	Reports - Evaluative (142) -- Tests/Questionnaires (160)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	Caregiver Child Relationship; Caregiver Role; *Child Caregivers; Compensation (Remuneration); *Day Care; Early Childhood Education; *Educational Environment; *Family Day Care; Foreign Countries; Infant Care; Models; National Surveys; Observation; Predictor Variables; Tables (Data); *Work Environment
IDENTIFIERS	Canada; Caregiver Attitudes; Caregiver Behavior; Caregiver Qualifications; *Day Care Quality; Quality Indicators

ABSTRACT

Canadian experts in diverse fields as well as people concerned about social justice and cohesion have identified quality child care as a crucial component in addressing a variety of broad societal goals. This study explored the relationships between quality in Canadian family child care homes and: provider characteristics and attitudes about family child care provision; provider income levels and working conditions; and the provider's use of support services, networking with other providers, and professional development opportunities. Data were collected from 231 regulated family child care providers across 6 Canadian provinces and 1 territory, followed by observations in each provider's home. Data analysis focused on identifying the critical factors that predict the level of quality in a family child care home. Findings suggest that physically safe environments with caring, supportive adults are the norm in a majority of family child care homes. However, only just over one third of child care homes provided care that would stimulate children's development. Key variables that predicted family child care home quality as indicated by the score on the Family Day Care Rating Scale were the provider's highest level of education in any subject, provider completion of a formal family child care-specific training course, provider networking with others through an organized association, provider's gross family child care income from the previous year, age of the youngest child present, and the provider's attitude about family child care provision. Findings suggest that methods to support and encourage quality should include recruiting well-educated individuals to

Reproductions supplied by EDRS are the best that can be made
from the original document.

the field, providing family child care-specific training, supporting development of networking organizations, developing strategies to enhance provider compensation, providing extra supports for people providing infant care, and promoting and recognizing family child care as a socially important and enjoyable career option. (Eleven appendices include an overview of research on the relation of family child care quality to child development outcomes, an overview of family child care requirements, data collection instruments, and a delineation of the predictor variables used in the analysis. Contains 131 references.) (KB)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 453 903

you bet I CARE!

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
Donna S. Lero
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
1

Caring and Learning Environments:

Quality in Regulated Family Child Care Across Canada

PS 029277
BEST COPY AVAILABLE
ERIC

Caring and Learning Environments:

Quality in Regulated Family Child Care Across Canada

Principal Investigators:

Gillian Doherty
Child Care Consultant, Ontario and
Adjunct Professor, Department of Family Relations and Applied Nutrition
University of Guelph

Donna S. Lero
Department of Family Relations and Applied Nutrition
University of Guelph

Hillel Goelman
Department of Educational and Counselling Psychology and Special Education
University of British Columbia

Jocelyne Tougas
Child Care Consultant, Québec

Annette LaGrange
Faculty of Education
University of Calgary

© 2000, Centre for Families, Work and Well-Being, University of Guelph, Ontario

Published by: Centre for Families, Work and Well-Being, University of Guelph, Ontario
Copy editing: Denis Alarie and Judith Bell
Translation: Jocelyne Tougas
Design/layout: Fairmont House Design
Printing: MOM Printing

To obtain additional copies of this report, please contact:
Centre for Families, Work and Well-Being
University of Guelph
Guelph, Ontario N1G 2W1
Tel: (519) 824-4120, ext. 3829
Fax: (519) 823-1388
e-mail: cfww@uoguelph.ca
Website: www.uoguelph.ca/cfww

Canadian Cataloguing in Publication Data

Main entry under title:
Caring and learning environments: quality in regulated
family child care across Canada

Includes bibliographical references and index.
ISBN 0-88955-506-0

1. Family day care — Canada. 2. Family day care — Canada — Evaluation.
I. Doherty, Gillian. II. University of Guelph. Centre for Families, Work and Well-Being.

HQ778.7.C3C372 2000 362.71'2'0971 C00-932778-9

This research was funded by the Child Care Visions Program of the Social Development Partnerships Division of Human Resources Development Canada. The views expressed are solely those of the authors and do not represent the official policy of the Department of Human Resources Development Canada.

Table of Contents

Acknowledgements ix

Executive Summary xi

Summary of Recommendations xv

Chapter 1: Introduction **1**
1.1. The Three Studies of the *You Bet I Care!* Project 1
1.2 The Importance of Child Care Quality 2
1.3 Family Child Care Quality and Its Influence on Child Development 3
1.4 Dimensions of Quality 4
1.5 The Uniqueness of Family Child Care 6
1.6 The Importance of Family Child Care in the Child Care System 6
1.7 The Regulatory Climate for Family Child Care in Canada 7
1.8 Provincial/Territorial Funding for Family Child Care 8
1.9 The Goals of the Study 9
1.10 The Purpose of This Report 10
1.11 Issues in Presenting the Findings 10
1.12 How This Report is Organized 11
Notes 12

Chapter 2: The Uniqueness of Family Child Care **13**
2.1 Introduction 13
2.2 The Nature of Family Child Care 13
2.3 Contributors to Family Child Care Quality: What Does the Research Tell Us? 16
2.4 Evolving Perspectives on Family Child Care 17
2.5 A Need for a Model of Quality that is Family Child Care-Specific 20
Notes 21

Chapter 3: Methodology **23**
3.1 Introduction 23
3.2 Sample Selection and Recruitment 23
3.3 Sample Representativeness 27
3.4 Data Collection Instruments 29
3.5 Observer Training and Inter-Rater Agreement Levels 32
3.6 Data Collection 33
3.7 Data Coding, Cleaning and Preparation 33
3.8 Data Analysis 34
Notes 34

Chapter 4: Family Child Care Providers: Who They Are and How They Feel about Their Work **35**
4.1 Introduction 35
4.2 Demographic Profile 36

ERIC Full Text Provided by ERIC

4.3 Education and Professional Development 36
4.4 Work History 40
4.5 Feelings about Their Work 43
4.6 The Positive Aspects of Working as a Family Child Care Provider 45
4.7 The Negative Aspects of Working as a Family Child Care Provider 45
4.8 Satisfaction with Their Career Choice 46
4.9 Advice to a Friend 48
4.10 Summary 49
Notes 50

Chapter 5: The Practice of Family Child Care 51
5.1 Introduction 51
5.2 The Children and Their Families 51
5.3 Days, Hours and Weeks of Work 56
5.4 Income 57
5.5 Benefits 59
5.6 Support from Other Providers 61
5.7 Support from Community Services and Programs 63
5.8 Relationship with the Licensing Official or the Agency 65
5.9 Summary 68
Notes 70

Chapter 6: Descriptive Data on the Quality of Family Child Care in Canada 71
6.1 Introduction 71
6.2 The *Caregiver Interaction Scale (CIS)* 71
6.3 The *Family Day Care Rating Scale (FDCRS)* 73
6.4 Individual Items on the *FDCRS* 75
6.5 Reasons for Optimism, Reasons for Concern 76
6.6 Intercorrelations among Quality Measures 77
6.7 The Findings from Previous Research 78
6.8 Summary 80
Notes 80

Chapter 7: What Correlates with Quality in Family Child Care? 81
7.1 Introduction 81
7.2 Issues in Presenting and Interpreting the Research Results 81
7.3 The Number and Ages of Children in the Observed Family Child Care Home 82
7.4 Providers' Demographic Characteristics, Overall Educational Background and Prior Child Care Experience 83
7.5 The Provider's Child Care-Specific Education, Training and Professional Development 84
7.6 The Adult Work Environment 85
7.7 Supervision and Support, the Provider's Affiliation with Organizations and Networks, and Use of Community Supports 87
7.8 The Provider's Perspectives, Motivation and Evidence of Intentionality 88
7.9 Summary 90
Notes 90

6

Chapter 8: Predictors of Quality in Family Child Care ... 91
8.1 Introduction ... 91
8.2 Predicting Process Quality ... 91
8.3 What Accounts for Differences Between Homes with the Highest and the Lowest Quality Scores? ... 92
8.4 Predicting Across the Full Range of Quality Scores ... 94
8.5 Strategic Policy Probe ... 96
8.6 Summary ... 96
Notes ... 98

Chapter 9: Summary and Recommendations ... 99
9.1 Introduction ... 99
9.2 Quality Child Care: A Crucial Component in Addressing Broad Societal Goals ... 99
9.3 Family Child Care: A Vital Part of the Child Care System ... 100
9.4 Regulated Family Child Care Quality in Canada ... 100
9.5 Predictors of Quality: A Dynamic Interaction of Different Variables ... 102
9.6 Major Issues in Family Child Care ... 104
9.7 Recommendations ... 105
9.8 Closing Words ... 117
Notes ... 117

Appendix A: Research on Family Child Care Quality and Its Influence on Child Development ... 119

Appendix B: Overview of Family Child Care Requirements by Jurisdiction ... 127

Appendix C: Research on Contributors to Family Child Care Quality ... 135

Appendix D: Home Child Care Program Questionnaire ... 141

Appendix E: Questionnaire for Individually Licensed Providers ... 149

Appendix F: Agency Caregiver Questionnaire ... 161

Appendix G: Interview with Provider ... 173

Appendix H: *Caregiver Interaction Scale* ... 177

Appendix I: An Overview of the *Family Day Care Rating Scale* ... 179

Appendix J: The Thirty Possible Predictor Variables Used in the Analyses ... 181

Appendix K: Strengths and Limitations of the Study, and Implications for Future Research ... 183

References ... 187

Glossary of Abbreviations ... 195

Tables

1.1: Provincial Recurring Grants to Family Child Care Providers, 1999 8
3.1: The Communities from Which Providers Were Drawn 24
3.2: The Final Sample: Participation and Refusal Patterns, by Jurisdiction 26
3.3: A Comparison of the 1996 Sector Study Sample and the 1999 *YBIC!* Study 3 Sample 28
4.1: Highest Level of Educational Attainment in Any Field, 1999 36
4.2: Completion of a Formal Family Child Care-Specific Training Course, 1999 37
4.3: Highest Level of Post-Secondary Education in ECCE or Related Discipline, 1999 38
4.4: Reasons for Participation in Professional Development Activities, 1999 39
4.5: Reasons for Becoming a Family Child Care Provider, 1999 40
4.6: Reasons for Joining the Regulated System, 1999 42
4.7: Degree of Perceived Stress Associated with Certain Situations, 1999 44
4.8: Most Frequently Cited Reasons for Not Expecting to Continue to Provide Family Child Care, 1999 47
5.1: Number of Children and Families Currently Being Served, by Jurisdiction, 1999 52
5.2: Average Number of Children Receiving Care in a Home in Each of Three Age Ranges, by Jurisdiction, 1999 53
5.3: Characteristics of the Children, 1999 55
5.4: Children's Length of Time with the Same Provider, by Jurisdiction, 1999 55
5.5: Median Daily Fees Charged for Full-Time Care, by Jurisdiction, 1999 57
5.6: Gross Child Care Income in the Previous Year, Study 3 Providers Working 48 Weeks or More Only, 1999 58
5.7: Percent of Gross Child Care Income Spent on Child Care-Related Expenses, Total Study 3 Sample, 1999 58
5.8: Proportion of Study 3 Providers Receiving Certain Types of Assistance, 1999 60
5.9: Benefits Available to Study 3 Providers, 1999 61
5.10: Providers' Reported Networking with Other Providers, by Jurisdiction, 1999 62
5.11: Providers' Average Frequency of Contact per Month with Other Providers, by Jurisdiction, 1999 62
5.12: Membership in a Child Care Organization, Study 3 Providers, by Jurisdiction, 1999 63
5.13: Use of Community Services by Study 3 Providers, 1999 64
5.14: Frequency of Visits by Licensing Official in the Four Jurisdictions where Providers Are Individually Licensed, and Average Duration of the Visits, 1999 65
5.15: Frequency of Visits by Home Visitor in the Three Provinces Using an Agency Model, and Average Duration of the Visits, 1999 66
5.16: Types of Assistance Desired from Home Visitor by Study 3 Providers, by Jurisdiction, 1999 66
5.17: Relationship with Home Visitor Reported by Study 3 Providers, by Jurisdiction, 1999 67
6.1: Range and Mean of *CIS* Sub-Scale Scores, Total Sample, 1999 72
6.2: Range and Mean of *CIS* Sub-Scale Scores, by Jurisdiction, 1999 72
6.3: Range and Mean of *CIS* Sub-Scale Scores, by Regulatory Type, 1999 73
6.4: Average *FDCRS* Sub-Scale and Total Scores, by Jurisdiction, 1999 75
6.5: Average *FDCRS* Sub-Scale and Total Scores, by Regulatory Type, 1999 76
6.6: *FDCRS* and *CIS* Correlations, 1999 77
6.7: Comparison of the Overall Profile of Child Care Centres and Family Child Care Homes in Canada, *YBIC!* Study 2 and Study 3 78

ERIC Full Text Provided by ERIC

6.8: Comparison of Mean Total *DCHRS* Scores Obtained in Previous Studies with the 1999 *FDCRS* Mean Total Scores for the Same Provinces 79
6.9: Comparison of the Profile of Overall Quality in Two Studies 80
7.1: *FDCRS* and *CIS* Correlations with Observed Variables, 1999 82
7.2: *FDCRS* and *CIS* Correlations with Provider's Overall Educational Background and Experience as a Child Care Provider, 1999 83
7.3: Average *FDCRS* Total Scores, by Educational Attainment, 1999 84
7.4: *FDCRS* and *CIS* Correlations with Provider's Child Care-Specific Educational Background, Family Child Care Training and Participation in Professional Development Activities, 1999 85
7.5: *FDCRS* Correlation with Provider's ECCE-Related Education, 1999 85
7.6: *FDCRS* and *CIS* Correlations with Aspects of Providers' Workload, Remuneration and Working Conditions, 1999 86
7.7: *FDCRS* and *CIS* Correlations with Providers' Networking, Affiliation with Local Associations and Family Child Care Organizations, and Use of Community Resources, 1999 87
7.8: *FDCRS* and *CIS* Correlations with Indicators of Intentionality, 1999 89
8.1: Distribution of Providers in Four Quartiles on the Basis of *FDCRS* Total Scores, by Jurisdiction, 1999 93
8.2: Comparison of Providers in the Top and Bottom Quartiles of *FDCRS* Total Scores, 1999 95
8.3: Predictors of Process Quality, 1999 97
8.4: Comparison of Providers with Different Combinations of: Some ECCE Courses, Having Completed Family Child Care-Specific Training, and Affiliation 98
9.1: *CIS* Scores, Total Study 3 Sample, 1999 101
9.2: Summary of Significant Correlations between High Provider Sensitivity Score and Various Variables, and the Variables that Predict Higher *FDCRS* Total Scores, 1999 103

Figure

6.1: Overall Quality in Family Child Care Homes as Measured by the *Family Day Care Rating Scale,* 1999 74

ERIC Full Text Provided by ERIC

Acknowledgements

The researchers wish to express their sincere appreciation to the agency directors and the family child care providers who gave so generously of their time and knowledge to complete the questionnaires. We are particularly indebted to those wonderful women who invited us into their homes, allowed us to observe their programs, and sometimes even fed our observers!

We also thank the Child Care Visions (CCV) Program of the Social Development Partnerships Division of Human Resources Development Canada for its financial assistance, and Penny Hammell of CCV for her unfailing support and encouragement. Without support from programs such as CCV, large studies of this type — so crucial for policy development and practice — would not occur. We are also grateful to the universities of Guelph, British Columbia and Calgary for their sponsorship.

Hats off to our site coordinators for a difficult job, well done. They were: Sandra Beckman (the Yukon), Leona Howard (Ontario), Sandi Moussadji (British Columbia), Lois Okrainec (Saskatchewan), Dixie van Raalte (New Brunswick), Jocelyne Richer (Québec) and Sherry Woitte (Alberta).

Our able data collectors were: Elizabeth Allsopp (Ontario), Monique Beaulieu (New Brunswick), Natalie Bigras (Québec), Annie Cloutier (Québec), Nathalie Demers (Québec), Carol Greenaway (Alberta), Laurie LaFortune (Saskatchewan), Nona Laird (Saskatchewan), Maryse Lortie (Québec), Marg Rodrigues (British Columbia), Sharon Pirie (Ontario), Tina Sykes (Ontario), Wendy Waite-Snow (New Brunswick), and Bonnie Walker (the Yukon).

Lee Dunster and Irene Kyle provided invaluable assistance in determining the content of the agency and provider questionnaires, and in helping us to identify the priority issues to explore.

Donna Lero, assisted by Leo Keating, did the data analyses that allowed us to identify some key predictors of quality in family child care.

Executive Summary

Canadian experts in diverse fields — for example, health,[1] education,[2] economics,[3] crime prevention[4] — as well as people concerned about social justice,[5] have identified quality child care as a crucial component in addressing a variety of broad societal goals. These goals include: (1) promoting the optimal development and school readiness of all children; (2) supporting economic productivity and labour-force attachment; and (3) promoting social cohesion. This report documents the findings of the largest, most systematic and most multi-jurisdictional study ever conducted in Canada to explore the relationships between quality in family child care homes and:

1. provider characteristics and attitudes about family child care provision;
2. provider income levels and working conditions; and
3. the provider's use of support services such as child care resource programs, networking with other providers, and professional development opportunities.

Data were collected from 231 regulated family child care providers across six provinces and one territory, followed by observations in each provider's home. The data analyses went beyond simple description of the associations found between quality and the characteristics of the providers and homes to identification of the critical factors that *predict* the level of quality in a family child care home.

The scores obtained by the providers as a group on the *Caregiver Interaction Scale (CIS)* indicate high levels of warm, attentive and engaged behaviour with children and low levels of harshness or detachment. The *CIS* scores, along with scores from the *Family Day Care Rating Scale (FDCRS)* indicate that physically safe environments with caring, supportive adults are the norm in the majority of family child care homes in Canada. As indicated by the *FDCRS*, over a third of family child care providers, 36.8%,

ERIC Full Text Provided by ERIC

were also providing activities that would stimulate social, language and cognitive development, thereby setting the stage for school readiness.

Despite the encouraging data from the *CIS*, the results from the *FDCRS*, a measure of the overall quality of the home as a child care setting, are cause for concern. The *FDCRS* is scored on a seven-point scale with scores of 3.0 or below indicating inadequate to minimal custodial care. Homes that score between 4.0 and 4.99 are protecting health and safety, and providing some activities that support children's development. A score of 5.0 is considered to be the cut-off between good custodial care and care that includes the deliberate provision of activities that not only support, but also stimulate, children's development.

The average score on the *FDCRS* obtained by the group as a whole was 4.5. The proportion of providers obtaining scores at each level was:

- below 3.0 — 7.8%;
- between 3.0 and 3.99 — 23.8%;
- between 4.0 and 4.99 — 31.6%;
- between 5.0 and 5.99 — 26.8%;
- 6.0 or higher — 10.0%.

In summary, only just over a third of providers in our sample were providing care that would stimulate children's development. Children under age 6 enrolled in full-time child care, as were most of the children observed, spend on average nine hours a day, five days a week in the child care setting. Given our knowledge about the importance of developmentally appropriate stimulation for young children, the *FDCRS* findings should be a major concern for the whole of society. Our findings represent thousands of lost opportunities to support young children's optimal development. The finding that quality tended to be lower when an infant under age 18 months was in the home is of special concern.

Statistical analyses identified six key variables that *predicted* the quality in a family child care home as indicated by the *FDCRS* score. These variables were:

1. The provider's highest level of attained education in any subject, with higher levels of education predicting higher quality.

2. Whether the provider had completed a formal family child care-specific training course, with completion of such a course predicting higher quality.

3. Whether the provider networks with others through an organized association or network, with networking predicting higher quality.

4. The provider's gross family child care income from the previous year, with higher income predicting higher quality.

5. The age of the youngest child present when the *FDCRS* observation was done. The average *FDCRS* score was lower for the group of providers who had at least one child under age 18 months present than for the group where the youngest child present was older than 18 months of age.

ERIC

6. The provider's attitude about family child care provision. Higher quality was predicted by providers who stated that they intend to continue providing family child care, enjoy the work and view it as their chosen career.

Part of the data analyses included a strategic policy probe to explore the importance of: (1) family child care-specific training and (2) provider involvement with a child care resource program or a family child care organization. The findings of this exercise underscore the value of providers having completed family child care training and of communities having local organizations that can offer information, training, provider networking and other resources to support family child care providers.

Our findings suggest that methods to support and encourage quality in family child care should include:

- taking steps to recruit well-educated individuals to be family child care providers;
- providing family child care-specific training for people who wish to enter this occupation or are already involved in it but lack such training as well as ongoing professional development opportunities;
- encouraging and supporting the development of local organizations such as child care resource and referral programs and provider networks to make opportunities available for networking, information sharing and the provision of concrete supports such as equipment loans;
- developing strategies to ensure that family child care providers have a level of income that is commensurate with the knowledge, skills and responsibility associated with good child care;
- providing extra supports for people who are caring for infants; and
- promoting and recognizing family child care as a socially important and enjoyable career option.

Notes

1 National Forum on Health 1997.
2 Council of Ministers of Education, Canada 1998.
3 Cleveland and Krashinsky 1998; Kent 1999.
4 National Crime Prevention Council 1996.
5 Jenson and Stroick 1999; National Council of Welfare 1999.

ERIC Full Text Provided by ERIC

Summary of Recommendations

Recommendation on Regulation

1. Starting immediately, all jurisdictions must examine their existing policies and practices to identify those that act as disincentives for family child care providers to join the regulated system. Policies and practices that act as disincentives must be changed. In addition, all jurisdictions must immediately begin work on the development and implementation of policies and practices that will encourage family child care providers to join and remain in the regulated system, including the implementation of our Recommendations 7 and 8.

Recommendations on Provider Preparation

2. Starting immediately, all jurisdictions must require the successful completion of a first-aid course, including CPR for young children, as a pre-condition to a provider becoming regulated.

14

Recommendations on Provider Preparation (cont'd)

3. By the year 2003, all jurisdictions must require regulated providers who have not completed a post-secondary ECCE credential to complete a basic family child care provider course within the first year of starting to provide care. This course should include units on: basic health and safety, setting up the environment, nutrition, child development, child guidance, working with mixed-age groups, formulating appropriate daily routines, partnerships with parents, good business practices, and balancing work and family responsibilities. Providers who have completed a post-secondary ECCE credential, but not a formal family child care-related course, must be required to take training on issues specific to family child care within the first year of providing care. This training should include working with mixed-age groups, appropriate business practices, and balancing work and family responsibilities.

4. By the year 2003, all jurisdictions must require regulated providers to engage in a minimum of six hours of professional development each year.

5. Between now and the year 2003, all jurisdictions must take the steps required in their jurisdiction to ensure the availability and accessibility of appropriate training and professional development for *ALL* family child care providers, regardless of their regulatory status.

Recommendation on Infrastructure

6. By 2003, all jurisdictions must ensure the availability of a variety of provider support services across their jurisdiction through adequate levels of funding for existing provider supports such as child care resource programs and family child care agencies, and creating new services where none exists. Particular attention must be given to financial assistance for the development and ongoing support of provider associations.

Recommendations on Provider Income

7. Starting immediately, all jurisdictions must implement an income-enhancement grant for regulated providers. The grant amount must ensure that all providers working full-time and caring for four or more children receive, after child care-related expenses and before taxes, the equivalent of what would be earned, on average, by an entry-level staff person working full-time in a centre in the same jurisdiction. Full-time for providers should be defined as at least eight hours a day, five days a week, for 48 weeks or more a year.

8. Starting immediately, all jurisdictions must begin providing start-up grants and annual operating grants to all regulated providers.

Recommendations Relating to Children with Specific Characteristics

9. Starting immediately, all jurisdictions must provide an "infant incentive grant" to regulated family child care homes providing care for a child under age 18 months in recognition of the additional time, expense and effort required to provide high-quality care for very young children.

10. All jurisdictions must work with family child care provider associations, family child care agencies and other organizations that deliver training and professional development to develop and implement opportunities for providers to obtain special training for working with infants and young toddlers in the context of a family setting and a mixed-age group.

11. Starting immediately, all jurisdictions must provide "special needs funding" to regulated family child care providers who look after a child with special needs. Such funding must take into account the particular needs of the individual child(ren) and the type of additional assistance or costs that might be required to give appropriate care. In situations where a provider cannot accept her full complement of children because of the time and attention required by the child, the special needs funding must include compensation for her lost income.

12. All jurisdictions must take action to ensure the provision of training specific to the child's needs, plus consultation and appropriate resources for providers caring for a child who has special needs.

Recommendation on Provider Recruitment

13. Governments, family child care organizations and professional organizations must immediately undertake public education/awareness strategies that will assist people to understand the link between the importance of children's experience during their early years and the value of people who work in child care.

ERIC Full Text Provided by ERIC

Chapter 1
Introduction

1.1 The Three Studies of the *You Bet I Care!* Project

The *You Bet I Care!* project involved three studies and covered both centre- and family-based child care settings serving children under the age of 6.

Study 1, the findings of which are reported in *You Bet I Care!: A Canada-Wide Study on Wages, Working Conditions and Practices in Child Care Centres,*[1] used mail-out questionnaires to obtain information about wages, working conditions, staff educational levels, centre practices and staff views on child care as a career from centres in each province, the Northwest Territories and the Yukon.

Study 2, the findings of which are reported in *Caring and Learning Environments: Quality in Child Care Centres Across Canada,*[2] collected similar information on a different sample of centres in six provinces and the Yukon. It also included on-site observations in the classrooms of teachers who had responded to a staff questionnaire. The purpose of Study 2 was to identify those factors most important for predicting and maintaining high-quality teacher-child interactions and experiences that promote children's learning and social development in centre-based care.

Study 3, the subject of the present report, is based on information about their experience, working conditions and job satisfaction collected from 231 regulated family child care providers in the same seven

ERIC Full Text Provided by ERIC

jurisdictions as used in Study 2, together with contextual information from 24 family child care agency directors.[3] Study 3 also involved on-site observations in the providers' homes. The purpose of this study was to identify those factors most important for predicting and maintaining sensitive, responsive provider-child interactions and experiences that promote children's learning and social development in family child care. The participating family child care providers were located in Alberta, British Columbia, New Brunswick, Ontario, Québec, Saskatchewan and the Yukon.

All three studies provide important information that can and should be used by policy-makers, child care professionals, educators and community planners as they consider the critical investments that must be made and the practical issues that must be addressed in order to promote and sustain access to high-quality child care services for Canada's children and families.

1.2 The Importance of Child Care Quality

> *"Learning in the early years must be based on quality, developmentally-attuned interactions with primary caregivers and opportunities for play-based problem-solving with other children that stimulates brain development."*
> — Margaret Norrie McCain and J. Fraser Mustard 1999, p. 7

An extensive body of research has been published, especially during the last 15 years, that documents the importance of stable, sensitive, high-quality child care for children and their parents. This literature has been summarized by developmental psychologists[4] who have identified the positive effects for *all* children of high-quality care on the young child's language, cognitive and social development. Based in part on this evidence, Canadian economists such as Gordon Cleveland and Michael Krashinsky[5] and Tom Kent[6] have made a convincing case that public investments in high-quality care for young children do not only have significant impacts on children's healthy development, readiness to learn, and later performance in school and with peers; these investments are also important for achieving broader social and economic goals related to economic productivity and labour-force attachment, reduced levels of child and family poverty, women's equality and community cohesion.

Much of the research reviewing the effect of child care on children is based on studies conducted in centres. However, as discussed in the following section, there is evidence that high-quality family child care also has positive effects on children's language and cognitive development. Moreover, the provision of sensitive care to very young children by providers who are actively involved with them and give good-quality care has been found to be associated with the development of secure attachment relationships between infants and toddlers and their provider.[7]

Recent studies using new techniques have confirmed the importance of children's early experiences for brain growth and brain functioning. Lack of appropriate experiences that promote active learning may limit opportunities for further development and/or limit the ways in which children respond to new stimuli or changing circumstances, with the result that their development may not reach its full potential.[8] This new stream of research not only supports the importance of early stimulation, it also confirms the importance of sensitive, consistent care for infants and young children in buffering stress reactions that can have significant longer-term effects. Research reported by Megan Gunnar[9] suggests that, while

ERIC Full Text Provided by ERIC

positive learning experiences promote brain development and organization, stressful experiences are associated with the release of cortisol. This hormone is associated with impaired learning and memory, greater emotionality and lessened self-control, weakening of the auto-immune system, and difficulty regulating and sustaining one's attention to important tasks. In summary, this new research confirms the importance of both consistent and sensitive care *and* stimulating learning opportunities to promote resiliency in children and to avoid a range of poor developmental outcomes.

1.3 Family Child Care Quality and Its Influence on Child Development

When parents, providers, researchers and policy-makers talk about quality family child care they have in mind the combination of:

- continuity of relationship and sensitive interactions between the provider and the children in her care;
- the provision of a safe and comfortable emotional and physical environment; and
- the provision of appropriate, stimulating experiences that promote children's learning and social development.

Mutually respectful and supportive communication between parents and providers could be added to this list as another key ingredient. A positive partnership between parent and provider is of benefit to both parties and also helps to support the quality and continuity of children's experiences at home and in child care.

A growing body of research is identifying how good-quality family child care can contribute to children's development, and has begun to specify the most important ingredients to assure quality (see Appendix A for a synopsis of the major studies). This research focuses on two main dimensions of quality in family child care: the care provider's interactions with the children; and the characteristics of the physical setting, and the activities and program provided. Collectively the research findings indicate that:

- Children who have providers who are warm and who respond promptly and appropriately to them have higher levels of social and/or cognitive skills. Similarly, the amount of social, language and/or cognitive stimulation provided by the adult is related to children's social skills, verbal abilities and complexity of play behaviour (which, in turn, is associated with later cognitive development).

- When measures of children's development and ratings of the overall quality of the home are made at the same point in time, a positive association is found between the observed level of quality and the level of the children's social and language skills, and/or cognitive competence. Research has also found a correlation between ratings of family child care quality and the security of the attachment between infant and provider.

- The overall quality of the family child care home may contribute to the children's later social, language and cognitive skills, and to their academic functioning well into adolescence. A longitudinal study conducted in Canada reports an association between children's scores on language tests while in child

ERIC

care — in turn associated with the quality of the home — and their scores as 13-year-olds on tests of arithmetic skills, reading comprehension, understanding of language and general intellectual ability.[10] A further follow-up of the children as 17- or 18-year-olds found that academic skills continued to be associated with the quality of the family child care experienced by the child, and that there were also positive correlations between family child care quality and measures of self-esteem and peer social skills in late adolescence.[11]

The association between family child care quality and child outcomes noted above cannot be assumed to indicate causation. However, repeated findings of the same or a similar association across a number of studies add strength to the hypothesis that high-quality, responsive, stimulating family child care can positively influence children's development.

1.4 Dimensions of Quality

Urie Bronfenbrenner's work on the "ecology" of child development has inspired a generation of researchers to examine how typical, community-based child care settings operate — both as complex systems themselves and as part of the larger systems in which they are embedded.[12] This theoretical framework is particularly appropriate for an understanding of how a wide variety of factors influence the quality of care. It also reminds us that quality itself is not a single factor, and that it is affected by influences operating at several levels in a complex and dynamic fashion.

Research on quality conducted mostly in centres has identified four major dimensions of quality that have also been applied to family child care.[13] Most often, researchers discuss the dimensions of process quality, structural quality, and the quality of the adult work environment. A fourth dimension, that of contextual influences, has been identified in recent studies.[14] Two layers of context seem to be important. The setting itself as context is one layer; both homes and centres differ among themselves in characteristics such as the number and ages of children served, and policies and other variables that affect quality. The second, and broader, contextual layer relates to factors outside the setting itself; it includes a provider's regulatory status, and government policies and practices in the jurisdiction in which the home operates. Such factors are now being recognized as having both direct and indirect effects on the quality of care provided (for example, in centre-based care by impacting on staff job satisfaction and turnover rates, as well as on the capacities of centres to invest in quality improvements).[15]

1.4a Process Quality

Process quality refers to the nature of children's daily experiences in the child care setting. It encompasses the nature of the children's daily interactions with their provider or teacher and with the other children, and the kinds of activities and opportunities provided to enhance children's development. The research studies reviewed in Section 1.3 and Appendix A focused particularly on aspects of process quality as they relate to children's development. Process quality, the focal point of much child care research, is believed to be heavily dependent upon the conditions in which care is provided, and hence is strongly associated with, and affected by, the other dimensions of quality described below.

1.4b Structural Quality

Structural quality refers to the specific conditions that are believed to influence most directly the behaviour of caregivers and other aspects of process quality. The elements most typically associated with

ERIC Full Text Provided by ERIC

structural quality are: (1) group size, that is, the number of children cared for; (2) adult:child ratios; and (3) the adults' educational background or specific training that prepares them for their work. These elements lend themselves to government regulation and monitoring, as do other requirements designed to protect children's health and safety. In and of themselves, these aspects of structural quality cannot guarantee process quality in a child care setting, but they can establish conditions that increase the likelihood that it will occur. Hence, many regulations specify the maximum number of children and/or the maximum number of infants and toddlers that a provider may care for. Some minimum level of training may also be required, and a number of jurisdictions, particularly in the United States, have added the requirement that caregivers participate in some form of training or professional development on an ongoing basis.[16]

1.4c The Quality of the Adult Work Environment

Process quality has also been shown to be influenced by the quality of the work environment. In centre-based care, aspects of the adult work environment that have been found to be important include: (1) the level of wages and the benefits provided to staff; (2) working conditions that provide staff with breaks during the day and with some input into decisions that affect them and the nature of the child care program; (3) the provision of opportunities for staff to extend their knowledge through workshops and other professional development activities; and (4) an environment that promotes positive and supportive relationships among co-workers and supervisors. These aspects of the adult work environment are increasingly being found to affect teachers' job satisfaction and staff turnover rates, in addition to being correlated with observed process quality.[17]

Aspects of the adult work environment in family child care include: (1) child care income; (2) total work hours; (3) whether providers are paid in various circumstances; and (4) the provider's relationship with parents and with licensing officials/home visitors. Another important dimension of the adult work environment for family child care providers is the extent of support they have from a variety of other people, including immediate family members, other providers, and local family child care associations or child care resource programs.[18] The amount of control that providers feel they possess to affect various aspects of their work, as well as the extent to which they have access to substitutes on occasion, have not been studied but appear likely to affect job satisfaction, job stress and process quality.

1.4d Contextual Dimensions of Quality

Research on the contextual dimension(s) of quality has been most visible in multi-jurisdictional studies of centre-based care. While centre auspice (whether a centre operates as a commercial enterprise or as a non-profit organization) has been a factor in research and public policy debates for some time, recent studies are beginning to show how other factors, such as the nature and amount of public funding, whether the centre receives subsidized rent, and different service mandates may affect such aspects as staff wages and job satisfaction, as well as the quality of care observed in the classroom.[19] The closest parallels to these variables in family child care may be regulatory status (which has been found to be a major factor across a range of studies), whether the provider is individually licensed or is affiliated with a family child care agency, and the policies and practices of the government in the jurisdiction in which the home operates.

1.4e The Dynamic Interaction of Dimensions of Quality

Aspects operating on all of the dimensions referred to above interact in a complex and dynamic fashion. The results of our companion study, the largest and most systematic study of quality in child care centres in Canada,[20] indicate that process quality (as measured by scores on the *Infant/Toddler Environment*

ERIC Full Text Provided by ERIC

Rating Scale [ITERS],[21] the *Early Childhood Environment Rating Scale–Revised [ECERS–R]*[22] and the *Caregiver Interaction Scale [CIS]*[23]) is related to variables that cut across these dimensions. The major direct and indirect predictors of quality in centre-based care were found to include: (1) staff wages and benefits; (2) adult:child ratio; (3) non-profit auspice; (4) whether the centre had subsidized rent and/or utilities; (5) average fees charged to full-fee paying parents; (6) teaching-staff job satisfaction; (7) whether the centre is used as a practicum site for student-teachers; and (8) teachers' level of satisfaction with their relationships with their colleagues and the work environment.[24]

1.5 The Uniqueness of Family Child Care

As discussed in the following chapter, family child care is a distinct entity. For example, unlike the teacher in a centre, the family child care provider works in her own home, usually has a mixed-age group, and often has her own child present so that she is simultaneously filling the role of mother and the role of care provider for other people's children. We believe that it is vitally important to study, to discuss research findings and to formulate policies and practices related to family child care on its own terms. In the following chapter, therefore, we discuss the nature of family child care, contributors to quality in family child care, some of the evolving perspectives on family child care quality, and the need for a model of quality that is specific to family child care. We urge the reader to use Chapter 2 as a framework within which to consider the findings and recommendations presented in this report.

1.6 The Importance of Family Child Care in the Child Care System

Family child care is a vital part of the child care system because:

- According to data collected by the National Longitudinal Survey of Children and Youth (NLSCY), 56.2% of children under age 6, and 51.1% of those age 6 to 11, who were receiving out-of-home, non-relative care on a regular basis in 1996/97, received this care in a family child care home. This translates into approximately 390,200 children under age 6 in this type of care, and an additional 246,400 children aged 6 to 11.[25]

- Family child care is able to address the diversity of parents' needs and preferences in out-of-home care for their children; for example, many parents prefer family child care to centre care for their infants and toddlers.[26] Parents' stated reasons for preferring family child care for this age group include having the same adult care for the child over the whole child care day, and having their young child in a setting that resembles the infant's home environment and that therefore provides more continuity for the child.[27] Other parents appreciate the convenience of having siblings together in the same setting.[28] Parents from minority cultures are often particularly anxious to find "caregivers [who] will honor and reinforce in their child the values that they themselves uphold in their homes."[29] Finding a caregiver who is from the same culture and who has similar religious beliefs and personal values may be easier in the family-based than in the centre-based system.

- Family child care often can address parents' concerns about convenience of location or the need for care that can accommodate changing schedules or extended work hours on occasion.[30] Some family child care providers are willing and able to provide evening or week-end care, while this is extremely difficult for centres to provide due to the need for additional staff.[31]

- Family child care accounts for over 50% of the broader child care workforce, employing an estimated 170,000 persons.[32]

The quality of family child care exerts a profound effect on Canada's children and their families, given the large numbers of children enrolled in family child care homes and the extent to which parents rely on this portion of "the child care system" on a daily basis.

1.7 The Regulatory Climate for Family Child Care in Canada

Family child care includes providers who are regulated, either by being licensed on an individual basis or through their affiliation with a family child care agency, and providers who operate on their own and are not licensed. The individual licence model is used in all jurisdictions in Canada except Alberta, Ontario, Québec and Nova Scotia. These four provinces use the agency model. In Newfoundland/Labrador, family child care providers can choose to be individually licensed or to be affiliated with an agency. Ontario very explicitly holds the agency "accountable for ensuring that providers and their homes are in compliance with the Day Nurseries Act and the Private Home Day Care Regulations regarding health, safety and child care practices."[33] In the other provinces, the regulatory responsibility is implicit, if not explicit, in the requirement that agency staff, known as home visitors, make regular in-home visits to observe the care being provided. The required frequency of these visits ranges from twice monthly in Nova Scotia to four times yearly in Ontario and Québec. Providers in jurisdictions that use the individual licensing model receive in-home visits from government officials. The required frequency of these visits ranges from once a year in British Columbia, New Brunswick, the Northwest Territories and Prince Edward Island, to one licensing visit and three or four unannounced visits each year in Saskatchewan and the Yukon.

1.7a The Permitted Number of Children

As indicated in Appendix B, all jurisdictions limit the number of children permitted at any one time. This number varies with the age mix of the children. No jurisdiction allows one provider to care for more than eight children, including her own, under age 12. Québec and the Yukon permit a larger number of children if the provider has an assistant working with her. With the exception of Nova Scotia, the regulations in all jurisdictions restrict the permitted number of children under age 2 or 3.

1.7b Provider Qualifications and Training

Provincial/territorial regulations require providers to have a first-aid certificate in all jurisdictions except Alberta, Ontario (unless working with a child who has a handicap) and Nova Scotia. In Newfoundland/Labrador, Prince Edward Island, Québec and the Yukon, regulated providers are required to complete a certain number of hours of formal child care-related training within the first or second year of starting to provide care. The length varies from 30 hours in Prince Edward Island to 60 hours in the Yukon (see Appendix B).

Providers in Québec must attend a minimum of six hours of child care-related professional development each year. In Nova Scotia, the requirement is a minimum of four hours. Saskatchewan "expects," but does not require, regulated providers to attend two workshops annually.

1.8 Provincial/Territorial Funding for Family Child Care

1.8a Grants to Providers

Regulated family child care providers in all jurisdictions can obtain government fee subsidies for eligible children. As illustrated in Table 1.1, in some jurisdictions they are also eligible for recurring grants.

Table 1.1

Provincial Recurring Grants to Family Child Care Providers, 1999

Jurisdiction	Grant Name	Amount
British Columbia	Infant/Toddler Incentive Grant	$3.00 a day per occupied space to a maximum of two children under age 2
Saskatchewan	Equipment Grant	$50.00 per space per year
Manitoba	Operating Grant	$584.00 per infant space per year, $199.00 per preschool or school-age space per year
Québec	Infant Incentive Grant	$6.86 per day per space occupied by an infant
Prince Edward Island	Infant Incentive Grant Operating Grant	$250.00 per year for each child under age 2 enrolled for at least 6 months $450.00 per year
Northwest Territories	Operating Grant	Ranges from $1.25 to $14.25 per occupied space per day, depending on the age of the child and the location of the home
Yukon	Operating Grant	Based on a formula that includes age mix and location of the home

Sources: Childcare Resource and Research Unit 2000; Cathy McCormick, Government of Prince Edward Island; Francine Lessard, Fédération des centres de la petite enfance du Québec.

Note: The grants in Prince Edward Island were frozen in 1992; this means that they become available for providers licensed after 1992 only when a previously licensed provider stops operating a licensed family child care home.

Start-up grants are available in Saskatchewan, the Northwest Territories and the Yukon while grants to assist in the integration of children who have special needs are available in British Columbia, the Northwest Territories, Prince Edward Island, Québec and Saskatchewan.[34]

1.8b Infrastructure Grants

The infrastructure supporting family child care providers includes: (1) family child care agencies in those provinces that use this model; (2) a network of provider resource programs in each of British Columbia and Ontario; and (3) provincial provider associations in a few provinces. Agencies in all five provinces using the agency model receive an "administration fee" from the provincial government to cover costs such as home visitors' salaries, and the provision of training and other supports for providers. Non-profit child care agencies in Nova Scotia and Ontario, and those Ontario commercial agencies that were licensed prior to 1987, receive a provider wage enhancement grant. In Québec, under the $5.00 a day fee to parents program, the government pays a top-up grant of between $15.00 and $19.60 per day for each child over age 18 months, plus the infant incentive grant of $6.86 for children under age 18 months.

British Columbia funds a network of Child Care Resource and Referral programs with a mandate to assist in the recruitment, support and training of both regulated and unregulated providers. Ontario funds a similar service, Child Care Resource Centres, which were originally targeted at the provision of support and training to the unregulated sector, but are used by both regulated and unregulated providers.[35] The provincial family child care organization in Québec also receives an annual grant of $50,000.[36] No other provincial or territorial government funds a family child care organization.

1.9 The Goals of the Study

Only one Canada-wide study of regulated family child care providers has included information about the nature of family child care provision and the characteristics and views of family child care providers.[37] While a few Canadian research projects have examined quality in Canadian family child care in specific locales,[38] no study has systematically examined a wide range of different variables in different jurisdictions using the same sampling, methodology and instrumentation. This was a major goal of the present study.

Specifically, the main goals of Study 3 in the *You Bet I Care!* project were:

1. To provide a detailed description of family child care provision, including basic information about the number and age mix of children cared for, and characteristics of family child care providers in the seven jurisdictions involved in this study.
2. To profile the current range of process quality (both caregivers' sensitivity to the children and ratings of the family child care home as an environment that promotes children's healthy development) in a sample of regulated family child care homes in Canada.
3. To explore the association between process quality and various structural aspects, provider characteristics and sources of support for providers in Canada.
4. To examine the relative importance of various elements for predicting process quality — for example, ratio, training and the extent to which providers are part of a community-based support system, as well as indications of the provider's feelings about supplying family child care.

ERIC

5. To determine the factors that are associated with providers' views of child care work, including sources of stress and satisfaction, and the factors that appear most important as correlates or predictors of their likelihood of continuing to provide family child care for at least three years.
6. To identify the practical and policy implications suggested by the findings that could be used to promote quality care for children in family child care homes, and to reduce job stress and the likelihood of turnover among family child care providers.

1.10 The Purpose of This Report

The report describes the observed quality of children's daily experiences in family child care homes in six provinces and the Yukon. It also uses information obtained from the providers and the observations to discuss the associations between various elements of quality and children's experience. Finally, the report moves from description to identification of the specific variables from the study that predict the level of quality in a child care home. The research evidence obtained in the study is used to make specific recommendations for maintaining and improving the quality of Canada's family child care system.

1.11 Issues in Presenting the Findings

1.11a Reporting by Jurisdiction

This report provides information for the sample as a whole and, where appropriate, by province and territory. It is important for readers to note that substantial differences were found among providers and caregiving characteristics on many variables. Specifically, major differences appear in demographic characteristics among providers in different jurisdictions, including their prior education and family child care-specific training, and their experience as regulated family child care providers. In some cases (family child care-specific training and the number of children enrolled, for example), the differences appear to reflect the influence of policies/regulations that can legitimately be inferred to represent the influence of jurisdictional differences. In other cases (for example, whether providers have young children of their own, providers' formal education in early childhood care and education [ECCE], the extent to which family child care is the provider's chosen career), jurisdictional differences apparently reflect other factors, such as general demographic differences and the availability of alternative labour-market opportunities.

We also note that the limited number of providers included in the study from each jurisdiction may not represent all the providers in that province/territory. In general, providers who agree to complete a fairly lengthy questionnaire and allow someone to observe in their home for an extended period of time are likely to be the people who are comfortable in English or French and are among the most confident about the quality of their care.

1.11b Reporting by Agency Affiliation and Individually Licensed Status

We had originally planned to contrast providers on the basis of their status as being individually licensed or affiliated with an agency; however, this was determined to be an inappropriate comparison for three reasons. First, we found that the agencies varied considerably, both across and within jurisdictions, in the supports they reported for providers. Second, we obtained information indicating seven individually licensed providers in Saskatchewan were associated with an organization that, to all intents and purposes, offers supports similar to those offered by a family child care agency in other provinces. Third, most of the

ERIC

providers in British Columbia were associated with a child care resource and referral program that also offers the types of training and supports provided by family child care agencies. As a result, we determined that comparisons based on individually licensed/agency-affiliated status would be invalid and uninformative. Therefore, analyses are presented for the total sample of providers, except in the case of specific analyses relating to the nature and type of support that providers receive from licensing officials and from their agency.

1.11c Reporting by Auspice

Variation in auspice only occurs in agencies. Twenty-four agencies participated in the study for a total of 120 providers. Only eight of the agencies (33%) were commercial, and six of those eight were located in Alberta. Analyses of differences among agency-affiliated providers by non-profit or commercial agency auspice were considered inappropriate for two reasons: first, on the basis of the small sample of commercial agencies; second, because of the undue influence province-specific factors in Alberta would have on the analyses when six of the eight commercial centres were in that province.

1.11d Findings from the Agency Questionnaire

Each agency director completed a questionnaire that sought information about: (1) the agency; (2) the services provided to children's families; (3) provider monitoring, fees and turnover; (4) home visitors; and (5) the level and types of support available to the providers. In the interest of making public the findings related to predictors of quality in child care homes as soon as possible, we decided to write a separate, subsequent report discussing the data we obtained through this questionnaire.[39] By doing so, we will be able to provide a more thorough exploration of the information obtained from that source.

1.12 How This Report is Organized

- **Chapter 2** discusses the unique nature of family child care, contributors to quality in family child care, evolving perspectives on family child care quality and the need for a model of quality that recognizes the unique features of family child care.
- **Chapter 3** provides information about the sample and how it was selected, the development and content of the agency and the provider questionnaires, the observational measures used to assess process quality, and the methods used to collect, code, clean and analyze the data.
- **Chapter 4** provides descriptive information about the providers' demographic characteristics, their experiential and educational levels, and their feelings both about their own work situation and family child care as an occupation.
- **Chapter 5** looks at the practice of family child care: the children served, the provider's hours of work, her income and other features of her work, her use of various types of support services and her relationship with her licensing official or home visitor.
- **Chapter 6** provides descriptive information about the quality of family child care observed in the family child care homes. Total scores and sub-scale variations are provided for the *Family Day Care Rating Scale (FDCRS)*[40] measure of global quality, and the *CIS*[41] measures of provider sensitivity, harshness and detachment. The chapter includes information about aspects of care on which family child care homes are doing well, and areas that need improvement.

ERIC

- **Chapter 7** provides extensive analysis of correlations between major variables such as the number of children present at the time of the observation and the provider's level of overall quality.
- **Chapter 8** goes beyond the correlational findings reported in Chapter 7 to explore the extent to which the variables examined in this study *predict* quality in family child care homes.
- **Chapter 9** summarizes the main findings and discusses their implications for policy and practice. A set of recommendations is presented that we believe will assist to sustain the availability of family child care and enhance its ability to provide children with experiences that encourage their development.

A glossary is provided at the end of the text.

Notes

1 Doherty et al. 2000.
2 Goelman et al. 2000.
3 A separate report, Doherty et al. in press, discusses the findings from the questionnaires completed by the 24 agency directors.
4 Doherty 2000; Vandell and Wolfe 2000.
5 Cleveland and Krashinsky 1998.
6 Kent 1999.
7 Eliker, Fortner-Wood and Noppe 1999.
8 Gopnick, Meltzoff and Kuhn 1999; McCain and Mustard 1999.
9 Gunnar 1998.
10 Kohen et al. 2000.
11 Ibid.
12 Bronfenbrenner 1979; Bronfenbrenner and Morris 1998.
13 Kontos 1994; Kontos et al. 1995
14 Goelman et al. 2000; Helburn 1995.
15 Ibid.
16 Azer and Morgan 1998.
17 Goelman et al. 2000; Whitebook, Howes and Phillips 1990.
18 Bollin 1993; Kontos and Reissen 1993; McConnell 1994; Pence and Goelman 1991.
19 Goelman et al. 2000; Helburn 1995; Whitebook, Howes and Phillips 1990.
20 Goelman et al. 2000.
21 Harms and Clifford 1990.
22 Harms, Clifford and Cryer 1998.
23 Arnett 1989.
24 Goelman et al. 2000.
25 Calculations done by Paul Roberts, Canadian Council on Social Development, using the 1996 NLSCY data set.
26 Galinsky et al. 1994; Goelman, Rosenthal and Pence 1990; Kontos 1992; Larner 1996; Modigliani 1994.
27 Larner 1996; Modigliani 1994.
28 Long, Garduque and Peters 1983; Pence and Goelman 1987.
29 Chang 1993, p. 34.
30 Ferguson 1998; Lero 1981; Lero et al. 1992.
31 Foster and Broad 1998.
32 Beach, Bertrand and Cleveland 1998, Table 4.
33 The Home Child Care Association of Ontario 1994, p. 1.
34 Childcare Resource and Research Unit 2000.
35 Ibid.
36 Francine Lessard, personal communication.
37 Goss Gilroy, Inc. 1998.
38 The *Atlantic Day Care Study* (Lyon and Canning 1995); a study conducted in Ontario (Stuart and Pepper 1988); The *Victoria Day Care Research Project* (Goelman and Pence 1987, 1988); and the *Vancouver Day Care Research Project* (Goelman and Pence 1991, 1994).
39 Doherty et al. in press.
40 Harms and Clifford 1989.
41 Arnett 1989.

Chapter 2

The Uniqueness of Family Child Care

2.1 Introduction

Family child care is a unique, multi-faceted and complex occupation. We believe that it is vitally important to study, to discuss research findings, and to formulate policies and practices related to family child care on its own terms. Therefore, as context for later chapters that discuss the findings of this study and for our recommendations, in this chapter we: (1) briefly look at the nature of family child care; (2) summarize prior research that explores the factors contributing to positive child experiences and outcomes in family child care; (3) discuss evolving perspectives on family child care; and (4) identify the need for a model of quality that is specific to family child care.

2.2 The Nature of Family Child Care

Family child care contains within it the contradictions and challenges associated with being a public service that is provided in a private home, and being paid work that shares many of the characteristics of unpaid care for one's own children.[1] Few occupations require other household members to be so involved. The provider's own children are often in daily contact with the child care children and are expected to share not only their possessions and space, but also their mother. Other adults living in the home are also directly affected by the demands and presence of the family child care work.

ERIC Full Text Provided by ERIC

2.2a A Public Service in a Private Home

Family child care is provided in someone's home and inevitably changes the family's control over its time and personal space.[2] The setting must accommodate the needs and desires of the family members but is also expected to meet the needs of a group of unrelated children receiving a paid-for service. Private family living space and family belongings have to be shared with these unrelated children for extended periods of time. The physical arrangement of the home may have to be adjusted to accommodate toys and equipment used for the child care program and/or to meet regulatory requirements. Non-family members, such as parents and licensing officials/home visitors, gain the right to enter the home. More importantly, the wife/mother has to balance the needs and demands for time and attention of both the child care children and their families with those of her own family.[3] Somehow she has to accommodate her work life to the needs and interests of a partner, and mediate between her own children's needs and those of the child care children. While the separation and balancing of work and personal/family life is a challenge for anyone in a home-based occupation, it is perhaps particularly difficult for providers who, as discussed below, often develop a very close and personal relationship with their "clients."

2.2b The Content and Context of the Work

Family child care providers protect, nurture and teach other people's children in the context of an affectionate relationship in a private home. Much of what they do is the same as is done by mothers with their own children, even though the relationship is different and the provider does not have the parent's right to make certain types of decision.[4] Family child care providers are frequently also looking after their own young children. As a result, paid and unpaid care is merged in a single setting at the same point in time.

Traditionally, work was something that was done outside the home and paid for, while care that was provided in the home, being a normative requirement of family life, was unpaid. Such unpaid activity, usually done by women, tended to be undervalued and defined as not being "real" work.[5] This traditional view fails to reflect or acknowledge the "work" aspects of caring occupations such as child care, especially when they are provided in a home setting. This failure plays itself out in a variety of ways. Irene Kyle found that many of the Ontario family child care providers in her study viewed their work primarily as an extension of their mothering role.[6] Similar findings are reported from the United States.[7] This perception makes it difficult for some providers to charge an adequate fee because they feel guilty about being paid for caregiving[8] or perceive their work as unskilled and something that could be done by anyone who has been a mother.[9] Parents sometimes act in ways that suggest they do not perceive family child care provision as work — for example, by failing to pick up a child at the appointed time on the basis that the provider will be there anyway.[10] In the sphere of public policy, the tendency to take carework for granted and to devalue it in terms of being "real work" means that it is seen as low-status and requiring only modest financial reward.[11] This view perpetuates poor remuneration levels that, in a circular fashion, contribute in our society to the continued low status of people engaged in child care provision, especially when they work at home.

2.2c The Multiple Roles of the Family Child Care Provider

The provider has multiple roles when in her work situation — mother to her own children who are present, paid care provider for other people's children, provider of support to child care families, and business owner/operator. Most providers work without an assistant, so they are also responsible for the practical tasks that must be done daily, such as meal preparation and cleaning, while in addition caring for children.

Even when the provider has a friendly, supportive relationship with the parent, as is often the case, she must set and enforce policies on a less personal, more business-like level. Setting boundaries between the caring aspect of the work and the need to be business-like has been identified as a particularly common challenge for people providing child care in their home.[12] Regulatory and/or agency administrative requirements further expand demands on the providers' time. Not surprisingly, balancing the demands of their multiple, and at times conflicting, roles has been associated with stress among family child care providers.[13]

2.2d The Relationship between Parent and Provider

> *"I often spend half an hour past pick-up time to discuss the child's day with the parents. Occasionally, if there is a problem that needs more time I arrange a time to sit and have a coffee for an hour or so, but this is rarely necessary."*
> — Ontario provider

A study comparing the extent and content of contact between parents and the person providing care for their child found that the mean amount of time spent with each parent per week was 13.7 minutes in centres and 54.7 minutes in family child care homes.[14] The amount of interaction between parents and providers gives opportunities for dialogue around policies, schedules and routines, and for the exchange of information about the children in care.

Family child care providers also appear to have a different and more intense relationship with parents than do centre staff. Kyle reports that among her sample of family child care providers in Ontario there was a clear sense that their role includes supporting the families. For example, the providers reported occasionally taking care of children overnight to allow the mother to have a break, or reducing their fees for parents in financial difficulties; they stated that they did so in order to assist the parent.[15] Interviews with American providers also documented the extent to which these women put themselves out "to accommodate the needs of parents and children with whom they have forged these strong emotional bonds."[16] A British Columbia study found that parents using family child care reported closer relationships with the caregiver than did parents using child care centres and were more likely to anticipate continued contact after the child leaves the child care setting.[17] Perhaps the continuity of one provider in family child care, versus a number of different teachers who work different hours in centres, facilitates the development of a more personal and closer relationship between caregiver and parent in family child care.

2.2e Family Child Care Working Conditions

There are several important variations in working conditions between family- and centre-based child care.[18]

First, the family child care provider works in isolation,[19] while centre staff have co-workers to provide support and assistance, and to allow a break from the children at coffee or lunch time.

Second, the work period is longer. In a 1996 Canada-wide survey, regulated providers reported an average of 46.7 hours a week in direct contact with child care children and an additional 9.0 hours of preparation.[20] A similar 1998 survey of centres across Canada reported that teachers worked an average of

ERIC

37.5 hours a week with children and spent an additional 5.3 hours in preparation.[21] The provision of evening or weekend care is also more prevalent in family child care homes than in centres. In the centre component of the *You Bet I Care!* project, we found that fewer than 1.0% of centres were open on the weekend and only 0.8% were open after 7:00 p.m.[22] In this study, the family child care component of the *You Bet I Care!* project, 6.5% of the providers reported providing child care on Saturday and/or Sunday, and an almost equal proportion, 6.1%, told us they regularly provide care after 7:00 p.m.

Third, it is not uncommon for a family child care provider to have a group that includes an infant, a toddler, a couple of preschool children and one or two school-age children.[23] Thus, she must provide activities for a wide range of developmental levels.

Fourth, family child care providers' earnings are unpredictably affected by events outside their control, such as the withdrawal of children without notice. One provider told us about a situation where two children were withdrawn at the same time because their mother got a salary increase and was no longer eligible for fee subsidy; the mother therefore switched to an unregulated provider who charged lower fees. Late payments are another concern. In contrast, teachers on permanent staff know they will receive a fixed salary, on time, at predictable intervals.

Finally, unlike centre staff, family child care providers do not have benefits such as paid sick days or vacation time. One provider who participated in our study summarized the working conditions as follows:

> *"Long hours, no lunch, coffee or bathroom breaks without children. Lack of adult contact throughout the day. Not recognized as a profession. Difficult to plan doctor, dentist or banking appointments. All have to be done in the evening and there are times I've had to go to see a doctor and take all my children with me."*
> — Alberta provider

2.3 Contributors to Family Child Care Quality: What Does the Research Tell Us?

To date, the research has identified four key variables (in addition to regulatory status) that appear to have consistent and pervasive effects on family child care quality. In the case of supports for the providers and "intentionality," these variables also correlate with providers' job satisfaction and likelihood of remaining in the occupation. The four variables are:

- the size of the group of children for whom the provider is responsible, taking into account the age mix — this is commonly referred to as the adult:child ratio;
- the provider's level of overall formal education and her specialized training related to the provision of family child care;
- the amount, type, diversity and strength of supports available to the provider; and
- the provider's motivation to start providing child care, her feelings about being a family child care provider and her commitment to providing high-quality care.

ERIC Full Text Provided by ERIC

This fourth element, often referred to as "intentionality,"[24] is gaining increasing attention because of its influence on care providers' behaviour with children[25] and its suspected importance as a predictor of turnover.[26] "Intentionality" encompasses a real liking for children, a belief that looking after children is important work, and a commitment to providing child care as a chosen career rather than as a temporary occupation. It manifests itself in purposeful planning of activities for the children, in actively seeking and building enduring mutual-support relationships with other providers, and in seeking out opportunities to learn more about children and how they develop.[27]

Kyle has broadened the concept of intentionality on the basis of her findings from semi-structured interviews with 30 Ontario providers. She reports that providers could articulate several important elements that they perceived to be essential for being a good provider and for offering care of consistent high quality. These interrelated elements are described as evidence of a clear sense of *personal agency* and *ethical responsibility* on the part of the provider, including intentionality.[28] The six interrelated elements are described by Kyle as:

- intentionality, or making a conscious choice to care for children over other forms of work;
- a sense of meaningfulness and job satisfaction;
- a sense of building interdependent, enduring relationships with children and families;
- a sense of their own personal integrity and trustworthiness;
- a sense that they are able to have control over their own work; and
- finding constructive ways to balance the demands of their family child care work with family obligations.

Other variables, such as length of experience as a provider and demographic characteristics, appear unrelated to measures of process quality. Appendix C provides a synopsis of the major studies that have explored the contributors to family child care quality.

2.4 Evolving Perspectives on Family Child Care

2.4a Defining Quality in Family Child Care

As discussed in Section 2.2, family child care contains within it the contradictions of being a public service that is provided in the private sphere of an individual's home. Moreover, the work the provider is paid to do is akin to mothering one's own children — a form of labour that is freely given and "priceless." Kyle, in particular, has described how family child care providers can be caught in the contradictory views of what constitutes caring and what is work, and between the "mothering discourse" and the "professional discourse."[29]

In addition to the confusions and contradictions that are inherent in the family child care situation, there appears also to be a diversity of opinion among providers themselves. Some equate quality largely with responsive mothering of other people's children and the provision of a home-like experience. Others see quality family child care as incorporating some aspects of ECCE for mixed-age groups, delivered in ways

ERIC Full Text Provided by ERIC

that are more appropriate to a smaller group of children in a home setting. It would be simplistic to suggest that these diverse points of view on what quality family child care means can be reduced to a debate about which is more important — caring/mothering or greater provision of structured learning opportunities. Many providers themselves acknowledge that good quality child care involves a mix of both with the proportions of each varying with every child. One provider defined three key components:

> *"As a caregiver, you should be like an extended family member to the children whom they can trust; your house should be like a second home where the children feel safe and comfortable; and you should offer a program of purposeful activities to meet their optimal growth."*
> — British Columbia provider

Understanding what quality is in family child care and how it can best be assessed, promoted and supported is central to further advances in program and policy development. It is also of critical importance to providers themselves. At the recent *Caring 'cross Canada* symposium, providers, family child care agency staff, researchers and organizational and government representatives discussed a research agenda for family child care in Canada. Collectively, they identified the following seven topics as having the greatest interest and importance for the field:

1. How do we define and assess quality in family child care?
2. What is the impact of regulation, support, networking and training on quality in family child care?
3. What current policies work to strengthen or jeopardize quality in family child care?
4. What resources, information and support do caregivers need to provide quality care and balance their multiple roles? How best can these be provided?
5. What are the key elements of a comprehensive community support system for families and caregivers?
6. Who is using family child care and why? What do families need and receive from family child care?
7. How do we support the development of an effective infrastructure that connects and empowers caregivers?[30]

These top priorities reflect the felt need for further exploration of the roles of caring and learning in order to better understand, define and appropriately assess quality in family child care. Second, they illustrate the field's concerns about effectiveness and about understanding how family child care might support parents and families in ways that extend current interpretations of qualty care. Third, they indicate the need to explore the impacts of alternative mechanisms on family child care so as to understand the components of an effective infrastructure to support providers.

2.4b A Growing Awareness of the Importance of Family Child Care as Work

In addition to the factors discussed above, there is also an increasing understanding that the quality of the context in which the provider works directly affects the quality of the care provided to the children in family child care homes. Research in family child care is just beginning to catch up with the amount and sophistication of research on wages, working conditions, organizational characteristics and turnover rates that has increased our understanding of how these factors influence the quality of child care work for centre staff and the quality of care provided to children in centres.[31]

ERIC

Most studies indicate that family child care providers are largely satisfied with the work itself, particularly enjoying their interactions with the children in their care.[32] Many obtain a real feeling of satisfaction from believing that they have made an important difference in the lives of the children.[33] Some also appreciate the important role they play as a support to parents, and value, in turn, the support they receive from their own families, from parents and from the family child care community.[34] Others are pleased to be able to work at home and to have autonomy in structuring their days; many appreciate being able to combine work with caring for their own children.[35]

In contrast, the low income that most providers realize, the lack of benefits, the long hours that most providers work — largely in isolation from others — and the lack of respect from the public that many feel are significant negative factors contributing to job dissatisfaction, job stress and relatively high turnover rates.[36] While the research does not provide sufficient evidence to suggest that there are strong correlations between these sources of dissatisfaction and the quality of care provided to children, turnover clearly contributes to instability in children's care arrangements. Studies have found that continuity of the same caregivers is associated with lower rates of distress behaviours among children[37] and higher rates of interaction between adult and child.[38] Children in centres with high teacher turnover rates are less attached to their caregivers, have lower developmental levels of play (which in turn is associated with later cognitive development) and obtain lower scores on measures of language development than peers in programs with less turnover.[39]

A number of Canadian studies have explored family child care providers' perception of their work situation. While, as noted above, providers enjoy the actual work with children, there is also clear evidence that other aspects of the work are problematic:

- A Canada-wide survey of regulated providers conducted in 1996 as part of the Child Care Sector Study reports that two-thirds of the respondents, 66%, expressed dissatisfaction with their income and half, 51%, were dissatisfied with their overall working conditions.[40]
- A study of agency-affiliated providers in Ontario in 1989 suggested that the turnover rate was almost 40% in the previous year, and that many providers left their agency within the first year or two.[41] Among the primary reasons given for leaving were the lack of adequate pay and benefits in addition to burnout and other factors that were indicative of a desire for alternative, more remunerative and less stressful, employment.
- In Alberta, a survey conducted in 1990 found an even higher turnover rate — 51% in the previous 12 months. Providers' reasons for leaving were similar to those found in Ontario. Almost half of them described family child care as only a temporary job and indicated that the most important reasons that they (and other providers) considered leaving were: inadequate pay, 77%; their own children suffering, 75%; lack of benefits, 52%; and lack of job security, 48%.[42]
- Many providers in the Alberta study, 63%, perceived their work as having very low status compared to all other jobs.[43] The 1996 Canada-wide survey of regulated providers reported that, while 74% of the providers who responded anticipated continuing to provide family child care for at least another three years and evidenced significant commitment to their work, only 36% were satisfied with the professional respect they received from others.[44]

While our study, like many others, focuses largely on the quality of care provided to children, this focus is inappropriate without explicitly noting the context in which the care is being provided. The main

theoretical framework that has guided our study and much of the research on child care quality is based on understanding the ecology of care. While the most immediate ecological environment under investigation is the caregiving environment that children experience, it is also critical to understand the experiences of providers and the contextual factors that hinder or facilitate their capacity to provide quality care on a consistent basis.

2.5 A Need for a Model of Quality that is Family Child Care-Specific

In Chapter 1, Section 1.4, we discussed the dimensions of quality used in analyses of centre-based care: (1) process quality, (2) structural quality, (3) the quality of the adult work environment, and (4) the contextual dimensions of quality. Susan Kontos,[45] among others, has employed the same dimensional framework in her analyses of quality in family child care. While this serves as a useful starting point, it is important to note that some aspects that are unique to family child care do not neatly fit into existing models. In particular, much more of what happens in the family child care home depends upon the provider's own perspective, skills and resources, the supports available to her, and her capacity to balance the caring and business aspects of being a provider. Providers, by virtue of their role, are both the "staff" who interact with the children directly and the administrators of their business.

> *"As the operator of a child care facility in her own home, the provider controls the availability of space and materials, the group size and composition, and the variety, complexity, duration and tone of caregiving activities. It is the provider herself who influences children's daily experiences that, in turn, affect their development."*
>
> — Brenda Krause Eheart and Robin Leavitt 1989, pp. 549-550

Provider characteristics such as training and previous experience, as well as her attitudes towards children and to being a family child care provider (sometimes referred to as intentionality) are likely to have a dominant impact on caregivers' behaviour with the children. Hence, they are more than background features that structure the environment for the children; they are central components in what might become a unique model of quality in family child care. While personality factors and motivation to provide care cannot be regulated, the importance of having both adequate preparation and ongoing support for the work of being a family child care provider is documented in a number of studies as being important both for the provider herself[46] and for process quality.[47] (See Section 2.3 and Appendix C.)

A number of challenges must be addressed in developing a family child care-specific model of the direct and indirect effects on quality of variables operating on different levels. Among these challenges are the following:

- The need for a better understanding of, and agreement about, what constitutes quality in family child care.
- The lack of measures that capture some elements of family child care quality. In particular, it is clear that one of the major features of quality family child care is successfully relating to, and engaging, children in mixed-age groups. Yet we have not developed ways of measuring this. The importance of the

skill is evident in the eagerness of providers for workshops that would enhance their skills in encouraging positive interactions among different-aged children and in planning activities that are developmentally appropriate for a wide age span.[48]

- The lack of research on provider-parent relationships in family child care, in spite of this being clearly one of the important facets of this work. Having positive, communicative relationships with parents promotes understanding of the child's behaviour, and is likely to lead to more longer-term, successful placements. Providers' skills in building and sustaining such relationships (and resolving conflicts when they occur) should probably be considered another facet of quality in family child care work.
- The lack of information about how contextual factors in the provider's community and at the broader service/policy level are likely to affect the resources available to providers to enhance quality care and their experiences as providers.
- The need to address the very important issues associated with understanding how to maintain the continued availability of family child care. For example, what lessens the likelihood of burnout among providers? How should the current difficulties in recruiting and retaining skilled caregivers be addressed? To date, quality family child care has generally been defined and studied on the basis of what is transpiring at a particular point in time in a particular provider's home, while vital human resource and system issues have received much less attention.

We anticipate that our study will contribute towards the development of a model of quality that is family child care-specific through identifying the various dimensions that predict the quality of the child's experience and the quality of the work experience, and by beginning to tease out how these interact with each other.

Notes

1 Kyle 1998.
2 Atkinson 1988.
3 Nelson 1988.
4 Nelson 1990.
5 Kyle 1997.
6 Kyle 1998.
7 Nelson 1990.
8 Kyle 1998.
9 Nelson 1990.
10 Atkinson 1988; Kyle 1998.
11 Kyle 1998.
12 Atkinson 1988; Kerr and Polyzoi 1996; Kyle 1998; Nelson 1990.
13 Dimidjian 1982.
14 Hughes 1985.
15 Kyle 1998.
16 Nelson 1991, p. 366.
17 Pence and Goelman 1987.
18 A good discussion about some of these differences is provided by Trawick-Smith and Lambert 1995.
19 Atkinson 1988; Kontos and Reissen 1993; McConnell 1994. Only Manitoba, Québec and the Yukon permit two providers in a single child care home. A 1997 national survey of regulated family child care providers reports that only 13% of providers have assistants and that, on average, an assistant is present for 4.8 hours a day (Goss Gilroy Inc. 1998, Table 6.3).
20 Goss Gilroy Inc. 1998, p. 28.
21 Doherty et al. 2000, p. 70.
22 Doherty et al. 2000, p. 115.
23 Kerr and Polyzoi 1996; Trawick-Smith and Lambert 1995.

ERIC Full Text Provided by ERIC

24 Galinsky et al. 1994; Kyle 1999.
25 Galinsky et al. 1994; Pence and Goelman 1991.
26 Fischer and Eheart 1991.
27 Galinsky et al. 1994.
28 Kyle 1999.
29 Kyle 1998.
30 National Family Day Care Training Project 1999, pp. 6-7.
31 See particularly Doherty et al. 2000, Goelman et al. 2000, as well as Helburn 1995 and Whitebook, Howes and Phillips 1990.
32 Eheart and Leavitt 1986; Goss Gilroy Inc. 1998; Kontos and Reissen 1993.
33 McConnell 1994.
34 Bollin 1993; Goelman, Shapiro and Pence 1990; Kontos and Reissen 1993; McConnell 1994.
35 Kontos 1992; Kontos et al. 1995; Goss Gilroy Inc. 1998.
36 Bollin 1993; Nelson 1990; Norpark 1989.
37 Cummings 1980.
38 Howes and Rubenstein 1985; Phillips, McCartney and Scarr 1987.
39 Whitebook, Howes and Phillips 1990.
40 Goss Gilroy Inc. 1998, p.9.
41 Norpark 1989.
42 Read and LaGrange 1990, p. 27.
43 Read and LaGrange 1990.
44 Goss Gilroy Inc. 1998, p. 9.
45 Kontos 1994.
46 Bollin 1993; Kontos and Reissen 1993; McConnell 1994.
47 See, for example, Fischer and Eheart 1991.
48 Trawick-Smith and Lambert 1995.

ERIC Full Text Provided by ERIC

Chapter 3
Methodology

3.1 Introduction

This chapter provides information about the *You Bet I Care!* Study 3 sample and how it was selected, the development and content of the agency and provider questionnaires, the observational measures used to assess process quality, and the methods used to collect, prepare and analyze the data. The study involved 231 family child care providers located in six provinces and the Yukon, and constitutes one of the largest studies of family child care ever undertaken in North America.[1] One of the main strengths of our study was the use of systematic procedures and valid measures that allowed us to obtain information about many aspects of family child care from a large and diverse sample of providers.

3.2 Sample Selection and Recruitment

Seven jurisdictions were selected to provide a sample that would be broadly representative of the diversity of family child care in Canada. The jurisdictions were: Alberta, British Columbia, New Brunswick, Ontario, Québec, Saskatchewan and the Yukon. In addition to providing geographic representation, these jurisdictions represent various points both along a continuum of government regulatory standards and in the extent of provincial or territorial supports provided for the child care system. Regulatory differences were evident in: (1) the number and age mix of children permitted in regulated family day care homes;

ERIC

(2) whether provisions include the option for a provider to care for a larger group of children if she has a full-time assistant; and (3) the extent to which minimum mandatory training is required of licensed or agency-affiliated providers. The jurisdictions also differed in the extent to which funding is made available to providers in the form of operating or incentive grants, and in the extent of government funding provided to family child care agencies and/or resource programs that can offer providers direct training and support. (See Chapter 1, Sections 1.7 and 1.8, and Appendix B for more details.)

Both individually licensed and agency-affiliated providers were recruited for this study. In order to participate, providers had to have been licensed or affiliated with their current agency for at least 12 months, and to have been providing care for at least three children (in addition to their own), at least two of whom were enrolled on a full-time basis. The requirement of having been licensed or agency-affiliated for at least a year was imposed for two reasons: first, so that the findings could present a picture of at least a minimally stable workforce; second, so that we could ask providers about the stability of child placements in the last year, their annual income from child care work, and the number and frequency of visits by a licensing official or home visitor in the previous 12-month period.

3.2a Sampling within Selected Communities

In most jurisdictions, sites were selected in and around major cities and their suburbs, and in nearby rural communities that contained a sufficient number of family child care providers for sample recruitment. Providers were clustered in geographic areas to minimize travel time and cost by having a trained observer actually resident in or near each target community. Two exceptions were made. In the Yukon, all providers selected were living in or near the city of Whitehorse (which has the largest provider and population base in the territory). The other exception was New Brunswick. Since there were only 22 licensed family child care providers in the whole province, all of them were invited to participate. Table 3.1 identifies the communities in which providers were sampled.

3.2b Sample Recruitment

The original intention was to obtain at least 40 providers from each jurisdiction in order to obtain a sample size that would permit appropriate statistical analyses. Exceptions had to be made in New Brunswick, where there were only 22 licensed providers, and the Yukon, where there were only 17 licensed providers residing in Whitehorse and the surrounding area.

Table 3.1

The Communities from Which Providers Were Drawn

Jurisdiction	Communities
British Columbia	Vancouver and surrounding area; White Rock
Alberta	Edmonton; Barrhead; Calmar; Fort Saskatchewan; Spruce Grove; Wetaskiwin
Saskatchewan	Regina and Saskatoon and immediately surrounding areas
Ontario	Burlington/Georgetown/Mississauga triangle; Ottawa
Québec	Québec City and suburbs and surrounding rural areas
New Brunswick	Whole province
Yukon	Whitehorse and immediately surrounding area

Potential providers were identified by consulting lists of family child care agencies and lists of individually licensed providers obtained from the relevant provincial/territorial child care authorities. The exception was British Columbia, where lists of licensed providers were obtained from the Westcoast Child Care Resource and Referral Program and the Western Canada Family Child Care Association of British Columbia.

A number of steps were taken before contacting family child care agencies or individual providers to seek their participation. First, approval of our proposed research procedures and data collection instruments was sought and received from the Behavioural Research Ethics Board of the University of British Columbia. This approval was accepted by the other two sponsoring universities (the University of Calgary and the University of Guelph). Second, a brief article about the study was published in *Interaction*, the bilingual journal of the Canadian Child Care Federation.[2] Third, government officials in each jurisdiction and relevant agency or provider groups were informed and asked to support the research. In British Columbia, the President of the Western Canada Family Child Care Association spoke to Vancouver-area members, and staff at the Westcoast Child Care Resource and Referral Program informed providers who used its services. Presentations were made to a meeting of representatives of family child care agencies in both Alberta and Ontario to inform them about the study and solicit their support, and a similar presentation was made at a provincial meeting of family child care providers in Saskatchewan.

Agency directors in Alberta, Ontario and Québec were sent a letter briefly explaining the project and informing them that they might be contacted and asked to participate. The letter acknowledged that the study would involve agency staff and provider time. Directors were told that each participating organization would receive $100.00 and each participating provider would be paid $50.00. In addition, both the sponsoring agency and the providers would receive a certificate of participation and a summary report of the findings based on results from the full sample of providers.

Approximately two weeks later, the site coordinator in each jurisdiction contacted agency directors to provide additional information and solicit participation. At this time, she explained that we wanted the agency to complete a short questionnaire about its organization and to obtain the agreement of between six and eight providers to be contacted about their possible participation in the study; these providers had to have been associated with the agency for at least a year and to be caring for at least three children placed by the agency. Directors were made aware of the fact that we hoped to obtain a sample of typical providers affiliated with their agency, and that it was important to have a range of quality among the providers who participated in the study. Directors who agreed to participate were given a letter to send or give to their providers, together with a one-page description of the study. Providers identified by their sponsoring agency were subsequently telephoned to give them additional information and to seek their participation. At this time, the site coordinator confirmed that the provider had been with the agency for 12 months, was caring for three children placed by the agency, and that at least two of these children were attending on a full-time basis. She also set a date and time for the observation.

In jurisdictions with individually licensed providers, all providers living in the target communities were sent a brief letter describing the study and the nature of providers' participation, and informing them that they might be contacted by a person whose name was given in the letter. This letter also informed the provider that each participant would receive $50.00 upon completion of the questionnaire and observation session, a certificate of participation, and a summary report of the findings from the total sample of providers. Approximately two weeks later, the site coordinator started contacting providers and continued

Table 3.2							
The Final Sample: Participation and Refusal Patterns, by Jurisdiction							
Jurisdiction	**Refusals**		**Provider backed out after agreeing**	**Completed sample**		**Overall provider participation rates**
	Agencies	**Providers**		**Agencies**	**Providers**	
British Columbia	N/A	30	1	N/A	45	58.4%
Alberta	1	2	6	8	39	83.0%
Saskatchewan	N/A	92	3	N/A	40	29.6%
Ontario	0	0*	0	8	39*	100.0%
Québec	2	0	4	8	42	91.3%
New Brunswick	N/A	8*	0	N/A	13*	73.3%
Yukon	N/A	4	0	N/A	13	76.5%
TOTAL	3	136	14	24	231	61.4%

* Two providers, one from Ontario and one from New Brunswick, participated in the study but upon data entry were found to be ineligible; they are shown as neither refusals nor participants.

until she had either spoken to every licensed provider, as was the case in New Brunswick and in Whitehorse, or succeeded in finding 40 providers willing to participate. When a provider agreed to participate, the site coordinator confirmed that she met the eligibility criteria and scheduled a time for the observation.

3.2c Participation and Refusal Rates

As illustrated in Table 3.2, the final sample consisted of 231 family child care providers; this number included 111 individually licensed providers and 120 providers who were affiliated with one of 24 agencies. Eight of the agencies were commercial enterprises: six in Alberta and two in Ontario. The three agencies that were approached but unable to participate were non-profit agencies that could not obtain sufficient providers willing to be contacted about the study.

The process of going through the agencies to obtain agency-affiliated providers was essential, since most agencies are reluctant to release lists of individual providers. In addition, agencies were in a position to ensure that the providers who were approached by the study team: (1) met eligibility criteria, (2) were typical providers, and (3) were reasonably likely to participate in the study and to permit an observation in their home. Providers were assured directly, both in the initial contact letter and by the site coordinator and observer, that the information they provided, and any scores or ratings based on observations in their home, were confidential and would not be shared with the agency or their home visitor. Similar assurances were made to individually licensed providers regarding confidentiality of their information in relation to licensing officials.

Once names of agency-affiliated providers were obtained, almost all agreed to participate when contacted by the site coordinator. However, it is not known how many potential providers were contacted by agency staff and did not agree to be contacted by the study team. As indicated in Table 3.2, a far higher proportion

ERIC

of individually licensed than agency-affiliated providers declined to participate when we contacted them. The participation rate for all agency-affiliated providers was 90.9%; the comparable participation rate across all individually licensed providers who were contacted was 46.3%. The overall participation rate for the full study sample was 61.4%, despite the fact that participation rates were close to or exceeded 75% in five of the seven jurisdictions in the study. Most cases of a provider backing out after agreeing to participate were due to illness or the withdrawal of a child, which then made her ineligible. In one situation, a parent expressed concern to the provider about the idea of a stranger coming into the home to complete an observation. Despite the challenges, the project team was successful in obtaining close to 40 providers in most jurisdictions, and close to 75% of providers in New Brunswick and in the Yukon, which had much smaller samples to draw from.

3.2d Possible Response Biases

Research studies of family child care providers have reported low to moderate rates of participation, especially when the study includes observations or requires that children in care have certain characteristics. One comparable American study which also asked individually licensed providers to complete a questionnaire and allow an observation in their home reported a refusal rate of 65%.[3] The 1996 Canada-wide survey of regulated family providers conducted as part of the Sector Study obtained a 50% response rate in a study that only required completion of a questionnaire.[4]

The voluntary nature of any social science study presents both challenges in obtaining the sample and risks of response biases affecting interpretation of results. In addition to the usual concerns of subjects about confidentiality and anonymity, in the case of family child care providers there are other challenges that may affect response rates. These include the fact that the majority of providers already work long hours and contribute unpaid hours as well, so participation in research is an added burden. Some providers may not be fluent in English or French or may find responding to a written questionnaire difficult. Most important, providers may find having yet another unknown person, in addition to licensing officials and home visitors, come into their home and evaluate their care to be intrusive, threatening or objectionable. Because of these factors, we acknowledge that providers who are willing to participate in studies such as this one may not only be more interested in participating for various specific reasons, they may also feel more competent and secure about the quality of the care they provide.

3.3 Sample Representativeness

The extent to which a research sample is an accurate reflection of the population from which the sample is drawn — its representativeness — is an important consideration. When research findings are used to inform practice or policy development, an implicit assumption is made that the results obtained from sample participants are generalizable to others. We cannot make the claim that the sample obtained in this study is *statistically representative* of all regulated providers in Canada who shared the eligibility criteria we imposed. To do so would have required the construction of a sampling frame of all "eligible" providers across the country, a much larger sample size, and the inclusion of providers from every jurisdiction and from many different locales. The costs involved in conducting observations of a statistically representative sample of providers across the country would be prohibitive.

We can, however, provide information about how our sample compares, in general terms, to the profile of regulated family child care providers obtained in the 1996 National Survey of Providers Working in the

ERIC Full Text Provided by ERIC

Regulated Sector. This survey, conducted as part of the federal government-sponsored Child Care Sector Study, was designed to provide a general, national profile of providers, their working conditions and their experiences; it was based on a random sample of 1,107 individuals.[5]

As indicated in Table 3.3, the sample from the current study is slightly older and has a higher level of general education than the 1996 sample. Fewer of the providers who participated in our study had young children living at home. Providers in our sample also had more years of experience in child care provision. Although between 41.0% and 48.0% of both sample groups had some experience as an unregulated provider, a higher proportion of people in our sample had worked in a child care centre (26.0% in contrast to 10.0%). These sample differences may reflect both differences in the selection process and differences in the amount of participation required. Providers were only eligible to participate in the current study if they had been licensed or affiliated with an agency for at least 12 months, while all regulated providers were eligible for participation in the Sector Study survey. Providers in both studies completed a written questionnaire, but providers in the *You Bet I Care!* study also agreed to an observation lasting approximately three hours. As a result of the observation requirement, we would expect that providers with higher levels of formal education, more experience and who feel more self-confident would be more likely to participate in our study than their colleagues with lower levels of overall education, or less experience and self-confidence.

Table 3.3

A Comparison of the 1996 Sector Study Sample and the 1999 *YBIC!* Study 3 Sample

Provider Characteristic	Sector Study sample (1996)	*YBIC!* Study 3 sample (1999)
Female	99%	100%
Age:		
20-29	14.6%	13.0%
30-39	46.4%	39.0%
40-49	29.0%	32.9%
50 and over	10.1%	15.1%
Married or living with a partner	89.0%	89.6%
At least one child living at home who is age 5 or younger	58.2%	29.9%
Highest educational level completed (any subject):		
Not completed high school	15.2%	8.3%
High-school diploma	26.9%	26.1%
Some college or university	22.0%	21.3%
Completed college program	27.6%	31.7%
B.A. or higher degree	8.3%	12.6%
Proportion affiliated with an agency	53.3%	51.9%
Total years of experience in providing child care in any type of setting (own home, child's home, child care centre)	Average 7.0 years	Average 10.1 years

Sources: *YBIC!* Study 3 Provider Questionnaire; Goss Gilroy Inc. 1998, Table 2.1, Figures 2.2, 3.1, 3.5 and p. v.

Even with the differences evident in Table 3.3, overall the sample of providers in the *You Bet I Care!* study is reasonably comparable to the national profile. Both studies, of course, are based on voluntary participation and probably were more successful in obtaining information from providers who are more committed to their work. It is likely that both studies underestimate the characteristics and views of providers who are less fluent in English or French, and those who have difficulty responding to written questionnaires. Researchers affiliated with the U.S. National Child Care Staffing Study noted a similar concern in their research on quality in child care centres. They cautioned that the final sample of centres they obtained may, on average, provide care of higher quality than the full population of centres across the United States.[6]

3.4 Data Collection Instruments

Data were collected using five instruments:

1. The *Home Child Care Program Questionnaire*, a self-completed questionnaire specially designed for this study and completed by agency directors.
2. The *Caregiver Questionnaire,* a self-completed questionnaire specially designed for this study and completed by providers.
3. A brief Provider Interview, used to obtain specific information required for completion of the *Family Day Care Rating Scale* and to obtain information from providers who were caring for a child with special needs.
4. The *Caregiver Interaction Scale (CIS),*[7] an observational measure of the provider's sensitivity, harshness and degree of detachment in her interactions with the children.
5. The *Family Day Care Rating Scale (FDCRS),*[8] an observational measure of various characteristics indicative of the quality of the family child care home.

3.4a The Survey Questionnaires

1. The Home Child Care Program Questionnaire

The Home Child Care Program Questionnaire,[9] developed for this study, was designed to collect information about the family child care agencies that sponsored the participating agency-affiliated providers. To our knowledge, there is practically no published information about family child care agencies that describes their organizational features, the specific services and supports they provide to client families and to providers, their policies and procedures, and their experiences in recruiting and retaining family day care providers. The findings from this questionnaire are reported in a separate document.[10]

The Home Child Care Program Questionnaire had five major sections that covered: (1) the agency and the population it serves; (2) the services provided to children's families; (3) provider monitoring, fees and turnover; (4) home visitors; and (5) the level and type of supports available to providers. A sixth section provided an opportunity for the director to identify the extent to which certain issues were a major concern for the family home child care program and to express opinions. This questionnaire is presented as Appendix D.

ERIC Full Text Provided by ERIC

2. The Caregiver Questionnaire

There were two versions of the Caregiver Questionnaire: one for individually licensed providers and the other for providers associated with an agency.[11] These are presented as Appendices E and F respectively. Both versions had sections covering: (1) the provider's child care experience; (2) the children in her care; (3) working conditions and income from child care provision; (4) the availability of various supports; (5) the provider's feelings about caregiving; (6) the provider's feelings about her own work situation; (7) the provider's educational background and participation in professional development activities; and (8) her personal background. A final section consisted of an open-ended question that asked providers what advice they would give to a friend who was thinking about becoming a family child care provider. The questionnaire for individually licensed providers also included some questions about the support provided by licensing officials, while the questionnaire for agency-affiliated providers sought similar information in relation to their home visitor and the agency.

The caregiver questionnaire also included a new measure of work-related stress designed for family child care providers by the authors. The ten-item Family Child Care Provider Stress Scale was found to have good reliability, based on its consistency of measurement across items. The standardized Cronbach Alpha coefficient was .80 for this sample.

3.4b Pilot Tests of the Survey Questionnaires

After the creation of English and French versions, the agency questionnaire was circulated for pre-testing in Alberta, Ontario and Québec. A total of seven agency directors provided feedback, two of whom were francophones from Québec. Prior to mailing the draft material, each director was telephoned by an anglophone or francophone Principal Investigator who explained the purpose of the pre-test and the need to be as specific as possible when providing written comments. Telephone follow-up was undertaken with two directors to further clarify their comments. Suggestions made by the directors were incorporated into the final version of the questionnaire.

Pre-testing of the draft versions of the two provider questionnaires was undertaken in Alberta, British Columbia, Ontario, Québec and Saskatchewan. This involved 15 providers, of whom eight were individually licensed and two were francophone. In Alberta and Saskatchewan, the site coordinators sat with the providers as they completed the questionnaires and obtained immediate feedback from them. In the other provinces, the providers were telephoned by either a francophone or an anglophone member of the research team who explained the purpose of the pre-test before mailing the draft material. Follow-up telephone calls were conducted after the completed material was received to obtain each provider's reactions and suggestions. Many of the suggestions given by the providers were incorporated into the final versions.

3.4c The Provider Interview

The provider interview was used to collect information that would assist the observer to complete the *FDCRS* scoring sheet. It also made possible the collection of information about the specific supports available to a provider who was looking after a child with special needs. The interview protocol is presented as Appendix G.

3.4d Observation Instruments

The two observational measures of child care quality were the *CIS*[12] and the *FDCRS.*[13]

1. The *Caregiver Interaction Scale*

The *CIS* was used as a means of gathering information on the affective or caregiving tone of provider-child interactions in the family child care home. The *CIS* has been used extensively in other studies in both centres and family child care homes to assess three specific dimensions of caregiver affect. The first sub-scale of the *CIS* focuses on the extent of a provider's *sensitivity*, behaviour that shows her to be warm, attentive and engaged in her interactions with the children. The second sub-scale focuses on *harshness*, the extent to which the provider is critical, threatening or punitive. The third sub-scale evaluates the extent of the provider's *detachment*; this term refers to low levels of interaction and supervision by the care provider. The three sub-scales involve a total of 23 behaviour descriptions. Each description is ranked on the extent to which it mirrors the provider's behaviour using the following four-point scale: "not at all," "somewhat," "quite a bit," and "very much." The *CIS* is presented in Appendix H. Scoring is based on observation and, in this study, was done after the observer had spent a block of about three hours in the home observing for the *FDCRS*.

The validity of the *CIS* — the extent to which it measures caregiver behaviours that are indicative of process quality — is supported by research findings. Care provider scores obtained on the *CIS* are associated with children's language development and with measures of infants' and toddlers' attachment security with their provider.[14] The reliability of the scale — the extent to which two different raters' scores in a given situation agree — has also been substantiated. Reported inter-rater reliability scores in two large U.S. multi-state studies ranged between 89% and 95%, depending on the sub-scale.[15]

2. The *Family Day Care Rating Scale*

The *FDCRS* is the most widely used measure of quality in family child care research. The authors suggest that its completion requires at least two hours of observation in the home. Observers in our study spent, on average, three hours observing. Ratings are made of 32 aspects of a family child care program, both care provider behaviour and the physical setting, using seven categories, each of which yields a sub-scale score, in addition to an overall total quality score. The seven categories focus on: (1) space and furnishings for care and learning; (2) basic care; (3) language and reasoning; (4) learning activities; (5) social development; and (6) provision for adult needs, such as balancing family and caregiving responsibilities. There is a supplementary scale for use in homes where there is a child who has special needs. Each item is presented as a seven-point scale with quality descriptors under 1 (inadequate), 3 (minimal), 5 (good), and 7 (excellent). Scoring is based on the observations, supplemented by answers to questions about any aspects of the program that were not observed during the visit. An overview of this scale is presented in Appendix I.

Concerns are sometimes expressed, not only by people in the field but also by researchers, that the *FDCRS*, being derived from an instrument designed for centres (the *Early Childhood Environment Rating Scale [ECERS]),*[16] fails to acknowledge or tap "several important aspects of family child care quality."[17] These include the provider's ability to capitalize on the presence of a mixed-age group as an opportunity for children to learn from other children, and the quality of the communication and interaction between provider and parent. The *FDCRS* also lacks indicators of quality related to the family child care situation as an adult work environment. Kathy Modigliani observes that family child care quality is influenced by the extent to which providers overcome the isolation characteristic of the occupation and by the extent to which they take real vacations away from their caregiving work. She notes that the extent to which these needs are addressed is not estimated in current assessment instruments.[18] Lee Dunster has written about

the importance of the provider ensuring that she has some daily personal time for rejuvenation, thus restoring the emotional and physical resources to provide good care for the children.[19] Again, this aspect of quality is not explored by the *FDCRS.*

In spite of the above-noted shortcomings that the *FDCRS* shares with other instruments for assessing family child care quality, there is reason to be confident that it does, in fact, provide an indication of the level of quality in a given home. First, our study found a positive correlation between the home having a high score on the *FDCRS* and the provider's score on the Sensitivity sub-scale of the *CIS;* and it found a negative correlation with the provider's score on both the Detachment and the Harshness *CIS* sub-scales (see Table 6.6). Second, several studies have found that children in homes with higher scores on the *FDCRS* are more competent or developmentally advanced on tests of language development and in the complexity of their play (an indicator of cognitive skills).[20] Third, research has documented a high correlation between assessments on the *HOME (Home Observation for Measurement of the Environment)* scale,[21] a well-established tool for assessing the extent to which a family home provides resources that stimulate children's social, language and cognitive development, and *FDCRS* scores in the same setting.[22] Fourth, the professional judgement of experienced agency home visitors supports the validity of the *FDCRS*. A Canadian study that used the precursor of the *FDCRS*, the *Day Care Home Environment Rating Scale* (*DCHERS)*[23] found that scores on the *DCHERS* were highly correlated (r = .80) with home visitors' ratings of the quality of the family child care homes.[24] (Readers are referred to Appendix A for a summary of many studies that used the *FDCRS* as a measure of quality.)

The reliability of the *FDCRS* (its capacity to yield consistent scores) is also well established. Across seven studies, inter-rater reliability scores (the extent of agreement when two people independently rate the same home at the same time) ranged from 79% to 90%.[25] The scale's developers report that inter-item consistency is also high, both for the Total score and the separate sub-scale scores. In the present study, a measure of inter-item consistency, the standardized Cronbach Alpha, was very high (r = .93).

3.5 Observer Training and Inter-Rater Agreement Levels

All the site coordinators except one had a minimum of a two-year ECCE credential and post-graduate experience. The site coordinator without the formal credential had extensive experience both as a home visitor and as the director of a family child care agency. Every observer was either an experienced family child care provider or had an ECCE credential and had worked in a child care centre. We had hoped to hire as observers only people with family child care experience, but found this was not possible. Before attending the training, each person was required within the previous month to do a practice observation using the *FDCRS.* The scoring sheets from these practices were used at the beginning of the formal part of the three-day training session to identify items that people had found difficult to score. During the training, participants used a training video tape to do a practice observation on both the *FDCRS* and the *CIS.*[26] Then, in teams of two, they did two field observations using both scales. The observations were followed, in each case, by a debriefing with the trainer and calculation of inter-rater agreement levels.

At the start of data collection each observer had attained an inter-rater agreement level of 87% or better on both instruments. Each site coordinator did a parallel observation with each obersver in her jurisdiction on the person's fifth or sixth data collection visit. At the time of this second inter-rater check, all obervers had an inter-rater agreement level of 87% or better on the *CIS* and 89% or better on the *FDCRS.*

ERIC Full Text Provided by ERIC

3.6 Data Collection

Data were collected between April and mid-June 1999. Each individually licensed provider who agreed to participate was mailed a package containing: (1) a thank-you letter which confirmed the date and time of the scheduled visit and also explained what to do with the other items in the package; (2) a one-page description of the study that could be shared with parents; (3) two copies of the consent form, one for the provider's own files and the other to be picked up by the observer before starting her observation; and (4) a copy of the provider questionnaire, with a flavoured tea bag attached and a note inviting her to "Have a nice cup of tea on us."

Each agency director who agreed to participate was mailed a package containing: (1) a thank-you letter which also explained what to do with the other items in the package; (2) a copy of a letter and a one-page description of the study that could be reproduced and shared with providers; (3) two copies of the agency consent form, one for the agency's files and one to be returned to the site coordinator; and (4) an agency questionnaire. No agency-affiliated providers were contacted without first having a signed consent form from the agency and a completed agency questionnaire. Agency-affiliated providers who agreed to participate were sent a similar package to that sent to individually licensed providers.

A telephone call was made to each provider one or two days before the scheduled visit to remind her both of the visit and that the observer would be picking up the consent form and completed provider questionnaire. No observation was undertaken without a signed consent from the provider. In most cases observations took place in the morning, with the observer arriving in time to see the children arrive.

Screening calls made to individually licensed providers and information obtained from the sponsoring agencies identified providers' preferred language of communication. All observations of French-speaking providers were done by a francophone observer, and site coordinators ensured that providers received communications and questionnaires in their preferred language. In the final sample, 185 providers responded to the English version of the Caregiver Questionnaire, and 46 responded to the French version. The latter group included 42 providers in Québec, three in New Brunswick, and one living in British Columbia.

3.7 Data Coding, Cleaning and Preparation

The Caregiver Questionnaires required the respondent to answer questions in various ways: by filling in or circling a number, checking an appropriate response alternative, or providing their own answer to open-ended questions. Codebooks were developed for each questionnaire and two coders at the University of Guelph were trained to code the open-ended questions and then to input the data. Coding of open-ended questions was thoroughly reviewed on a continuing basis by one of the Principal Investigators, who also supervised and reviewed data entry. All responses to open-ended questions and spontaneous comments in French were translated into English by a francophone Principal Investigator.

Data from the observation forms were checked for completeness and accuracy, and were entered into the computer by the senior research assistant. The *FDCRS* has a single score for each item, which, in turn, allows for the development of sub-scale scores and a Total scale score. The calculation of the Total score and sub-scale scores was done by computer to avoid errors. Different items on the *CIS* are combined to provide the three sub-scale scores, one for each of: sensitivity, harshness and detachment. These were also

ERIC Full Text Provided by ERIC

computed according to previously input formulae. Derived variables were created where appropriate from individual item responses to summarize the data in a meaningful way.

There were very few instances of missing data or out-of-range responses. On occasion, it was possible to estimate or impute a value to such a question, based on replies to another question in the same questionnaire, or on the information collected at the time of the observation. However, in most cases, non-responses were simply coded as missing. The results reported in this document reflect valid responses.

3.8 Data Analysis

Data were analyzed using the SPSS-X Program for Windows™. Descriptive data, including means, ranges, medians, modes, standard deviations and frequencies, were generated first. The next step of descriptive analysis consisted of correlational analyses, in which relationships among variables were explored, particularly correlations between provider variables and the three scores derived from the *CIS*, and the *FDCRS* Total and sub-scale scores. As described in Chapter 8, this was followed by analyses that permitted the identification of those key variables that predicted the quality of the family child care homes, based on their scores on the *FDCRS*.

Notes

1 The *National Day Care Home Study* conducted in the United States was based on 305 families (Divine-Hawkins 1981), while the more recent *Quality in Family Child Care and Relative Care* (Kontos et al. 1995) involved 172 family child care providers and 50 relatives providing care.
2 Doherty 1999.
3 Kontos, Hsu and Dunn 1994.
4 Goss Gilroy Inc. 1998.
5 Ibid.
6 Whitebook, Howes and Phillips 1990.
7 Arnett 1989.
8 Harms and Clifford 1989.
9 In developing this questionnaire we expanded on an agency questionnaire used in Alberta by Read and LaGrange 1990. We also gratefully acknowledge the advice and consultation provided by Lee Dunster and Irene Kyle.
10 Doherty et al. in press.
11 In developing this questionnaire, we expanded on the questionnaires used in previous Canadian research in the family child care area, specifically Goss Gilroy Inc. 1998, and Read and LaGrange 1990. Again, we gratefully acknowledge the advice and consultation provided by Lee Dunster and Irene Kyle.
12 Arnett 1989.
13 Harms and Clifford 1989.
14 Whitebook, Howes and Phillips 1990.
15 Helburn 1995; Whitebook, Howes and Phillips 1990.
16 Harms and Clifford 1980.
17 Modigliani 1990, p. 20.
18 Ibid.
19 Dunster 1994.
20 Goelman and Pence 1987, 1991; Howes and Stewart 1987; Kontos 1994; Kontos, Hsu and Dunn 1994.
21 Caldwell and Bradley 1979.
22 Goelman and Pence 1991.
23 Harms, Clifford and Padan-Belkin 1983.
24 Pepper and Stuart 1992.
25 Clifford et al. 1992.
26 The exception was the training session in Québec, because a training videotape in French was not available.

ERIC Full Text Provided by ERIC

Chapter 4

Family Child Care Providers: Who They Are and How They Feel about Their Work

4.1 Introduction

Much of the research literature that addresses the issue of child care quality focuses on variables such as the physical safety of the setting, the number of children in the group and the adult's behaviour. The underlying assumption, confirmed by research, is that such variables are linked to positive outcomes for children. The past few years have seen a growing recognition that quality considerations can and must be considered from another perspective — that of the person providing the care.[1] How family child care providers feel about their work directly influences both how they respond to children and the likelihood of their continuing to provide family child care.

This chapter looks at the personal and experiential backgrounds of the 231 women who participated in this study and how they feel about their work. The next chapter discusses the daily work experience of the study participants, their working conditions and the supports they obtain from people outside their immediate family. Chapter 6 gives information on the level of quality observed in the family child care homes as a group, while Chapter 7 identifies those variables that are most clearly associated with quality. In Chapter 8, we move ahead to identify the variables that actually *predict* the level of quality in a given home. The final chapter, Chapter 9, provides conclusions and recommendations.

4.2 Demographic Profile

All the participants in this study were female. The largest percentage, 39.0%, were between the ages of 30 and 39, with an additional 32.9% aged 40 to 49. Only 15.1% were over age 50. Most, 89.6%, were married or living with a partner. Nearly half the participants, 47.7%, had at least one child under age 12 living at home. Children 5 years or younger were present in the homes of 29.9% of the sample, and 72.0% of these homes had at least one child under age 3 living in it. Nearly a third of the participants, 32.9%, either had no children living at home or only children age 18 or older. See Table 3.3 for a comparison of our sample with that of the 1996 Canada-wide survey of 1,107 regulated providers.[2]

4.3 Education and Professional Development

As indicated in Table 3.3, the participants in the present study had a slightly higher level of overall education than that found in the 1996 survey of regulated providers.[3] It is not possible to compare their level of child care-specific education since this was not explored in the previous study. Neither is it possible to compare the two samples in terms of participation in professional development, since the 1996 study asked about participation in the previous 12 months, while our study inquired about participation in the previous three years.

4.3a Highest Level of Education, Any Subject

Nearly half the participants, 44.3%, had completed a college or university program in some field. Of these 102 providers, 61 had completed a program with a specialization in early childhood education, child development or a related field. An additional 21.3% of our sample had taken some college or university courses. A substantially higher proportion of providers living in New Brunswick reported that they had not completed high school than was the case in any other jurisdiction. At the other end of the spectrum, a higher proportion of participants in British Columbia, 24.4%, than in any other jurisdiction reported having completed a university degree.

Table 4.1

Highest Level of Educational Attainment in Any Field, 1999

Highest educational level	B.C. N = 45	Alberta N = 39	Sask. N = 40	Ontario N = 38	Québec N = 42	N.B. N = 13	Yukon N = 13	TOTAL N = 230
Some high school	4.4%	7.7%	7.5%	7.9%	9.5%	30.8%	0	8.3%
High-school diploma	20.0	38.5	30.0	26.3	26.2	23.1	0	26.1
Some college or university	15.6	20.5	22.5	31.6	16.7	15.4	30.8	21.3
College credential	35.6	28.2	20.0	28.9	38.1	23.1	61.5	31.7
University degree	24.4	5.1	20.0	5.3	9.5	7.7	7.7	12.6

Note: One participant did not provide information about her highest level of education.

52

ERIC

Table 4.2								
Completion of a Formal Family Child Care-Specific Training Course, 1999								
Course	B.C. N = 45	Alberta N = 39	Sask. N = 40	Ontario N = 39	Québec N = 42	N.B. N = 13	Yukon N = 13	TOTAL N = 231
Good Beginnings	60.0%	0%	0%	0%	0%	0%	0%	11.7%
Step Ahead	0	42.6	0	0	0	0	0	7.8
Québec government-approved course	0	0	0	0	45.2	0	0	8.2
Other formal course	20.0	8.7	12.5	10.3	14.3	23.1	7.7	12.6
TOTALS	80.0%	48.7%	12.5%	10.3%	73.8%	23.1%	7.7%	40.3%

A small proportion of providers, 6.1%, reported being currently enrolled in a certificate, diploma or degree program at a post-secondary institution.

4.3b Child Care-Specific Education

Two questions explored formal education related specifically to the provision of child care. One question asked whether the individual had completed a family child care training course such as *Step Ahead*[4] or *Good Beginnings*.[5] The second question asked if the individual had completed a certificate, diploma or degree in early childhood education or three other identified areas of study at a college, university or other post-secondary institution.

Over a third of the study participants, 40.3%, reported having completed a course or courses specifically for family child care providers. As illustrated in Table 4.2, the largest proportions of providers with such training were in British Columbia, Québec and Alberta. In all three provinces, training courses are widely available and promoted.

Completion of a certificate, diploma or degree program in early childhood education or one of three related areas at a post-secondary institution was reported by 33.4% of the study participants. The related areas were: child development, child and family studies, and teaching. As illustrated in Table 4.3, nearly a quarter of the study participants, 20.4%, had such education at the two-year credential or higher level. An additional 9.1% reported partial completion of a credential, either because they were once enrolled but did not complete the program or they are currently enrolled.

At the time of data collection in the Spring of 1999, policy in the Yukon required providers without an ECCE credential to complete a 60-hour family child care or equivalent course within the first year of providing care. The Yukon was the only jurisdiction in the study with such a requirement. Effective from September 1999, Québec providers must complete a 45-hour training course within the first two years of operation. Two other jurisdictions, Prince Edward Island and Newfoundland/Labrador, that were not part of this study, also require providers to take formal training within a set period of time (see Appendix B).

ERIC

Table 4.3								
Highest Level of Post-Secondary Education in ECCE or Related Discipline, 1999								
Highest level	B.C. N = 45	Alberta N = 39	Sask. N = 40	Ontario N = 39	Québec N = 42	N.B. N = 13	Yukon N = 13	TOTAL N = 231
Course lasting less than one year	8.9%	12.8%	0%	5.1%	0%	7.7%	30.8%	6.9%
One-year credential	8.9	2.6	5.0	0	7.1	7.7	23.0	6.1
Two- or three-year credential	15.6	7.7	10.0	15.4	19.0	7.7	30.8	14.3
B.A. degree or higher	11.1	2.6	7.5	0	9.5	7.7	0	6.1
TOTALS	44.5%	25.7%	22.5%	20.5%	35.6%	30.8%	84.6%	33.4%

Overall, 66.2% of the study participants had either completed a family child care-specific training course or a program in early childhood education or a related discipline at a post-secondary institution. Both completion of a family child care course and an ECCE or related program at a post-secondary institution was reported by 16.5% of the providers.

4.3c Participation in Professional Development

> *"A PET [Parent Effectiveness Training] course helped me to actively listen and communicate effectively with children and adults."*
> — Alberta provider

The majority of study participants, 89.5%, reported having participated in some type of professional development during the previous three years. The rate of participation ranged from 61.5% in New Brunswick to 97.8% in British Columbia and 100.0% in Saskatchewan. At the time of data collection, Saskatchewan child care policy required providers to attend at least two professional development workshops each year; it was the only jurisdiction in the study with such a requirement. Québec has subsequently instituted a requirement that providers participate in a minimum of six hours of professional development each year. One other jurisdiction that was not part of the study, Nova Scotia, also requires providers to participate in professional development activities each year (see Appendix B).

Among the providers who had engaged in professional development in the previous three years:

- 84.9% reported attending one or more workshops;
- 64.3% had attended a conference;
- 34.7% had taken at least one non-credit course at a post-secondary institution; and
- 18.6% had taken at least one credit course at a post-secondary institution.

It should be noted that people were asked to identify all the different types of professional development activity they had participated in. As a result, one person could identify more than one type of activity.

ERIC Full Text Provided by ERIC

Table 4.4	
Reasons for Participation in Professional Development Activities, 1999	
Reason for participation	**Proportion of providers identifying this reason**
To learn more about the work I do	84.8%
To obtain information on a particular problem or concern	83.8
To network with other providers	66.2
To meet the training requirements of the licensing system	64.1
To be able to charge higher fees	2.5
Other reason	16.5

In addition, we provided the participants with a list of five possible reasons for engaging in professional development activities and asked them to indicate all that applied to them; there was also space to write in another reason.

As illustrated by Table 4.4, the most frequently reported reasons for participating in professional development were related to obtaining information about a particular problem or learning more about child care provision in general. The most frequently identified "other" reason was "to obtain new ideas."

In response to being asked which single professional development activity had been the most useful, 27.0% of the providers cited provider conferences. One provider told us: "I find going to a conference gives me a boost in being a family child care provider, it's a lot of fun too." Such responses echo the frequent identification of networking with other providers as a reason for participating in professional development (see Table 4.4). The other most frequently cited activities were: workshops on child health, 18.5%; presentations on safety awareness, 11.2%; workshops on program planning, 10.1%; and presentations related to children who have special needs, 9.6%.

Some providers took the opportunity to identify concerns about current professional development opportunities. As evident in the following quotes, the timing of activities may be a barrier and more experienced providers may find it difficult to locate a course or workshop that meets their needs for information that goes beyond basic knowledge.

> *"Most don't seem to apply to what I really need, e.g. speech and language information for a child who has a language delay or skill building for certain problems, or I can't go when what I need is presented."*
> — Saskatchewan provider

> *"I find that most courses offer information which should be basic and common knowledge so most I find repetitive and redundant. An AIDS workshop drew forth a couple of interesting arguments and another on discipline offered a few angles but overall was disappointing."*
> — Ontario provider

"Any courses offered I have to turn away simply because I am the sole care provider and time during the day is out."
— New Brunswick provider

4.4 Work History

4.4a Reasons for Becoming a Family Child Care Provider

Study participants were given a list of eight possible reasons for becoming interested in being a family child care provider and were asked to identify no more than three that applied to them. There was also space where a response could be added.

As indicated by Table 4.5, the most frequently cited reasons were love of children and looking for a way to earn an income while at home with their own child. Few people identified having gone into family child care provision because no other employment options were available or because someone they knew was seeking care for a child. The most frequently cited "other" reasons were: had experience as a teacher (3.9%), and a friend encouraged me to become a provider (3.0%).

There were interesting differences across jurisdictions in providers' stated reasons for going into family child care. The largest proportion of people identifying their love of children and desire to work with them was in British Columbia, 82.0%. Nearly a fifth of providers in this province, 17.8%, stated that they had worked in a centre and had gone into family child care because they wanted to operate their own program. Responses such as these indicate "intentionality" — a deliberate choice to become a family child care provider and a commitment to this as a career. As discussed in Chapter 2, Section 2.3, intentionality is gaining increasing attention because of its influence on providers' behaviour with children and its suspected importance as a predictor of turnover.

Table 4.5

Reasons for Becoming a Family Child Care Provider, 1999

Reason	Percent responses
I love children and wanted to work with them	68.0%
I was looking for a way of earning income while caring for my own child(ren)	66.2
I had worked in a child care centre and wanted to operate my own program	23.4
I wanted companions for my child(ren)	17.7
A friend/relative/neighbour was seeking care	15.2
I responded to an advertisement by an agency	6.1
Other employment options were not available	5.2
I was unable to find child care for my own child(ren)	3.5
Other reason	21.6

In contrast, 76.9% of Ontario providers indicated that they had been looking for a way to earn an income while at home with their own child, and 30.8% had been seeking a companion for their child. These responses suggest family child care as a temporary occupation until the individual's own child starts school full-time. A higher proportion of people in New Brunswick than in any other jurisdiction stated that they became family child care providers because someone they knew needed child care, 38.5%, or no other employment was available, 15.4%. These responses suggest the possibility of a person having become a provider not because they wanted to work with children but because they felt they had to help out a friend or relative, or needed to earn an income and could not get any other type of work.

A multi-state American study looked at the association between providers' reasons for entering this occupation and both their sensitivity with children and the overall quality of the home.[6] The researchers report that providers whose primary reason for becoming a provider was "child-oriented" — because they love children or want to be at home with their own child — were rated as more sensitive and as providing better care. Providers with "adult-oriented" reasons, such as a feeling of obligation to help out a relative or friend, were rated as less sensitive and responsive with the children and as providing a lower quality of overall care.

4.4b Prior Involvement in Child Care Provision of Any Type

On average, the *You Bet I Care!* Study 3 participants had been part of the regulated system for 6.1 years, with a range from 4.4 years in the Yukon to 8.2 years in Saskatchewan. Many of the providers had previous child care experience, as follows:

- in their own home as an unlicensed provider — 48.1% (average of 2.3 years with a range from 0.7 years in the Yukon to 5.2 years in New Brunswick);
- in a child care centre — 26.0% (average of 1.3 years with a range from 0.8 years in New Brunswick to 2.2 years in the Yukon);
- in a child's home as a "nanny" or paid caregiver — 15.6% (average of 0.4 years with a range of 0.1 years in Alberta to 0.5 years in New Brunswick).

As noted above, the largest proportion of providers had prior experience as an unregulated provider, and this was also the prior experience with the greatest average length of time. The average total number of years of child care experience in any type of setting for the group was 10.1 years.

4.4c Reasons for Becoming Regulated

The providers were given a list of seven possible reasons for joining the regulated system and were asked to identify no more than three that applied to them. Again, there was also a space to write in another reason. As indicated by Table 4.6, demonstrating that their care met certain standards/they were professional was the most frequently cited reason by both agency-affiliated and individually licensed providers. The second most frequently identified reason was the hope that becoming regulated would provide greater access to support services. About a third of both agency-affiliated and individually licensed providers also perceived becoming regulated as desirable because it would enable them to serve families receiving fee subsidy.

ERIC Full Text Provided by ERIC

Agency-affiliated providers frequently identified, as a motivation for their affiliation, their preference for having the agency deal with parents around administration issues. This, of course, is not applicable for people who are individually licensed. A substantial proportion of individually licensed providers indicated that one motivation had been the ability to care for more children, which translates into higher income. Three jurisdictions that licence providers individually — British Columbia, New Brunswick and the Yukon — permit fewer children in an unregulated home (see Appendix B). Joining the regulated system in order to be able to care for more children was cited by 75.6% of the B.C. providers, 23.1% of New Brunswick respondents, and 38.5% of the providers from the Yukon. In Saskatchewan, where providers are also licensed on an individual basis, the permitted number of children is the same, regardless of regulatory status. Only one provider in this province identified being able to care for more children as a reason for becoming licensed. In all three participating provinces using the agency system, unregulated providers are permitted to care for the same number of children as regulated providers, and only 0.8% of agency-affiliated providers cited being able to care for more children as a motivator.

There were other differences across jurisdictions that are not related to the regulatory approach. A higher proportion of New Brunswick providers than respondents in any other jurisdiction, 23.1%, identified becoming licensed as a way of getting in touch with other providers. A much lower proportion of providers in the Yukon, 15.4%, and in Alberta, 23.3%, cited getting more support as a reason for joining the regulated system.

Table 4.6

Reasons for Joining the Regulated System, 1999

Reason	Agency-affiliated N = 120	Independently licensed N = 111	Total sample N = 231
To demonstrate to parents that my care meets standards of quality/to be more professional	69.2%	80.2%	74.5%
As a way of getting more support (such as training, equipment loans)	50.0	32.4	41.6
To enable me to care for families who were receiving subsidy	32.5	37.8	35.5
Preferred having the agency deal with parents around contracts and money issues	56.7	N/A	29.4
As a means of finding client families	25.0	10.8	18.2
As a way of getting in touch with other caregivers	12.5	10.8	11.7
To be able to care for more children than permitted as an unlicensed provider	0.8	38.7	19.1
Other reason	10.0	9.9	19.9

Note: Providers could, and often did, select three reasons.

ERIC Full Text Provided by ERIC

4.5 Feelings about Their Work

4.5a Self-Perception

We asked providers to tell us how they identify themselves in relation to caring for other people's children. Only 3.9% responded with "babysitter." The preferred terms were family child care provider, 51.5%, and caregiver, 27.7%. An additional 12.6% identified themselves as an early childhood educator.

4.5b Perception of the Job

Providers were given a list of four statements that could describe how they felt about the occupation of child care provider, and were asked to identify the description that best reflected their view. There was also a place to indicate "none of the above." The majority, 75.1%, indicated that family child care was their chosen occupation. Another 10.9% identified it as not their chosen occupation but good while their own children were young. Only 9.6% saw their job as a stepping-stone to other work in child care or a related field, while another 1.7% identified family child care as something they were doing until a better job became available.

Again there was some variability across jurisdictions. While 81.0% of providers in Québec identified family child care as their chosen occupation, this response was made by only 61.5% of providers in the Yukon and 64.1% in Alberta. The highest proportion of study participants viewing family child care as a stepping stone to other work in child care or a related field, 23.1%, was in the Yukon; the lowest proportion, 2.4%, was in Québec.

4.5c Feelings about the Work Situation

One of the unique components of this study was the use of a new measure developed by the researchers to assess the extent of a family child care provider's feelings of stress. The providers were given a list of ten possible sources of stress. They were asked to indicate the extent to which each situation was stressful for them using a five-point scale from 1 (no stress) to 5 (a great deal of stress). There was also a place to indicate that the situation did not apply (for example, "expectations of my spouse/partner" would not apply to a person who was not in such a relationship). Total scores were computed, in addition to the score for each item. Inter-item reliability was calculated using the Cronbach Alpha technique. The standardized reliability coefficient was .79, indicating that the items on this scale reliably measured one common characteristic.

The item with the highest stress rating was "financial concerns re: lack of benefits, e.g. lack of pension." The average score on this item for the whole sample was 3.3, with nearly half the providers, 48.7%, giving it a rating of 4 or 5. For these providers, lack of benefits was clearly a source of considerable concern. The item rated second highest, "income fluctuations," obtained an average score of 2.9. Just over a third of the providers, 34.6%, rated this as a 4 or 5. Thus, the two items with the highest stress rating were financial. Previous Canadian studies have noted that dissatisfaction with the income level and concern about lack of benefits is a common reason for providers to decide to leave the occupation.[7] The agency directors in our study identified provider turnover as one of the

ERIC

Table 4.7			
Degree of Perceived Stress Associated with Certain Situations, 1999			
Situation	**Average score**	**Percent giving the item a rating of 4 or 5**	**SD***
Financial concerns re: lack of benefits, e.g. lack of pension	3.3	48.7%	1.44
Income fluctuations	2.9	34.6%	1.31
Children leaving care	2.7	26.5%	1.33
Problems with parents, e.g. late pick-up, late payments	2.5	22.0%	1.24
Meeting the demands of my own family while providing child care	2.4	15.9%	1.08
Helping new children and families adjust	2.3	13.7%	1.08
Expectations of parents of the child care children	2.3	12.8%	1.06
Lack of privacy for me and my family	2.2	15.0%	1.17
Dealing with licensing rules/regulations	1.9	9.3%	1.09
Expectations of spouse/partner	1.8	10.0%	1.07

* SD: Standard deviation.

biggest concerns faced in the previous year and cited provider dissatisfaction with their income as one of the main reasons for people leaving.[8] When a family child care home closes, the children have to adjust not only to a new adult and a new physical setting, but must do so without the support of a familiar peer group. This can be quite stressful for them and may have a negative effect on their development. Data from the Canadian National Longitudinal Survey of Children and Youth (NLSCY) indicate that repeated changes in child care arrangements are associated with slower verbal development and difficult temperaments among preschoolers.[9]

Table 4.7 identifies the average score for each item, starting with the most stressful. It also identifies the standard deviation (SD), that is, the spread of the distribution of the scores. If the scores are grouped closely around the average score, the SD is relatively small; if they are spread out in each direction, the SD is relatively large. The proportion of providers who gave each item a rating of 4 or 5 (high end of the stress continuum) is also shown.

We also asked providers to indicate the extent to which they felt they had control over most of the important things that affect their satisfaction with their work situation. The scale went from 1 (little control) to 5 (plenty of control). The average score of 3.9 for this group, with a standard deviation of 0.9, indicates that most of the providers felt that they had a good degree of control over things that affected their job satisfaction.

4.6 The Positive Aspects of Working as a Family Child Care Provider

We asked providers to list the three most positive aspects of providing home child care. One summarized her perception as follows:

> *"Helping parents out and teaching children, observing children developing and learning, knowing what I do is important."*
> — New Brunswick provider

According to a provider from Saskatchewan, one of the most positive aspects was that, "I was able to remain at home and raise our children and still have an income." The responses of the sample as a whole can be categorized as:

- the joy of working with children — 41.4%;
- being able to work and care for my own child at the same time — 41.0%;
- being my own boss — 36.1%;
- working at home — 30.8%;
- contributing to the development of young children — 24.7%;
- positive relationships with children and parents — 12.3%;
- earning an income — 7.9%;
- providing playmates for my own child — 7.5%.

The high proportion of providers identifying the joy of working with children or being able to contribute to children's development as a positive aspect is consistent with the high proportion that cited a love of children as their reason for becoming a family child care provider (68.0%).

4.7 The Negative Aspects of Working as a Family Child Care Provider

Providers were also asked to list the three most negative aspects of providing home child care. One respondent summarized the most commonly perceived negative aspects when she told us:

> *"... isolation from other adults and poor financial income for long hours worked."*
> — Ontario provider

ERIC

Another provider noted:

> *"I enjoy my job very much but find it frustrating when others feel you don't have a real job because you don't get up and leave every day. Long, long hours and extremely low overtime fees, at times parents take you for granted, for example, being late."*
> — Ontario provider

The negative aspects identified by the providers as a group can be categorized as:

- the workload — 60.0%;
- working on my own, isolation during the work day — 53.2%;
- low income, income fluctuations — 26.8%;
- conflicts with parents — 26.4%;
- lack of privacy for my family, sharing our private living space — 19.5%;
- lack of recognition of the value of my work — 16.4%;
- lack of benefits — 11.4%.

On average, the family child care providers in our sample reported spending 50.5 hours a week in direct contact with child care children and an additional 5.7 hours on related duties when child care children are not present. As a result, their average work week lasts 56.2 hours. This is considerably more than the standard work week for people who are salaried employees. The high identification of isolation as a negative aspect suggests that contact with other providers is important. As discussed later, we found that providers who were linked with provider support networks also had higher scores on both a measure of overall quality and a measure of their sensitivity towards children. Conflict with parents, especially around issues such as late pick-ups and failure to pay fees on time, has been identified as a problem faced by many providers in previous family child care research.[10]

4.8 Satisfaction with Their Career Choice

We asked the study participants two questions about their satisfaction with their career choice. The first question asked the individual whether she expected to be providing home child care in three years time and the second question asked, "If you were choosing a career again, would you choose home child care?" In each case, a follow-up question asked the provider to explain her answer.

4.8a Will They Continue?

Most providers, 69.4%, indicated that they expected to be in home child care in three years' time. Another 16.2% indicated that they did not, and 14.4% stated that they didn't know. There was some variation across jurisdictions. The highest proportion of people expecting still to be providing home child care were in British Columbia and Saskatchewan, 77.8% and 74.4% respectively. The lowest

Table 4.8	
Most Frequently Cited Reasons for Not Expecting to Continue to Provide Family Child Care, 1999	
Reason	**Percent responses**
Ready for a career change	29.7%
Plan to go back to school	18.9
My own children will no longer require me to be at home	18.9
I feel I need a break	16.2
Financial instability	10.8

proportions were in Alberta, 61.5%, and Ontario, 65.8%. The most frequently cited reason for expecting to continue as a family child care provider was that the individual liked this occupation, 64.1%. Just over 16.0% said they would still be providing care because they would still have young children at home. All other reasons for continuing to provide care were cited by fewer than 10.0% of the participants.

Providers who did not expect still to be working in this field in three years' time gave a variety of reasons that reflected: (1) the possibility of burnout or the desire to move into a field where the prospects might be better; or (2) the fact that the person had only intended to stay in the field until their children started school full-time; or (3) concerns about financial stability. The specific reasons are identified in Table 4.8. Being ready for a career change was cited by 50.0% of providers in the Yukon who did not expect to continue working in home child care, and 42.9% in Saskatchewan. Financial stability was most often cited as a reason in Saskatchewan (28.6% of the providers in that province who did not expect to continue working in this field). The response of an Alberta provider who had been regulated for four years and had completed the *Step Ahead* training course is illustrative; she told us:

> *"No ... mainly due to low income, income fluctuations. I cannot financially afford to continue this for another three years."*

4.8b Would You Choose Family Child Care Again as a Career?

> *"I like what I am doing and am proud of myself when children are happy."*
> — Québec provider

Two-thirds of the study participants, 65.5%, said that they would choose a career in family child care again. However, nearly a quarter, 21.4%, said they would not, while 13.1% responded that they did

63

ERIC

not know. By far the most frequently cited reason for choosing family child care again was that the individual liked the job, 64.4%. Another 12.9% identified providing family child care as their chosen occupation. Almost 16.0% of the providers (15.9%) indicated that this type of work was good while their own children were young. "I now have other career aspirations," was the most frequent reason given by people who would not go into family child care again, 42.6%.The second most frequently cited reason, given by 23.4%, was the financial instability. Isolation and lack of support were also cited as reasons, each by 6.4% of the participants. Combining these two responses suggests that 12.8% of providers might have regretted the decision to work alone in their own home.

4.9 Advice to a Friend

As a way of tapping into the knowledge of these experienced providers we asked them, "If a friend told you she was thinking about becoming a home-based caregiver, what three pieces of advice would you give her?" Two British Columbia respondents provided the following pieces of sage advice:

> *"You must love being with children — not just abstractly like kids — but enjoy talking, playing with, and caring for them. Test drive this in a volunteer capacity before committing to this career."*
>
> *"Examine yourself — whether you really enjoy children and are willing to learn continuously. Can you work alone for a long time?"*

The most frequently given responses, cited below, indicate the importance of viewing family child care provision as an occupation and not allowing it to take over one's whole life. The responses of the sample as a whole can be categorized as:

- be sure to balance your family life and your work life — 27.2%;
- establish clear policies and communicate them to parents — 26.8%;
- plan and structure your day — 24.6%;
- use all available resources — 15.2%;
- take time out for yourself — 13.8%;
- take training — 13.4%.

Fifty percent of the agency-affiliated providers said they would advise a friend to become an agency provider.

ERIC

4.10 Summary

The providers in our sample were all women, mainly between the ages of 30 and 49, living with a spouse or partner and with at least one child under age 12 living at home. Nearly half, 44.3%, had completed a college or university program in some discipline and 33.4% had a college or university credential in early childhood education or a related field such as child and family studies. Over a third, 40.3%, had completed a family child care provider course and the majority, 89.5%, had participated in at least one professional development activity within the past three years.

Two thirds, 68.0%, told us that they had become family child care providers because they loved children and wanted to work with them. On average, the study participants had been part of the regulated system for 6.1 years; 48.1% had prior experience as unregulated providers. In addition, 26.0% had worked in a centre and 15.6% had provided care in a child's home as a "nanny." The average amount of child care provision in any type of setting was 10.1 years. The most frequently given reasons for becoming regulated were: (1) to demonstrate to parents that their care meets standards/to be more professional; (2) as a way of getting support such as training or equipment loans; and (3) to enable them to care for children whose families were receiving a fee subsidy.

The study participants' preferred ways of identifying themselves were as a family child care provider, 51.5%, or a caregiver, 27.7%. Only 3.9% told us that they refer to themselves as a "babysitter." The majority, 75.1%, stated that family child care was their chosen occupation. However, it was clear from other responses that for some people it is a chosen temporary occupation until their own children begin school.

Financial concerns, such as lack of benefits and income fluctuations, were identified as sources of considerable stress by the study providers. Other issues identified as stressful by a substantial number were: (1) dealing with children leaving care, and (2) problems with parents (for example, late pick-ups and/or late payment of fees).

Most providers, 69.4%, stated that they expected to be in family child care in three years' time; 16.2% said they did not. The most commonly given reasons for not expecting to be in the field in the future were: (1) I'm ready for a career change; (2) I plan to go back to school; (3) my own children will no longer require me to be at home; and (4) I need a break. Some of these responses suggest burnout and/or a desire for an occupation that might have better prospects.

When we asked the providers what advice they would give to a friend who was thinking of entering family child care, the most frequent responses were: (1) be sure to balance your family life and your work life — 27.2%; (2) establish clear policies and communicate them to parents — 26.8%; (3) plan and structure your day — 24.6%; (4) use all available resources — 15.2%; and (5) take time out for yourself — 13.8%.

ERIC Full Text Provided by ERIC

Notes

1 Jorde-Bloom 1996; Katz 1993.
2 Goss Gilroy Inc. 1998.
3 Ibid.
4 Alberta Association for Family Day Home Services 1996.
5 Western Canada Family Child Care Association of B.C. 1996.
6 Galinksy et al. 1994.
7 Norpark 1989; Read and LaGrange 1990.
8 Doherty et al. in press.
9 Kohen, Hertzman and Wiens 1998.
10 Atkinson 1988; Kyle 1998; Nelson 1990.

ERIC Full Text Provided by ERIC

Chapter 5

The Practice of Family Child Care

"We are greatly responsible for their [the children's] safety and well-being but beyond that we must teach them how to love life, develop their curiosity, open them up to who they are, their potential, and to be proud of themselves."
— Québec provider

5.1 Introduction

This chapter provides information about the children in the family child care homes, the working conditions, income and benefits of the child care providers, their use of community supports, and their relationship with their licensing official or their sponsoring agency. In so doing, it provides a snapshot of the practice of family child care in the 231 homes that participated in the study.

5.2 The Children and Their Families

5.2a Overall View

The combination of the number of children and the number of client families gives an indication of the number of relationships that the provider is engaged in and thus, to some extent, the complexity of her job. Table 5.1 presents information about the average number of children and families associated with each home in each jurisdiction. When reading this table it is important to note that the regulations in Québec

ERIC Full Text Provided by ERIC

and the Yukon specifically permit a provider and an assistant to work in the same home at the same time. The regulations also permit a larger group of children when two caregivers are present (see Appendix B).

The age of the children also makes a difference to the number for whom an individual provides care. In Saskatchewan, 40.0% of the providers reported that three or more of the children in their care were over age 6. These children would be attending on a part-time basis and possibly at different times of the day; this would enable the provider to maintain the group size at any one time within the regulatory limit of eight. Thirteen percent of British Columbia providers care for two children over age 6, while an additional 15.6% reported having three children in this age range.

On average, the study participants were currently providing care for five families, with a range from one to fifteen. The highest number of reported families currently receiving care was 11 in the Yukon and 15 in Québec; both these jurisdictions permit one provider and an assistant to work together in a home. While this arrangement provides for a sharing of responsibility for the children, the provider herself is likely to be solely responsible for negotiations with parents around hours of care, payment and other administrative issues unless this is undertaken by an agency.

Two-thirds of the providers, 65.2%, told us that they were caring for siblings. This practice was most frequently reported in Saskatchewan, 85.0%, and Ontario, 76.9%. Caring for siblings was least often reported by providers in New Brunswick, 38.5%.

5.2b Ages Served

A large proportion of the providers in our sample were caring for infants and toddlers (see Table 5.2). Nearly half, 48.5%, reported providing care for at least one child under the age of 18 months. Over two-thirds, 69.7%, were caring for at least one child under the age of 2, while almost every provider, 93.5%,

Table 5.1

Number of Children and Families Currently Being Served, by Jurisdiction, 1999

Jurisdiction	Number of children			Number of families		
	Average	Range	SD*	Average	Range	SD*
B.C. (N = 45)	6.2	3.0 - 12.0	2.1	5.4	2.0 - 10.0	1.7
Alberta (N = 39)	5.0	3.0 - 9.0	1.4	4.2	2.0 - 6.0	1.2
Saskatchewan (N = 40)	7.0	3.0 - 11.0	2.0	5.2	2.0 - 9.0	1.7
Ontario (N = 39)	4.7	2.0 - 9.0	1.4	3.7	1.0 - 7.0	1.3
Québec (N = 42)	7.3	4.0 - 16.0	2.7	6.2	3.0 - 15.0	2.6
New Brunswick (N = 13)	5.7	3.0 - 8.0	1.4	5.3	3.0 - 8.0	1.3
Yukon (N = 13)	7.8	5.0 - 15.0	2.8	5.6	3.0 - 11.0	2.3
TOTAL SAMPLE (N = 231)	6.1	2.0 - 16.0	2.3	5.0	1.0 - 15.0	2.0

Note: The regulations in Québec and the Yukon permit a provider and an assistant to work in the same home at the same time and to care for a larger number of children than is permitted to a single provider. Thus ranges and standard deviations in these two jurisdictions are greater than elsewhere, reflecting a combination of providers working on their own and providers working with an assistant.

* SD: Standard deviation. This indicates the spread in the distribution of numbers around the average. If the numbers are grouped close to the average, the standard deviation is relatively small, as in the number of children in Alberta. If there is a broad distribution of numbers in each direction of the average, the SD is relatively large.

Table 5.2			
Average Number of Children Receiving Care in a Home in Each of Three Age Ranges, by Jurisdiction, 1999			
Jurisdiction	**Children under age 3**	**Children under age 6**	**Children over age 6**
British Columbia	2.5	5.2	1.0
Alberta	2.0	4.5	0.5
Saskatchewan	1.6	4.5	2.5
Ontario	1.8	3.5	1.3
Québec	2.6	7.0	0.3
New Brunswick	2.5	4.8	0.6
Yukon	2.4	4.9	2.5
TOTAL SAMPLE	2.2	4.9	1.6

was caring for at least one child under the age of 3. In many instances, multiple young children were reported. Twenty-four percent of providers caring for a child under 24 months of age had two, and in a small number of cases three, children in this age range. Among providers looking after at least one child under age 3, 40.3% reported two children in this age range while 34.2% said they had three or more children age 3 or younger. Having three or more children under age 3 was most frequently reported in the Yukon, 53.8%, British Columbia, 51.1%, Québec, 47.6%, and New Brunswick, 46.2%. Almost all the providers, 93.1%, reported at least one child in the age range of 3 to 5 years. Just over half, 52.3%, of the study participants were providing care for at least one child age 6 or older. Seventy percent of these providers were looking after one or two children in this age range.

In summary, almost every provider reported caring for at least one child under age 3, all were looking after children under age 6, and over half were providing care for children over age 6. Over a third of the providers, 35.5%, had a group of children ranging in age from under 24 months to over age 6. These statistics show that it is not uncommon for a provider to have a group that includes one or two infants or toddlers, a couple of preschoolers, and at a least one child over age 6. This means that she has to plan and provide activities for a broad range of developmental levels.

5.2c Characteristics of the Children

The information in this section is summarized in Table 5.3.

1. Children Who Speak a Language Other than English or French at Home

During her visit, the observer conducted a short provider interview that included asking about the enrolment of children who do not speak English at home — or, for a francophone provider, do not speak French at home (see Appendix G). Nearly a fifth of the providers, 18.8%, identified at least one child whose mother tongue was neither English nor French. The range was considerable, from 53.3% in British Columbia to none in both New Brunswick and the Yukon. Typically, given the communities in which the homes were located, these children would have been from immigrant families. The fact that a number of providers look after children whose mother tongue is neither English nor French highlights the importance of the family child care home as a setting where the child can develop competence in the language he or

ERIC

she will need for school. It also underlines the importance of the provider implementing a language-rich environment through talking and singing with the children, reading to them, and providing a variety of books and games.

2. Children with Special Needs

The challenge of providing appropriate, sensitive care is increased when a child has special needs. In some situations the provider will require specific training to undertake medical procedures or to supplement language or other therapy being received by the child. We asked providers whether they were caring for a child with special needs, giving them the following definition of a special need: "A physical or intellectual disability identified by a professional such as a physician or speech therapist or a diagnosed behaviour or emotional disorder." A total of 15.2% of the providers reported having a child who has special needs. The largest proportion of providers looking after such children was in Saskatchewan, 30.0%, followed by the Yukon, 23.1%, and Québec, 19.0%.

Providers in Saskatchewan and the Yukon are individually licensed and therefore cannot turn to an agency to seek training or advice to assist them to meet a child's special needs. Instead, they must rely on other sources, such as the local public health unit or an infant stimulation program. However, it appears that many agency-affiliated providers would also have to turn to other sources for consultation and training. While 17 of the 24 agency directors told us that their agency was currently providing care for at least one child with a special need, only two reported that their agency would provide special training for a caregiver if she needed it. Other agency directors told us that the provider could access services through a community organization, but it was not clear from their responses whether the agency would assist them to do so. One director reported that her agency would provide a respite caregiver every Friday morning. However, as noted by a Saskatchewan provider, there may be times when a second pair of hands is required to provide daily care.

> *"Ratios for special needs/high needs children are a concern, real trained professional help not available for what I can afford to pay."*
> — Saskatchewan provider

3. Children Whose Fees Are Subsidized

In all jurisdictions, fee subsidy for low-income parents is paid directly to the service provider on behalf of the parent. In the agency model, the agency may look after making fee subsidy claims for its providers. However, individually licensed providers have to handle this administrative task themselves. Over two-thirds of the providers in this study, 71.6%, reported that they were providing care for at least one child whose parent was receiving a fee subsidy. The largest proportions of providers with at least one subsidized child were in the Yukon, 100%, and Saskatchewan, 92.5%. The smallest proportion, 37.5%, was in Québec, where the provincial government had already instituted a program whereby parents of children in regulated child care pay only $5.00 a day; at the time of data collection, this program covered 3- and 4-year-olds, but not younger children.

5.2d The Number of Hours per Week that Children Are Receiving Care

As indicated in Table 5.2, the majority of children receiving care in the family child care homes in our sample were under age 6. Just over half, 51.1%, of the providers reported that two or three of the children in their care were with them for over 40 hours a week. Another 17.7% had four children who stayed with

ERIC

Table 5.3			
Characteristics of the Children, 1999			
Jurisdiction	**Proportion of providers caring for a child who speaks neither English nor French at home**	**Proportion of providers caring for a child who has special needs**	**Average number of children per home whose fees are subsidized**
British Columbia	53.3%	13.3%	1.6
Alberta	12.8	5.1	1.3
Saskatchewan	7.5	30.0	4.6
Ontario	13.5	10.3	2.4
Québec	14.3	19.0	0.9
New Brunswick	Nil	Nil	1.8
Yukon	Nil	23.1	4.8
TOTAL SAMPLE	18.8%	15.2%	2.3

Note: The proportion of children who do not speak English or French at home is, in part, a function of the communities in which data were collected. For example, most of the B.C. providers lived in Vancouver, and the proportion for Ontario would have been much greater if the sample of homes had been in downtown Toronto.

them for over 40 hours each week, while 12.6% had five or more children receiving care for this length of time. In summary, 81.4% of the providers had two or more children who were in their care for 40 or more hours a week. This represents a substantial proportion of a young child's week, so the amount and quality of interaction and stimulation received in the family child care home is very important. The average number

Table 5.4			
Children's Length of Time with the Same Provider, by Jurisdiction, 1999			
Jurisdiction	**Average number of children who started with the provider in the previous 12 months**	**Average number of children who left the provider's care in the previous 12 months**	**Average longest time in care of any child (in months)**
British Columbia	3.8	2.6	37.6 months
Alberta	3.2	2.6	34.5
Saskatchewan	4.2	2.5	42.7
Ontario	2.7	1.8	35.7
Québec	3.4	2.5	40.5
New Brunswick	4.2	1.9	38.6
Yukon	4.8	2.3	35.3
TOTAL SAMPLE	3.6	2.4	38.0 months

ERIC Full Text Provided by ERIC

of children in the provider's care for under 20 hours a week was 1.3 for the total sample, with a range from 0.8 in Alberta to 1.9 in Saskatchewan.

5.2e The Number of Years Children Remain with the Same Provider

On average, our sample of providers had 3.6 children who had come into their care within the previous 12 months and 2.4 who had left their care in that time period (see Table 5.4). The average longest time that a child had been in the same provider's care was 38 months (3 years, 2 months). In Québec and Saskatchewan it was 40.4 months and 42.7 months respectively.

5.3 Days, Hours and Weeks of Work

The majority of the study participants, 92.2%, reported working five days a week. A small number reported providing care on six or seven days a week. Only 1.3% of providers indicated that their work week was less than five days. Some, 6.5%, reported having child care children in their home on Saturday and/or Sunday. Among providers working on the weekend, the average number of hours that a child was in the home was 9.2 hours on Saturday and 9.4 hours on Sunday. In other words, when care was provided on the weekend, it was full-day care.

The first child was reported as arriving before 7:00 a.m. by 17.3% of the providers. This early start to the day was most frequently noted by people living in Saskatchewan (27.5%), New Brunswick (23.1%) and Ontario (20.5%). Providing care after 6:00 p.m. was reported by 13.4% of the study participants, and after 7:00 p.m. by 6.1% of them. The largest proportions of people providing care after 7:00 p.m. were in New Brunswick (15.4%) and Saskatchewan (12.5%). A quarter, 25.1%, of the study participants reported that they provided care before 7:00 a.m., and/or after 7:00 p.m., and/or on weekends.

On average, the providers had at least one child care child in their home for 50.5 hours a week, with a range from an average of 48.6 hours in British Columbia to 53.2 hours in Saskatchewan. In addition, the study participants spent an average of 5.8 hours a week on care-related duties such as preparing activities and meeting parents at times when no child care child was present. Thus the average total number of paid and unpaid hours of work per week for the group was 56.3 hours.

We asked the providers, "In total, in the past 12 months how many weeks did you personally provide child care? Exclude your vacation days and days when an alternate or substitute looked after your child care children." Most providers, 63.0%, responded that they had provided care for between 48 and 51 weeks in the past 12 months. An additional 18.7% had worked for 26 to 47 weeks during the previous year. Nearly a fifth, 16.1%, said they had worked all 52 weeks.

Reported average vacation time ranged from 19.2 days in Québec and 16.0 days in British Columbia, to 10.0 days in New Brunswick and 9.0 days in Saskatchewan. The average length of time for the total group was 13.0 days. We asked the providers to indicate how easy it was for them to take time off, using a five-point scale with 1 indicating that it was "not difficult" and 5 indicating that it was "very difficult." The average score of 2.7 is almost in the middle of the scale. Providers indicating the greatest difficulty were those in Alberta, where the average score was 3.9.

5.4 Income

"I believe that child care is very underpaid. It is very sad to see that people in general underestimate such an important job as raising, educating and loving someone else's children."
— Alberta provider

5.4a Parent Fees

Providers were asked to tell us what a full-fee parent would pay for care provided from 8:00 a.m. to 5:30 p.m., Monday to Friday, for a 9-month-old infant with no special needs, and what they would pay in the same situation for a 3-year-old child. They were also asked what the fee would be for a 7-year-old child with no special needs on a day when the child is in their care for lunch and after school for a total of four hours.

Table 5.5 presents information on the *median* daily fee reported by the providers. Median values are used (the point at which an equal number of cases fall above and below that value) because averages are strongly affected by extreme values, such as a few cases of unusually low or high fees.

Nearly two-thirds of the providers, 61.6%, reported that the fees charged to full-fee parents had been raised in the past three years. The highest proportion of providers indicating that their fees had increased were in Québec, 88.1%, and Alberta, 76.5%. The lowest proportion was in the Yukon, 30.8%.

5.4b Provider Income

As illustrated in Table 5.6, 45.1% of providers who worked for 48 weeks or more in the previous year reported a gross income from their provision of child care of between $15,000 and $24,999. Over two-thirds of the providers who worked full-time, 69.3%, had a gross income below $25,000. Sixty percent of

Table 5.5

Median Daily Fees Charged for Full-Time Care, by Jurisdiction, 1999

Jurisdiction	Infant age 9 months cared for from 8:00 a.m. to 5:30 p.m., Monday to Friday	Child age 3 years cared for from 8:00 a.m. to 5:30 p.m., Monday to Friday	Child age 7 years with care provided for 4 hours a day
British Columbia	$31.15	$27.69	$15.00
Alberta	16.15	16.00	10.95
Saskatchewan	19.61	18.07	13.15
Ontario	22.00	20.00	9.57
Québec	21.00	20.00	11.23
New Brunswick	17.00	15.00	8.00
Yukon	27.69	24.00	11.54
TOTAL SAMPLE	$20.77	$19.35	$12.69

ERIC Full Text Provided by ERIC

Table 5.6		
Gross Child Care Income in the Previous Year, Study 3 Providers Working 48 Weeks or More Only, 1999		
Gross child care income	**Number of providers (Total = 182)**	**Percent of providers**
Less than $10,000	12	6.6%
$10,000 to 14,999	32	17.6
$15,000 to 19,999	43	19.8
$20,000 to 24,900	46	25.3
$25,000 to 29,000	21	11.5
$30,000 to 34,999	18	9.9
$35,000 or more	17	9.3
All income levels	182	100.0%
Note: Data based on 182 providers; of the others, some did not report this information while a few had worked less than 48 weeks in 1998.		

all providers reported spending between 30.0% and 59.0% of their income on care-related expenses such as food and toys. Thus, providers' net income before taxes is considerably lower than their gross income. However, since they are treated as self-employed persons for the purpose of their income tax returns, they can deduct business-related expenses and a portion of the cost of maintaining their home when calculating their tax owing.

There was considerable variation in average reported gross annual income across the jurisdictions. The highest proportion of providers reporting a gross annual income of less than $10,000 was in Ontario,

Table 5.7		
Percent of Gross Child Care Income Spent on Child Care-Related Expenses, Total Study 3 Sample, 1999		
Estimated percent of gross income spent on child care-related items in the previous year	**Number of providers**	**Percent of providers**
Less than 15%	7	3.1%
15 - 29%	48	21.3
30 - 44%	69	30.7
45 - 59%	67	29.8
60 - 75%	34	15.1
All respondents to this question	225	100.0%
Note: Percentages calculated on the actual sample of 225 who responded to this question.		

20.5%, followed by Alberta, 17.9%. A gross income of over $34,999 in the previous year was most frequently reported by providers in British Columbia and the Yukon. These variations in reported income among jurisdictions reflect a combination of provincial/territorial differences in the average number of children for whom care is provided and the average fee charged a full-fee parent. Fees, in turn, are influenced by the average wage in the jurisdiction and the relative cost of living.

A few of the study participants, 13.5%, relied on the income they earned through the provision of child care to cover 80% or more of the cost of maintaining their household. The more general situation was that of the 61.4% of respondents who reported that their income covered less than 49% of their household expenditures. These findings are not surprising, given the gross annual incomes reported above and the relatively large proportion of such income used for expenditures related to child care provision (see Table 5.7). At current income levels, family child care is an occupation that is best done only when there is a second earner in the family.

5.5 Benefits

5.5a Items that Might Assist in Doing the Work

The providers were asked whether certain things that might assist them in their work were available to them. While the list of items for both agency-affiliated and independently licensed providers had some similarities, there were also a couple of differences reflecting their different circumstances.

As indicated by Table 5.8, the majority of providers, whether agency-affiliated or not, had received an orientation and sample parent contracts, attendance forms and similar documents. Most agency-affiliated providers, 89.1%, had a written contract with the agency and 62.2% had a written job description. A sensitively completed performance appraisal by someone who understands the practice of family child care has the potential to assist the provider to identify areas that may require attention and to develop a plan to address these. Approximately half of the total sample reported receiving regular written performance appraisals. Only a third of the independently licensed providers and about half of those affiliated with an agency indicated that they had access to an appeal procedure in situations such as parent complaints.

The lowest proportion of independently licensed providers reporting having received an orientation, 38.5%, and the lowest proportion reporting access to sample parent contracts and similar documents, 53.8%, were from New Brunswick. This province also had the lowest proportion of providers reporting access to an appeal procedure, 7.7%, and the highest reporting receipt of none of the types of assistance listed, 23.1%.

There was also some provincial variation among the types of assistance available to agency-affiliated providers in regard to access to a written performance appraisal or to an appeal procedure. A larger proportion of Québec providers, 66.7%, than providers in Alberta or Ontario (61.5% and 59.5% respectively) reported receiving a written performance appraisal. Access to an appeal procedure was reported by 78.6% of Québec providers but only 42.1% of those in Ontario and 38.5% of those living in Alberta.

Table 5.8

Proportion of Study 3 Providers Receiving Certain Types of Assistance, 1999

Type of assistance	Individually licensed providers (N = 111)	Agency-affiliated providers (N = 120)	Total sample (N = 231)
Sample parent contracts, attendance forms, etc.	84.0%	95.8%	90.2%
Orientation session to explain agency or licensing requirements and policies	73.6	92.7	83.6
Written policy/procedure manual	69.8	87.4	79.1
Regularly written performance appraisal or evaluation	49.1	54.6	52.0
Written contract between me and the agency	N/A	89.1	47.1
An appeal procedure for situations such as parent complaint, suspension of license	34.9	53.8	44.9
Written job description	N/A	62.2	32.9
None of the above	4.7%	0%	1.3%

5.5b Income Protection, Overtime Payments and Insurance Benefits

We gave the providers a list of possible benefits and asked them to indicate whether they have or receive any of them. Providers affiliated with an agency were asked specifically to report only those benefits available through the agency. However, independently licensed people were simply asked if they had the benefit.

Table 5.9 indicates that while most providers have their income protected when a child is absent on a temporary basis, almost half do not have protection for loss of income when a child is withdrawn from care without notice. An even larger proportion, 89.0%, lack protection for loss of income resulting from illness or disability. Fewer than two-thirds are protected against the possibility of having to make a substantial payment as a result of being sued for liability, for example, should a child be injured while in their care.

Family child care providers, even when affiliated with an agency, are considered to be self-employed. As a result, as well as not having benefits such as disability insurance or a pension plan, unless they purchase it themselves, they do not receive paid sick days or paid holiday time.

Table 5.9			
Benefits Available to Study 3 Providers, 1999			
Benefit	**Individually licensed providers**	**Agency-affiliated providers**	**Total sample**
Payment in the event of a child's absence due to illness or family holidays	96.3%	85.7%	90.8%
Payment for statutory holidays, e.g. New Year's Day	85.3	67.2	75.9
Payment for overtime, e.g. late pick-up	39.5	47.1	43.4
Payment in the event of a child being withdrawn from care without notice	54.1	51.3	52.6
Disability insurance (short- or long-term)	16.5	5.9	11.0
Liability insurance	51.4%	66.4%	59.2%

5.6 Support from Other Providers

5.6a Networking with Other Providers

Networking with other providers lessens the isolation of a job where the individual often works alone; it also provides a source of tips and information from others in the field. We asked providers whether they network with others and, if so, whether they do so through an organized association/network, informally, or through both avenues. Providers were also asked how often per month, on average, they meet or speak to others in family child care.

As reported in Table 5.10, most providers, 73.2%, said that they networked on an informal basis, while 47.6% reported being part of a formal network or association. Over a quarter of the study participants told us that they use both approaches. A small proportion of the providers, 13.4%, reported that they did not network with other providers at all.

A quarter of the providers, 24.3%, told us that they meet or speak to another provider eight or more times a month. An additional 30.5% reported having contact with colleagues between two and eight times a month. Again, there were variations across jurisdictions. The largest proportions of providers reporting eight or more contacts were in Saskatchewan, 41.0%, and Ontario, 35.9%. Table 5.11 provides information on the average frequency of contact with others by providers in each of the six provinces and the Yukon. The relatively high standard deviations in New Brunswick and Saskatchewan indicate that the range of frequency of contact across providers was greater in these two jurisdictions than elsewhere.

ERIC

Table 5.10				
Providers' Reported Networking with Other Providers, by Jurisdiction, 1999				
Jurisdiction	**Through an organized association**	**Informally**	**Both informally and through an association**	**Do not network with other providers**
British Columbia	73.3%	77.8%	51.1%	0%
Alberta	25.6	71.8	15.4	17.9
Saskatchewan	72.5	72.5	52.5	7.5
Ontario	33.0	71.8	25.6	20.5
Québec	47.6	78.6	35.7	9.5
New Brunswick	7.7	38.5	Nil	53.8
Yukon	30.8	84.6	30.8	15.4
TOTAL SAMPLE	47.6%	73.2%	34.2%	13.4%

5.6b Membership in a Child Care Organization or Association

Membership in a child care organization provides opportunities for contacts with other providers and suggests a certain degree of commitment to the child care profession. Providers were given a list of five possible organizations to which they might belong and were asked to select all that applied to them. A space was provided so that a respondent could write in an organization that was not identified.

Forty-one percent of the providers reported that they did not belong to any child care organization. As illustrated by Table 5.12, variation across the seven jurisdictions was considerable. All the British Columbia providers reported at least one affiliation, but 84.6% of providers in Alberta told us that they

Table 5.11		
Providers' Average Frequency of Contact per Month with Other Providers, by Jurisdiction, 1999		
Jurisdiction	**Average frequency**	**SD***
British Columbia	5.1	5.5
Alberta	4.1	5.2
Saskatchewan	8.2	6.9
Ontario	6.3	6.2
Québec	4.2	4.9
New Brunswick	3.0	8.2
Yukon	1.7	1.4
TOTAL SAMPLE	5.2	6.0

* SD: Standard deviation.

ERIC

did not belong to any child care organization or association. Overall, when providers did identify an affiliation, it was usually with a local community organization. Only 12.1% told us that they belonged to the Canadian Child Care Federation, while 2.2% reported membership in the Child Care Advocacy Association of Canada.

British Columbia has funded a network of child care resource and referral (CCRR) programs across the province. The provincial government has made specific efforts to publicize these services and to encourage providers to use them. For example, providers who belong to a CCRR program are eligible to receive $3.00 a day per occupied space, to a maximum of two spaces for each child under age 3. This grant is not available to other providers. Ninety-three percent of the British Columbia providers reported belonging to a CCRR program. The Ontario government funds 180 child care resource programs across the province;[1] however, only 15.4% of Ontario providers in our sample reported belonging to one of these programs.

5.7 Support from Community Services and Programs

Community resources can provide opportunities to meet other providers, activities for the children, information related to child development or the provision of child care, and/or other forms of assistance

Table 5.12

Membership in a Child Care Organization, Study 3 Providers, by Jurisdiction, 1999

Organization	B.C.	Alta.	Sask.	Ont.	Qué.	N.B.	Yukon	TOTAL
A local caregiver network or association in their community	55.6%	5.1%	77.5%	28.2%	14.3%	Nil	15.4%	33.3%
A child care resource program or child care resource and referral program	93.3	Nil	12.5	15.4	Nil	7.7%	Nil	23.4
A provincial or territorial organization	35.6	5.1	45.0	5.1	19.0	7.7	46.2	22.9
Canadian Child Care Federation	24.4	Nil	22.5	2.6	Nil	7.7	46.2	12.1
Child Care Advocacy Association of Canada	Nil	Nil	5.0	Nil	4.8	Nil	7.7	2.2
Other	2.2%	5.1	12.5	10.3	11.9	15.4	7.7	8.7
None	Nil	84.6%	7.5%	59.0%	54.8%	61.5%	30.8	40.7%

ERIC

Table 5.13		
Use of Community Services by Study 3 Providers, 1999		
Service	**Used at least once in the previous 12 months**	**Used weekly or monthly**
Opportunities for bulk buying, e.g. food, supplies	57.6%	38.7%
Resource library for books or videos on child care	58.5	36.3
Telephone support or advice on child care matters	57.2	30.0
Toy-lending library	42.5	29.1
Play group	38.6	27.0
Library story hour	42.4	24.6
Other adult/child activities, e.g. Gym and Swim	36.0	21.2
Large equipment loans	28.3	15.7
Drop-in for adults and children	19.7%	12.8%

such as equipment loans. We gave the study participants a list of nine community services and programs and asked them to tell us the frequency with which they had used each in the previous 12 months (see Table 5.13). A follow-up question asked if any services existed in the community, but that the provider could not access because of difficulties such as lack of transportation.

There was considerable variation in the use of the nine community services by providers in the different jurisdictions. To some extent, this may reflect variations in the service's availability; for example, the highest proportions of providers who reported using a toy-lending library and/or equipment loans on a weekly or monthly basis were in the three agency-model provinces and British Columbia, which has a network of CCRR programs.

Thirty percent of the providers told us that there were services in their community that they would like to use but could not. The proportion of providers giving this response varied from 72.7% in the Yukon to 23.5% in Saskatchewan. The services that providers most frequently identified as being unable to access were a drop-in program and the local library, each identified by 36.1% of the study participants. The other most frequently identified resources were a play group, 19.7%, and a swim program, 18.0%. Lack of transportation was identified as a barrier by 62.9% of those providers having access problems and the cost of the program was cited by another 29.0% of this group.

The very real transportation problems faced by providers are illustrated by the following two responses to the question about barriers to their use of existing services:

ERIC Full Text Provided by ERIC

"I enjoy taking the children on outings but I always encounter the problem of transportation. I have looked for different options but all of them are too costly (e.g. taxi, school bus) or very impractical (city bus, the service is inappropriate for my needs)."
— Alberta provider

"The law requires that children be in a car seat which is bracketed in, so with 5 preschoolers this means I cannot take them ***ever*** *in a car. The buses in my neighbourhood are few and far between and are rarely an option."*
— Ontario provider

5.8 Relationship with the Licensing Official or the Agency

The dual roles of provider of information and enforcer of rules and regulations associated with being a government licensing official or an agency home visitor may inhibit some sharing of problems by the provider. Nevertheless, someone in this role who can address the challenge of its two contradictory aspects may be able to provide significant support. We asked the study participants to tell us the number of visits they had received from their home visitor or licensing official in the previous 12 months, and the average length of time of a visit (see Tables 5.14 and 5.15). Then we asked the providers to rank the degree to which the visits are helpful.

5.8a Visits from the Government Licensing Official

As illustrated in Table 5.14, on average providers in British Columbia and the Yukon received the fewest visits, and the low standard deviation (SD) indicates that there was little variation from the average number. The relatively high SD for New Brunswick indicates greater variation and suggests that some providers received more than four or five visits, while others were visited less frequently.

Providers were asked to indicate on a five-point scale the extent to which they found the home visit helpful, with 1 indicating the visit is "not helpful" and 5 indicating that it is "very helpful." There was

Table 5.14

Frequency of Visits by Licensing Official in the Four Jurisdictions Where Providers Are Individually Licensed, and Average Duration of the Visits, 1999

Jurisdiction	Number of visits in previous 12 months		Length of a visit (minutes)	
	Average	SD*	Average	SD*
British Columbia	1.5	0.9	45.0	30.9
Saskatchewan	3.6	2.3	67.1	32.4
New Brunswick	4.2	4.9	72.1	47.7
Yukon	1.2	0.6	84.2	44.4
All four combined	2.5	2.5	60.8	37.5

* SD: Standard deviation.

ERIC

Table 5.15				
Frequency of Visits by Home Visitor in the Three Provinces Using an Agency Model, and Average Duration of the Visits, 1999				
Jurisdiction	**Number of visits in previous 12 months**		**Length of a visit (minutes)**	
	Average	SD*	Average	SD*
Alberta	12.9	2.9	67.0	20.8
Ontario	11.9	3.4	63.3	28.2
Québec	5.1	3.4	66.2	40.0
All three combined	9.9	4.7	65.5	29.9

* SD: Standard deviation.

little variation in the average rank of the degree of helpfulness across the four jurisdictions. The average score for the total group was 3.5, just over the mid-point on the scale. The highest average was in New Brunswick, 3.7, and the lowest in British Columbia and the Yukon, both 3.4. The SD for the total group was only 1.3.

5.8b Visits from the Agency Home Visitor

Providers were asked to indicate on a five-point scale the extent to which they found the home visit helpful, with 1 indicating the visit is "not helpful" and 5 indicating that it is "very helpful." Providers in Alberta and Ontario rated the visits as providing substantial support, with an average ranking of 4.0 and 4.2, respectively. Québec providers gave the visits an average rating of 3.6.

The agency providers were also asked to tell us the types of assistance they receive through the home visits and to identify the assistance they would like to receive through them. The majority of providers, 86.6%, wrote in that the home visitor provided advice and support during the visit. The next most frequently identified type of assistance was the provision of ideas for activities with the children, 24.1%.

Table 5.16				
Types of Assistance Desired from Home Visitor by Study 3 Providers, by Jurisdiction, 1999				
Desired Assistance	**Alberta**	**Ontario**	**Québec**	**TOTAL**
More personal support	9.7%	14.3%	39.3%	20.7%
Relief (substitute to enable time off)	9.7	10.7	7.1	9.2
Ideas for activities	3.2	7.1	17.9	9.2
Advice regarding problem situations	3.2	3.6	17.9	8.0
Supplies, resource materials	12.9	3.6	3.6	6.9
Opportunities for provider socializing	3.2	3.6	0	2.3
Other	6.4%	3.6%	0%	3.4%

Nearly a fifth of the providers, 17.9%, identified the assistance given as "monitors for compliance" with rules and requirements. Some providers, 13.4%, identified the home visits as the time when they received supplies and resource materials. This response was most often given by providers in Alberta, 23.1%, and least often by those in Québec, 2.8%.

Just over half, 54.0%, of the providers responded to the question about the types of support they would like from the home visitor by replying that everything was satisfactory. This response was made most frequently in Ontario, 71.4% of the providers. Table 5.16 illustrates the other most frequent responses to this question.

One provider's wish list for assistance from her home visitor was:

> *"Organized outings, phone lists of other providers, help with emergency doctor appointments, craft and story ideas, a provider tea-time with no agency business — just down time."*
> — Ontario provider

5.8c Relationship with the Home Visitor

The providers were asked to put a check mark beside each of a number of statements that could describe their relationship with the home visitor. As indicated by Table 5.17, the responses were very positive. Most providers feel that they are respected and supported by their home visitor. Furthermore, the home visitor is perceived as understanding and appreciating the challenge of balancing work and family responsibilities when providing family child care. Few providers indicated feeling that they were over-supervised or that the home visitor was unavailable. No provider put a check mark beside the option, "Is hard to please." Interpretation of these responses must be tempered with the realization that the agency chose the providers it would ask to participate in the study, and in many cases the home visitor would have made the choice.

Table 5.17

Relationship with Home Visitor Reported by Study 3 Providers, by Jurisdiction, 1999

Statement	Alberta	Ontario	Québec	TOTAL
Home visitor trusts my judgement	94.9%	89.7%	68.4%	84.5%
Home visitor provides support and helpful feedback	97.4	89.7	76.3	87.9
Home visitor encourages me to try new ideas	82.1%	69.2	71.1	74.1
Home visitor appreciates the difficulties of balancing work and family responsibilities	84.6%	76.9	50.0	70.7
Home visitor sets high but realistic standards	46.2	53.8	13.2	37.9
Home visitor supervises me too closely	2.6	5.1	5.3	4.3
Home visitor is unavailable	2.6	2.6	5.3	3.4
Home visitor makes me feel inadequate	0%	2.6%	0%	0.9%

ERIC Full Text Provided by ERIC

5.8d Satisfaction with the Agency

The providers were asked two questions that would give some indication of their satisfaction with their agency. First they were asked to indicate their satisfaction with the support services provided by the agency, such as equipment loans. Then they were asked if they expected to be associated with the agency in three years' time. A follow-up question asked the provider to elaborate on her response.

The question asking about satisfaction with the agency support services required the provider to indicate her answer on a five-point scale, with 1 indicating "very dissatisfied" and 5 indicating "very satisfied." The average satisfaction rank for the Québec providers was 4.0. This was slightly higher than for providers in Alberta, 3.7, and a little lower than the Ontario providers' average rating of 4.2.

Most of the providers, 72.3%, told us that they expected to be working with the same agency in three years' time. Another 16.8% said that they did not know. The most frequently given reason for continuing with the agency, cited by 58.7% of the providers, was that they were "very satisfied." Another 16.0% of the study sample stated that they felt recognized and valued by the agency, while 9.3% cited their good relationship with the agency as a reason for continuing with it.

Among the 10.9% of providers who indicated that they did not expect to continue be with the agency, 50.0% gave as their reason their plan to change careers. The second most commonly given reason was that the provider intended to retire, 16.7% of respondents.

5.9 Summary

On average, the study participants were currently providing care for five families; in 65.2% of the cases this included providing care for siblings. Almost every provider, 93.5%, reported looking after at least one child under age 3. All were providing care for children under age 6, and half of the providers were providing care for children over age 6. These statistics illustrate that it is not uncommon for a provider to have a group that includes one or more infants or toddlers, a couple of preschoolers, and at least one child over age 6. Nearly a fifth of the providers, 18.8%, reported caring for at least one child who did not speak English (or French for a francophone provider) at home. Fifteen percent provided care for at least one child with special needs. Most of the providers, 81.4%, had two or more children who were in their care for more than 40 hours a week.

The majority of the study participants, 92.2%, told us that they work five days a week. A small proportion, 6.5%, reported having child care children in their home on Saturday and/or Sunday. The first child was reported as arriving before 7:00 a.m. by 17.3% of the providers. A total of 13.4% of the respondents told us that they provide care after 6:00 p.m. while 6.1% provide care until after 7:00 p.m. In all, 25.1% of the study participants reported that they provide care before 7:00 a.m., and/or after 7:00 p.m., and/or on the weekend. On average, the providers reported having at least one child care child in their home for 50.5 hours a week. They spend an additional 5.8 hours a week when no child care child is present on tasks related to their child care program. Most providers, 63.0%, told us they had provided care for between 48 and 51 weeks in the past 12 months. An additional 16.1% said they had worked all 52 weeks.

ERIC Full Text Provided by ERIC

Reported vacation days ranged from 19.2 days in Québec and 16.0 days in British Columbia to 10.0 days in New Brunswick and 9.0 days in Saskatchewan. The average vacation time for the total group was 13.0 days.

The median fees charged for full-day care by the group as a whole were reported as $20.77 a day for a 9-month-old infant and $19.35 a day for a 3-year-old child. The average daily fee cited for a 7-year-old being looked after for four hours was $12.69. Forty-five percent of providers reported a gross annual income between $15,000 and $24,999 from their child care provision in the previous year. Twelve percent had earned between $25,000 and $29,999. Providers spend part of the gross income on expenditures related to their child care program. Nearly a third of the study participants, 30.7%, estimated having spent between 30% and 44% of their gross income on such expenditures in the previous year. An additional 29.8% estimated having spent between 45% and 59% of their gross child care income in this fashion. Few of the study participants, 13.5%, relied on the income they had earned through the provision of child care to cover 80% or more of their household expenditures. The more general situation was that of the 61.4% who reported that their child care income covered less than 49% of the household expenses.

The majority of providers, whether or not they were affiliated with an agency, had received an orientation and sample parent contracts and similar documents. Most agency-affiliated providers, 89.1%, had a written contract with the agency and 62.2% had a written job description. Only a third of the independently licensed providers and about half of those affiliated with an agency reported that they had access to an appeal procedure in situations such as a parent complaint.

While most providers have their income protected when a child is absent on a temporary basis, almost half do not have protection for loss of income when a child is withdrawn from care without notice. An even larger proportion, 89.0%, lack protection for loss of income resulting from illness or disability. Less than two-thirds reported having liability insurance.

Most providers, 73.2%, said that they network with other providers on an informal basis, while 47.6% reported being part of a formal provider network or association. A small proportion of the study participants, 13.4%, said that they do not network with colleagues at all. The average reported frequency of contact with other providers for the group as a whole was 5.2 times a month. Forty-one percent of the study participants reported that they do not belong to any child care organization. When providers did report this type of affiliation, it was generally with a local community organization. Only 12.1% of the study participants reported belonging to the Canadian Child Care Federation, while only 2.2% reported membership in the Child Care Advocacy Association of Canada.

Providers were asked about their use of a variety of community resources. Those most often reported as used at least monthly were: (1) opportunities for bulk buying, 38.7%; (2) a resource library for books or videos on child care, 36.3%; (3) telephone support or advice, 30.0%; and (4) a toy-lending library, 29.1%. Thirty percent of the providers told us there were community services they would like to use but could not because of access problems. The most common problems cited were lack of transportation and the cost of the service.

Finally, we asked the study participants about their relationship with their government licensing official or agency home visitor. The average number of licensing-official visits within the previous year was 2.5, with an average duration of 60 minutes. Most providers ranked the usefulness of these visits at 3.5 on a five-point scale of from 1, "not useful," to 5, "very useful." On average, agency affiliated providers received 9.9 visits from the home visitor, with each visit lasting an average of 65 minutes. Most providers gave these visits a ranking of 4.0, thus indicating a perception that they were useful. The majority of the providers also gave a very positive picture of their relationship with the home visitor. As a group, they felt the visitor respected them and provided support and assistance. The most frequently cited type of additional assistance desired was "more personal support."

Nearly three-quarters of the providers, 72.3%, told us that they expected to be working for the same agency in three years' time. Among the 10.9% of people who did not expect to be still affiliated with the agency, the most frequent reason was a desire for a career change.

Note

1 Childcare Resource and Research Unit 2000, p. 41.

Chapter 6

Descriptive Data on the Quality of Family Child Care in Canada

6.1 Introduction

This chapter presents an overall profile of observed quality in the homes of the 231 providers who participated in the study. The quality and emotional tone of the interpersonal relationships was measured using the Sensitivity, Harshness and Detachment sub-scales of the *Caregiver Interaction Scale* (*CIS*). The overall quality of the physical environment, the basic care provided and the opportunities for various activities were explored using the *Family Day Care Rating Scale* (*FDCRS*). Additional information on these two instruments is provided in Chapter 3, Section 3.4d. Here, we first report the results of the *CIS* and then the results of the *FDCRS*.

The chapter focuses mainly on the mean (average) scores and the standard deviations (variability of scores) for the two measures that were used. In it, we present information by the total sample, by jurisdiction and by regulatory type (individually licensed or affiliated with an agency). We include information about aspects of care on which family child care homes are doing well, and identify areas where many homes need improvement. We also present the results of the analyses of correlation (association) among the quality measures themselves.

6.2 The *Caregiver Interaction Scale (CIS)*

The *CIS* scores indicate the frequency with which different kinds of interaction were observed. A provider with a high score on the Sensitivity sub-scale is warm, attentive and actively engaged with the children.

ERIC Full Text Provided by ERIC

Table 6.1			
Range and Mean of *C/S* Sub-Scale Scores, Total Sample, 1999			
Statistic	***C/S* Sensitivity**	***C/S* Harshness**	***C/S* Detachment**
Range	1.20 - 4.00	1.00 - 3.67	1.00 - 3.00
Mean	3.36	1.26	1.25

Someone who scores high on Harshness shows behaviour that is critical and punitive. Detachment refers to a low level of interaction, expression of interest and/or supervision, such as the passive watching of the children rather than interacting with them. Therefore, high scores on Sensitivity are desirable, while high scores on the Harshness and Detachment sub-scales are not. Scores on the sub-scales range from 1.0 to 4.0.

The scores reported in Table 6.1 for the sample as a whole indicate high levels of warm, attentive and engaged behaviour with children and low levels of harshness and detachment. In Table 6.2, we present the scores for each individual jurisdiction.

Table 6.2				
Range and Mean of *C/S* Sub-Scale Scores, by Jurisdiction, 1999				
Jurisdiction	**Statistic**	***C/S* Sensitivity**	***C/S* Harshness**	***C/S* Detachment**
British Columbia	Range	2.00 - 4.00	1.00 - 3.00	1.00 - 2.75
N = 45	Mean	3.52	1.23	1.07
Alberta	Range	1.90 - 4.00	1.00 - 2.67	1.00 - 2.50
N = 39	Mean	3.46	1.21	1.31
Saskatchewan	Range	2.70 - 4.00	1.00 - 2.78	1.00 - 2.50
N = 40	Mean	3.60	1.30	1.22
Ontario	Range	1.20 - 4.00	1.00 - 3.67	1.00 - 3.00
N = 39	Mean	3.16	1.44	1.38
Québec	Range	2.30 - 3.80	1.00 - 2.22	1.00 - 2.75
N = 42	Mean	3.28	1.20	1.22
New Brunswick	Range	2.20 - 4.00	1.00 - 2.00	1.00 - 2.25
N = 13	Mean	3.23	1.23	1.25
Yukon	Range	1.50 - 3.90	1.00 - 1.33	1.00 - 2.25
N = 13	Mean	2.73	1.05	1.42
TOTAL SAMPLE	Range	1.20 - 4.00	1.00 - 3.67	1.00 - 3.00
N = 231	Mean	3.36	1.26	1.25

Table 6.3				
Range and Mean of *CIS* Sub-Scale Scores, by Regulatory Type, 1999				
Regulatory type	**Statistic**	***CIS* Sensitivity**	***CIS* Harshness**	***CIS* Detachment**
Individually licensed	Range	1.50 - 4.00	1.00 - 3.00	1.00 - 2.75
N = 111	Mean	3.42	1.24	1.19
Agency-affiliated	Range	1.20 - 4.00	1.00 - 3.66	1.00 - 3.00
N = 120	Mean	3.30	1.28	1.30

As illustrated in Table 6.3, there were also some differences between the individually licensed group as a whole and the group of agency-affiliated providers. As a group, the agency-affiliated providers had marginally lower mean Sensitivity scores and marginally higher mean Harshness and Detachment scores.

6.3 The *Family Day Care Rating Scale (FDCRS)*

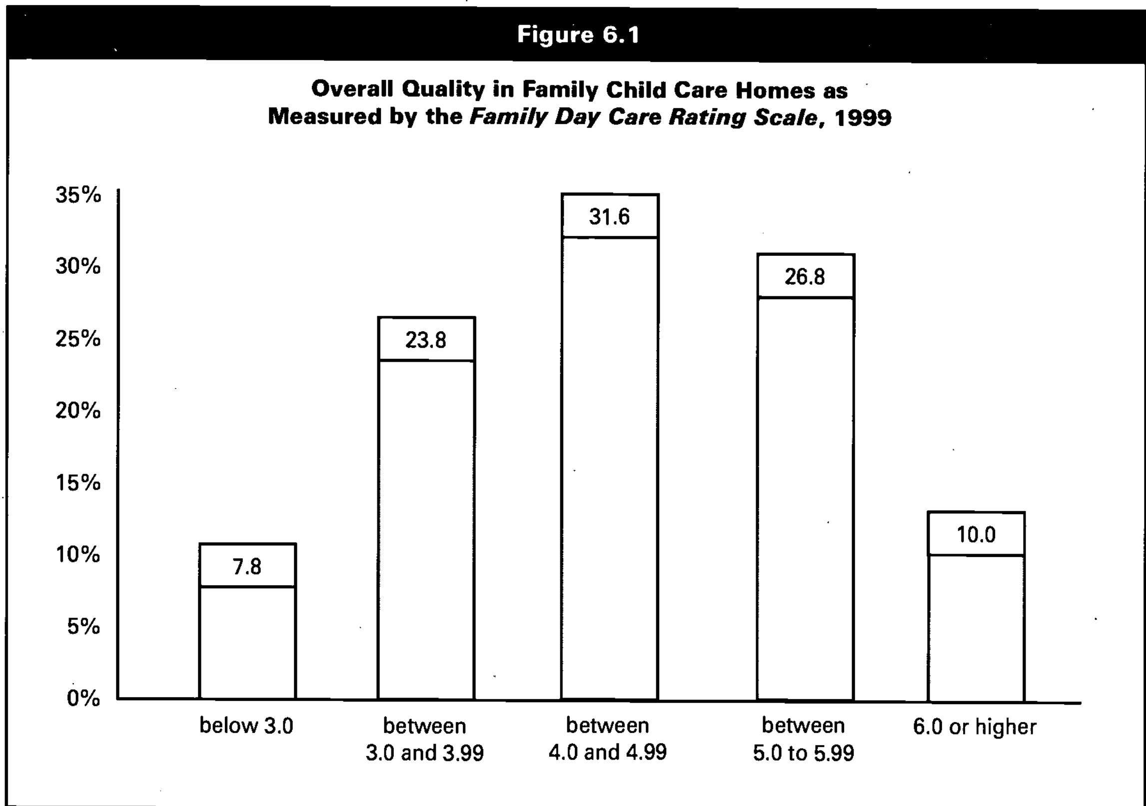
The *FDCRS* is composed of 32 items, each of which is rated on a seven-point scale. According to the authors, Total scale scores of 1.0 or 2.0 reflect care that is likely to compromise children's development due to poor physical facilities, inadequate caregiver supervision or undesirable interaction between care provider and children, such as harshness. Scores of 3.0 indicate custodial care where the child's health and safety is protected but little stimulation is provided. Homes that obtain scores of 4.0 are providing good custodial care and also some stimulation that will support children's development.[1] A score of 5.0 is considered to be the cut-off point between good custodial care and good quality care that not only protects health and safety but also includes the deliberate provision of activities that will encourage children's social, language and cognitive development. A score of 7.0 is interpreted as "excellent."

The *FDCRS* Total score (that is, the combined scores from all the items) for the sample of 231 homes was 4.5. Figure 6.1 presents a breakdown of the distribution of the *FDCRS* average Total scores for the whole sample. Just over a third of the homes, 36.8%, obtained a score of 5.0 or above, indicating that they not only protect health and safety, they also provide activities that stimulate children's development. An additional third, 31.6%, obtained scores between 4.0 and 4.99. These homes provide good custodial care and some stimulation. About a quarter of the homes, 23.8%, were providing adequate custodial care, but the observed care in the remaining 7.8% of homes was inadequate.

Table 6.4 presents information on the scores obtained for the Total *FDCRS* scale and for each of its six sub-scales for the sample as a whole and for each jurisdiction (see Appendix I for an overview of each of the six sub-scales). The sub-scale scores for the whole sample ranged from 4.0 for Basic Care to a high of 5.5 for Adult Needs.

The Adult Needs sub-scale received the highest score (5.5). This sub-scale addresses items such as the extent to which the provider balances her caregiving and family responsibilities and takes advantage of professional development opportunities. The second highest sub-scale score, 4.7, was obtained on the

ERIC Full Text Provided by ERIC



Language and Reasoning sub-scale, which looks at the provider's use of informal language and her attempts to assist children to understand and use language.

The lowest score, 4.0, was obtained on the Basic Care sub-scale, which deals with the provisions for protecting health and safety, such as handwashing and food-handling practices. Low scores on this sub-scale reflect poor handwashing and lack of attention to hygiene when preparing or serving food. Babies and infants exposed to this type of care are particularly vulnerable to illness because of their immature immune systems. The second lowest sub-scale score for the entire sample was obtained on the Social Development sub-scale. This looks at the provider's methods for guiding children's behaviour, as well as her provision of toys and activities that reflect cultural diversity and do not limit children to traditional roles. In our sample, the average score on the item related to cultural awareness and lack of gender stereotyping was below 3.0.

Table 6.4 illustrates considerable variation across the seven jurisdictions. This may be related to factors such as differences in the levels and types of support available to providers, and differences in regulatory requirements. For example, 93.3% of the study participants in British Columbia reported belonging to a child care resource and referral program but none of the providers in Alberta or New Brunswick reported belonging to a child care support service (see Table 5.12). Saskatchewan expects licensed family child care providers to attend two professional development workshops each year. At the time of data collection,

Table 6.4								
Average *FDCRS* Sub-Scale and Total Scores, by Jurisdiction, 1999								
Jurisdiction	**Statistic**	***FDCRS* Sub-scale**						***FDCRS* Total**
		Space and Furnishings	**Basic Care**	**Language and Reasoning**	**Learning Activities**	**Social Development**	**Adult Needs**	
B.C	Mean	5.4	5.4	5.8	5.4	5.0	6.3	5.5
N = 45	SD*	1.2	1.0	1.7	1.4	1.1	1.1	1.1
Alberta	Mean	4.3	3.3	4.3	4.5	4.0	5.5	4.2
N = 39	SD	1.3	1.0	1.5	1.0	1.0	0.9	0.9
Sask.	Mean	4.6	3.7	4.7	4.6	4.5	5.6	4.5
N = 40	SD	1.0	1.1	1.5	1.0	0.8	0.8	0.8
Ontario	Mean	3.8	3.2	4.2	3.8	3.9	5.1	3.9
N = 39	SD	1.3	1.2	1.6	1.2	1.3	1.2	1.1
Québec	Mean	5.0	3.9	4.3	4.5	4.4	5.6	4.5
N = 42	SD	1.0	1.0	1.2	1.0	0.9	0.9	0.7
N.B.	Mean	4.5	3.9	4.7	4.0	4.5	4.3	4.2
N = 13	SD	1.1	1.1	1.4	1.1	0.8	0.8	0.9
Yukon	Mean	4.7	4.6	4.3	4.7	4.1	4.9	4.6
N = 13	SD	1.3	1.1	1.1	1.0	1.4	1.3	1.0
TOTAL	Mean	4.6	4.0	4.7	4.6	4.4	5.5	4.5
N = 231	SD	1.3	1.3	1.6	1.2	1.1	1.1	1.1

* SD: Standard deviation.

the Yukon was the only other jurisdiction in the study that required providers to participate in professional development (see Appendix B).

In addition to the variation in the Total score and the sub-scale scores across jurisdictions illustrated by Table 6.4, there was also variation based on regulatory type. Table 6.5 illustrates that, as a group, individually licensed providers obtained higher scores than their agency-affiliated colleagues on all the sub-scales. The difference is particularly noticeable for the Basic Care and Language and Reasoning sub-scales.

6.4 Individual Items on the *FDCRS*

As noted earlier, the lowest average sub-scale score was on Basic Care. Within this sub-scale, average scores below 3.0 for the total sample were obtained on the Personal Grooming item and the Safety item. Personal grooming looks at provisions and practices associated with handwashing and the children's general appearance; for example, does the provider comb a child's hair after nap, does she encourage self-help by providing a mirror at children's eye level? The safety item looks for obvious safety problems such

ERIC

Table 6.5			
Average *FDCRS* Sub-Scale and Total Scores, by Regulatory Type, 1999			
***FDCRS* Sub-scale**	**Statistic**	**Individually licensed (N = 111)**	**Agency-affiliated (N = 120)**
Space and Furnishings	Mean	4.9	4.4
	SD*	1.2	1.3
Basic Care	Mean	4.5	3.5
	SD	1.3	1.1
Language and Reasoning	Mean	5.1	4.3
	SD	1.6	1.4
Learning Activities	Mean	4.9	4.3
	SD	1.3	1.1
Social Development	Mean	4.6	4.1
	SD	1.0	1.1
Adult Needs	Mean	5.7	5.4
	SD	1.2	1.0
TOTAL SCALE	Mean	4.9	4.2
	Median	4.9	4.4
	SD	1.1	1.0

* SD: Standard deviation.

as cleaning materials not being locked up. It also checks safety-related procedures, such as having monthly emergency exit practices.

Average scores of below 3.0 were also obtained on the Child-Related Display, Sand and Water Play, and Cultural Awareness items. When scoring the child-related display item, the observer looks for things such as provisions for children's art-work to be displayed and whether children's pictures are at the children's eye level. The sand and water play item deals with provisions for these types of activities. The cultural awareness item goes beyond cultural and racial diversity to look as well for pictures, stories and activities that have males and females doing similar activities, rather than those traditionally associated with their gender.

6.5 Reasons for Optimism, Reasons for Concern

The *CIS* scores indicate high levels of warm, attentive and engaged provider interaction with children, and low levels of harshness or detachment. These *CIS* scores, along with the *FDCRS* scores, indicate that physically safe environments with caring, supportive adults are the norm in the majority of homes. In

addition, 36.8% of the sample are providing activities that stimulate children's social, language and cognitive development. However, our finding that almost two-thirds of the homes were not providing care that stimulates children's development is of concern since this situation represents thousands of lost opportunities to maximize early childhood development. Of even greater concern is that small proportion of homes, 7.8%, where the observed level of basic care was rated as inadequate.

6.6 Intercorrelations among Quality Measures

How consistent are the *FDCRS* and the three *CIS* scales in measuring child care quality? The *FDCRS* measures a wide range of factors in the home environment that are important for health and safety, and captures the extent to which materials, activities and interactions promote language development and learning. It also includes some items that asses the emotional tone of provider-child interactions. The *CIS* focuses specifically on the interaction between provider and child. We therefore wondered how often high scores on the *FDCRS* and its individual sub-scales matched with *CIS* ratings indicating high sensitivity and little harshness or detachment.

As shown in Table 6.6, there were significant positive correlations between the *FDCRS* Total scores and its respective sub-scales. In addition, *FDCRS* Total scores and all the sub-scale scores also correlated positively with the *CIS* Sensitivity score. These data indicate that family child care providers in homes with higher levels of overall quality engaged in more sensitive caregiving. Similarly, higher *FDCRS* Total and sub-scale scores were associated with *lower* levels of *CIS* Harshness and Detachment. More sensitive

Table 6.6

***FDCRS* and *CIS* Correlations, 1999**

Scale/sub-scale	*FDCRS* Total	*CIS* Sensitivity	*CIS* Harshness	*CIS* Detachment
FDCRS Total	1.000	.62**	-.43**	-.55**
FDCRS Space and Furnishings sub-scale	.84**	.43**	-.31**	-.38**
FDCRS Basic Care sub-scale	.81**	.40**	-.29**	-.45**
FDCRS Language and Reasoning sub-scale	.86**	.64**	-.40*	-.51**
FDCRS Learning Activities sub-scale	.92**	.54**	-.39**	-.47**
FDCRS Social Development sub-scale	.75**	.73**	-.47**	-.62**
FDCRS Adult Needs sub-scale	.63**	.44**	-.26*	-.40**
CIS Sensitivity	.62**	1.000	-.49**	-.69**
CIS Harshness	-.43**	-.49**	1.000	.38**
CIS Detachment	-.55**	-.69**	.38**	1.000

Note: * = p < .05; ** = p < .01.

ERIC Full Text Provided by ERIC

care providers were less likely to be engaged in harsh or detached caregiving. Similarly, higher *FDCRS* Total and sub-scale scores were associated with lower levels of harsh or detached caregiving. Providers who had higher total quality scores on the *FDCRS* were observed to be providing more sensitive caregiving. Providers with lower quality scores on the *FDCRS* were less likely to have high scores on the Sensitivity scale and displayed somewhat more detached and harsh caregiving. Higher levels of harshness were also positively correlated with higher levels of detachment (that is, low levels of involvement with the children).

6.7 The Findings from Previous Research

6.7a Canadian Research

The companion study from the *You Bet I Care!* project, *Caring and Learning Environments: Quality in Child Care Centres Across Canada,*[2] also used the *CIS* and the two centre-based equivalents of the *FDCRS* — the *Infant/Toddler Environment Rating Scale (ITERS)*[3] and the *Early Childhood Environment Rating Scale–Revised (ECERS–R).*[4] Table 6.7 compares the findings from these two studies. The observations in both studies were carried out in the same six provinces and the Yukon. However, there were slight differences between the two studies in the procedures used to obtain the sample.

As illustrated in Table 6.7, the overall quality of the setting was highest in preschool rooms, followed by family child care homes. Adult sensitivity was highest in family child care homes.

Table 6.7

Comparison of the Overall Profile of Child Care Centres and Family Child Care Homes in Canada, *YBIC!* Study 2 and Study 3

	Study 2, 1998		Study 3, 1999
Study setting	**Infant/toddler rooms**	**Preschool rooms**	**Homes**
Sample size	115	211	231
Mean Total *ITERS*, *ECERS–R* or *FDCRS* score	4.4	4.7	4.5
Mean Total score distribution: - Below 3.0 - Between 3.0 and 4.9 - 5.0 or above	 7.8% 63.5% 28.7%	 7.1% 48.5% 44.3%	 7.8% 55.4% 36.8%
CIS Sensitivity	3.28	3.25	3.36
CIS Harshness	1.14	1.28	1.26
CIS Detachment	1.41	1.38	1.25

Source: Goelman et al. 2000.

ERIC Full Text Provided by ERIC

Table 6.8						
Comparison of Mean Total *DCHERS* Scores Obtained in Previous Studies with the 1999 *FDCRS* Mean Total Scores for the Same Provinces						
Study characteristics	British Columbia		British Columbia		Ontario	
	Victoria Study	*YBIC!* Study 3	*Vancouver Study*	*YBIC!* Study 3	Ontario study	*YBIC!* Study 3
Date	1983-85	1999	1987	1999	1984-5	1999
Sample size	24	45	28	45	157	39
Total score	3.4	5.5	5.3	5.5	5.0	3.9

Sources: *The Victoria Study*, Goelman and Pence 1987; *The Vancouver Study*, Goelman and Pence 1991; Ontario study, Pepper and Stuart 1992.

The *FDCRS* is a revision of a previous scale with very similar items that was known as the *Day Care Home Environment Rating Scale (DCHERS)*.[5] This scale was used in two earlier studies in British Columbia and one in Ontario. While the 1999 *You Bet I Care!* Study 3 used the *FDCRS*, and differing sampling techniques were used across the three earlier provincial studies, comparison of these data with those of the current study can be useful.

The difference in mean *FDCRS* Total score between the two earliest British Columbia studies is striking. Both studies were carried out in the same province during the 1980s and were conducted in homes operating under the same provincial government regulations. However, there were two significant differences between the two samples. The Vancouver group was recruited through a variety of means, including membership lists from a family child care association. Such membership suggests a level of commitment to the field and ongoing opportunities to network with other providers. The Vancouver sample also included a number of participants who had completed a brief course specific to family child care offered by a Vancouver community college.[6] The Victoria sample was obtained through lists provided by the government licensing authority.[7] Providers in this sample did not have the same easy access to a family child care college course as their Vancouver colleagues. The striking difference in the mean *FDCRS* Total scores between the two groups may reflect differences in the proportion of participants with some training related to family child care and/or the proportion of providers who were affiliated with a provider network or association.

The 1999 Total score for the Ontario participants in the current study is substantially below that reported from research conducted in 1984-85. Both samples came from southern Ontario. In both cases, agency names were identified through lists provided by the provincial licensing authority and the agency was asked to identify providers willing to participate. Differences in samples and procedures severely limit any kind of causal interpretation of the differences in scores between 1984-85 and 1999. However, as context, it is interesting to note that the apparent decline in *FDCRS* scores in Ontario occurred in a period during which funding for community support services in general has declined, including services that might be used by providers to supplement those obtained through the agency.

6.7b American Research

The largest American study to use the *FDCRS* also used the *CIS*. The 112 regulated family child care providers in the American study had an average mean *FDCRS* Total score of 3.92,[8] in contrast to the mean of 4.54 obtained by the participants in the present study. A higher proportion of the American providers than those in our sample obtained scores below 3.0 on the *FDCRS*, signifying inadequate care, or between 3.0 and

ERIC

Table 6.9		
Comparison of the Profile of Overall Quality in Two Studies		
	Kontos et al. 1995	***YBIC!* Study 3**
Date of data collection	1992	1999
Sample Size	112*	231
Total *FDCRS* score	3.92	4.54
FDCRS score distribution:		
- Below 3.0	13%	7.8%
- Between 3.00 and 4.99	75%	55.4%
- 5.0 or above	12%	36.8%
CIS scores:		
Sensitivity	3.03	3.36
Harshness	1.58	1.26
Detachment	1.46	1.25

Source: Kontos et al. 1995.

* Although this study also included a sample of unregulated providers, all the findings cited are solely for the group that was regulated.

5.0, signifying custodial care. On the *CIS*, the American providers obtained mean scores of 3.03 on Sensitivity, 1.58 on Harshness and 1.46 on Detachment. The mean Sensitivity score for providers in our study was 3.36, while their mean scores on Harshness and Detachment were 1.26 and 1.25, respectively.

In comparison to the American providers, the people in our sample were providing care that was more sensitive and less harsh or detached. Its overall quality, as measured by the *FDCRS*, was also better.

6.8 Summary

The data reported in this chapter replicate, confirm and extend descriptive data reported in previous family child care research. The chapter provides a profile of quality in family child care and illustrates its variation across jurisdictions. It also identifies some of the areas where substantial numbers of providers do not meet the requirements for good practice — for example, in basic hygiene. Of particular concern is the finding that only 4 out of 10 providers in our sample were providing the type of care that would stimulate children's development. Instead, the majority were providing good custodial care.

Notes

1 Clifford, Harms and Cryer 1991.
2 Goelman et al. 2000.
3 Harms and Clifford 1990.
4 Harms, Clifford and Cryer 1998.
5 Harms, Clifford and Padan-Belkin 1983.
6 Pence and Goelman 1991.
7 Goelman and Pence 1988.
8 Kontos et al. 1995.

ERIC Full Text Provided by ERIC

Chapter 7

What Correlates with Quality in Family Child Care?

7.1 Introduction

Previous chapters have described the personal, educational and experiential backgrounds of the providers in this study, their caregiving practices, the children they care for and their feelings about their work. The context in which regulated family child care provision takes place has also been described. This chapter goes beyond simply describing these variables to attempt to identify which of the variables are significantly correlated (associated) with the measures of process quality used in this study: the *Family Day Care Rating Scale* (*FDCRS*) and the *Caregiver Interaction Scale* (*CIS*).

The key question addressed in this chapter is: To what extent is process quality, as measured by the *FDCRS* and the *CIS*, associated with: (1) the characteristics of the children being cared for; (2) the characteristics of the provider; and/or (3) contextual variables such as working conditions and the availability of supports in the community? Variables were selected for closer examination on the basis of the review of the literature cited in Appendix C and on questions related to current regulations and policies pertaining to family child care in different jurisdictions.

7.2 Issues in Presenting and Interpreting the Research Results

The data from the present study represent a rich and extensive set of information, the most comprehensive ever collected on family child care homes in Canada. Some limitations do exist, however, in presenting

ERIC

and interpreting these findings. First, there are limits to the number of variables that any one study can examine while still being manageable; in this, the first large-scale study of family child care providers in Canada that included measures of observed quality, we focused primarily on those variables that we believed were likely to be the most important. Second, our findings are based on a sample of providers drawn from specifically targetted communities, not from a random sample of either communities or family child care homes. Given the variability and diversity of child care across Canada, the claim cannot be made that the participating providers are representative of all regulated providers in Canada. Third, the analyses presented here are based on one extended observation in the family child care home; this means that the observations that produced the *FDCRS* scores and *CIS* ratings of provider sensitivity, harshness and detachment reflect that particular time sample.

7.3 The Number and Ages of Children in the Observed Family Child Care Home

As shown in Table 7.1, child care quality was not significantly correlated with either the total number of children present or the adult:child ratio in the observed family child care home. The number of the providers' own children (in the 37.0% of homes where the provider's children were present) was slightly negatively correlated with the *CIS* Sensitivity score.

While the number of children was not correlated with quality, the number of caregivers present in the home was. The presence of another adult correlated positively with *FDCRS* Total scores and with sub-scale scores on furnishings and basic care. Thirteen percent of providers had another caregiver present whom they described as a regular assistant or substitute. This was most common in Québec (40.5%) and British Columbia (15.6%). Both these jurisdictions, as well as the Yukon, permit a larger number of children to be cared for when the provider has an assistant.

The age of the youngest child present had the strongest association with observed quality among those variables discussed in this section. There are two issues about age: (1) the age of the youngest child present, whatever that age might be; and (2) whether a child was present who was under age 18 months.

Table 7.1

***FDCRS* and *CIS* Correlations with Observed Variables, 1999**

Observed variables	*FDCRS* Total	*CIS* Sensitivity	*CIS* Harshness	*CIS* Detachment
Number of children present ‡	-.05	-.08	-.05	.06
Observed adult:child ratio	-.12	-.10	.03	.11
Number of provider's children present	-.06	-.14*	.02	.11
Number of caregivers present	.14**	.03	-.12	-.07
Age of youngest child present	.20**	.16*	-.12	-.14*
Youngest child <18 months	-.20**	-.17**	.20**	-.10

Note: ‡ Includes own children as well as child care children; * = $p < .05$; ** = $p < .01$.

98

ERIC

Table 7.2				
***FDCRS* and *CIS* Correlations with Provider's Overall Educational Background and Experience as a Child Care Provider, 1999**				
Provider's education and child care experience	***FDCRS* Total**	***CIS* Sensitivity**	***CIS* Harshness**	***CIS* Detachment**
Highest level of overall education	.30**	.18**	-.16*	-.07
Years as a regulated provider	-.04	.09	.09	.02
Years as an unregulated provider	-.18**	-.08	.08	.14*
Years worked in a child care centre	.18**	.08	-.10	-.10
Note: * = p< .05; ** = p< .01.				

The *older* the youngest child present, the higher the *FDCRS* Total score, the higher the *CIS* Sensitivity score and the lower the *CIS* Detachment score. The presence of a child under age 18 months was negatively correlated with the *FDCRS* Total score. The 95 providers (41.1%) who had a child younger than 18 months in their home when they were observed had an average *FDCRS* Total score of 4.3. The other 136 providers (59.5%) who had no children present under the age of 18 months had an average Total score of 4.7. The presence of a child under age 18 months was also associated with caregiving that was less sensitive and more harsh.

7.4 Providers' Demographic Characteristics, Overall Educational Background and Prior Child Care Experience

None of the demographic factors (provider's age, marital status, or the number and age of children living at home) was related to any aspect of observed quality. However, the provider's educational background and aspects of her experience as a provider were strongly related to quality scores.

Of all the variables in our study, the highest level of overall education attained by the provider had one of the strongest positive correlations with process quality. Educational attainment (in any field) was significantly correlated at the .01 level with *FDCRS* Total scores and scores obtained for each sub-scale. Providers with a higher educational background demonstrated more sensitive and less harsh caregiving as well.

Table 7.3 illustrates the different average *FDCRS* Total scores obtained by groups of providers with different levels of overall education. Of the 102 providers who had completed a college or university program, 61 (59.8%) had done so in early childhood education, child development or a related field. Other providers had post-secondary education in a range of areas, including music, secretarial studies and business administration.

ERIC

Table 7.3		
Average *FDCRS* Total Scores, by Educational Attainment, 1999		
Educational attainment	**Average *FDCRS* Total Score**	**SD***
Some high school (N = 19)	4.13	0.79
High-school diploma (N = 60)	4.22	1.04
Some post-secondary education (N = 49)	4.39	1.13
College diploma (N = 73)	4.83	0.99
University degree (N = 29)	5.09	0.96

* SD: Standard deviation.

Contrary to expectations, providers' length of time as regulated providers (either individually licensed or agency-affiliated) was not correlated with *FDCRS* scores or with any of the *CIS* scales. This may reflect less variability among the providers in this study or suggest that other factors related to length of time as a regulated provider operate in ways that reduce its association with process quality. What emerged far more clearly is that length of time as an *unregulated* family child care provider was negatively correlated with *FDCRS* Total scores and with most of its sub-scores. As illustrated in Table 7.2, providers who had spent longer as an unregulated family child care provider also displayed more detached behaviour in interactions with the children. These findings on length of time as an unregulated provider point to the importance of encouraging providers to become regulated. As discussed in Chapter 9, being regulated increases the likelihood of access to training and other provider supports.

Finally, we note that years spent as a teacher or assistant in a child care centre was positively correlated with *FDCRS* Total scores (see Table 7.2) and with scores on sub-scales measuring Furnishings, Language and Reasoning, and Learning Activities. The 110 providers in our sample who had previously worked in a child care centre tended to have had at least some post-secondary education in ECCE or a related area, including some who transferred from centre care to home child care when they had their own children.

7.5 The Provider's Child Care-Specific Education, Training and Professional Development

Table 7.4 reveals significant correlations between observed quality and both ECCE-related education and family child care-specific training.

As illustrated in Table 7.5, there was a direct relationship between the mean *FDCRS* Total score and the amount of ECCE-related education the provider had completed. The difference in the *FDCRS* score between the group of providers without any ECCE-related courses and those with at least some ECCE-related courses was significant at the .005 level.

ERIC Full Text Provided by ERIC

Table 7.4				
***FDCRS* and *CIS* Correlations with Provider's Child Care-Specific Educational Background, Family Child Care Training and Participation in Professional Development Activities, 1999**				
Provider's child care education, training, professional development	***FDCRS* Total**	***CIS* Sensitivity**	***CIS* Harshness**	***CIS* Detachment**
Highest ECCE-related education completed	.29**	.10	-.16*	-.06
Has taken Family Child Care Training	.20**	.09	-.10	-.04
Participated in professional development activities in the last 3 years	.21**	.17*	-.06	-.18*
Note: * = p< .05; ** = p< .01.				

Table 7.5		
***FDCRS* Correlation with Provider's ECCE-Related Education, 1999**		
Provider's ECCE-related education	**Average *FDCRS* Total score**	**SD***
None (N = 133)	4.29	1.08
Some courses, including a certificate or diploma requiring less than 2 years (N = 51)	4.79	0.95
2-year credential or higher (N = 47)	4.99	0.98
* SD: Standard deviation.		

Post-secondary education in ECCE or a related field is not the only route to process quality (see Table 7.4). Completion of a formal family child care training program (such as *Step Ahead*, *Good Beginnings* or a course approved by the Québec government) was associated with quality scores on the *FDCRS* (but not with any of the observational assessments of caregiver-child interaction). Participation in professional development activities such as courses, workshops and conferences was also associated with quality — in this case, with both *FDCRS* Total scores and its sub-scale scores, and with higher scores on the *CIS* Sensitivity scale and lower ratings of the frequency of detached, unresponsive care.

7.6 The Adult Work Environment

Extensive information was collected about the number and ages of children enrolled in the provider's home, how long they had been in her care, the days and hours that providers worked, conditions of

payment and annual child care income (see Chapter 5). No pattern of relationships emerged in the total number of children enrolled, the number or percentage of children under age 3, age 6 or older, or the age range of children included. No correlation was found between observed quality and the number of children who were in care for 40 or more hours per week. (This may be due to limited variability among our sample providers.) While providers who cared for one or more children who had been with them for a relatively long time (several years) scored higher on observed Sensitivity, there was no correlation between the number of children who left care in the past 12 months and any aspect of care that was observed in the study.

Table 7.6 identifies the correlations that were found with providers' workload, child care income, payment arrangements and fees charged. Several points are worth noting about the correlations in Table 7.6. First, while total contact hours with children was not correlated with quality, the providers' report of the number of extra (that is, *unpaid*) hours spent in shopping, cooking, cleaning, book-keeping, planning and materials/activities preparation was positively correlated with observed quality. Gross 1998 child care income was positively correlated with *FDCRS* Total scores and with more sensitive care and less detachment. The number of vacation days, compensation for additional hours and charging a higher daily fee were all positively correlated with *FDCRS* Total scores and with most *FDCRS* sub-scale scores. In short, providers who reported better working conditions (with the exception of a higher number of unpaid child care hours) were observed to provide better care. The positive correlation between observed quality and the number of unpaid hours, which would appear to be a negative working condition, may reflect the provider's commitment and the extra effort needed to provide better quality care.

Table 7.6

***FDCRS* and *CIS* Correlations with Aspects of Providers' Workload, Remuneration and Working Conditions, 1999**

Aspects of providers' workload, remuneration and working conditions	*FDCRS* Total	*CIS* Sensitivity	*CIS* Harshness	*CIS* Detachment
Total weekly contact hours with family child care children	.02	.05	.00	.02
Additional unpaid hours related to family child care	.23**	.05	-.03	-.09
Gross child care income (1998)	.30**	.18**	-.13	-.17**
Number of vacation days taken	.16*	.09	-.04	.00
Payment when children are absent, for holidays, compensation for overtime, or early withdrawal from care	.14*	.07	-.02	-.12
Daily fee charged for a 3-year-old, full-time	.33**	.00	-.05	-.13

Note: * = $p < .05$; ** = $p < .01$.

ERIC Full Text Provided by ERIC

7.7 Supervision and Support, the Provider's Affiliation with Organizations and Networks, and Use of Community Supports

Providers affiliated with family child care agencies were asked about the frequency and duration of home visits, the kinds of assistance given by home visitors, how helpful providers thought their home visitors were, and the degree to which they felt supported and trusted. Descriptive information on these relationships was provided in Chapter 5. None of the variables relating to support and supervision from home visitors was correlated with *FDCRS* Total scores or scores on the three *CIS* scales.

A more limited set of questions was asked of individually licensed providers: these were on frequency and duration of licensing visits and the degree to which those visits were perceived as helpful. Among individually licensed providers, the number of licensing visits was negatively correlated with *FDCRS* Total scores (r = -.22*) and with scores on the Basic Care sub-scale (r = -.40**). Higher quality scores were associated with fewer, not more, visits by licensing officials. This suggests that unless practice dictates otherwise, licensing officials are priorizing whom they visit, seeing providers who demonstrate higher quality, especially on health and safety concerns, less often. While that may be efficient, the data give other indications that individually licensed providers may feel more isolated, and that licensing inspection visits are an important potential source of support.

Table 7.7

***FDCRS* and *CIS* Correlations with Providers' Networking, Affiliation with Local Associations and Family Child Care Organizations, and Use of Community Resources, 1999**

Providers' networking, affiliations and community resource use	*FDCRS* Total	*CIS* Sensitivity	*CIS* Harshness	*CIS* Detachment
Network with other providers through an organized association	.21**	.14*	.00	-.14*
Network informally	.15*	.10	-.04	-.08
Member of a local FCC organization, network, or Child Care Resource Program	.24**	.21**	.07	-.19**
Member of a provincial/ territorial (family) child care association	.21**	.04	-.06	.01
Use of community resources related to children	.11	.09	.08	.05
Use of community resources that support caregivers	.14*	.02	.08	.00

Note: * = p <.05; ** = p <.01.

103

ERIC Full Text Provided by ERIC

As illustrated in Table 7.7, we found a far more significant set of relationships when we examined providers' networking with other family child care providers, their contacts with family child care resource programs or associations, and their use of caregiver supports in their local community.

Involvement with local networks of providers and local organizations that offer information and support to family child care providers; as well as the use of community-based resources such as toy-lending libraries, telephone support and bulk buying opportunities, are positively correlated with *FDCRS* Total scores *and* with more sensitive caregiving. Affiliation with a provincial/territorial or national child care association and the use of community resources that support caregivers was associated with higher *FDCRS* Total scores, but had no observable relationship to sensitivity in provider-child interactions.

7.8 The Provider's Perspectives, Motivation and Evidence of Intentionality

"You must really love being with children — not just abstractly like kids, but enjoy talking, playing with, and caring for them."
— A British Columbia provider

"Think of child care as a career — not just a stop-gap until a better job comes along. Realize the value of the service you provide."
— Another British Columbia provider

Our final section of correlations indicates the importance of the relationship between providers' feelings and observations of quality. The term "intentionality"[1] has been used to refer to that combination of a provider's feelings about children, belief that child care is important work, and commitment to providing child care as a career, not just a temporary job. As noted in Chapter 2, Section 2.3, intentionality manifests itself in purposeful planning of activities for the children, in actively seeking and building mutual-support relationships with other providers, and in seeking out opportunities to learn more about children and how they develop.[2] The concept of intentionality is gaining increased attention because of its influence on care providers' behaviour with children and its suspected importance as a predictor of turnover (see Appendix C).

Table 7.8 illustrates those indicators of intentionality that we found to be correlated with process quality as measured by the *FDCRS* Total score and, in some cases, one or two of the *CIS* sub-scale scores. The indicators as a group illustrate the importance for quality of: (1) the provider having a real liking for children and enjoying working with them; (2) her perception of the work as making a valuable contribution; and (3) her commitment to family child care as a career. For example, providers whose advice to a friend considering starting family child care included statements such as, "You must really love children," "Appreciate the value of this work," and "It takes commitment," had higher *FDCRS* Total and higher *CIS* Sensitivity scores.

ERIC Full Text Provided by ERIC

Table 7.8				
***FDCRS* and *CIS* Correlations with Indicators of Intentionality, 1999**				
Indicators of intentionality	***FDCRS* Total**	***CIS* Sensitivity**	***CIS* Harshness**	***CIS* Detachment**
Advice to a friend thinking of becoming a provider: Comments related to really loving children and/or being commited to child care as a career	.16*	.20**	-.10	-.11
Advice to a friend: Comments related to appreciating the value of this work to children and families	15*	.18*	-.07	-.15*
Reason provider gave for deciding to become licensed or affiliated with an agency: "To demonstrate to parents that my care meets standards of quality," "To be more professional"	.23**	.07	.01	-.09
Positive aspects of being a provider: Comments related to enjoying working with children and/or contributing to their development	.17*	.13	-.08	-.11
Positive response to being asked if she expected to be providing family child care in three years, and reason is related to enjoyment of the work and/or it is her chosen occupation	.13*	.01	.07	-.12
Positive response to being asked if she were choosing a career now, would she choose family child care, and reason is related to enjoyment of the work and/or it is her chosen occupation; would choose child care again	15*	.03	-.11	-.06
Note: * = $p < .05$; ** = $p < .01$.				

ERIC Full Text Provided by ERIC

7.9 Summary

The correlates of observed quality, as assessed by the *FDCRS* and the *CIS* instruments, include:

- the provider's highest level of overall education;
- whether the provider has ECCE-related or family child care-specific education;
- the provider's previous type of experience in child care provision;
- the age of the youngest child present;
- annual income from child care provision; and
- certain working conditions.

In addition, the providers' own reasons for being licensed/affiliated with an agency and several indications of provider commitment to, and enjoyment of, family child care work also appear to be associated with observed aspects of quality care for children. The fact that neither observed *group size* nor *ratio* nor the *age mix of children* enrolled was associated with observed quality in this study does not mean that these factors are unimportant for quality provision. Instead, it appears that current regulations and provider practices are enabling providers to function within a range of comfort and effectiveness so that quality is not compromised, in most cases, when the maximum group size and ratio set within provincial/territorial regulations are observed.

Notes

1 Galinsky et al. 1994; Kyle 1999.

2 Galinsky et al. 1994.

ERIC Full Text Provided by ERIC

Chapter 8

Predictors of Quality in Family Child Care

8.1 Introduction

Chapter 6 presented the descriptive findings from the observations conducted in the homes of the 231 Study 3 participants. Chapter 7 identified those variables that are most closely associated or correlated with quality. As *descriptive information*, the analyses in Chapters 6 and 7 tell us what we actually found in the family child care homes where the data were collected. In Chapter 8 we move ahead and address the following key question: "Of all the variables in this study, which are the most important *predictors* of family child care quality?" That is, if we only knew a few important pieces of information about a family child care home, could we accurately predict the quality of that home? The statistical analyses reported in this chapter identify not only the particular variables that are the most powerful predictors of quality, but also how well those variables work in combination to predict process quality scores.

8.2 Predicting Process Quality

We used two different but complementary statistical analyses, both of which are designed to tell us how well we can predict differences in providers' overall quality as measured by scores obtained on the *Family Day Care Rating Scale (FDCRS)*. First, we present the results of a technique — discriminant function analysis — that contrasts the 25% of providers with the *highest FDCRS* Total scores with the 25% of providers who obtained the *lowest FDCRS* Total scores. Our purpose in making this comparison was to answer the question: "What are the variables that discriminate most strongly between the highest and lowest quality homes in our sample?"

ERIC Full Text Provided by ERIC

The second statistical procedure we used to identify the predictors of quality — stepwise multiple regression — made use of the data from *all* the providers in our sample. In this case, our purpose was to answer the question: "Do those variables identified when we contrast providers receiving the highest and the lowest scores, also predict quality for the entire sample?"

The process quality measure used in both analyses was providers' *FDCRS* Total score. The *CIS* scores of providers' observed sensitivity, harshness and detachment were not used for two reasons. The first is that, of the three *CIS* scales, only the ratings on Sensitivity generated a range of scores sufficient to make these analyses feasible; incidents of harsh and punitive responses to children and observations of providers being detached and unconcerned were relatively rare in this sample. The second reason is that, as illustrated in Table 6.6, the *CIS* Sensitivity scores were highly correlated with the *FDCRS* Total scores; it would be unlikely, therefore, that predictors would emerge that are very different from those evident in the more rigorous analyses conducted on the *FDCRS* scores.

8.3 What Accounts for Differences Between Homes with the Highest and the Lowest Quality Scores?

Discriminant function analysis belongs to a family of statistical procedures that are used to determine the most accurate way of predicting membership in discrete groups. It has been widely used in large-scale epidemiological studies that attempt to predict, for example, which individuals are likely to manifest certain diseases, based on specific information such as age and medical history, or which children do well or poorly in different kinds of educational settings or with different kinds of instructional approaches.

The basic statistical question addressed by this procedure is this: "In comparing high- and low-quality family child care homes, how accurately can we predict on the basis of a few specific variables whether a certain provider will be in one group or the other?" Since the decision involves a choice between only two options, we should always have a 50% chance of being right. By knowing more about the provider, how well can we improve on the 50% chance level of guessing which group she is in?

8.3a Method

All providers in the study were first ranked from lowest to highest according to their *FDCRS* Total scores. In our sample, providers obtained scores on the *FDCRS* that ranged from 1.37 (inadequate) to 6.84 (excellent). The top 25% of all 231 family child care homes in this study (the top quartile) had *FDCRS* scores of 5.34 or above, a score that places these providers in the good to excellent range. Providers with scores in this category are described by the scale's authors as having acquired ratings indicative of positive interaction, planning and personalized care, and the availability of good materials.[1] The quality of care they provide goes beyond meeting children's needs for basic, nurturing care, to care that fosters children's total development. Providers in the bottom 25% of all family child care homes (the bottom quartile) had scores of 3.80 or below. These 58 individuals included 18 whose scores were below 3.0, and 40 who were at the low end of what researchers variously refer to as minimally adequate or mediocre care — care that is custodial and inadequate for fostering children's social, language and cognitive development. Providers in the middle range (the second and third quartiles) were not included in the discriminant analysis. They had scores in the respective ranges of 3.81 to 4.56, and 4.57 to 5.33.

Table 8.1 shows the distribution of providers in each of the four quartiles for each of the jurisdictions in the study.

ERIC

Table 8.1

Distribution of Providers in Four Quartiles on the Basis of *FDCRS* Total Scores, by Jurisdiction, 1999

Jurisdiction	Statistic	Bottom quartile (1.37 - 3.80)	Second quartile (3.81 - 4.56)	Third quartile (4.57 - 5.33)	Top quartile (5.34 -6.84)	Total
B.C.	Number	4	6	4	31	45
	Row %	8.9%	13.3%	8.9%	**68.9%**	100.0%
Alberta	Number	15	9	10	5	39
	Row %	**38.5%**	23.1%	25.6%	12.8%	100.0%
Sask.	Number	7	16	10	7	40
	Row %	17.5%	**40.0%**	25.0%	17.5%	100.0%
Ontario	Number	17	11	7	4	39
	Row %	**43.6%**	28.2%	17.9%	10.3%	100.0%
Québec	Number	7	12	17	6	42
	Row %	16.7%	28.6%	**40.5%**	14.3%	100.0%
N.B.	Number	5	2	4	2	13
	Row %	**38.5%**	15.4%	30.8%	15.4%	100.0%
Yukon	Number	3	2	6	2	13
	Row %	23.1%	15.4%	**46.2%**	15.4%	100.0%
TOTAL SAMPLE	Number	58	58	58	57	231
	Row %	25.0%	25.0%	25.0%	25.0%	100.0%

Note: Shaded cells identify circumstances that include more than a third of the providers in the province or territory and constitute the predominant quartile in each jurisdiction.

Based on the correlational analyses presented earlier and on the research literature, we identified a set of 30 possible predictor variables from the questionnaire completed by the provider and from the observational data. These potential predictors encompassed five dimensions: (1) structural aspects of quality — e.g., number of children being cared for, age of the youngest child present when the observation was done; (2) provider characteristics — e.g., highest level of general education attained, number of years the person had worked as an unregulated provider; (3) variables that reflected the quality of the adult work environment — e.g., number of hours per week spent in child care-related tasks when no child care children are present, child care income; (4) contextual influences related to providers' access to, and use of, a range of caregiving supports, and (5) indicators of providers' feelings and intentionality related to their work. (See Appendix J for the full list of variables included as potential predictors.) Our question was: "Which of these variables most effectively discriminate between providers in the top and bottom quartiles, based on their *FDCRS* scores?"

The discriminant function analysis procedure identifies variables that differentiate between the two groups, and is then used to assess how effectively those variables, when weighted according to specific statistical equations, can correctly predict membership in each group.[2] For example, two variables (such as highest level of education completed in any subject area, and highest level of ECCE-related education) may each distinguish between providers in the top and bottom quality quartiles, but may be highly correlated with each other. In such a situation, the discriminant function procedure selects the stronger of the two predictor variables, rather than both variables. In other words, it selects the variable that makes the

ERIC Full Text Provided by ERIC

most difference statistically in contrasting the top and bottom quality groups on the basis of associated *FDCRS* scores. It then adds the next variable that can make an independent contribution that distinguishes between the high- and low-quality groups.

8.3b Results of the Discriminant Function Analyses

The discriminant function analysis resulted in the identification of six key variables that most effectively discriminate between providers in the top and bottom quartiles, based on their *FDCRS* scores. These variables are listed below. The numbers in parentheses after each variable indicate the relative predictive power of each, with the largest number signifying the most powerful predictor. The six variables, *in order of their predictive power,* are:

1. The highest level of education attained by the provider in any subject **(.70)**.
2. Whether the provider has completed a formal family child care-specific training course **(.51)**.
3. Whether the provider networks with other providers through an organized association or provider network **(.45)**.
4. The provider's gross income realized from her family child care work in the previous year **(.36)**.
5. The age of the youngest child present when the observations were made (the presence of an infant or young toddler was more frequently associated with lower *FDCRS* scores) **(.35)**.
6. The provider states that she expects to continue providing care for another three years, enjoys the work, and is committed to family child care as a career **(.32)**.

On the basis of these findings, we can conclude that providers who received the highest scores on the *FDCRS* — those in the good to excellent range — are much more likely to have a higher general level of education than providers in the bottom quartile. They are more likely to have completed a family child care training course and to network with other providers through a formal providers' network, local family child care organization or a child care resource program. Providers in the top quartile are also likely to have earned more money from their child care work in the previous year. They were less likely to have a very young child (an infant or young toddler) present when observations took place. Finally, providers in the highest quartile were more likely to voice their commitment to, and enjoyment of, their work than were providers in the lowest quartile. Table 8.2 shows the differences between the top and bottom quartile groups on these specific variables.

The discriminant function analysis not only identifies those individual variables that are most effective in discriminating between the two groups; the analysis also determines what happens when all six variables are known for a given family child care home. On a chance basis alone, we could correctly identify a home as belonging to either the highest or lowest quartile 50.0% of the time, even though we know nothing about the provider or the ages of the children receiving care. If we knew the information on all six variables for a given child care situation, we would be able to improve the likelihood of a correct prediction from 50.0% to 80.9% of the time. This indicates that the six variables identified by the procedure are very effective predictors of process quality.

8.4 Predicting Across the Full Range of Quality Scores

The discriminant function analysis described in the previous section identified six key variables that are able to classify correctly 80.9% of the providers as being in either the top or the bottom quartile of quality scores. In this section, we present the results of a complementary statistical procedure that addresses the

ERIC Full Text Provided by ERIC

Table 8.2		
Comparison of Providers in the Top and Bottom Quartiles of *FDCRS* Total Scores, 1999		
Provider Characteristics	**Bottom quartile (*FDCRS* < 3.80)**	**Top quartile (*FDCRS* > 5.34)**
Highest completed level of education:		
- Some high school	12%	0%
- High-school diploma	35%	12%
- Some college or university	28%	23%
- College certificate or diploma	18%	40%
- University degree	7%	25%
Has taken a family child care-specific training course	28.0%	56.1%
Networks with other providers through an organized association / provider network	34.5%	68.4%
1998 Gross child care income:		
- Less than $10,000	26.3%	7.0%
- $10,000 - $19,999	42.2%	26.3%
- $20,000 - $24,999	15.8%	26.3%
- $25,000 - $29,999	7.0%	14.0%
- $30,000 and above	8.8%	26.3%
Age of youngest child present when observations were made:		
- Under 12 months	20.7%	10.5%
- 12 - 17.5 months	32.8%	17.5%
- 18 - 23.5 months	17.2%	17.5%
- 24 - 35.5 months	24.1%	36.8%
- 36 months or older	5.2%	17.5%
Type of reason given for continuing to provide family child care for the next 3 years: I love it! It's my chosen career.	50.0%	69.2%

question: "How well can certain variables in our study, acting together, predict the relative ordering of *all* the providers in our sample on the basis of their *FDCRS* scores?" The procedure used in this section is called stepwise multiple regression. It is widely used by social scientists who are interested in studying how multiple influences affect some particular outcome, such as self-esteem or perceived quality of life. The final "pool" of variables used in the multiple regression consisted of the same 30 variables used in the discriminant function analysis (see Appendix J).

The 12 predictor variables that emerged from the multiple regression procedure included six that were the same or very similar to the six variables identified in the discriminant function analyses. Thus, as illustrated in Table 8.3, the multiple regression analyses confirmed that the six variables that were able to classify correctly 80.9% of providers as being in either the top or bottom quartile of the quality scores

ERIC Full Text Provided by ERIC

were also important for predicting the relative ordering of all providers, based on their *FDCRS* Total scores. In addition, as also illustrated in Table 8.3, six new variables emerged. The variables in boldface in the two columns of Table 8.3 are those that were the same or similar across both procedures. The non-boldface variables are the six new variables that emerged when we sought to predict quality across the full sample.

Acting together, the 12 variables identified through the stepwise multiple regression resulted in a multiple correlation of .62 and accounted for more than 35% of the variance in *FDCRS* scores. The proportion of explained variance is very high relative to the 10-15% usually found in social science research and is statistically significant at less than the .0001 level. In non-statistical terms, this statement means that the 12 predictors, working together, explained 35% of the full 100% of reasons for the scores of the providers in our sample. Statistically speaking, there is less than one chance in 10,000 that these significant variables would be selected on a purely chance or random basis.

8.5 Strategic Policy Probe

Both of the statistical procedures identified three predictor variables related to the education, training and professional affiliation of the provider. These variables are: (1) having completed at least some post-secondary ECCE courses; (2) the completion of a formal family child care-specific training program; and (3) the provider is affiliated with a local family child care association or child care resource program. All three of these variables can be influenced by government action. In this section we examine the effects on quality when providers have one, two or three of these variables in different combinations.

Table 8.4 indicates that the mean *FDCRS* Total score for providers with all three variables differed significantly from the score obtained by providers:

- with family child care-specific training only;
- with some ECCE courses and family child care-specific training;
- with only an affiliation with a local family child care association or child care resource program; and
- without any ECCE courses or training or an affiliation.

The findings reported in Table 8.4 indicate that an affiliation with a local child care association and/or a child care resource program, and having either ECCE courses or family child care-specific training, results in significantly higher *FDCRS* scores than those obtained by people who have no affiliation, and no ECCE courses or family child care training. While having only some ECCE courses also has a positive effect, the value of this is boosted when the individual has an affiliation, probably because this provides opportunities for networking with others, information and professional development activities.

8.6 Summary

Statistical procedures identified a number of variables that were predictors of quality, as measured by the *FDCRS*. A set of six predictors was able to classify correctly 80.9% of providers as being in either the top or bottom quartile of quality scores, and the same variables were found to be important for predicting the relative ordering of all providers on the basis of their *FDCRS* scores. These six variables were:

Table 8.3

Predictors of Process Quality, 1999

Dimension	Variables that distinguish top and bottom quartiles	Variables that predict quality across the full sample
Structural aspects	**Age of the youngest child present when the observation took place**	**Age of the youngest child present when the observation took place**
Provider characteristics	**The highest level of formal education completed in any subject**** **Provider has completed family child care-specific training**	**The highest level of ECCE-related education completed** **Provider has completed family child care-specific training** Years worked as an unregulated provider Years worked in a child care centre
Adult work environment	**Gross child care income received in previous year**	**Gross child care income received in previous year** Number of non-contact hours spent on paperwork, preparing activities, etc. (more hours associated with higher *FDCRS* score)
Context	**Provider networks with other family child care providers through a local organized association or provider network**	**Number of local child care associations or organizations provider is associated with**
Provider feelings about family child care work	**Provider states that she expects to continue providing care for another three years, enjoys the work, is committed to family child care as a career**	**Provider states that she would choose family child care as a career again because she enjoys the work, sees it as her chosen occupation** Provider states that she became regulated to demonstrate that her care meets standards and/or to be more professional Advice to a friend would be: Be sure that this is what you want to do; research it; know yourself; must love this work One of the three most negative aspects of being a family child care provider is: Being alone most of the time; full responsibility for the children

Notes: Boldface identifies variables that were the same or similar across both procedures.

** Providers' highest level of education in any subject and highest level of ECCE-related education overlapped to a large extent ($r = .60$). Of the 102 providers who had completed a college or university program, 59.8% had received a credential in ECCE or a related discipline.

Table 8.4		
Comparison of Providers with Different Combinations of: Some ECCE Courses, Having Completed Family Child Care-Specific Training, and Affiliation, 1999		
Variables	**Number and percent of providers (Total = 231)**	**Average *FDCRS* Total score**
ECCE, plus training, plus affiliation	21 (9.1%)	5.39
Training plus affiliation	26 (11.3%)	4.98
ECCE plus affiliation	27 (11.7%)	4.86
ECCE only	33 (14.3%)	4.81
Training only	29 (12.6%)	4.45*
ECCE plus training	17 (7.4%)	4.44*
Affiliation only	30 (13.0%)	4.27*
No ECCE, no training, no affiliation	48 (20.8%)	3.83*

Note: * = $p < .05$ where compared with providers having the combination of ECCE, plus training, plus affiliation. Percentages do not add to 100% due to rounding.

1. The highest level of formal education completed by the provider in any subject (among the 102 providers who had completed a college or university program, 61 had done so in ECCE or a related subject).
2. Whether the provider has completed formal family child care-specific training.
3. Whether the provider networks with other providers through a local organized family child care association or provider network and/or is a member of a local child care resource program.
4. The provider's gross income from child care provision in the previous year (those with higher incomes tended to obtain higher *FDCRS* scores).
5. The age of the youngest child present when the observation was done (the *FDCRS* score tended to be lower when an infant or young toddler was present).
6. The provider's feelings about family child care work, including her enjoyment of the work and commitment to family child care as a career.

Additional analyses indicated that having either family child care-specific training or at least some ECCE courses plus affiliation with a local family child care association or a child care resource program, results in *FDCRS* scores significantly higher than those obtained by people who do not have an affiliation and do not have either training or ECCE courses.

Notes

1 Clifford, Harms and Cryer 1991.

2 Tabachnick and Fidell 1996.

Chapter 9

Summary and Recommendations

9.1 Introduction

This report discusses the findings of the largest, most systematic and most multi-jurisdictional Canadian study to have addressed the relationships between family child care quality and: (1) provider characteristics and attitudes about family child care provision; (2) income levels and working conditions; and (3) the provider's use of support services such as child care resource programs, networking with other providers and professional development opportunities. The findings are used to discuss what is needed to improve the stability and support the quality of the family child care system across Canada, and to make recommendations.

9.2 Quality Child Care: A Crucial Component in Addressing Broad Societal Goals

The evidence from the neurosciences, from developmental psychology and from paediatrics is powerful — the early years of development, particularly prior to age 6, form the basis for the competencies and coping skills that will be required throughout life.[1] The evidence is also clear that "learning in the early years must be based on quality, developmentally-attuned interactions with primary caregivers and opportunities for play-based problem-solving with other children that stimulates brain development."[2]

ERIC Full Text Provided by ERIC

Quality child care is recognized as a crucial component in addressing broad societal goals by people in education,[3] by economists[4] and by other groups not ordinarily involved in child care issues. The National Forum on Health, comprising authorities from the medical community, has stated that, "The negative effects of poor quality child care and the positive effects of high quality child care have an impact on children regardless of social class. Access to affordable, high quality child care should be accessible to all."[5] Similarly, the National Crime Prevention Council has noted that high-quality child care assists children to learn social skills, to combat their aggressive tendencies, and to respect authority. The Council concluded that quality child care services are an important delinquency prevention initiative that should be available to all children.[6] In a 1999 report, the National Council of Welfare notes that children are poor because their families are poor, and improving family income — for example, by enabling parents to work — is the only way to address children's poverty. The report states that, "Any social policy that is serious about supporting children and families must have child care at its centre. Good child care makes an enormous difference to the ability of poor families to find and keep jobs."[7]

9.3 Family Child Care: A Vital Part of the Child Care System

Statistics from the National Longitudinal Survey of Children and Youth indicate that in 1996, family child care was the primary out-of-home, non-relative care used by approximately 390,200 children under age 6 and another 246,400 age 6-11 while their parents engaged in the paid workforce or studied. Fifty-six percent of the children under age 6, and 51.1% of those age 6-11 who were receiving out-of-home child care on a regular basis received this in a family child care home.[8] Given the number of young children spending a substantial proportion of each day in family child care, and the strong evidence of the importance of young children's daily experiences, the quality of these settings should be a major concern for parents, politicians, policy analysts and children's advocates.

9.4 Regulated Family Child Care Quality in Canada

Major strengths of the study on which this report is based are its systematic and standardized use of questionnaires, observations and training procedures to examine quality, and its examination of the influence on quality of a wide range of variables. The data analyses went beyond simple identification of associations between quality and variables such as provider characteristics, to identify those key variables that predict the quality of children's experience in family child care.

9.4a Reasons for Optimism

The *Caregiver Interaction Scale (CIS)* scores indicate the frequency with which different kinds of interactions were observed. A provider with a high score on Sensitivity is warm, attentive and actively engaged with the children. Someone who scores high on Harshness shows behaviour that is critical and punitive. Detachment refers to a low level of interaction, expression of interest and/or supervision, such as passively watching the children instead of interacting with them. Therefore, high scores on the Sensitivity sub-scale are desirable, while high scores on the Harshness and Detachment sub-scales are not. The scores in this study ranged from 1.0 to 4.0 on the three sub-scales.

ERIC

Table 9.1			
***CIS* Scores, Total Study 3 Sample, 1999**			
Statistic	***CIS* Sensitivity**	***CIS* Harshness**	***CIS* Detachment**
Range	1.20 - 4.00	1.00 - 3.67	1.00 - 3.00
Mean	3.36	1.26	1.25

The scores on the *CIS* illustrated in Table 9.1 reflect high levels of warm, attentive and engaged behaviour with children, and low levels of harshness or detachment. The *CIS* scores, along with scores from the *Family Day Care Rating Scale (FDCRS)* reported in the following section, indicate that physically safe environments with caring, supportive adults are the norm in the majority of homes. Thus, our findings suggest that most children in regulated family child care are in situations that meet their basic needs for physical and emotional safety. As indicated by the *FDCRS,* over a third of the family child care providers, 36.8%, were also providing activities that stimulate children's social, language and cognitive development, thereby setting the stage for school readiness. The existence of a cadre of providers who are warm, sensitive and responsive, with an additional 36.8% providing care that was also of a calibre that would stimulate and encourage development, is reason for optimism. It indicates a solid base upon which to build a family child care system that supports and fosters children's early development.

9.4b Reasons for Concern

Despite the encouraging data from the *CIS*, the results from the *FDCRS* are cause for concern. The *FDCRS* has 32 items, each of which is scored on a seven-point scale. These scores are used to determine a Total score that can range between 1.0 and 7.0. According to the authors of the *FDCRS*, Total scores of 3.0 or below indicate inadequate to minimal custodial care where little stimulation is provided. Homes that obtain a score of 4.0 are providing good custodial care and some stimulating activities.[9] A score of 5.0 is considered to be the cut-off between good custodial care and care that not only protects health and safety but also provides activities that stimulate children's development. A score of 7.0 indicates excellent care, where the adult not only provides activities that stimulate development, but specifically plans for children's individual learning needs.

The average Total score obtained by the sample as a whole was 4.5; the proportion of providers obtaining Total scores at each level was:

- below 3.0 — 7.8%;
- between 3.0 and 3.99 — 23.8%;
- between 4.0 and 4.99 — 31.6%;
- between 5.0 and 5.99 — 26.8%;
- 6.0 or higher — 10.0%.

Nearly two-thirds of the homes, 63.2%, obtained a score below 5.0. This included about a third, 31.6%, that obtained scores between 4.0 and 4.9, and 7.8% where the observed care was at a level considered

ERIC Full Text Provided by ERIC

inadequate. In summary, only just over a third of the providers in our sample, 36.8%, were providing care that would stimulate and encourage children's development. This represents thousands of lost opportunities to maximize early child development, a situation that, as discussed below, reflects the failure to provide adequate support to family child care provision as an important part of a comprehensive quality child care system.

The *FDCRS* findings are of concern for a number of reasons. First, it is simply unacceptable to have inadequate to mediocre levels of quality in a large proportion of settings providing care for children during their most vulnerable and developmentally sensitive years. As a society, we owe it to our children to give *all* of them the best possible start in life. In so-doing, we also increase the probability that they will grow up to be self-confident, competent adults. Second, there is reason to suspect that the providers in our sample had somewhat higher levels of formal education and were more self-confident than providers in general. All the participants volunteered and, as noted by other researchers, people who volunteer to participate in this type of research tend to be more highly educated and more interested in the issue being addressed.[10] Thus, given the likelihood that the providers in our sample were among the "cream of the crop" — which was characterized by inadequate to mediocre levels of quality — our findings raise even more concern about those providers who did not participate in the study. Third, the findings from previous research have identified many of the contributors to family child care quality. However, with variations across jurisdictions, policy and practice have not capitalized on this knowledge. For example, several studies have documented an association between higher levels of quality and providers who have specialized training related to family child care, yet only four jurisdictions[11] have policies or regulations requiring family child care providers to complete a training course within a given period after starting to provide care. The report of the findings from the Family Day Care Training Project[12] identified major availability and accessibility barriers to training across the country. Our findings document the results of our failure to act upon what we already knew.

Having noted the reasons for concern, we also want to state that:

> ***We firmly believe that family child care quality in Canada can be supported and enhanced through systematic implementation of coherent and coordinated policies and practices. Getting from "here" to "there" is do-able given public commitment and political will.***

In Section 9.7, we discuss the implications of our findings and present our recommendations for remedying the current situation.

9.5 Predictors of Quality: A Dynamic Interaction of Different Variables

The statistical analyses of the data collected identified a set of variables which, taken together, can indicate the quality of family child care providers and homes with convincing statistical accuracy. In all of the analyses it was very clear that "good things go together." Family child care quality is the result of a dynamic interaction of different kinds of variables. These include, but are not limited to:

ERIC

- provider characteristics — for example, whether the individual has completed a family child care-specific training course, the provider's attitude towards her work;
- the adult work environment — for example, remuneration levels, whether the provider is caring for an infant or young toddler; and
- the level and types of support available to, and used by, the provider.

All the providers in our study were regulated, so we were unable to explore the effect of regulation on quality; several other studies have done so, however, and report that regulation is associated with higher ratings of family child care quality.[13] It is thus evident that regulation is another important variable and as such it will be discussed below.

Table 9.2 summarizes the findings reported in Chapters 7 and 8. As the table illustrates, several of the variables found to correlate with high levels of provider sensitivity with children were also found to be predictors of *FDCRS* Total scores. However, the presence of a child under the age of 18 months in the home at the time of observation was associated with lower levels of provider sensitivity and predicted lower scores on the *FDCRS*.

It should be noted that the highest level of general education and completion of a post-secondary ECCE or related program was highly correlated in our sample (r = .60). As a result, in many cases quality was

Table 9.2

Summary of Significant Correlations between High Provider Sensitivity Score and Various Variables, and the Variables that Predict Higher *FDCRS* Total Scores, 1999

Variable	Correlates with degree of Sensitivity	Predictor higher *FDCRS* Total score
Provider's highest level of general education (of the 102 providers who had completed a college or university program, 59.8% had done so in ECCE, child development or a related field)	✔	✔
Provider networks with other providers through an organized association or provider network	✔	✔
Gross income realized from family child care work	✔	✔
Provider has completed a formal family child care-specific training course		✔
Provider is a member of a local family child care organization or a child care resource program	✔	
Provider likes her work and is committed to it as a chosen career		✔
Provider had participated in professional development within the previous three years	✔	

ERIC Full Text Provided by ERIC

influenced by a combination of a higher level of general education and having ECCE-related education, not just the provider's level of general education acting in isolation.

9.6 Major Issues in Family Child Care

9.6a Inadequate Infrastructure

Family child care is used for a substantial number of young children while their parents work or study and is the preferred choice of some parents. It must be acknowledged and supported as a vital component of a comprehensive system that promotes early childhood development and supports parents. This requires an appropriate infrastructure of policies, programs and government funding in addition to parent fees, that will ensure the stability and quality of family child care across Canada. As discussed later in this chapter, the current minimal supports in most jurisdictions and little public funding perpetuate the low income levels and the recruitment difficulties and high turnover[14] that threaten the viability of family child care as a service option. This, in turn, threatens the stability of children's placements and thus their feelings of security.

> *"Compared to 10 years ago, home child care is really starting to show the chronic under funding. Since 1991 I have had one raise of approximately $60 a year on a home with five kids. We used to have monthly craft and idea booklets as well as supplies. My home visitor now has an annual craft budget of $200 for* ***25 providers****. I spent $800 on toys and crafts for myself last year! The training has also dropped off and we are now charged for it. The saying is true, it isn't the government who provides daycare subsidy for parents, it is the daycare workers who are working for low wages!"*
> — Ontario provider

The negative effects of the chronic underfunding of child care, both on the parents and children who need this service and on the people who provide it, has been documented previously.[15] In a recent proposed model framework for early childhood development services within the National Children's Agenda, Ken Battle and Sherri Torjman of the Caledon Institute of Social Policy suggest that over a five-year period:

- The federal government contribute $500 million towards the expansion and further development of early childhood services for the first year, and an additional $500 million each year thereafter on an accumulating basis for a cumulative total of $7.5 billion over five years. This money should be divided among the provinces and territories according to a formula based on population growth and economic need.

- Similar provincial/territorial contributions derived from a combination of sources should be added to the federal contribution.[16]

9.6b Most Providers Are Unregulated

The Child Care Sector Study estimated that in 1994/95, only 8.8% of Canada's family child care providers were regulated.[17] Estimates of child care use patterns from the National Longitudinal Survey of Children and Youth suggest that in 1996, approximately 75% of children under age 6 receiving family child care

ERIC

were in unregulated arrangements.[18] While the quality of unregulated homes may be excellent in some cases, the fact remains that they do not have to meet basic health and safety standards and are not monitored by anyone other than the parents. While our study did not explore the effect of regulation on quality, other research has done so. Studies in both Canada[19] and the United States[20] have found that while the quality of care is variable across both regulated and unregulated homes, regulated providers as a group are generally rated as providing higher quality care on standardized measures. As discussed in more detail later, current government policies and practices not only fail to provide incentives for becoming regulated, they actually result in disincentives. Furthermore, the sometimes lower fees in the unregulated sector, where homes do not have to meet standards, act as an incentive for parents to use unregulated care, especially if they cannot obtain a fee subsidy.

9.6c Children Are Safe and Nurtured, but May Not Receive Adequate Stimulation

Recent studies on brain functioning confirm the importance for young children's optimal development of both: (1) sensitive, responsive care and (2) opportunities for exploration and play-based problem solving with other children.[21] Our findings indicate that physically and emotionally safe environments are the norm in Canada's family child care homes. However, in many cases, the children do not receive adequate opportunities to develop their language and cognitive skills. We believe that this situation is a direct reflection of the inadequate provision of training and professional development opportunities and other supports for family child care providers in many parts of Canada.

9.7 Recommendations

Collectively, the variables in Table 9.2, and the association of poorer quality with the presence of a child under age 18 months, can be organized into five separate but related categories:

1. Provider preparation (general education, family child care-specific training, professional development activities).
2. Infrastructure (family child care associations, child care resource programs).
3. Income realized from child care provision.
4. The characteristics of the children receiving care.
5. Provider "intentionality" — a term that encompasses factors such as making a conscious choice to provide family child care rather than engage in another form of work, and a commitment to family child care as a long-term career.

To make recommendations we will use these five categories. While they serve as a tidy way to organize a discussion about what is required to enhance family child care quality and improve its stability, we again remind the reader that quality is the result of the dynamic interaction among variables. There is no "quick fix" — improvements in family child care will depend upon addressing the complex interaction among variables, not just addressing one or two of them. Although our study did not explore the effect of regulation, we know from previous research that regulation is an important building block for quality; so we will start with a recommendation in this area.

9.7a Regulation

Regulation establishes a framework for quality through setting basic health and safety standards, limiting the number and age mix of children present at any one time, and providing monitoring by an outside person. In so doing, it increases the likelihood of a safe physical and emotional environment for the children. Regulation can serve as a vehicle for directly or indirectly accessing training, consultation and other support services: directly, through a family child care agency in jurisdictions using this model; indirectly, when government licensing officials provide individually licensed providers with information about sources of training and support. As noted in Chapter 8, we found that the longer a person had worked as an unregulated provider before becoming regulated, the more likely they would be to obtain a low *FDCRS* Total score. Attracting potential or currently unregulated family child care providers into the regulated system is an important first step towards enhancing the quality of family child care in Canada.

ISSUES

1. The Ease of Opening an Unregulated Home

Anyone can legally operate a family child care home without becoming a regulated provider, as long as they do not exceed the number of children permitted by the provincial/territorial legislation in their jurisdiction.

2. Lack of Incentives and the Presence of a Disincentive to Becoming Regulated

In Canada, there are three incentives to become regulated; in each case, however, policies or practices in one or more jurisdictions undermine their effectiveness. The potential incentives are: (1) access to children whose parents are eligible for a fee subsidy; (2) being permitted to care for more children than an unregulated provider, with a resultant potential for higher income; and (3) access to training and other supports. The incentive of access to children whose parents are receiving a government fee subsidy is lost when a jurisdiction, such as British Columbia or the Northwest Territories,[22] permits fee subsidies to be used in unregulated homes in any situation. Similarly, the incentive becomes weaker when a government, such as Ontario, permits fee subsidies to be used in unregulated homes by people in job training programs.

Over a third of the providers in our study, 35.5%, identified the ability to care for more children as one of the main reasons they joined the regulated system. Five jurisdictions permit fewer children in unregulated homes;[23] the others, with the exception of Ontario, permit the same number of children in both situations. Ontario permits no more than five, *excluding* the provider's own in the unregulated sector, but only five, *including* the provider's own under age 6, in regulated homes.[24] In family child care, income increases with each additional child for whom care is provided. The exclusion of the provider's own children under age 6 from the total permitted number in the unregulated sector in Ontario means that an Ontario provider with young children can earn more in the unregulated sector.

Access to training and supports was identified as one of the major reasons for becoming affiliated with an agency by 50% of the agency providers in our study. However, agency directors in both Alberta and Ontario told us that they were having to cut back on, and/or charge for, supports such as training because of inadequate operating budgets and their inability to charge higher fees and still keep spaces filled.[25] At the same time, providers in both Alberta and Ontario reported that they could obtain higher fees from private placements than for children placed by the agency. This fact may be a disincentive to remaining regulated if a provider cannot access supports through the agency that are not otherwise available, or has to pay for them.

The main disincentive to becoming regulated is the expenditure incurred as a result. Providers, when they apply for regulation, usually incur costs connected with upgrading their home/buying equipment in order to meet regulatory standards — for example, having to fence an unfenced garden. They also incur annual expenses in order to maintain their home and equipment/materials at the level required by the regulations. Only three jurisdictions that license providers individually offer start-up grants.[26] Start-up assistance might theoretically be available through agencies in the five provinces using this model; however, respondents to the agency questionnaire indicated that their operating funds were severely limited.[27] Annual equipment or operating grants for individually licensed providers are also available in only some jurisdictions using this regulatory approach (see Table 1.1).[28] Again, agencies do not have the funds to provide annual financial assistance for needed repairs and replacement of toys and equipment.

REQUIREMENTS

In a situation with few incentives to become regulated, a strategy is needed to entice providers into the regulated sector. Making it illegal to care for more than a certain number of unrelated children would simply drive many providers underground, thereby eliminating their access to support services from agencies and child care resource programs. Therefore, instead of recommending that all family child care providers must be regulated, we are recommending a series of steps that will make regulation attractive by, for example, increasing income potential and providing financial recognition of the start-up and annual costs associated with meeting regulatory standards. We also urge that use of fee subsidies be restricted to regulated homes, except in very small or isolated communities where no regulated home exists and regulation is not practical. Not only would this provide an incentive to become regulated, it also provides more accountability for the use of public funds. We also urge that the number of children permitted in an unregulated home be reduced to no more than four, including the provider's own under age 6, with a maximum of two children under the age of 2, as is currently the case in Manitoba.[29]

Unrealistic standards would also be a disincentive to becoming regulated. Family child care is a unique entity that serves as an alternative to centre-based care. Many parents prefer family child care, especially for infants and toddlers, because they value the home-like environment and feel that, for young children, it provides more continuity with the child's home.[30] Family child care providers also value the home-like environment that they can offer.[31] Regulations must recognize the unique aspects of family child care or risk changing the nature of the service and those aspects that parents and providers most appreciate. It is also important for monitoring to be respectful of the provider's privacy and that of her family, and to strike a balance between the provider's autonomy and what is desirable for protecting children. We urge governments to consult with, and include, people from the family child care sector when reviewing and developing regulations and policies on family child care.

Recommendation 1

Starting immediately, all jurisdictions must examine their existing policies and practices to identify those that act as disincentives for family child care providers to join the regulated system. Policies and practices that act as disincentives must be changed. In addition, all jurisdictions must also immediately begin work on the development and implementation of policies and practices that will encourage family child care providers to join and remain in the regulated system, including the implementation of our Recommendations 7 and 8.

Expanding the supply of high-quality regulated family child care homes is a key policy tool for supporting children's development and assisting parents to assure their family's economic security and, hence, the quality of their children's lives. Few jurisdictions currently have any recruitment strategy, tending instead to rely on potential providers to seek regulation. While we expect that implementation of our Recommendations 7, 8 and 13 would assist in making family child care a more appealing occupation, there is also a need for governments to undertake and/or fund active efforts to recruit providers through outreach campaigns and other means.

9.7b Provider Preparation

Having discussed regulation, we now move to the first category of variables identified in Table 9.2 — provider preparation. The provision of care for a group of unrelated children, care that not only provides a physically and emotionally safe environment but also supports and encourages their development, is a skilled occupation. As with other skilled occupations, doing it well requires a repertoire of knowledge and skills. While some of these can be attained through experience, such as in caring for one's own children, our research and that of others attests to the value of family child care-specific training and on-going professional development opportunities. Training assists the provider to understand and anticipate children's needs, to provide developmentally appropriate and stimulating activities, to access information and to solve problems. There is also some evidence that training assists the provider to cope with the stressors associated with the work.[32]

ISSUES

1. Current Regulatory Expectations

At its most basic, quality care requires protecting children's health and safety and the ability to respond to emergencies. Most jurisdictions require regulated providers to have a first aid certificate prior to starting to provide care, or to obtain one within six months. Some provinces, however, do not have this requirement. At the present time, only four jurisdictions require regulated providers to take family child care-related training within a set period of time after starting to provide care. Annual involvement in professional development is a policy expectation but not a regulation in three provinces (see Appendix B). We believe that regulated providers must be required to have a first aid certificate before beginning to provide care, to take a basic family child care-related course within the first year, and to engage in professional development each year thereafter in order to be exposed to new information and keep themselves informed about current thinking on best practice.

2. Barriers to Obtaining Training and Engaging in Professional Development

The National Family Day Care Training Project obtained information from 145 family child care providers across the country, in 17 provider focus groups, about how they had trained themselves and their experiences with various training opportunities. It also obtained information from more than 150 trainers, parents who use family child care, advocates and researchers through other focus groups and interviews. These data were supplemented by a national survey of 259 organizations that offer training or learning opportunities for family child care providers. In its synthesis report,[33] the Project identifies the following barriers to training/learning opportunities faced by providers: (1) availability; (2) accessibility; (3) the provider's inability to obtain recognition for prior learning or experience; and (4) lack of materials in the provider's mother tongue. Family child care agencies and organizations providing training and/or professional development opportunities reported barriers such as lack of financial resources to cover

training costs. As a result, they can only offer learning opportunities on a cost-recovery basis. They also cited barriers such as lack of available resource materials, and difficulties meeting the training needs of new providers while offering training that is challenging enough to interest those with experience.

The availability barrier reflects the fact that, in many communities, family child care training either is not available or is limited to providers affiliated with a family child care agency. The exceptions are British Columbia, which has established a network of Child Care Resource and Referral Programs, and Ontario, where the government funds child care resource centres that have a specific mandate to provide training and support to the unregulated sector. Only 12 community colleges across the whole country offer training specific to family child care.[34] Accessibility problems include courses offered during the day and the cost/difficulty faced by providers who need a substitute to care for the children, the tuition cost for some courses and professional development activities, transportation difficulties, and the other demands on providers' time and energy.

Recommendation 2

Starting immediately, all jurisdictions must require the successful completion of a first-aid course, including CPR for young children, as a pre-condition to a provider becoming regulated.

Recommendation 3

By the year 2003, all jurisdictions must require regulated providers who have not completed a post-secondary ECCE credential to complete a basic family child care provider course within the first year of starting to provide care. This course should include units on: basic health and safety, setting up the environment, nutrition, child development, child guidance, working with mixed age groups, formulating appropriate daily routines, partnerships with parents, good business practices, and balancing work and family responsibilities. Providers who have completed a post-secondary ECCE credential, but not a formal family child care-related course, must be required to take training on issues specific to family child care within the first year of providing care. This training should include working with mixed-age groups, appropriate business practices, and balancing work and family responsibilities.

Recommendation 4

By the year 2003, all jurisdictions must require regulated providers to engage in a minimum of six hours of professional development each year.

Requirements for training and professional development must be accompanied by expanded funding for family child care agencies, child care resource programs, family child care organizations and community colleges so that they can provide free, or very low cost, training and professional development. It is essential to recognize that family child care agencies' provision of training and on-going learning opportunities (for example, the one-to-one consultation provided by the home visitor) is a key function that requires funding in addition to that provided for agency administration.

Access to learning opportunities must be extended to unregulated providers in all jurisdictions. Not only would this improve overall quality, it is also a proven way to encourage them to join the regulated system. We note the importance of providers and provider associations being heavily involved in the development and implementation of educational opportunities. Access issues must be addressed by mechanisms such as the following: provision of a stipend to cover the hiring of a child care substitute while a provider takes a course; the provision of bursaries or other forms of financial assistance; the implementation of educational opportunities through a variety of approaches such as self-directed learning, distance education, and mentoring; and the production of materials in a variety of languages in addition to English and French.

Recommendation 5

Between now and the year 2003, all jurisdictions must take the steps required in their jurisdiction to ensure the availability and accessibility of appropriate training and professional development opportunities for ALL family child care providers, regardless of their regulatory status.

9.7c Infrastructure

Infrastructure is the second category that we are using to frame our recommendations. We observed greater sensitivity when the provider reported networking regularly with other providers through an organized association or network, and/or when the provider was a member of a local family child care organization or child care resource program. Regular networking with other providers also predicted the quality of the home as assessed by the *FDCRS.* Our study found a positive correlation between belonging to a local family child care association or a child care resource program, and both completing a formal family child care-related training course and having participated in professional development activities in the previous three years.

Family child care associations and child care resource and referral programs often provide training or other learning opportunities and both cover topics and do so at times that suit the needs of a wide range of providers. Some, such as the Westcoast Child Care Resource Centre in Vancouver, have developed informational materials in various languages. Support services, whether delivered through a family child care agency or organization, a child care resource and referral program, a family support program or another organization, give a sense of belonging and opportunities for borrowing materials to learn about child development, borrowing toys and large equipment, attending workshops and so on. They are also sources of advice and information from more experienced providers. In these many ways, support services help to develop provider skills, aid the provision of stimulating activities for children and lessen provider feelings of isolation.

ISSUES

1. The Variability in the Availability of Support Services

Considerable variability in the extent of supports available to providers — both within the same province and across provinces — was reported by the agency directors in our study.[35] British Columbia is the only jurisdiction that licenses individual providers and also funds a network of provider support services.

Family resource and similar programs do exist in other provinces but, with the exception of Ontario, these are relatively few in any jurisdiction and they depend on sources such as the United Way for their operating funds.[36]

Only Québec gives financial assistance to family child care associations. Few other jurisdictions have provider associations and, where these exist, they are struggling to survive on membership fees and fund-raising activities.

2. Inadequate Funding of Support Services

In our study, agencies from all three participating provinces using the agency model reported that inadequate levels of agency funding had resulted in them either cutting back on their support services or charging providers a fee for a service that was previously free.[37] At current remuneration levels, having to pay for a support service is a disincentive for many providers. Agency directors are aware of this and several expressed concern that their inability to provide free supports could have a negative impact on the quality of care received by the children.

REQUIREMENT

Governments must recognize that a range of accessible provider support services across the country is a necessary accompaniment to provider training and professional development in any endeavour to enhance the quality of family child care.

Recommendation 6

By 2003, all jurisdictions must ensure the availability of a variety of provider support services across their jurisdiction through adequate levels of funding for existing provider supports such as child care resource programs and family child care agencies, and creating new services where none exists. Particular attention must be given to financial assistance for the development and ongoing support of provider associations.

Existing entities, such as family child care agencies and child care resource programs, could and should be used to implement both Recommendation 5 and Recommendation 6, including the development and support of provider associations. We urge governments to build on the infrastructure that exists, where it does, rather than developing new entities.

9.7d Income

The third category being used to frame our recommendations addresses providers' income and costs. The majority of providers in our sample worked full-time, five days per week, caring for between four and seven children for 48 weeks or more in the previous year. Almost half of these full-time workers, 44.0%, realized a *gross* 1998 income from their child care provision of less than $20,000, including 24.2% who earned less than $15,000 (see Table 5.6). Providers, on average, reported spending between 30% and 44%

ERIC

of their earned income on child care-related expenses. Thus, assuming (on a fairly generous basis) that an average provider received gross earnings of $20,000 and spent 35% of that on food, toys and so on for the children, her pre-tax annual income would be $13,000. This is somewhat higher than the findings of a Canada-wide survey conducted in 1996. That study calculated that, after deducting child care-related expenses but before taxes, the average annual earnings for a regulated provider working full-time and caring for five children would be $8,400.[38]

A before-tax income of $13,000 is low for a person working full-time, having sole responsibility for four or more children, and caring for children for an average of 50.5 hours a week, excluding unpaid preparation time. According to the findings of Study 1 of the *You Bet I Care!* project, this is lower than the before-tax income earned by assistant teachers in centres who, by definition, always work with, and under the direction of, another person.[39] Furthermore, permanent centre staff receive paid sick days and vacation time, and have half of their Canada/Québec Pension Plan (C/QPP) premium paid by the centre. Family child care providers do not have paid sick or vacation days and are responsible for paying the whole C/QPP premium if they contribute to these plans. A before-tax income of $13,000 is also lower than would be obtained by a person working the same number of hours in 1998 at the minimum hourly wage for an adult in the jurisdiction with the lowest hourly rate.[40] Some tax relief is available to family child care providers through the ability of self-employed people in home-based occupations to deduct business-associated costs when calculating their income tax owed, including a proportion of the cost of maintaining their home.

ISSUES

1 Income Levels Predict Quality Levels

Our study found that sensitive, engaged caregiving and the provision of activities that would stimulate children's development occurred most often when the provider's income from her child care work was at the higher end of the remuneration continuum. This does not mean that raising provider income levels would be an automatic "quick fix" though, as indicated below, such an initiative would assist in recruiting new providers and retaining those with experience. It might also attract people with higher levels of overall education into the occupation.

2. Current Low Income Levels Fuel Turnover and Hamper Recruitment

Having to move to a new family child care home can be a serious blow to a young child who has to adjust not only to a new adult and a new physical setting but also must do so without the support of a familiar peer group. Continuity of relationship also assists a provider to understand better the child's development level and unique ways of communicating. This, in turn, increases the likelihood of sensitive and appropriate care. Data from the Canadian National Longitudinal Survey on Children and Youth indicates that repeated changes in child care arrangements are associated with slower verbal development and difficult temperaments among preschoolers.[41]

Our study did not directly measure turnover rates. However, 16.2% of the participating providers told us that they did not expect to be providing family child care in three years' time and another 14.5% said they did not know if they would be. Provider turnover was identified as a concern by nearly half of the family child care agency directors who participated in the study. When asked to identify the three main reasons for providers leaving, one of the most frequently identified reasons was "dissatisfied with their income."[42]

Two other Canadian studies also found that dissatisfaction with income fuelled turnover among family child care providers.[43]

Recruitment was a concern for over two-thirds of the agency directors. Our study did not explore potential reasons for this. However, other research in both Canada[44] and the United States[45] has identified the expectation of low income and few benefits as major barriers to recruitment of people to become regulated family child care providers. At current income levels, a second source of family income is essential. The inability to earn an income through family child care provision that would sustain a family limits the potential pool of regulated family child care providers to people who have partners or another source of income.

3. The Cap on Providers' Ability to Increase Fees

Providers' child care income, like centre revenues, depends on the number of children enrolled, parent fees (and/or fee subsidies) and other government grants, such as infant incentive grants, minus child care-related expenditures. The maximum number of children is capped by the regulations. In order to maximize her income, the provider must keep all her permitted spaces occupied. The fee that the provider can charge or receives depends upon what parents can or will pay, or by what the agency can afford. Fees are closely linked to the wages that women can earn in the paid labour force, and these wages tend to be lower than those of men. Women who are working because of the need for a second income for their own family are unable to spend a substantial proportion of their income on child care. Therefore, if fees are above a certain proportion of their income, they are forced to use unregulated, cheaper family child care unless they can obtain a fee subsidy.

REQUIREMENTS

Governments must recognize that quality child care is an investment in children, families and communities, and that family child care is a vital part of a comprehensive approach to promoting early child development and supporting parents. The sustainability of the family child care sector and the encouragement of a level of quality that supports and fosters children's development requires financial investment. As a first step, provider income levels must be increased. Not only would this encourage providers to remain in the occupation, it would help to attract people with higher levels of education, a factor that predicts quality care. Since it is not realistic to expect parents to pay higher fees, income levels must be increased through government income-enhancement grants. This could be implemented by a process through which a provider would make a periodic claim to the government for an income-enhancement grant for each child, with different levels for infants, toddlers, preschoolers and older children, and different levels for full-and part-day care.

As noted at the beginning of this chapter, when providers become regulated they face various capital costs for improvements required for compliance with health and safety standards, and for programming materials. They also incur annual expenses to maintain their adherence to regulatory standards. Currently, only three jurisdictions that license providers on an individual basis have a start-up grant and only four jurisdictions provide an annual operating grant.[46] While in theory such assistance might be given to their affiliated providers by family child care agencies, the directors who responded to our survey indicated that the current levels of government operating grants were inadequate and that they were having to reduce the supports they could provide.

ERIC

Recommendation 7

Starting immediately, all jurisdictions must implement an income-enhancement grant for regulated providers. The grant amount must ensure that providers working full-time and caring for four or more children receive, after child care-related expenses and before taxes, the equivalent of what would be earned, on average, by an entry-level staff person working full-time in a centre in the same jurisdiction. Full-time for providers should be defined as at least eight hours a day, five days a week, for 48 weeks or more a year.

Recommendation 8

Starting immediately, all jurisdictions must begin providing start-up grants and annual operating grants to regulated providers.

Lack of benefits also presents a barrier to recruitment and may contribute to decisions to leave family child care provision. It certainly appears to add to providers' stress. Among the items that we asked providers to rate on a five-point scale as sources of stress, two related to income and lack of benefits. These two items had the highest ratings as stressors and the highest percentage of providers who rated them as a major source of stress. Almost half of the providers, 48.7%, rated "Financial concerns including a lack of benefits, e.g. lack of pension" as a major stressor. More than a third, 34.6%, rated "Income fluctuations" as a major source of stress.

At current income levels, many providers cannot afford to purchase disability insurance, to contribute to the C/QPP, or to put some money aside for periods of low income. If an income enhancement grant were implemented, and a network of adequately funded family child care agencies/family child care organizations were developed across Canada, providers would be better able to afford insurance, especially if agencies/organizations could obtain group rates, and to pay their C/QPP premiums.

9.7e The Characteristics of Children Receiving Care

ISSUES

1. Infants and Young Toddlers

In our study, the presence of a child younger than age 18 months was associated with lower levels of provider sensitivity and lower *FDCRS* scores on the sub-scales involving learning activities, language, reasoning and social development.. Anyone who has looked after infants is aware of their need for focused attention and responsive, individualized care, and that this is time-consuming. Furthermore, babies' and young toddlers' needs are immediate and their distress can be very vocal when their needs are not promptly addressed. When a provider has a number of other children competing for her time and attention, the demands of the infant or young toddler can be quite stressful. Only three jurisdictions currently provide an "infant incentive grant"[47] in recognition of the additional time and effort required to care for children under age 18 months.

ERIC

Recommendation 9

Starting immediately, all jurisdictions must provide an "infant incentive grant" to regulated family child care homes providing care for a child under age 18 months in recognition of the additional time, expense and effort required to provide high-quality care for very young children.

While it is essential for babies and toddlers to receive affectionate, nurturing care, they also require linguistic and cognitive stimulation to support their optimal development. Language games, songs, clear naming of objects and people must be embedded in everyday caregiving, along with opportunities to manipulate an assortment of objects and being read to regularly. Specialized training is an essential ingredient in helping adults to understand and respond appropriately to the developmental needs of very young children. However, the popular notion is still that any motherly type can care for babies, *"because all one needs to know is how to rock them and change diapers."*[48] In the companion study, *Caring and Learning Environments: Quality in Child Care Centres Across Canada*, the highest average Total score on the *Infant/Toddler Environment Rating Scale* was obtained by teachers in British Columbia.[49] This is the only jurisdiction in Canada to require that every infant/toddler group have at least one teacher who has specialized infant/toddler training in addition to a basic post-secondary ECCE credential.

Recommendation 10

All jurisdictions must work with family child care provider associations, family child care agencies and other organizations that deliver training and professional development, to develop and implement opportunities for providers to obtain special training for working with infants and young toddlers in the context of a family setting and a mixed-age group.

2. Children Who Have Special Needs

Fifteen percent of our sample of providers reported that they were looking after a child who has special needs. We defined special needs for the providers and for the agency directors as, "A physical or intellectual disability or emotional disorder diagnosed by a physician or other health professional." Seventy-one percent of the participating agency directors told us that their agency was currently providing care for at least one child who had a special need. Only two of these directors told us that the agency would provide training for a provider looking after such a child. Seven respondents said that the provider could access consultation through a community organization such as an infant stimulation program. Their responses did not indicate whether the agency had a special arrangement with such an organization, or if the provider would simply access the service as any parent would. One director reported that her agency would provide periodic respite care to allow the provider to have a break.

There is a growing recognition that the small group size and continuity of having the same adult at all times in a family child care home can provide a particularly appropriate setting for a child who has special needs. However, providing personalized and appropriate care requires an understanding of the child's condition and may require the provider to adapt daily activities and/or her way of communicating with

ERIC Full Text Provided by ERIC

children. Special training and on-going consultation are thus very important supports for family child care providers working with children who have special needs.[50] Caring for a child who has special needs sometimes requires adaptations to the physical setting or the use of special equipment or chairs. In other cases, an extra pair of hands might be necessary. Five of the nine jurisdictions that licence providers individually currently recognize the associated costs of looking after a child who has special needs and provide "special needs funding."[51] Eighteen of the 24 agency directors reported that providers affiliated with their agency who are looking after a child with special needs would receive a higher fee.

Recommendation 11

Starting immediately, all jurisdictions must provide "special needs funding" to regulated family child care providers who look after a child with special needs. Such funding must take into account the particular needs of the individual child(ren) and the type of additional assistance or costs that might be required to provide appropriate care. In situations where a provider cannot accept her full complement of children because of the time and attention required by the child, the special needs funding must include compensation for her lost income.

Recommendation 12

All jurisdictions must take action to ensure the provision of training specific to the child's needs, plus consultation and appropriate resources for providers caring for a child who has special needs.

9.7f Provider Intentionality

Provider intentionality is the final category being used to frame our recommendations. Our findings indicate that a provider's genuine liking for children, her enjoyment of her work and her feeling of pride in what she is doing contribute substantially to the quality of children's daily experiences. However, income levels are low and many providers feel that their work is not valued by the general public. A 1996 Canada-wide survey of regulated providers reports that only 36% believed that their work was respected by society.[52] A low-paying occupation with no benefits and little status, such as family child care, is less likely to be chosen by people who like children and might be attracted to the opportunity of working independently if they have a relatively high level of education and other options. Increasing income levels, as already suggested, would assist in the recruitment of such people. However, we believe that there is also a need for substantially increased public understanding of the knowledge and skills required to provide high-quality child care and of its importance for children's development.

Recommendation 13

Governments, family child care associations and professional organizations must immediately undertake public education/awareness strategies that will assist people to understand the link between the importance of children's experience during their early years and the value of people who work in child care.

9.8 Closing Words

We believe that:

1. Child care is, and must be recognized and supported as, a positive investment in children, families and communities and as a means to address a variety of broad societal goals, including the promotion of early child development and the provision of support to families.

2. Family child care is, and must be recognized as, a vital component of the child care system and supported as such, with due regard for its uniqueness and contribution as an alternative to centre child care.

3. The extreme variation in both family child care quality and policies across Canada must be addressed. It is essential that *all* children have access to quality family child care, regardless of where they live or their family's economic status.

4. The sustainability of the family child care sector and the enhancement of its quality requires government leadership, the investment of public funds, and the development of appropriate policies and practices in collaboration with the family child care field.

5. There is no single "quick fix." Family child care quality results from a variety of factors working in combination, and all the major variables that predict quality must be addressed.

We have presented a number of recommendations which, in combination, would expand the availability of high-quality family child care and help to stabilize the family child care sector. We believe that Canada has the capacity to implement these recommendations and, in so doing, develop a broader, more coherent approach to promoting children's healthy development and supporting families. The challenge is whether we have the political will to do so.

Notes

1 Doherty 1997; Guy 1997; McCain and Mustard 1999.
2 McCain and Mustard 1999, p. 7.
3 Council of Ministers of Education, Canada 1998.
4 Cleveland and Krashinsky 1998; Kent 1999.
5 National Forum on Health 1997, p. 7.
6 National Crime Prevention Council 1996, pp. 26-27.
7 National Council of Welfare 1999, p. 70.
8 Calculations done by Paul Roberts, Canadian Council on Social Development, using the 1996 NLSCY data set.
9 Clifford, Harms and Cryer 1991.
10 Palys 1997.
11 Newfoundland/Labrador, Prince Edward Island, Québec and the Yukon. Saskatchewan requires an "orientation" session, and Saskatchewan and Nova Scotia expect providers to participate in professional development every year.
12 Taylor, Dunster and Pollard 1999.
13 Carew 1980; Fosburg 1981; Galinsky et al. 1994; Goelman and Pence 1988; Pence and Goelman 1991; Pepper and Stuart 1992.
14 Doherty et al. in press.
15 Canadian Council on Social Development 1998; Doherty, Friendly and Oloman 1998.
16 Battle and Torjman 2000, p. 6.
17 Beach, Bertrand and Cleveland 1998, Table 4.

ERIC Full Text Provided by ERIC

18 Calculations done by Paul Roberts, Canadian Council on Social Development, using the 1996 NLSCY data set.
19 Goelman and Pence 1988; Pence and Goelman 1991; Pepper and Stuart 1992.
20 Galinsky et al. 1994.
21 Gopnick, Meltzoff and Kuhl 1999; Gunnar 1998; McCain and Mustard 1999.
22 Childcare Resource and Research Unit 2000.
23 Manitoba, New Brunswick, Newfoundland/Labrador, the Northwest Territories and the Yukon.
24 Government of Ontario 1997.
25 Doherty et al. in press.
26 Saskatchewan, Northwest Territories, the Yukon (Childcare Resource and Research Unit 2000).
27 Doherty et al. in press.
28 Childcare Resource and Research Unit 2000.
29 Ibid.
30 Larner 1996; Modigliani 1994.
31 Nelson 1991.
32 Todd and Deery-Schmitt 1996.
33 National Family Day Care Training Project 1998.
34 Ibid., p. 8.
35 Doherty et al. 2000.
36 Kyle and Kellerman 1998.
37 Doherty et al. in press.
38 Goss Gilroy Inc. 1998, p. 31.
39 Doherty et al. 2000, Table 6.1, calculated on the basis of the lowest hourly rate for assistant teachers, $6.34, for an eight-hour day, five days a week.
40 The jurisdiction with the lowest minimum hourly rate for experienced adult workers in 1998 was Manitoba, where the rate was $5.40 an hour (Human Resources Development Canada, http://labour-travail.hrdc-drhc.gc.ca).
41 Kohen, Hertzman and Wiens 1998.
42 Doherty et al. in press.
43 Norpark 1989; Read and LaGrange 1990.
44 Norpark 1989.
45 Modigliani 1994.
46 Childcare Resource and Research Unit 2000.
47 Ibid.
48 Whitebook, Howes and Phillips 1990, p. 46.
49 The average *ITERS* score for the sample as a whole was 4.4, while the average for B.C. was 5.6 (Goelman et al. 2000, Table 4.4).
50 Canning and Lyon 1990; Harms and Clifford 1989.
51 Childcare Resource and Research Unit 2000.
52 Goss Gilroy Inc. 1998, p. 9.

ERIC Full Text Provided by ERIC

Appendix A

Research on Family Child Care Quality and its Influence on Child Development

An Overview

The earliest studies on child care tended to be dominated by the very broad question, "Is child care good or bad for children?" Later research compared care provided in different settings, contrasting centre-based with home-based care. This second "wave" of studies has been followed by a third wave that has tried to identify those factors that contribute most to quality and to positive effects for children *within* each type of care.

This third body of research is yielding a relatively consistent picture. Care that is responsive and sensitive to children's needs and abilities, and is provided in an environment that offers children a variety of learning activities and encourages language development, is associated with secure attachments between infants and toddlers and their caregivers; it is also associated with higher scores on measures of children's understanding and use of language, complex play behaviour (indicative of cognitive skills) and sociability. Moreover, there is some evidence that these positive effects may be sustained over time, contributing to children's school readiness, with possible impacts on school achievement and self-esteem in later childhood. The most sophisticated research now recognizes the importance of understanding how characteristics of the child, the child's family and the child care setting work together to affect child outcomes, and is beginning to explore this complex interaction.

ERIC

Specific Findings

A brief synopsis follows of some of the major studies conducted in the last 15 years to identify the important contributors to quality in family child care. Studies were selected that used rigorous observational methods and direct assessments of the children. Only a few studies in family child care research include a longitudinal follow-up at this time. Such studies are expensive undertakings and require significant cooperation from parents and providers. Nonetheless, their importance is self-evident.

The studies reviewed here focus on two main dimensions of quality in family child care: the care provider's behaviour with the children, and the characteristics of the physical setting and the activities and program provided. Our review starts with a discussion of studies that have combined both dimensions and have assessed quality using a global measure such as the *Family Day Care Rating Scale (FDCRS)*.[1] It then looks at the research that has focused specifically on the care provider's behaviour.

Studies Using a Global Measure of Quality

1. Canadian Research

The *Victoria Day Care Research Project*[2] was conducted in 49 homes in British Columbia. It involved both regulated and unregulated family child care providers and a specific three- or four-year-old child for whom they were providing care. Program quality was assessed in two ways. One method involved using the *Day Care Home Environment Rating Scale* (*DCHERS*),[3] an earlier version of the *FDCRS*.[4] The second method involved trained coders using a standard observation scale[5] to record the amount and type of interaction between the care provider and children and the activities engaged in by the children. Standard tests were also used to assess the level of the children's understanding of language[6] and their ability to express themselves.[7]

Children in homes with higher total scores on the *DCHERS* obtained higher scores on both measures of language development. There was also an association between children's level of language understanding and the home's score on the *DCHERS* sub-scale measuring the general tone of interaction in the home. Children's expressive language was associated with scores on the sub-scale that measures the availability of materials and activities likely to stimulate language development. The researchers also examined differences when the homes were split into two groups — high and low quality — on the basis of their total *DCHERS* score. The average test score for children in the "high quality" group was 23 points higher for the test of language understanding and 15 points higher on the test of expressive language. Other findings from the second observational measure indicated that children in homes in the "high quality" group spent a larger proportion of their time in interactive play involving reading, sharing information between adult and child, and in activities involving fine and gross motor materials. Children in low quality homes spent smaller proportions of time in interactive play and greater amounts of time watching television.

Two follow-up studies of the children from the original *Victoria Day Care Research Project* have been conducted when they were, on average, 13 years old and again when they were 17 or 18.[8] An association was found between the scores on each of the language tests when the children were in child care and the

children's scores as 13-year-olds on tests measuring arithmetic skills,[9] reading comprehension,[10] understanding of language[11] and general intellectual ability.[12] In other words, children who had higher levels of language skills when observed as preschoolers obtained higher scores on tests of academic achievement and general intellectual ability at age 13. In the most recent follow-up, the measures of academic skills obtained when the children were 13/14 years old were associated with similar competencies at age 17/18, as well as with measures of school engagement and sociability. In addition, scores obtained on expressive and receptive language abilities in early childhood that were associated with higher quality family child care were positively correlated with measures of self-esteem and sociability with peers, as well as with a measure of cognitive competence. Thus, early childhood experiences in family child care homes assessed to be of higher quality appeared to have both direct and indirect effects on children's academic performance, self-esteem and social skills through late adolescence.[13]

The *Vancouver Day Care Research Project*[14] was an expansion of the Victoria study. It involved 3- and 4-year-olds in 28 homes in Vancouver and used the same two measures of children's language skills as in the Victoria study. It also used the *DCHERS* as one of two ways to assess the overall quality of the home. The other quality measure was the *HOME (Home Observation for Measurement of the Environment)* scale,[15] used to assess the quality of stimulation available in children's own homes. It includes variables such as: the apparent warmth and affection felt by the adult for the child; the extent to which social skill development is encouraged through modelling and other strategies; the availability of cognitive and language stimulation through toys, games and reading materials; and the types of activity done by the adult with the child. The final and fifth measure involved a 20-minute observation of each caregiver/child pair in a semi-structured play situation involving puppets and snapping plastic toys that fit together in a variety of ways.

The level of children's ability to express themselves was associated with both the total score on the *DCHERS* and the total score on the *HOME* scale. It was also associated with the *DCHERS* sub-scales related to furnishings and equipment, language development, learning activities and the social tone of the home, and to the *HOME* sub-scale score related to the availability of stimulation through toys, games and reading materials. Both types of language skill — expressive and receptive — were related to the general amount of two-way conversation observed during the structured play situation and the extent to which the care provider asked the child what something was, or labelled and described something. No follow-up has been conducted on the Vancouver children.

2. American Research

The *FDCRS*[16] is a revision of the *DCHERS* that was used in the Victoria and Vancouver studies. It has been used in many of the American studies, and is now often supplemented with one or more additional measures, particularly those more specific to capturing the quality of relationship in provider-child interactions. The most common measure of this type is the *Caregiver Interaction Scale* (*CIS*).[17] This observational measure (also used in the present, *YBIC!*, study) yields ratings of caregiver sensitivity, harshness and detachment.

The largest American study of quality in family child care, *Quality in Family Child Care and Relative Care,* was conducted in three states, involved 112 regulated family child care providers, 54 unregulated family child care providers, and 60 people providing care for a related child in their own, rather than the

ERIC

child's, home.[18] That study, like the one which is the subject of this report, used both the *FDCRS* and the *CIS*, as well as a measure of caregiver involvement in interactions with the children. The researchers found that children in the homes with higher total scores on the *FDCRS* were more likely to show behaviours indicative of a feeling of trust and security towards the care provider than were children in homes that received lower ratings of global quality. There was also an association between the level of the caregiver's responsiveness to the children — that is, the extent to which she reacts promptly and appropriately to children — and the complexity of the children's play. Complexity of play is considered to be a measure of cognitive development in children.

A second study ranked the relative quality of 55 family child care homes on the basis of a composite measure consisting of the number of children being cared for, the number of children per care provider and the home's *FDCRS* score.[19] Children in the higher quality homes obtained higher scores on a standard test of the complexity of their social play with peers, and higher scores on measures of their level of play with objects and with the care provider. The instrument used to measure the complexity of play with peers predicts peer social skills and acceptance by peers when the child is a preschooler.[20] An association has been found between a child's level of cognitive and socio-emotional development at 3 and 4 years of age, and the child's skill level in play with objects when a toddler.[21]

A third study[22] used the *FDCRS* in 57 homes to create two sub-scales. The first, "appropriate caregiving," reflected adult-child interactions involving language, adult supervision of children's activities and behaviour guidance. The other, "developmentally appropriate activity," was a measure of the educational environment; for example, the availability of learning materials and the provision of planned appropriate activities. An association was found between the children's level of cognitive competence and the level of appropriate caregiving, but not between cognitive skills and the level of developmentally appropriate activity.

Yet another study[23] involved 30 homes, 26 of which were regulated. It used both the *FDCRS* and an observation of the quality of the interactions between children and care provider. Children in homes with higher *FDCRS* total scores obtained higher scores on a standard test of language understanding.[24] When care providers were rated as providing higher levels of warmth, more frequent proximity to the children, more verbal interaction and greater frequency of behaviour that went beyond essential routines, children were rated as more sociable with other children and as having better language skills.

Two very recent studies focused particularly on infants and toddlers. One of these,[25] involving 41 toddlers age 12-19 months and the 23 registered providers who were caring for them, focused specifically on infants' attachment security with their providers. The researchers considered both the observed level of infant-provider interactive involvement and *FDCRS* scores, as well as family socioeconomic status (SES) and the length of time the child had been in the provider's care. Results indicated that the strongest independent predictors of infant attachment security were the level of infant-caregiver involvement, family SES, and *FDCRS* quality scores. Moreover, infant-caregiver attachment and the amount of caregiver-child involvement were associated with the length of time the child had been in the provider's care.

Finally, we present findings from the ongoing longitudinal study of early childhood care being conducted by the U.S. National Institute of Child Health and Human Development (NICHD) Early Child Care

ERIC Full Text Provided by ERIC

Research Network. This research indicates that infants who attended better quality family child care homes, as rated on a measure called the CC-HOME Inventory (a measure derived from the original *HOME* scale that captures many of the variables included in the *FDCRS*), obtained higher scores on the Bayley tests of infant development at 24 months. At 36 months, these infants obtained higher scores on measures of school readiness and language comprehension than toddlers who were in poorer quality child care homes.[26]

Studies that Focused on the Provider's Behaviour

Some of the studies discussed above that examined the influence of the home's overall quality also reported findings related specifically to care provider behaviour. Two studies reported that the level of children's language skills is associated with the amount of verbal stimulation by the care provider.[27] A third found an association between the level of the care provider's responsiveness and the level of complexity in the children's play, a measure of cognitive skill.[28] The studies summarized below did not use overall quality ratings, but included measures of the kinds of behaviour that are highly correlated with high scores on global rating scales.

1. American Research

The first study to examine the relationship between care provider behaviour and children's development was conducted during the mid-1970s.[29] It followed 140 children who entered family child care, and 107 who entered centre care between the ages of 2 months and 21 months. The amount of social, language and cognitive stimulation provided by the adult when the child was a 2-year-old correlated with both the level of the child's social competence and their language skills at age 3.

The NICHD longitudinal study mentioned above followed 201 children in family child care and 103 in centre care from the age of 6 months to 36 months.[30] It assessed setting quality through an observational scale specially designed for the study. Focusing on one child, the scale records both the amount of a certain care provider behaviour as well as the tone (for example, sensitivity or harshness) and content of the activity. The observations are used to create a "positive caregiving" score for each care provider. This is based on the frequency of behaviours indicating one of the following: (1) positive affect or contact; (2) sensitive or responsive behaviour towards the child; and (3) activities that stimulate the child's social, language or cognitive development. Children who had a care provider with a high "positive caregiving" rating during their first two years were more cooperative and sociable with peers at age 24 months. They were reported as having fewer behaviour problems by their care providers at both age 24 and age 36 months.[31] Children with more responsive, sensitive care providers, who talked more with them, did better on assessments of cognitive and language development at age 15, 24 and 36 months. At age 36 months, they scored better on a standard measure of school readiness than children whose caregivers had low "positive caregiving" ratings.[32]

A third study involved 130 children age 2 and 3 in one of four forms of care: at home with mother, at home with a "nanny," enrolled in a family child care home, or enrolled in a centre.[33] Information about the interactions between the care providers and children was collected through betweeen four and eight hours of observation. Standard tests were given to the children to assess their level of social and verbal skills and

ERIC Full Text Provided by ERIC

cognitive ability. The researchers report that, "... children from day-care homes did better in our assessments of intellectual and social competence when the caregiver had more one-to-one conversations with them, and when she touched, read to and gave more directions to them. ... Children in both in-home and family day care homes were more competent when the quality of their interactions with the caregiver was more responsive."[34] When children spent more time playing alone with toys and objects than in interacting with the caregiver, they did less well on both the assessment of social skills and intellectual competence.

2. Research from Other Countries

Two studies, one from Sweden and one conducted in Israel, yield findings similar to those reviewed above. The Swedish study examined the development of social competence among children who started family child care or centre care at the age of, on average, 16 months.[35] In this particular study, children's social skills were not related to the quality of centre or family care one year after enrollment in alternate care.[36] However, two years after enrollment, the care provider's score on the Belsky and Walker checklist (a measure that includes various aspects of responsive and stimulating care) predicted both the children's level of social skills and their rate of social participation with peers.[37]

The study conducted in Israel by Miriam K. Rosenthal[38] used an adaptation of the *FDCRS* and another scale to develop a composite measure of quality derived from scores for the physical environment, the amount and variety of play materials, the number of children, the daily schedule, and the proportion of educational and physical care activities. In addition, a daily log continuously recorded the activities of the care provider and the children. An association was found between the extent of the adult's positive interaction with the child (a composite of responsiveness, frequency of one-to-one involvement, encouragement, and positive use of language) and the child's positive interaction with the other children. Children in higher-quality environments, based on the composite score used in the Rosenthal study, spent more time in activities associated with skill development and less time in gross motor activities and aimless wandering than did children in low-quality homes.

Summary of the Research Findings

Children who have care providers who are warm and respond promptly and appropriately to them have higher levels of social[39] and/or cognitive[40] skills. Similarly, the amount of social, language and/or cognitive stimulation provided by family child care providers is related to children's social skills,[41] verbal skills[42] and measures of complex play behaviour, factors associated with later cognitive development.

When measures of children's development and ratings of overall quality are made concurrently, there is most often a positive association between the observed quality of the family child care home as measured by the *DCHERS*, *FDCRS* or *HOME* scales, and security of infant-provider attachment relations,[43] the level of children's social skills,[44] language skills[45] and cognitive competence.[46] There is evidence that these positive outcomes provide a foundation for continued adaptive functioning and school readiness in early childhood. In the longer term, some evidence now suggests that the overall quality of the family child care home may be associated both directly and indirectly with children's peer social skills, language and cognitive skills, school readiness, and scores on tests of arithmetic skills and reading comprehension at

age 13.[47] Longer-term outcomes extending into late adolescence (academic and social skills, self-esteem) may also be related to the quality of early child care experiences that prepare children for success in school and in social relationships throughout their school years.

Such associations cannot be assumed to indicate causation. However, repeated findings of the same or a similar association across a number of studies add strength to the hypothesis that high-quality, responsive, stimulating family child care can positively influence children's development.

Notes

1 Harms and Clifford 1989.
2 Goelman and Pence 1987, 1988.
3 Harms, Clifford and Padan-Belkin 1983.
4 Harms and Clifford 1989.
5 Goelman 1983.
6 Dunn 1979.
7 Gardner 1979.
8 Kohen et al. 2000.
9 Wormeli and Carter 1990.
10 Ibid.
11 Dunn 1979.
12 Thorndike et al. 1986.
13 Kohen et al. 2000.
14 Goelman and Pence 1991, 1994.
15 Caldwell and Bradley 1979.
16 Harms and Clifford 1989.
17 Arnett 1989.
18 Galinsky et al. 1994; Kontos et al. 1995.
19 Howes and Stewart 1987.
20 Howes 1985.
21 Rubenstein and Howes 1983.
22 Kontos, Hsu and Dunn 1994.
23 Kontos 1994.
24 Dunn and Dunn 1981.
25 Eliker, Fortner-Wood and Noppe 1999.
26 Clarke-Stewart et al. 2000.
27 Goelman and Pence 1991, 1994; Kontos 1994.
28 Galinsky et al. 1994.
29 Golden et al. 1979.
30 NICHD Early Child Care Research Network 1996.
31 Vandell 1999.
32 Clarke-Stewart 1999.
33 Clarke-Stewart 1987.
34 Ibid., p. 34
35 Lamb et al. 1988a, 1988b.
36 Lamb et al. 1988a.
37 Lamb et al. 1988b.
38 Rosenthal 1994.
39 Lamb et al. 1988b.

ERIC

40 Clarke-Stewart and Gruber 1984; Galinsky et al. 1994.
41 Golden et al. 1979.
42 Goelman and Pence 1991, 1994; Kontos 1994.
43 Eliker, Fortner-Wood and Noppe 1999.
44 Howes and Stewart 1987.
45 Kontos 1994.
46 Kontos, Hsu and Dunn 1994.
47 Kohen et al. 2000.

ERIC Full Text Provided by ERIC

Appendix B

Overview of Family Child Care Requirements by Jurisdiction, 1999

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
British Columbia	Permitted numbers	No more than two children unrelated by blood or marriage, excluding the provider's own.	Up to seven children under age 12, including the provider's own. No more than five preschoolers, three under age 3 or one under age 1.
	Educational requirements		Must have a first-aid certificate; no ECCE training requirements.
	Formal provision for support	Network of child care resource and referral programs that have a mandate to provide support to both the unregulated and regulated sectors.	Annual licensing visit (policy, not statutory requirement) by a licensing official who is not required to have an ECCE background. Child care resource and referral programs.

ERIC

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Alberta	Permitted numbers	No more than six children under age 12, including the provider's own. Maximum of three under age 2.	No more than six children under age 12, including the provider's own. Maximum of three under age 3 and two under age 2.
	Educational requirements		None.
	Formal provision for support		Providers connected with an agency that is expected to visit once a month (not a statutory requirement and may change with the transfer to regional children's authorities in 1999). Home visitor not required to have an ECCE background. Agency expected, but not required, to provide support services.
Saskatchewan	Permitted numbers	No more than eight under age 13, including the provider's own.	No more than eight under age 13, including the provider's own. No more than five under age 6; of these, only two can be under age 30 months.
	Educational requirements		Must have first-aid certificate and attend an orientation session with a government program consultant. Expected to attend two professional development workshops each licensing year (policy, not regulation).
	Formal provision for support		Minimum of three visits a year by a government program consultant (policy, not statutory) who is not required to have an ECCE background.

ERIC

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Manitoba	Permitted numbers	No more than four under age 12, including the provider's own. Maximum of two children under age 2.	No more than eight under age 12, including the provider's own. Maximum of five children under age 6, and three under age 2. **With two providers**: no more than twelve children under age 12, including the providers' own; no more than three may be under age 2.
	Educational requirements		Must have a first-aid certificate that includes CPR training relevant to the group being cared for. No ECCE training requirements.
	Formal provision for support		Minimum of one licensing and three drop-in visits per year (policy, not statutory) by a government licensing official who must have an ECCE III certificate and child care experience.
Ontario	Permitted numbers	No more than five children under age 12, excluding the provider's own.	No more than five children under age 12, including the provider's own under age 6. Not more than two may be under age 2, not more than three under age 3.
	Educational requirements		First-aid certificate, but only if working with handicapped children. No ECCE training requirements
	Formal provision for support	200 child care resource programs (also known as family resource programs) funded by the Child Care Branch, with a mandate to provide support to both the unregulated and regulated sectors.	Providers connected with an agency that is required by legislation to make quarterly home visits. Home visitors must have an ECCE-related post-secondary credential and at least two years' experience working with children. Regulatory requirement that agencies have a training plan for each provider, but no requirement for type, frequency or length of training. Agencies expected to provide some support services. Network of child care resource programs.

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Québec	Permitted numbers	No more than six under age 9, including the provider's own.	No more than six under age 9, including the provider's own. No more than two under age 18 months. **With two providers**: No more than nine, including the providers' own. No more than four under age 18 months.
	Educational requirements		First-aid certificate within six months of starting to provide care, and completion of a 45-hour ECCE training program within the first two years (as of September 1999). A minimum of six hours professional development each year.
	Formal provision for support		Providers connected with an agency that must do quarterly home visits. Home visitors are not required to have an ECCE qualification but must have three years experience in direct services for children. Agency expected but not required to provide some training and support services.
New Brunswick	Permitted numbers	No more than five, including the provider's own under age 12. Maximum of two infants, maximum of four if children are age 2-5.	No more than six children age 0-12, including the provider's own. No more than three under age 2, or five between age 2 and 5. May have nine children, including provider's own, if all are over age 6.
	Educational requirements		Must have first-aid training; no ECCE training requirements.
	Formal provision for support		Statutory requirement for an annual licensing visit and spot checks by provincial licensing officals who are required to have a B.A. in child studies, an ECCE diploma or related qualification.

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Nova Scotia	Permitted numbers	No more than six under school age, including the provider's own. May have eight if all, including the provider's own, are of school age.	No more than six under school age, including the provider's own. May have eight if all, including the provider's own, are of school age.
	Educational requirements		None before starting to provide care. Required to attend four hours of ECCE workshops each year.
	Formal provision for support	Child Care Connections NS in Halifax provides training and support to unregulated and regulated providers in its area.	Providers connected with an agency that must do two home visits each month (policy, not statutory). Home visitors must have a two-year ECCE diploma, or an ECCE certificate and experience (regulation). Agency required to provide 10 hours of workshops a year.
Prince Edward Island	Permitted numbers	No more than five in a mixed-age group up to age 10, with maximum of two under age 2. If all children are under age 2, maximum of three; maximum of five preschoolers with no more than two under age 2. All numbers include provider's own preschool children.	No more than seven children, including the provider's own under age 12. Maximum of three children under age 2.
	Educational requirements		Current first-aid certificate and 30-hour ECCE training program within the first year of providing care.
	Formal provision for support		Annual licensing inspection by a government official (policy, not statutory) who is not required to have an ECCE background.

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Newfoundland/ Labrador	Permitted numbers	No more than four, including the provider's own under age 7.	Effective June 1, 1999. No more than six in a mixed-age group, including the provider's own under age 6. Maximum of three under age 3 or two under age 2. If all children are under age 2, maximum of three.
	Educational requirements		First-aid certificate. Must complete an orientation course in early childhood education within the first year of providing care.
	Formal provision for support		Providers can be either linked with an agency or independently licensed. An agency is required to do an annual monitoring visit and additional monthly visits for consultation. Home visitors must have an ECCE background. Annual licensing visits by government consultants to independently licensed providers and several unscheduled visits each year. Licensing officials are not required to have an ECCE background.
Yukon	Permitted numbers	No more than three, excluding the provider's own.	No more than eight, including the provider's own under age 6. Maximum of four infants, or no more than six pre-school children, with a maximum of three infants. **With two providers**: may add four school-age children.
	Educational requirements		First-aid certificate. Completion of a 60-hour ECCE course, family child care course or equivalent within the first year of providing care (policy, not regulation)
	Formal provision for support		Policy of one annual inspection and four or five unannounced spot checks per year by a government Child Care Coordinator who is required to have a background in early childhood education.

ERIC Full Text Provided by ERIC

Jurisdiction	Variable	Requirements for *unregulated* care	Requirements for *regulated* care
Northwest Territories	Permitted numbers	No more than four, including the provider's own under age 12.	No more than eight under age 12, including the provider's own. Maximum of six age 5 or under, maximum of three under age 3, and maximum of two under age 2.
	Educational requirements		First-aid certificate. No ECCE training requirements.
	Formal provision for support		Annual visits by a government licensing official who is required to have a two-year ECCE diploma and four years child care experience.

Sources: Childcare Resource and Research Unit 2000; Government of Newfoundland, *An Act Respecting Child Care Services in the Province*, 1998, and *Regulation 37/99*; written information supplemented by Jocelyne Tougas, personal communication regarding Québec; and telephone interviews with government officials in all other jurisdictions conducted by Gillian Doherty in May 1999.

ERIC

Appendix C

Research on Contributors to Family Child Care Quality

An Overview

The following four key elements appear across a variety of studies as consistent contributors to the quality of children's experiences in family child care and, in the case of support and intentionality, also correlate with providers' job satisfaction and likelihood of turnover:

- the number of children in the provider's care (ratio);
- her formal education and family child care-specific training;
- the nature and extent of support available to her; and
- her motivation to provide child care, her feelings about the occupation, and her commitment to providing responsive, high-quality care (intentionality).

The Number of Children in Care (Ratio)

The most common arrangement in family child care is a single provider working with a group of children; as a result, ratio and group size are usually the same. However some jurisdictions (Manitoba, Québec and the Yukon) permit two providers and specify the maximum number of children allowed in that case. This is occasionally referred to as group family child care.

ERIC

Ten studies have examined the correlation between ratio and provider behaviour, and several have studied the relationship between the number of children enrolled and scores on the *Family Day Care Rating Scale (FDCRS)*.[1] Earlier studies, in particular, reported a higher proportion of desirable adult behaviours when the child-to-adult ratio is lower. In those studies, providers who have fewer children to care for show higher rates of warmth and affection towards the children,[2] are more responsive[3] and more sensitive.[4] They engage in a higher proportion of interactions with the children that involve language or cognitive stimulation[5] and are less restrictive.[6] Not surprisingly, the frequency of the care provider's interactions with individual children decreases with a rise in the number of children.[7]

The earlier studies also indicated that toddlers in settings with three or fewer children engaged in more talking and more interactive play than peers in homes with more children,[8] and that 2- and 3-year-olds did better on tests of social competence when five or fewer children were enrolled in their family child care home. Another study, however, reported results in the opposite direction; it found that children in settings with higher ratios obtained higher scores on measures of intellectual development.[9]

A few recent studies suggest that, in some family child care homes, having more rather than fewer children is associated with higher-quality scores on the *Day Care Home Environment Rating Scale (DCHERS)*[10] and *FDCRS*,[11] or that the number and age mix of children (within allowed limits) is less important than the provider's education and family child care-specific training.[12] In addition, the range in ratios (the variability within the sample of homes in the study) in more recent studies is fairly small. It appears that, as regulations on maximum group size and age mix have become more strict, group size per se is less of a direct factor affecting caregiver behaviour and measured quality. Moreover, a few studies now indicate that providers with higher levels of intentionality and who are more committed to careers in family child care deliberately maintain a full enrollment pattern, both to have an interesting mix of children to work with, and to ensure a stable income.

Education Level and Specialized Training

Research on child care centre staff, particularly the 1990 U.S. Child Care Staffing Study,[13] identified the complementary effects of general education and ECCE-specific education and training for quality child care. The same appears to be the case in family child care. Both the highest level of formal education completed (in any subject) and education and training related to ECCE and/or family child care appear to be important contributors to providers' understanding of children's needs, and to their capacities to plan a variety of activities, make decisions and solve problems as they arise.

1. Overall Educational Level

Several studies have reported an association between quality and the provider's general level of education. In Canada, higher levels of general education have been associated with higher levels of child language skills[14] and higher total scores on the *DCHERS*.[15] American researchers report associations between the provider's level of general education and the extent to which she is sensitive and responsive[16] or provides children with social and language stimulation.[17] The level of children's scores on tests of social and intellectual competence[18] and the home's *FDCRS* score[19] have also been associated with the provider's level of general education.

2. Specialized Training Related to Child Care Provision

Correlational studies consistently show that past training is related to more desirable provider behaviour. Two large U.S. national studies found that previous training is associated with higher rates of helping children, dramatic play and language stimulation,[20] and more frequent positive provider behaviours such as positive physical contact and responsiveness.[21] Smaller American studies have also reported that previous training is associated with higher rates of responsiveness and sensitivity,[22] and more time spent directly relating to and playing with the children.[23] One study went beyond correlations to use a statistical procedure that permits determination of the extent to which care providers' characteristics predict outcome. The researchers found that previous specialized training predicted the likelihood of adult/child interactions involving language, as well as the level of the children's social play with peers and cognitive functioning.[24] Another study found that training in child care (a composite measure that combined formal ECCE education and family child care-specific training) accounted for over half of the variance in *FDCRS* scores.[25]

The extent to which providers participate in ongoing professional development is also a factor that contributes to quality care, and reflects providers' commitment to and interest in their career. Susan Kontos' review of the literature[26] concluded that provider satisfaction is a consistent outcome of provider training, and Kathy Modigliani has suggested that participation in training, including ongoing professional development workshops, serves the additional purpose of helping providers network, thereby enhancing their opportunities for mutual support and reinforcing their interest in further training.[27]

The literature on the effects of specific training courses for people already providing family child care is inconsistent and less positive.[28] Only a few studies have been conducted on the impact of training on providers already in the field. The inconsistency of the results reflects, in part, the fact that the training given varies considerably in content, depth and duration, and providers also have differing needs according to their background and experience. Some evidence suggests that individual training (mentoring or coaching) is particularly useful for providers who are not affiliated with any professional child care organization.[29]

A recent Canada-wide survey of providers found that sometimes training fails to meet their perceived needs.[30] The Canadian National Family Day Care Training Project is actively working with the family child care community and other key players in an effort to develop a variety of approaches to training that will meet the needs of providers with different levels of experience and be available through a variety of formats.[31]

Provider turnover is a particular concern in family child care since the child then has to adjust to a new adult, a new physical setting and, quite often, a new peer group. Two studies report a lower turnover rate among providers who have specialized training.[32] In both cases, the researchers suggest that training may modify stress levels by enabling providers to cope more effectively with the daily challenges of providing care and education for a group of unrelated children.

The Availability of Support

Most providers report receiving support from a network of adults, including their immediate family, neighbours, friends and relatives.[33] The value of this support is illustrated in two Canadian studies. The first found that the level of family child care quality, as measured by the *DCHERS*, was highest in homes where family members provided a high degree of support for each other.[34] In the second study, there was a

ERIC

high correlation between the provider's level of job satisfaction and her perception of the amount of support she received from her family.[35] In this study, support from licensing officials and the provincial family child care organization was also correlated with feelings of job satisfaction. However, the relationship was not as strong. An American study found that providers who reported higher levels of support from family, friends, neighbours and community organizations also reported lower levels of perceived stress and higher levels of job satisfaction.[36] A second study from the United States reports a correlation between job satisfaction and perceived support from the client parents.[37]

More formal sources of support include government licensing officials, family child care agencies and child care organizations. The remainder of this section reviews studies that have examined these types of support.

1. Support from Licensing Officials

A Manitoba study reports an association between the perceived level of support from the government licensing official and the level of the provider's job satisfaction.[38] In British Columbia, nearly a third of providers whose homes were rated as high quality (30.4%), in comparison to 17.4% of providers from "low quality" homes, cited the government licensing official as one of their sources of support.[39]

2. Agency Sponsorship

In jurisdictions that use a family child care agency model, the provincial government contracts with or licenses agencies that are responsible for recruiting, screening, training, supervising and supporting providers who themselves are not individually licensed. In Canada, agencies are required to monitor providers through periodic home visits and may also provide training or other assistance, such as equipment loans. Five Canadian provinces[40] and several U.S. states use the agency model to regulate and support family child care.

In Ontario, when agency-sponsored providers were compared with unregulated providers, the agency providers obtained higher Total scores on the *DCHERS*.[41] They also obtained higher scores on the *DCHERS* sub-scales related to active involvement with the children, use of routines as learning opportunities, helping children understand language, and the provision of varied and balanced activities.

Studies from other jurisdictions report inconsistent results when comparing providers on the basis of agency affiliation. A large U.S. national study found that sponsored providers had higher rates of interaction with children than either independently licensed or unregulated providers.[42] They also spent more time in activities that would encourage motor or language development, such as direct teaching, playing with the children and engaging them in conversation. No information is given about the level or types of support provided by the agencies. A single-state study reported no differences on the *FDCRS* between sponsored and non-sponsored providers.[43] Again, there is no information about the agency role in that state.

Data obtained from agency directors in the present study revealed that agencies can vary greatly, both across jurisdictions, and even within a province, in the nature of supports and resources that are made available to providers.[44] These differences appear to be related, in part, to the level and kind of financial support available to agencies from the provincial government to supervise, train and support providers, as well as to differences in philosophy about the role of the agency *vis-à-vis* its providers. In some provinces, such as Ontario, agencies and child care resource programs may make available complementary forms of support to local providers.

3. Support from Child Care Organizations

Providers who are actively involved with a family child care organization or network have been rated as more sensitive and responsive than those without such affiliation.[45] A study of providers in Manitoba found an association between the perceived level of support obtained from a family child care organization and providers' job satisfaction.[46] The *Vancouver Day Care Study* also noted that providers offering higher-quality care had both deeper and more diverse support systems, and were far more likely to be affiliated with a family day care association. In contrast, an American study reported no difference in job satisfaction between providers who were or were not affiliated with a provider network.[47] In this study, 47% of the unaffiliated group, in comparison to 20% of the "networked" providers, were still in their first year of providing care. As noted by the researcher, providers who had been looking after children for less than a year "may not have had sufficient time to experience isolation and burnout."[48] Three studies report that members of child care organizations obtain higher scores on a global measure of quality, either the *DCHERS* or the *FDCRS*.[49] Membership in family child care associations and professional organizations may indicate a greater sense of professional identity as a family child care provider.

Intentionality

The term "intentionality" encompasses elements such as making a conscious choice to provide child care rather than engage in some other form of work, and a commitment to family child care as a long-term career. Kontos and her colleagues have suggested that intentionality consists of a broad pattern of actions and motivations that are associated both with sensitive and responsive care for children and with process quality.[50] These include seeking out opportunities to learn about child care and children's development, being planful and creative in organizing activities for the children, and seeking out the company of other providers.

One aspect of data analysis in the *Vancouver Day Care Research Project* involved comparing providers with the highest and lowest scores on the *DCHERS*. Information collected through a structured interview with each provider revealed that nearly half, 47.8%, of the providers in the low-quality group would have preferred to be engaged in another type of employment in contrast to 21.7% of those in the high-quality group. The group of providers who stated that they viewed family child care provision as their chosen profession obtained *DCHERS* scores substantially higher than those of the other providers.[51]

The multi-state U.S. study of family child care and relative care also found that providers whose stated reason for giving care was a desire to work with children were rated as more sensitive and responsive than others in the sample. Those who expressed a commitment to family child care as a career were also rated as more sensitive than others and obtained higher scores on the *FDCRS*. Sixty-five percent of the providers who identified family child care as their chosen occupation obtained *FDCRS* scores indicative of good quality, while most of the others were giving what the researchers identified as "adequate/custodial care." In contrast, 81% of the providers who identified family child care as temporary employment obtained a *FDCRS* scores indicative of inadequate care.[52]

Summary

The following four key elements have appeared in the research literature as consistent contributors to the quality of children's experiences in family child care: (1) ratio; (2) the provider's level of formal education and family child care-specific training; (3) the nature and extent of the supports available to the provider; and (4) her motivation to provide child care, her feelings about the occupation and her commitment to providing high-quality care. Other variables, such as length of experience as a provider and demographic characteristics, have not been found to be related to measures of process quality.

ERIC Full Text Provided by ERIC

Notes

1 Harms and Clifford 1989.
2 NICHD Early Childhood Research Network 1996; Stith and Davis 1984.
3 Howes 1983; NICHD Early Child Care Research Network 1996; Stith and Davis 1984.
4 Howes and Norris 1997; NICHD Early Childcare Research Network 1996.
5 Howes 1983; NICHD Early Childcare Research Network 1996.
6 Howes 1983.
7 Fosburg 1981; Kontos 1994.
8 Howes and Rubenstein 1985.
9 Kontos, Hsu and Dunn 1994.
10 Harms, Clifford and Padan-Belkin 1983.
11 Goelman and Pence 1987; Kontos et al. 1995.
12 Burchinal et al. in press.
13 Whitebook, Howes and Phillips 1990.
14 Goelman and Pence 1987.
15 Stuart and Pepper 1988.
16 Galinsky et al. 1994.
17 Fosburg 1981.
18 Clarke-Stewart 1987.
19 Galinsky et al. 1994.
20 Fosburg 1981.
21 NICHD Early Child Care Research Network 1996.
22 Galinsky et al. 1994; Howes 1983; Howes and Norris 1997.
23 Howes 1983.
24 Kontos, Hsu and Dunn 1994.
25 Fischer and Eheart 1991.
26 Kontos 1992.
27 Modigliani 1994.
28 Kontos, Howes and Galinksy 1996.
29 DeBord and Sawyers 1995.
30 Taylor, Dunster and Pollard 1999.
31 Lee Dunster, Project Manager, Family Day Care Training Project, personal communication.
32 Nelson 1990; Todd and Deery-Schmitt 1996.
33 Kontos 1992.
34 Goelman, Shapiro and Pence 1990.
35 McConnell 1994.
36 Kontos and Riessen 1993.
37 Bollin 1993.
38 McConnell 1994.
39 Pence and Goelman 1991.
40 Alberta, Nova Scotia, Ontario and Québec rely solely on the agency model; Newfoundland permits providers to choose to be individually licensed or to be affiliated with a licensed agency.
41 Pepper and Stuart 1992.
42 Fosburg 1981.
43 Fiene and Melnick 1989.
44 Doherty et al. in press.
45 Galinsky et al. 1994.
46 McConnell 1994.
47 Jones 1991.
48 Jones 1991, p. 41.
49 DeBord and Sawyers 1995; Fischer and Eheart 1991; Pence and Goelman 1991.
50 Kontos et al. 1995
51 Pence and Goelman 1991.
52 Galinsky et al. 1994.

ERIC

Appendix D

Home Child Care Program Questionnaire

General instructions

We are interested in learning more about how your home child care program operates and the challenges you face. Therefore, we are asking information about the children enrolled, your caregivers, and program practices. This information, collected from Alberta, Ontario and Québec, will help us to better understand the agency home child care model.

The survey is to be completed only by the home child care program director/owner or a person delegated by the director/owner. Please provide an answer to **each** question unless specifically instructed to skip a question. If we have not provided enough space for your answer to any question, please add your additional comments in the page margin or the space provided at the end of the questionnaire.

All the information that you provide will be treated confidentially. We will code the information you provide so that it cannot be traced back to you or to your agency. Absolutely no identifying information regarding individual responses will ever be released or published. Information will only be reported as group data.

The survey will take about an hour to complete. Please return the questionnaire in the self-addressed stamped envelope that was sent with it.

If you have any questions about this survey or the study please contact the Site Coordinator for your province:

Name: ______________________ Toll-free number: ______________________________

ERIC

Section A: Your Organization

A1. Which of the following best describes your home child care program? Please put a check mark (✔) beside only **one** response.

- ☐ A stand-alone organization (that is, we only provide home child care)
- ☐ Part of an organization that offers other child care services (e.g. group care)
- ☐ Part of a multi-service organization that offers a variety of community and family services
- ☐ Other, please specify ____________________

A2. When did your home child care program start operation?

19________

A3. How many children are currently enrolled in your child care program in each of the age groups below? Please write in a number or N/A beside each age group.

a) Age 5 or younger ____________________ children

b) Over age 5 ____________________ children

A4. How many children started care in your home child care program and how many left it during the **past 12 months**? Please write in a number or N/A beside each age group.

Age group	# of children who started care	# of children who left care
a) Age 5 or younger	____________	____________
b) Over age 5	____________	____________

A5. How many active caregivers are currently with your home child care program?

__________ caregivers.

A6. How many home visitors are employed by your home child care program?

__________ a) Full-time (30 hours or more per week)

__________ b) Part-time (less than 29 hours per week)

A7. We would like to get a sense of the range of fees that parents pay for home child care. What is the usual (average) rate a full-fee parent would pay in **each** of the following three situations? Quote by day or month, whichever is easier for you.

For care provided from 8:00 a.m. to 5:30 p.m., Monday to Friday, for a child who does not have any special needs:

a) Nine-month-old infant

$ ________ per day OR

$ ________ per month

ERIC

b) Three-year-old child

$ __________ per day

OR $ _______ per month

c) For care provided to a seven-year-old, who does not have special needs, and is in care over lunch and after school for a total of four hours a day

$ __________ per day

OR $ _______ per month

A8. Does your home child care program serve a community with any of the following special circumstances? Please put a check mark beside all that are appropriate.

- ☐ High immigrant population
- ☐ Low socio-economic area
- ☐ Large geographic area (rural community)
- ☐ Community with high levels of seasonal employment
- ☐ Community with high levels of chronic unemployment
- ☐ Community with specific language and/or cultural needs

Section B: Relationships with Families

B1. Which, if any, of the following **pre-placement** services do you provide to families? Please put a check mark beside all that apply.

- ☐ Telephone interview to determine the child care needs/preferences
- ☐ Face-to-face interview with parent only to determine the child care needs/preferences
- ☐ Face-to-face interview with parent and child to determine the child care needs/preferences
- ☐ Information/orientation sessions to explain home child care program policies and procedures, services, rights and expectations
- ☐ Written information/packages to explain home child care program policies and procedures, services, rights and expectations
- ☐ Other similar services, please specify: ______________________________

B2. How are placements made? Select all that apply.

- ☐ Home child care program staff match family with caregiver
- ☐ Families are provided with a short list of selected caregivers
- ☐ Families are provided with the list of all the home child care program's caregivers
- ☐ Other, please briefly describe/identify ______________________________

B3. Does the home visitor participate in parent and caregiver pre-placement interviews?

- ☐ No
- ☐ Yes

B4. Which, if any, of the following **ongoing** services does your home child care program provide to families if needed or requested? Select all that apply.

- ☐ Assistance in applying for a government fee subsidy for low income families
- ☐ Information/education regarding child health, guidance
- ☐ Information/education regarding partnering with your caregiver
- ☐ Contact (phone or in-person) on a regular basis to discuss any concerns
- ☐ Mediation/assistance with child care related problems
- ☐ Involvement with regular evaluation of the care provided and agency services
- ☐ Newsletters/bulletins
- ☐ Opportunity to participate on Board of Directors, Advisory Committees, etc.
- ☐ None of the above
- ☐ Other, please specify: ____________________

Section C: Caregivers

C1. Considering all your current active caregivers, approximately what percentage would you estimate to have been with your home child care program for:

a) Less than one year ________ %
b) One to three years ________ %
c) Three to five years ________ %
d) Five to ten years ________ %
e) Ten or more years ________ %

C2. In the past **12 months**, what were the three main (most frequent) reasons that caregivers left the home child care program **voluntarily**? Please indicate no more than three reasons. If no caregivers left voluntarily, skip to C3.

a) Family responsibilities ________
b) Family move ________
c) To work outside the home ________
d) To provide care privately ________
e) To go to school ________
f) Found work too stressful ________
g) Health reasons ________
h) Dissatisfied with income ________
i) Don't know ________
j) Other, please specify ____________________

C3. How many homes did the agency close **in the past 12 months**? Please write in a number or N/A.

__________ homes closed. **If none, skip to C 5.**

ERIC

C4. How many homes were closed by the home child care program in **the past 12 months** for each of the following reasons? Please indicate the **single** primary reason for each closure. Write in a number or N/A beside each option.

_________ a) Insufficient demand for care in home's area

_________ b) Caregiver consistently failed to meet agency/regulatory requirements

_________ c) Home/environment consistently failed to meet requirements

_________ d) Complaints from parents

_________ e) Other, please specify _________________________

C5. What desired/recommended training requirements for caregivers does your home child care program have? Write in N/A if none.

a) Pre-placement: _________________________

b) Ongoing: _________________________

C6. In which, if any, of the following circumstances would a caregiver receive a higher than usual payment per child? Please indicate all that apply.

- ☐ Caregiver has reached a certain level of experience with our home child care program (e.g. an increase after a certain period of time with the home child care program)
- ☐ Caregiver has an ECE certificate or has completed the *Step Ahead* program
- ☐ Caregiver is looking after a child who has been diagnosed as having a special need by a physician or other health professional
- ☐ Caregiver is providing extended care (e.g. weekend, overnight)
- ☐ None of the above
- ☐ Other, please specify: _________________________

C7. What procedure, if any, do you have for periodic performance evaluation or developing an individual professional development plan for caregivers? Please describe, including its usual frequency, or write in N/A if none.

____

C8. What course of action is taken if there are concerns about a caregiver's performance or the home environment?

____

____

Section D: Home Visitors

D1. What are average home visitor case loads? Please write in a number or N/A (not applicable)

_________ homes OR

_________ children for a full-time home visitor (or FTE if all are part-time)

ERIC Full Text Provided by ERIC

D2. What qualifications, if any, are home visitors required to have to be employed by your home child care program? Please identify both **experience and education requirements**. Write in N/A if there are no particular requirements.

a) Prior experience required: ____________________

b) Educational requirements: ____________________

D3. What, if any, requirements do you have for home visitors to participate in ongoing professional development? Please identify or write in N/A if no requirements.

____

D4. How many, if any, of your agency's home visitors have experience as **home** child care providers? Please write in a number or N/A.

__________ Home visitors

Section E: Supports to Caregivers

E1. Sometimes there is a difference in the frequency and length of home visits to new caregivers (those with less than one year experience) and more experienced caregivers. Please indicate which of the following apply to the usual practice with **new** caregivers in your home child care program. Check off more than one answer if appropriate.

- ☐ a) New caregivers receive more home visits
- ☐ b) Home visits to new caregivers usually last longer
- ☐ c) Home visits tend to be at the same frequency for all caregivers
- ☐ d) Home visits tend to last about the same length of time for all caregivers
- ☐ e) The frequency and duration of the home visits is determined by the individual needs of the caregiver

E2. On average, how often do planned home visits occur for an **experienced** caregiver (one who has been with the your program for more than a year), assuming a home where there are no specific concerns or problems? Please check off **one** option only.

- ☐ More than once a month
- ☐ Once a month
- ☐ Once every two months
- ☐ Once every three months
- ☐ Less than once every three months. How often? ____________________

E3. On average, how long is a planned home visit?

__________ minutes or

__________ hours

E4. Does your agency specifically facilitate networking/contact among caregivers?

- ☐ No
- ☐ Yes. Please describe how the agency facilitates caregiver networking ____________________

____

E5. Which, if any, of the following are provided to caregivers by your home child care program? Please indicate yes or no beside each option.

Support Service	Yes	No
a) Provision of workshops/conferences at no charge to the caregiver	☐	☐
b) Payment of fees for training/PD activities that the caregiver would otherwise have to pay for	☐	☐
c) Payment of the caregiver's child care expenses while she/he participates in training	☐	☐
d) Provision of free alternate care while the caregiver participates in training or PD activities	☐	☐
e) Free on-site child care while participating in training	☐	☐
f) Paid time off to participate in training	☐	☐
g) Free transportation to training/PD activities	☐	☐
h) Free one-to-one training in the caregiver's home	☐	☐

E6. Your agency may provide a range of services to caregivers, with or without charge, from newsletters to play groups or equipment loans. Please tell us what you think are the three most important / valuable services you provide to your caregivers. **Do not include home visits or training in your list.**

1. ____________________
2. ____________________
3. ____________________

E7. Does your home child care program currently provide care to any child with a special need (a physical or intellectual disability or emotional disorder diagnosed by a physician or other health professional)?

☐ No

☐ Yes. Please identify what, if any, supports are available to caregivers looking after children with special needs, for example, special training or respite care.

____

E8. What process or arrangement is there for a caregiver to reach a home child care program staff person in an emergency after office hours?

____

E9. How is alternate care arranged when a caregiver becomes ill or has an emergency in her own family?

____

E10. Approximately how many of the caregivers with your home child care program, if any, have acted in the following capacities in the **past 12 months**? Please write a number or don't know beside each option.

__________ Trainers, workshop leaders

__________ Mentors (providing support to other caregivers)

__________ Served on Board of Directors (write in N/A if no Board)

__________ Served on Advisory, Training or other agency committees

E11. Does your home child care program have any special way in which it acknowledges the contribution of caregivers as a group and/or those who provide exemplary care?

☐ No

☐ Yes. Please describe ____________________

____

ERIC

Section F: Final Thoughts

F1. To what extent has each of the following been a major issue for your home child care program? Please circle your choice for each on the one to five scale, 1 indicating not a major issue and 5 indicating a very major issue.

	Not a major issue				A very major issue
a) Caregiver turnover	1	2	3	4	5
b) Recruiting caregivers in general	1	2	3	4	5
c) Recruiting caregivers to match the cultural/ ethnic diversity of the families we serve	1	2	3	4	5
d) Ensuring that we have supports that are appropriate for experienced caregivers as well as beginning caregivers	1	2	3	4	5

F2. What has been the impact on your home child care program, if any, of changes in government policies, regulations and/or funding in the **past three years**?

____

____

F3. What do you consider to be the three greatest strengths of your home child care program?

1. ____
2. ____
3. ____

F4. What, if anything, would you most like to change in your home child care program?

1. ____
2. ____
3. ____

Thank you for completing this survey. We realize that filling it out took both time and effort and we appreciate your assistance. Are there any comments, thoughts, or suggestions that you would like to share with us?

Additional comments:

____

____

____

____

Please return the completed questionnaire in the self-addressed, stamped envelope that was provided.

ERIC Full Text Provided by ERIC

Appendix E

Questionnaire for Individually Licensed Providers

General instructions

The purpose of this questionnaire is to develop a better understanding of home-based child care. Therefore, it seeks information about your experiences, the multiple roles you have, and your feelings about the system that you work in. The findings of this study will draw attention to what is involved in providing child care in a home setting.

We encourage you to answer **each** question unless specifically instructed to skip a question or questions. Please feel free to add any additional comments in the page margin or the space provided on the final page.

Here are answers to some questions that you might have.

- **Will my answers be confidential?** Yes. All the information you provide will be treated confidentially. Absolutely no identifying information regarding individual responses will ever be released or published. Information will only be reported as group information.
- **What if I decide to withdraw before completing the questionnaire?** The choice of whether to take part is up to you. If you decide to withdraw at any time, you may.
- **How much time will be required?** We have set up the questionnaire in stand-alone sections. You can either do it section by section, as you have the time, or tackle it all at once. Most of the questions simply ask you to choose from a list of possible responses. It takes about an hour to complete the whole thing.
- **When and how should the questionnaire be returned?** The person coming to your home will pick up the completed questionnaire when she visits.

If you have any questions about this survey or the study please contact the Site Coordinator for your Province or Territory:

Name ______________________ **Toll-free telephone number** ______________________

ERIC

Section A: Child Care Experience

A1. People who care for other people's children use a variety of terms to identify themselves. Which word/phrase do you usually use to describe your work? Please put a check mark (✔) beside only **one** option.

- ☐ Caregiver
- ☐ Family child care provider
- ☐ Early childhood educator
- ☐ Babysitter
- ☐ Other, please specify ____________________

Note: For consistency, we will use the term "caregiver" throughout this questionnaire.

A2. How did you become interested in being a home-based caregiver? If several of the following reasons apply, please put a check mark (✔) beside no more than **three** of them.

- ☐ I was looking for a way of earning income while caring for my own child(ren)
- ☐ I love children and wanted to work with them
- ☐ A friend/relative/neighbour was seeking care
- ☐ I was unable to find child care for my own children
- ☐ I wanted companions for my child(ren)
- ☐ Other employment options were not available
- ☐ I responded to an advertisement for caregivers
- ☐ I had worked in a child care centre and wanted to operate my own program
- ☐ Other, please specify ____________________

A3. Please put a check mark (✔) beside each of the following forms of child care that you have provided and write in the length of time in years for each.

Type of Care	Length of Time (in years)
☐ In your home as a licensed caregiver	________
☐ In your home as an unlicensed caregiver	________
☐ In a child care centre	________
☐ In a child's home as a nanny/paid caregiver (do not include occasional babysitting as a teenager)	________

A4. Why did you decide to become licensed? If several reasons apply, please indicate no more than **three** reasons.

- ☐ As a means of finding client families
- ☐ To be able to care for more children than permitted as an unlicensed caregiver
- ☐ As a way of getting in touch with other caregivers
- ☐ As a way of getting more support (such as training, equipment loans)
- ☐ To enable me to care for families who were receiving subsidy
- ☐ To demonstrate to parents that my care met standards of quality
- ☐ To be more professional
- ☐ Other, please specify ____________________

Section B: The Children in Your Care

B1. Starting with the youngest child currently in **paid care**, indicate the child's age in years and months. Then the approximate number of hours per week the child is in your care and when the child entered your care.

Child #	*Child's age (years & months)*	*Approximate number of hrs/wk*	*Entered my care (month & year)*
Example:	2 yrs, 4 months	45 hours	April 1998
1	___________	___________	___________
2	___________	___________	___________
3	___________	___________	___________
4	___________	___________	___________
5	___________	___________	___________
6	___________	___________	___________
7	___________	___________	___________
8	___________	___________	___________
9	___________	___________	___________

B2. In all, how many families are you currently providing care for?

___________ families

B3. How many children began regular care in your home in the **past 12 months**?

___________ children

B4. Other than temporary periods, e.g. summer holidays, how many children left your care in the **past 12 months**?

___________ children

B5. How many of the children in your care are receiving a government fee subsidy for low-income parents?

___________ children receiving fee subsidy for low-income parents.

ERIC Full Text Provided by ERIC

Section C: Working Conditions, Income, and Benefits

C1. Using last week as your guide, identify the days of that week when you looked after child care children. Then, for each of these days, indicate the time the first child arrived (start time), the time the last child left (finish time), and the total number of hours that child care children were in your home.

Day	*Start time* (time 1st child arrived)	*Finish time* (time last child left)	*Total hours* (child care children were in your home)
Monday	________	________	________
Tuesday	________	________	________
Wednesday	________	________	________
Thursday	________	________	________
Friday	________	________	________
Saturday	________	________	________
Sunday	________	________	________

C2. Approximately how many hours a week do you spend on child care-related duties such as paperwork, preparing activities and meeting parents when there are **no child care children** present?

Approximately ________ hours per week.

C3. What would a full-fee parent pay in each of the following situations? If you do not have a child of one of the ages listed, please estimate what you would charge. Write in the rate on an hourly OR daily OR monthly basis, whichever is easiest for you.

For care provided from 8:00 a.m. to 5:30 p.m., Monday to Friday, and the child does not have any special needs:

a) For a nine-month-old infant
$ ________ an hour OR
$ ________ a day OR
$ ________ a month

b) For a three-year-old child
$ ________ an hour OR
$ ________ a day OR
$ ________ a month

c) For a seven-year-old child who does not have any special needs on a day when the child is in your care for lunch and after school for a total of four hours of care
$ ________ an hour OR
$ ________ a day OR
$ ________ a month

C4. Have you raised the fees you charge full-fee parents in the past three years?

- ☐ No
- ☐ Yes

ERIC

C5. What was your gross income (income before deductions or expenses) from child care provision in 1998? Put a check mark in the appropriate box.

- ❑ less than $4,999
- ❑ $5,000 - $9,999
- ❑ $10,000 - $14,999
- ❑ $15,000 - $19,999
- ❑ $20,000 - $24,999
- ❑ $25,000 - $29,999
- ❑ $30,000 - $34,999
- ❑ more than $35,000

C6. Approximately how much of the 1998 income you earned from child care was spent on child care-related expenses (for example, food, toys)?

- ❑ less than 15%
- ❑ 15% - 29%
- ❑ 30% - 44%
- ❑ 45% - 59%
- ❑ 60% - 75%

C7. Approximately what percentage of the total cost of maintaining your household is covered by your child care earnings?

- ❑ 80% to 100% of the cost of maintaining my household
- ❑ Over 50% but less than 80% of the cost
- ❑ Over 25% but less than 50% of the cost
- ❑ Less than 25% of the cost

C8. In total, in the past **12 months** how many weeks did you personally provide child care? Exclude your vacation and days when an alternate or substitute looked after your child care children.

- ❑ 52 weeks
- ❑ 48 - 51 weeks
- ❑ 36 - 47 weeks
- ❑ 24 - 35 weeks
- ❑ less than 24 weeks

C9. In the past **12 months**:

a) How many days did you not provide care because you took a vacation?

__________ days

b) How many days did you want to provide care but had no child care children?

__________ days

c) Did you have any unfilled spaces that you would have liked to have filled?

- ❑ Yes
- ❑ No

ERIC Full Text Provided by ERIC

C10. Which of the following are available to you as a licensed caregiver? Check all that apply.

- ❑ Orientation session to explain licensing requirements and policies
- ❑ Sample parent contracts, attendance forms, etc.
- ❑ Written policy/procedure manual
- ❑ Regular written performance appraisal/evaluation
- ❑ An appeal procedure for situations such as parent complaint, suspended license
- ❑ None of the above

C11. Please indicate on the following table whether or not you have/receive any of these benefits. If receiving the benefit depends on the particular child, put a check mark in the "sometimes" column.

Benefit	*Yes*	*No*	*Sometimes*
a) Payment in the event of a child's absence due to illness or family holidays	❑	❑	❑
b) Payment for statutory holidays, e.g. New Year's Day	❑	❑	❑
c) Payment for overtime, e.g. late pick-up	❑	❑	❑
d) Payment in the event of a child being withdrawn from care without notice	❑	❑	❑
e) Disability insurance (short- or long-term)	❑	❑	❑
f) Liability insurance	❑	❑	❑

C12. Generally speaking, how easy is it for you to take time off when you have to? Circle your choice on the 1 to 5 scale with 1 indicating not difficult, whether absences planned or unplanned, and 5 very difficult.

Not difficult 1 2 3 4 5 Very difficult

Section D: Supports

D1. Do you network formally or informally with other home-based caregivers? Check all that apply.

- ❑ Yes, through an organized association/network
- ❑ Yes, informally with other caregivers I know
- ❑ No

D2. On average, how often do you speak or meet with other caregivers?

___________ times per month

D3. Which, if any, of the following child care organizations or associations do you currently belong to? Select all that apply.

- ❑ A local caregiver network or association in my community
- ❑ A family resource program (FRP) or child care resource and referral program (CCRRP)
- ❑ A provincial or territorial child care organization
- ❑ The Canadian Child Care Federation (CCCF)
- ❑ The Child Care Advocacy Association of Canada (CCAAC)
- ❑ Other, please specify ______________________________
- ❑ None

ERIC Full Text Provided by ERIC

D4. Please indicate whether you have used any of the following services or community programs in the past **12 months** and generally how often you use them.

	Service	Used?	Frequency of use
a) Playgroups	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
b) Drop-in for adults and children	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
c) Library story hour	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
d) Other adult and child activities (e.g. Gym and Swim)	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
e) Toy-lending library	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
f) Large equipment loans (e.g. cots, climbers)	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
g) Opportunities for bulk buying (e.g. food, craft supplies)	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
h) Resource library (e.g. for books, videos on child care)	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑
i) Telephone support or advice on child care matters	No ❑	Yes ❑	Weekly ❑ Monthly ❑ Occasionally ❑

D5. Are there any services that you use that we have missed?

❑ No

❑ Yes, please identify ____________________

D6. Are there any services that exist in your community and you would like to use but cannot?

❑ No

❑ Yes

a) Please identify the service (s) ____________________

b) What is the nature of the difficulty (e.g. lack of transportation, fee charged) ____________________

____

ERIC

Section E: Your Feelings About Caregiving

E1. Which statement **best** describes how you view your job as a home-based child caregiver? Indicate only **one** choice. I see home child care as:

- ☐ My chosen occupation
- ☐ A stepping-stone to other work in the child care or a related field
- ☐ Not my chosen occupation but good while my children are young
- ☐ Something I'm doing until a better job is available
- ☐ None of the above

E2. In your opinion, what are the three most positive aspects of providing home child care? Write in the three that are most important to you.

1. ______________________________
(most positive)

2 ______________________________
(second most positive)

3. ______________________________
(third most positive)

E3. In your opinion, what are the three most negative aspects of providing home child care? Write in the three aspects that you feel are the most negative.

1. ______________________________
(most negative)

2. ______________________________
(second most negative)

3. ______________________________
(third most negative)

E4. Do you expect to be providing home child care three years from now?

- ☐ No. Why not? ______________________________
- ☐ Yes. Why? ______________________________
- ☐ Don't know

E5. If you were choosing a career now, would you choose home child care?

- ☐ No. Why not? ______________________________
- ☐ Yes. Why? ______________________________
- ☐ Don't know

Section F: Feelings About Your Work Situation

F1. We all experience some stress in connection with our work. In the following chart we have indicated several possible sources of stress. Please indicate on a scale of 1 to 5 (1 indicating no stress and 5 indicating a great deal of stress) how much stress you experience from each of these sources. Put a check mark in the "Doesn't apply" column if a source is not applicable to your situation.

Possible sources of stress	Doesn't apply	No stress				A great deal of stress
a) Expectations of spouse/partner	❑	1	2	3	4	5
b) Meeting the needs of my own family while providing child care	❑	1	2	3	4	5
c) Problems with parents (late pick-ups, late payments, etc.)	❑	1	2	3	4	5
d) Dealing with licensing rules/regulations	❑	1	2	3	4	5
e) Income fluctuations	❑	1	2	3	4	5
f) Lack of privacy for me and my family	❑	1	2	3	4	5
g) Expectations of parents of child care children	❑	1	2	3	4	5
h) Helping new families and children adjust	❑	1	2	3	4	5
i) Children leaving care	❑	1	2	3	4	5
j) Financial concerns re: lack of benefits, e.g. lack of pension	❑	1	2	3	4	5

F2. To what extent do you feel that you have control over most of the important things that affect your satisfaction with your job? Circle your choice on the 1 to 5 scale, 1 indicating a feeling of little control over some important things and 5 indicating plenty of control.

Little control 1 2 3 4 5 Plenty of control

Section G: Licensing

G1. In the past **12 months**, how often has the licensing person (government consultant) visited your home? ______________

G2. On average, how long does a visit from the licensing person (government consultant) last? ______________

G3. How helpful do you find the licensing person (government consultant) visits? Circle your response on the scale from 1 to 5 (1 indicating not helpful, 5 indicating very helpful).

Not helpful 1 2 3 4 5 Very helpful

ERIC

Section H: Educational and Professional Background

H1. What is the highest level of education that you have completed?

- ☐ Some high school
- ☐ High-school diploma
- ☐ Some college/university, but did not complete certificate/diploma/degree
- ☐ Completed college/university, please specify certificate/diploma/degree received: ______________________

H2. Which, if any, of the following home child care provider training courses have you completed?

- ☐ *Step Ahead* (Alberta Association of Family Day Care Homes)
- ☐ *Good Beginnings* (The Western Canada Child Care Association of B.C.)
- ☐ *Training Plan for Family Day Care Providers* Manual (Family Day Care Assoc. of Manitoba)
- ☐ B.C.'s 150-hour orientation to child day care course
- ☐ Saskatchewan's 120-hour orientation to child day care course
- ☐ None of the above

H3. Have you completed any certificate, diploma or degree courses specifically related to children or child care through a community college, university or other post-secondary institution? (Please exclude first aid and CPR certificates and anything identified in the previous question).

- ☐ No
- ☐ Yes . Please indicate the certificate, diploma or degree and the duration of the program in the appropriate box in the following table. You may indicate more than one if appropriate, e.g. an early childhood certificate and a degree in teaching.

Area studied	Certificate	Diploma	University degree	Program length (e.g 10 months)
Early childhood education				
Child development				
Teaching				
Child and Family Studies				
Other, please specify				

H4. Are you currently enrolled in a certificate, diploma or degree program at a college, university or other post-secondary institution?

- ☐ No
- ☐ Yes. Please specify type of program (e.g. certificate, diploma, degree) and area of study (if applicable)

Type of program: ______________________

Area of study (e.g. ECE): ______________________

ERIC Full Text Provided by ERIC

H5. Have you participated in any professional development activities during the **past 3 years**, for example conferences, workshops or courses?

- ❑ Yes
- ❑ No. **Skip to Section J**

H6. How many of each of the following activities related to child care did you participate in during the **past 3 years**?

a) Conference ____________________

b) Workshop/seminar ____________________

c) Non-credit course ____________________

d) Credit course ____________________

e) Other, please specify ____________________

H7. Why do you participate in professional development activities? Please check all that apply.

- ❑ To meet the training requirement of the licensing system
- ❑ To get information on a particular problem/area of concern
- ❑ To learn more about the work I do
- ❑ To network with other caregivers
- ❑ To be able to charge higher fees
- ❑ Other, please specify ____________________

H8. Of all the professional development activities that you participated in during the past three years, which was **most** helpful and why/how?

____

____

____

Section J: Personal Background

J1. What was your age on your last birthday?

- ❑ Under 20
- ❑ 20 - 29
- ❑ 30 - 39
- ❑ 40 - 49
- ❑ 50 - 54
- ❑ Over 55

ERIC

J2. What is your marital status?

- ☐ Married or living with a partner
- ☐ Single (includes separated, divorced or widowed)

J3. Please indicate the number of children in each of the following age groups who live with you full or part-time:

- ☐ None
- ☐ Children 0 to 35 months old
- ☐ Children 3 to 5 years old
- ☐ Children 6 to 11 years old
- ☐ Children 12 to 18 years old
- ☐ Children over 18 years old

Section K: Recommendations

K1. If a friend told you she was thinking about becoming a home-based caregiver, what three pieces of advice would you give her?

1. ______________________________
2. ______________________________
3. ______________________________

Thank you for completing this questionnaire. We realize that it took time and effort. Are there any comments, thoughts or suggestions that you would like to share with us?

Additional comments:

____

____

____

____

The person coming to your home will collect your completed questionnaire when she visits.

ERIC

Appendix F

Agency Caregiver Questionnaire

General Instructions

The purpose of this questionnaire is to develop a better understanding of home-based child care. Therefore, it seeks information about your experiences, the multiple roles you have, and your feelings about the system you work in. The findings of this study will draw attention to what is involved in providing child care in a home setting.

We encourage you to answer **each** question unless specifically instructed to skip a question or questions. Please feel free to add any additional comments in the page margin or the space provided on the final page.

Here are answers to some questions that you might have.

- **Will my answers be confidential?** Yes. All the information you provide will be treated confidentially. Absolutely no identifying information regarding individual responses will ever be released or published. Information will only be reported as group information.
- **What if I decide to withdraw before completing the questionnaire?** The choice of whether to take part is up to you. If you decide to withdraw at any time, you may.
- **How much time will be required?** We have set up the questionnaire in stand-alone sections. You can either do it section by section, as you have the time, or tackle it all at once. Most of the questions simply ask you to choose from a list of possible responses. It takes about an hour or a little longer to complete the whole thing.
- **When and how should the questionnaire be returned?** The person coming to your home will pick up the completed questionnaire when she visits.

If you have any questions, contact the Site Coordinator for your Province or Territory:

Name ______________________ **Toll-free telephone number** ______________________

ERIC

Section A: Child Care Experience

A1. People who care for other people's children use a variety of terms to identify themselves. Which word/phrase do you usually use to describe your work? Please put a check mark (✔) beside only **one** option.

- ☐ Caregiver
- ☐ Family child care provider
- ☐ Early childhood educator
- ☐ Babysitter
- ☐ Other, please specify ______________________________

Note: For consistency, we will use the term "caregiver" throughout this questionnaire.

A2. How did you become interested in being a home-based caregiver? If several of the following reasons apply, please put a check mark (✔) beside no more than **three** of them.

- ☐ I was looking for a way of earning income while caring for my own child(ren)
- ☐ I love children and wanted to work with them
- ☐ A friend/relative/neighbour was seeking care
- ☐ I was unable to find child care for my own children
- ☐ I wanted companions for my child(ren)
- ☐ Other employment options were not available
- ☐ I responded to an advertisement by an agency
- ☐ I had worked in a child care centre and wanted to operate my own program
- ☐ Other, please specify ______________________________

A3. Please put a check mark (✔) beside each of the following forms of child care that you have provided and write in the length of time in years for each.

Type of Care	Length of Time (in years)
☐ In your home as an agency caregiver	________
☐ In your home as an unlicensed caregiver	________
☐ In a child care centre	________
☐ In a child's home as a nanny/paid caregiver (do not include occasional babysitting as a teenager)	________

A4. Why did you decide to work with an agency? If several reasons apply, please indicate no more than **three** reasons.

- ☐ As a means of finding client families
- ☐ Preferred having the agency deal with parents around contracts and money issues
- ☐ To be able to care for more children than permitted as an unlicensed caregiver
- ☐ As a way of getting in touch with other caregivers
- ☐ As a way of getting more support (such as training, equipment loans)
- ☐ To enable me to care for families who were receiving subsidy
- ☐ An agency recruited me to provide care

ERIC Full Text Provided by ERIC

- ☐ To demonstrate to parents that my care met standards of quality
- ☐ To be more professional
- ☐ Other, please specify ____________________

Section B: The Children in Your Care

B1. Starting with the youngest child currently in **paid care**, indicate the child's age in years and months. Then the approximate number of hours per week the child is in your care and when the child entered your care.

Child #	*Child's age (years & months)*	*Approximate number of hours/week*	*Entered my care (month & year).*
Example:	2 yrs, 4 months	45 hours	April, 1998
1	________	________	________
2	________	________	________
3	________	________	________
4	________	________	________
5	________	________	________
6	________	________	________
7	________	________	________
8	________	________	________
9	________	________	________

B2. In all, how many families are you currently providing care for?

________ families

B3. How many children began regular care in your home in the **past 12 months**?

________ children

B4. Other than temporary periods, e.g. summer holidays, how many children left your care in the **past 12 months**?

________ children

B5. How many of the children in your care are receiving a government fee subsidy for low-income parents?

________ Children receiving fee subsidy for low-income parents

________ Don't know how many are receiving fee subsidy for low-income parents

ERIC

Section C: Working Conditions, Income, and Benefits

C1. Using last week as your guide, identify the days of that week when you looked after child care children. Then, for each of these days, indicate the time the first child arrived (start time), the time the last child left (finish time), and the total number of hours that child care children were in your home.

Day	*Start time* (time 1st child arrived)	*Finish time* (time last child left)	*Total hours* (child care children were in your home)
Monday	______	______	______
Tuesday	______	______	______
Wednesday	______	______	______
Thursday	______	______	______
Friday	______	______	______
Saturday	______	______	______
Sunday	______	______	______

C2. Approximately how many hours a week do you spend on child care-related duties such as paper work, preparing activities and meeting parents when there are **no child care children** present?

Approximately ______ hours per week.

C3. For each of the following situations, please estimate the rate you would be paid by the agency, and the rate you would be paid by a full-fee parent in a private arrangement. If you do not accept children through a private arrangement, put N/A (for not applicable) in that column. If you are not paid by the day, write in your hourly or monthly rate. In this case, cross out the word "day" and write in "hour" or "month".

	Agency placement	*Private arrangement*
For care provided from 8:00 a.m. to 5:30 p.m., Monday to Friday, and the child does not have any special needs:		
a) For a nine-month-old infant	$____ a day	$____ a day
b) For a three-year-old child	$____ a day	$____ a day
c) For a seven-year-old child who does not have any special needs on a day when the child is in your care for lunch and after school for a total of four hours of care	$____ a day	$____ a day

C4. Has the agency raised the fees it pays you in the past three years?

- ❑ Yes
- ❑ Not applicable, I have not been with the agency for three years
- ❑ No

C5. What was your gross income (income before deductions or expenses) from child care provision in 1998? Put a check mark in the appropriate box.

- ❑ less than $4,999
- ❑ $5,000 - $9,999
- ❑ $10,000 - $14,999
- ❑ $15,000 - $19,999
- ❑ $20,000 - $24,999
- ❑ $25,000 - $29,999
- ❑ $30,000 - $34,999
- ❑ more than $35,000

C6. Approximately how much of the 1998 income you earned from child care was spent on child care-related expenses (for example, food, toys)?

- ❑ less than 15%
- ❑ 15% - 29%
- ❑ 30% - 44%
- ❑ 45% - 59%
- ❑ 60% - 75%

C7. Approximately what percentage of the total cost of maintaining your household is covered by your child care earnings?

- ❑ 80% to 100% of the cost of maintaining my household
- ❑ Over 50% but less than 80% of the cost
- ❑ Over 25% but less than 50% of the cost
- ❑ Less than 25% of the cost

C8. In total, in the past **12 months** how many weeks did you personally provide child care? Exclude your vacation and days when an alternate or substitute looked after your child care children.

- ❑ 52 weeks
- ❑ 48 - 51 weeks
- ❑ 36 - 47 weeks
- ❑ 24 - 35 weeks
- ❑ less than 24 weeks

C9. In the past **12 months**

a) How many days did you not provide care because you took a vacation?

___________ days

b) How many days did you want to provide care but had no child care children?

___________ days

c) Did you have any unfilled spaces that you would have liked to have filled?

- ❑ Yes
- ❑ No

ERIC

C10. Which of the following are available to you through your agency? Check all that apply.

- ☐ Orientation session to explain agency requirements and policies
- ☐ Written job description
- ☐ Written contract between me and the agency
- ☐ Sample parent contracts, attendance forms, etc.
- ☐ Written policy/procedure manual
- ☐ Regular written performance appraisal/evaluation
- ☐ An appeal procedure for situations such as parent complaint
- ☐ None of the above

C11. Please indicate on the following table whether or not you have/receive any of these benefits through the agency.

Benefit	*Yes*	*No*
a) Payment in the event of a child's absence due to illness or family holidays	☐	☐
b) Payment for statutory holidays, e.g. New Year's Day	☐	☐
c) Payment for overtime, e.g. late pick-up	☐	☐
d) Payment in the event of a child being withdrawn from care without notice	☐	☐
e) Disability insurance (short- or long-term)	☐	☐
f) Liability insurance	☐	☐

C12. Generally speaking, how easy is it for you to take time off when you have to? Circle your choice on the 1 to 5 scale with 1 indicating not difficult, whether absences planned or unplanned, and 5 very difficult.

Not difficult 1 2 3 4 5 Very difficult

Section D: Supports

D1. Do you network formally or informally with other home-based caregivers? Check all that apply.

- ☐ Yes, through an organized association/network
- ☐ Yes, informally with other caregivers I know
- ☐ No

D2. On average, how often do you speak or meet with other caregivers?

___________ times per month

D3. In addition to your agency connection, which, if any, of the following organizations or associations do you currently belong to? Select all that apply.

- ☐ A local caregiver network or association in my community
- ☐ A family resource program (FRP) or child care resource and referral program (CCRRP)
- ☐ A provincial or territorial child care organization
- ☐ The Canadian Child Care Federation (CCCF)
- ☐ The Child Care Advocacy Association of Canada (CCAAC)
- ☐ Other, please specify ___________________________
- ☐ None

ERIC Full Text Provided by ERIC

D4. Please indicate whether you have used any of the following services or community programs in the past **12 months** and generally how often you use them.

Service	*Used?*		*Frequency of use*
a) Play groups	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
b) Drop-in for adults and children	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
c) Library story hour	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
d) Other adult and child activities (e.g. Gym and Swim)	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
e) Toy-lending library	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
f) Large equipment loans (e.g. cots, climbers)	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
g) Opportunities for bulk buying (e.g. food, craft supplies)	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
h) Resource library (e.g. for books, videos on child care)	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐
i) Telephone support or advice on child care matters	No ☐	Yes ☐	Weekly ☐ Monthly ☐ Occasionally ☐

D5. Are there any services that you use that we have missed?

☐ No

☐ Yes, please identify ____________________

D6. Are there any services that exist in your community and you would like to use but cannot?

☐ No

☐ Yes.

a) Please identify the service (s) ____________________

b) What is the nature of the difficulty (e.g. lack of transportation, fee charged) ____________________

182

ERIC Full Text Provided by ERIC

Section E: Your Feelings About Caregiving

E1. Which statement **best** describes how you view your job as a home-based child caregiver? Indicate only **one** choice. I see home child care as:

- ☐ My chosen occupation
- ☐ A stepping-stone to other work in the child care or a related field
- ☐ Not my chosen occupation but good while my children are young
- ☐ Something I'm doing until a better job is available
- ☐ None of the above

E2. In your opinion, what are the three most positive aspects of providing home child care? Write in the three that are most important to you.

1. ______________________________
(most positive)

2. ______________________________
(second most positive)

3. ______________________________
(third most positive)

E3. In your opinion, what are the three most negative aspects of providing home child care? Write in the three aspects that you feel are the most negative.

1. ______________________________
(most negative)

2. ______________________________
(second most negative)

3. ______________________________
(third most negative)

E4. Do you expect to be providing home child care three years from now?

- ☐ No. Why not? ______________________________
- ☐ Yes . Why? ______________________________
- ☐ Don't know

E5. If you were choosing a career now, would you choose home child care?

- ☐ No. Why not? ______________________________
- ☐ Yes. Why? ______________________________
- ☐ Don't know

ERIC Full Text Provided by ERIC

Section F: Feelings About Your Work Situation

F1. We all experience some stress in connection with our work. In the following chart we have indicated several possible sources of stress. Please indicate on a scale of 1 to 5 (1 indicating no stress and 5 indicating a great deal of stress) how much stress you experience from each of these sources. Put a check mark in the "Doesn't apply" column if a source is not applicable to your situation.

Possible sources of stress	Doesn't apply	No stress				A great deal of stress
a) Expectations of spouse/partner	☐	1	2	3	4	5
b) Meeting the needs of my own family while providing child care	☐	1	2	3	4	5
c) Problems with parents (late pick-ups, late payments, etc.)	☐	1	2	3	4	5
d) Dealing with licensing rules/regulations	☐	1	2	3	4	5
e) Income fluctuations	☐	1	2	3	4	5
f) Lack of privacy for me and my family	☐	1	2	3	4	5
g) Expectations of parents of child care children	☐	1	2	3	4	5
h) Helping new families and children adjust	☐	1	2	3	4	5
i) Children leaving care	☐	1	2	3	4	5
j) Financial concerns re: lack of benefits, e.g. lack of pension	☐	1	2	3	4	5

F2. To what extent do you feel that you have control over most of the important things that affect your satisfaction with your job? Circle your choice on the 1 to 5 scale, 1 indicating a feeling of little control over some important things and 5 indicating plenty of control.

Little control 1 2 3 4 5 Plenty of control

Section G: Relationship with Your Agency

G1. In the past **12 months**, how often have you been visited by your home visitor? ______________________

G2. On average, how long does the home visitor stay? ______________________

G3. What assistance do you receive through the visit by the home visitor?

____

____

G4. What assistance would you like to receive through visits by the home visitor?

____

____

G5. How helpful do you find visits by the home visitor? Circle your response on the scale from 1 to 5 (1 indicating not helpful, 5 indicating very helpful).

Not helpful 1 2 3 4 5 Very helpful

G6. Put a check beside each of the following statements that describes your relationship with your home visitor?

- ☐ Encourages me to try new ideas
- ☐ Supervises me too closely
- ☐ Provides support and helpful feedback
- ☐ Sets high but realistic standards
- ☐ Makes me feel inadequate
- ☐ Trusts my judgement
- ☐ Is unavailable
- ☐ Appreciates the difficulties of balancing work and family responsibilities
- ☐ Is hard to please

G7. Does your agency provide services for its caregivers, with or without charge, such as equipment loans, a toy-lending library, bulk buying, or playgroups?

- ☐ No
- ☐ Yes. Overall, how satisfied are you with these services? (Circle your choice on the 1 to 5 scale, 1 indicating very dissatisfied, 5 indicating very satisfied)

Very dissatisfied 1 2 3 4 5 Very satisfied

G8. Do you expect to be associated with the same agency three years from now?

- ☐ No. Why not? ______________________________
- ☐ Yes. Why? ______________________________
- ☐ Don't know

Section H: Educational and Professional Background

H1. What is the highest level of education that you have completed?

- ☐ Some high school
- ☐ High-school diploma
- ☐ Some college/university, but did not complete certificate/diploma/degree
- ☐ Completed college/university, please specify certificate/diploma/degree received: ______________

H2. Which, if any, of the following home child care provider training courses have you completed?

- ☐ *Step Ahead* (Alberta Association of Family Day Care Homes)
- ☐ *Good Beginnings* (The Western Canada Family Child Care Association of B.C.)
- ☐ *Training Plan for Family Day Care Providers Manual* (Family Day Care Association of Manitoba)
- ☐ B.C.'s 150-hour orientation to child day care course
- ☐ Saskatchewan's 120-hour orientation to child day care course
- ☐ None of the above

H3. Have you completed any certificate, diploma or degree courses specifically related to children or child care through a community college, university or other post-secondary institution? (Please exclude first aid and CPR certificates and anything identified in the previous question.)

- ☐ No
- ☐ Yes. Please indicate the certificate, diploma or degree and the duration of the program in the appropriate box in the following table. You may indicate more than one if appropriate, e.g. an early childhood certificate and a degree in teaching.

ERIC

Area studied	Certificate	Diploma	University degree	Program length (e.g 10 months)
Early childhood education				
Child development				
Teaching				
Child and Family Studies				
Other, please specify				

H4. Are you currently enrolled in a certificate, diploma or degree program at a college, university or other post-secondary institution?

- ❑ No
- ❑ Yes. Please specify type of program (e.g. certificate, diploma, degree) and area of study (if applicable)

Type of program: ____________________

Area of study (e.g. ECE): ____________________

H5. Have you participated in any professional development activities during the **past 3 years**, for example conferences, workshops or courses?

- ❑ Yes
- ❑ No. **Skip to Section J**

H6. How many of each of the following activities related to child care did you participate in during the **past 3 years**?

a) Conference ____________________

b) Workshop/seminar ____________________

c) Non-credit course ____________________

d) Credit course ____________________

e) Other, please specify ____________________

H7. Why do you participate in professional development activities? Please check all that apply.

- ❑ To meet the training requirement of the licensing system
- ❑ To get information on a particular problem/area of concern
- ❑ To learn more about the work I do
- ❑ To network with other caregivers
- ❑ To be able to charge higher fees
- ❑ Other, please specify ____________________

H8. Of all the professional development activities that you participated in during the past three years, which was **most** helpful and why/how?

____

____

ERIC

Section J: Personal Background

J1. What was your age on your last birthday?

- ☐ Under 20
- ☐ 20 - 29
- ☐ 30 - 39
- ☐ 40 - 49
- ☐ 50 - 54
- ☐ Over 55

J2. What is your marital status?

- ☐ Married or living with a partner
- ☐ Single (includes separated, divorced or widowed)

J3. Please indicate the number of children in each of the following age groups who live with you full or part-time:

- ☐ None
- ☐ Children 0 to 35 months old
- ☐ Children 3 to 5 years old
- ☐ Children 6 to 11 years old
- ☐ Children 12 to 18 years old
- ☐ Children over 18 years old

Section K: Recommendations

K1. If a friend told you she was thinking about becoming a home-based caregiver, what three pieces of advice would you give her?

1. ____________________
2. ____________________
3. ____________________

Thank you for completing this questionnaire. We realize that it took time and effort. Are there any comments, thoughts or suggestions that you would like to share with us?

Additional comments:

____

____

____

____

The person coming to your home will collect your completed questionnaire when she visits.

ERIC

Appendix G

Interview with Provider

Home I.D. ____________________

Agency I.D. (if applicable) ____________________

Information to be obtained before starting the observation

1. Number of children present

   ____

2. How many of these are the caregiver's own children?

   __________ ***(Observer: make a mental note which children these are)***

3. Age range of the children present, from __________ to __________ months.

4. How many currently enrolled children are absent today?

   __________ If none, go to 6.

ERIC

5. Do any of the children who are **absent** have a special need or a significant health problem?
We are using the term "special needs" to include a physical or intellectual disability identified by a professional such as a physician or speech therapist or a diagnosed behaviour or emotional disorder.
   a) No ☐
   b) Yes ☐ What is the nature of the child's special need? ____________________

   ____

6. Are there any children **present** today who have a special need or multiple special needs? ***(Observer: include the caregiver's own children if relevant)***
   a) No ☐
   b) Yes ☐ How many? ____________________
   c) What is the nature of the special need?

   Child #1 ____________________

   Child #2 ____________________

   Child # 3 ____________________

7. Are there any children present whose families do not speak English at home? (or French for a francophone provider)
   a) No ☐
   b) Yes ☐ How many? ____________________

8. What language do you generally speak in the home when the child care children are present?
   a) English ☐
   b) French ☐
   c) Other, please specify ____________________

   ____

9. Number of caregivers present (put a checkmark beside appropriate answer):
   a) One only ☐ (do not include teen child of caregiver who may come home at lunch and may even help feed the child care children)
   b) Two ☐ Is the second person:
   c) a regular assistant? Yes ☐ OR
   d) a substitute for a regular assistant? Yes ☐ OR
   e) an ECE student on practicum placement? Yes ☐

10. Is there anything out of the ordinary today, for example, a volunteer or parent present, a child who is teething?
   a) No ☐
   b) Yes ☐ What is it? ____________________

ERIC

Information to be sought *after* the observation

11. Ask any questions required to complete the FDCRS, that is, to check on things that were not/could not be observed.

To be asked only if there is a child with special needs present or enrolled (even if absent today) — otherwise thank person and stop interview:

12. Have you received ***specific*** training to assist you to work with the children you are caring for who have special needs? **(Probe for a match between the child's special need and the training, e.g. training in positioning and lifting a child with a physical disability, training in signing for a child who has impaired hearing)**

    a) No ☐

    b) Yes ☐ Please describe the training (**not who provided** but what was demonstrated or taught) ____________________

    ____

    ____

13. On a scale from 1 to 5, with 1 being only a little or not at all and 5 being a lot, to what extent has this training helped you to feel comfortable caring for the child(ren) with special needs? **(Circle the number reflecting the answer given)**

    A little/not at all   1   2   3   4   5   A lot/very helpful

14. Is there any one else, apart from yourself (and assistant, if applicable) involved with the child(ren) with special needs while they are in your home, i.e. another person who comes to your home to work with or provide a service for the child?

    a) No ☐ Skip to next question

    b) Yes ☐ What is this person (i.e. speech therapist, nurse) ____________________

    c) What is their role? (e.g. to provide one-to-one speech therapy)

    ____

    ____

15. Who do you speak to when you have an issue or concern regarding a child who has special needs and you feel you need advice? **(Only use the list of options if a prompt required — multiple answers are possible)**

    ☐ a) No-one, skip to question 16

    ☐ b) The child's parent

    ☐ c) A consultant from my FDC agency or a resource and referral program

    ☐ d) Occupational/physical therapist (OT/PT)

    ☐ e) Speech/language therapist

    ☐ f) Behaviour therapist/psychologist/other mental health worker

    ☐ g) Paediatrician or nurse

    ☐ h) Other, please specify ____________________

ERIC Full Text Provided by ERIC

16. On a scale from 1 to 5, with 1 being only a little and 5 being a lot/very helpful, to what extent do you feel you are able to obtain sufficient support and assistance from these people? **(Circle the number reflecting the response given)**

    Only a little 1 2 3 4 5 A lot/very helpful

17. Do you have to meet with consultants who are involved with the child(ren) with special needs on your own time, that is, unpaid time?

    a) Yes ❑

    b) No ❑

Thank you for answering these questions for me.

ERIC Full Text Provided by ERIC

Appendix H

Caregiver Interaction Scale

	Not at all	Somewhat	Quite a bit	Very much
1. Speaks warmly to the children	❑	❑	❑	❑
2. Seems critical of the children	❑	❑	❑	❑
3. Listens attentively when children speak to him/her	❑	❑	❑	❑
4. Places high value on obedience	❑	❑	❑	❑
5. Seems distant or detached from the children	❑	❑	❑	❑
6. Seems to enjoy the children	❑	❑	❑	❑
7. When the children misbehave, explains the reason for the rule they are breaking	❑	❑	❑	❑
8. Encourages the children to try new experiences	❑	❑	❑	❑
9. Speaks with irritation or hostility to the children	❑	❑	❑	❑
10. Seems enthusiastic about the children's activities and efforts	❑	❑	❑	❑
11. Threatens children when trying to control them	❑	❑	❑	❑
12. Spends considerable time in activity not involving interaction with the children	❑	❑	❑	❑
13. Pays positive attention to the children as individuals	❑	❑	❑	❑
14. Talks to children on a level they can understand	❑	❑	❑	❑

ERIC Full Text Provided by ERIC

	Not at all	Somewhat	Quite a bit	Very much
15. Punishes the children without explanation	❑	❑	❑	❑
16. Encourages children to exhibit prosocial behaviour, e.g. sharing	❑	❑	❑	❑
17. Finds fault easily with children	❑	❑	❑	❑
18. Doesn't seem interested in the children's activities	❑	❑	❑	❑
19. Seems to prohibit many of the things children want to do	❑	❑	❑	❑
20. Doesn't supervise the children very closely	❑	❑	❑	❑
21. Expects the children to exercise developmentally inappropriate self-control, e.g. to be undisruptive for group, teacher-led activities, to be able to stand in line calmly	❑	❑	❑	❑
22. When talking to children, kneels, bends or sits at their level to establish better eye contact	❑	❑	❑	❑
23. Seems unnecessarily harsh when scolding or prohibiting children	❑	❑	❑	❑

Administration:

Observation should last for a minimum of two hours. The observer puts a check mark in the appropriate column beside each descriptor to indicate whether, overall, the adult's behaviour was like the descriptor "not at all" (less than 25% of observed instances), "somewhat" (roughly between 25% and 50% of observed instances), "quite a bit" (roughly between 50% and 75% of observed instances), or "very much" (description very typical of the behaviour observed).

Scoring:
Not at all = 1 point
Somewhat = 2 points
Quite a bit = 3 points
Very much = 4 points

Subscale score calculation:
(a) Add scores from items 1, 3, 6, 7, 8, 10, 13, 14, 16 & 22 = (Sensitivity score)
(b) Add scores from items 2, 4, 9, 11, 15, 17, 19, 21 & 23 = (Harshness score)
(c) Add scores from items 5, 12, 18 & 20 = (Detachment score)

Appendix I

An Overview of the Family Day Care Rating Scale

The *Family Day Care Rating Scale (FDCRS)*[1] has six sub-scales that are used in the assessment of any home. A seventh, *Supplementary Items: Provisions for Exceptional Children*, can be used in a home where there is a child with special needs. The items examined in each sub-scale are listed below.

1. ***Space and Furnishings for Care and Learning:*** The safety and appropriateness of the furnishings for personal care and for the provision of a child care program; the provisions for pictures and mobiles that will appeal to children and for the display of children's artwork; the adequacy of the amount of indoor space and of the outdoor space that is used by the child care children, and its safety; the availability of materials and equipment for outdoor play.

2. ***Basic Care:*** Routines and practices around children arriving and departing; provisions for diapering and toileting; provisions for children's naps or rest period; appropriateness of meals and snacks and the way food is handled; health and safety provisions and practices.

3. ***Language and Reasoning:*** The amount and quality of the language interaction between the provider and the children; the availability of activities and materials that will stimulate the development of children's language and reasoning skills.

4. ***Learning Activities:*** The availability and appropriateness of materials and activities that encourage eye-hand coordination; the availability of art, music and music activities; the provision of opportunities for sand and water play and for dramatic play; the appropriateness of the use of TV; the variety of

activities provided and the extent to which there is a balance of different types of activities; the provision of developmentally appropriate supervision, both indoors and outdoors.

5. ***Social Development:*** The general emotional tone of the home (e.g., do the children and care provider seem relaxed and cheerful or are children hurried along?); the care provider's methods of behaviour guidance; the extent to which toys, pictures, books and activities reflect diversity (cultural/racial, gender, ability/disability, different ages).

6. ***Adult Needs:*** The extent to which the care provider balances personal and caregiving responsibilities; the policies and practices related to communication with parents; the extent to which the provider participates in professional development.

7. ***Provisions for Exceptional Children:*** The extent to which adaptations are made to routines, activities, equipment and toys to provide appropriate care for the child; the extent to which the provider adapts her communication for the child if this is necessary; the extent to which provisions are made to maximize the child's inclusion in activities with other children; the extent to which the provider seeks additional information or skills required for the care of the child, and the provider's sharing of information with the child's parents.

Note

1 Harms and Clifford 1989.

ERIC

Appendix J

The Thirty Possible Predictor Variables Used in the Analyses

Structural Aspects

1. Total number of children enrolled
2. Age of youngest child present when observation done
3. Number of caregivers present when observation done

Provider Characteristics

4. Highest level of formal education completed in any subject
5. Highest level of ECCE-related education completed
6. Has completed a formal family child care-specific training course
7. Participated in at least one professional development activity within the past three years
8. Time worked as an unregulated provider
9. Time worked in a child care centre
10. Time worked as a nanny/paid caregiver in a child's own home

Adult Work Environment

11. Gross income from child care provision in the previous year
12. Fee per day for a three-year-old
13. Number of benefits received; e.g., payment for statutory holidays
14. Number of non-contact hours per week spent on child care-related activities; e.g., paperwork
15. Number of days' vacation in previous 12 months

ERIC

Context

16. Provider networks informally with other providers
17. Provider networks with other providers through an organized association/network
18. Provider belongs to a local caregiver network or association in her community
19. Number of local child care associations or organizations provider is associated with
20. Provider belongs to a provincial or territorial child care association
21. Number of services/programs used regularly out of the first four listed in question D4 of the provider questionnaires (Appendix E and F)
22. Number of services/programs used regularly out of the remaining five listed in question D4 of the provider questionnaires (Appendix E and F)

Provider Feelings about Family Child Care Work

23. Provider states she expects to continue family child care for another three years and her reasons indicate enjoyment of the work and commitment to the occupation
24. Provider says she would choose family child care as a career again because she enjoys the work, sees it as her chosen occupation
25. Provider states reason for participating in professional development is to learn more about the work she does
26. Provider motivation to become regulated is to demonstrate her care meets standards and/or to be more professional
27. Provider identifies being alone most of the time as one of the most negative aspects of family child care provision
28. Advice to a friend: Be sure this is what you want to do, research it, know yourself, must love the work
29. Advice to a friend: Realize the value of the service you provide
30. Advice to a friend: Use all the resources you can find

Appendix K

Strengths and Limitations of the Study, and Implications for Future Research

Strengths

This study had a number of strengths, including:

1. A large sample: we completed observations in 231 homes in six provinces and one territory. The largest study conducted on family child care that also involved in-home observations was the *National Day Care Home Study* in the United States.[1] It had a sample of 305 homes across three states. The more recent *Quality in Family Child Care and Relative Care,*[2] which also conducted in-home observations, included 112 regulated providers, 60 non-regulated providers and 54 relative caregivers, for a total of 226 homes in three states. Other studies involving in-home observations have had much smaller samples in single locations.[3]

2. Providers were from seven jurisdictions selected to be broadly representative of the diversity of family child care in Canada. The jurisdictions represented various points along the continuum of government regulatory standards and the extent of provincial or territorial supports to family child care. Three of the participating provinces use the agency model of regulation, while the other jurisdictions licence providers individually.

ERIC

3. The use of systematic procedures and valid measures that allowed us to collect information about many aspects of family child care from our sample.

4. Data analyses that went beyond the identification of associations between quality and caregiver variables to identify those variables that *predict* quality in family child care.

Limitations

Sampling and Sample Size

Results generated from self-selected samples must always be considered with caution. Inclusion in our study, as in all studies of this type, depended entirely on voluntary participation. Furthermore, our sample was based on providers drawn from particular communities. The extent to which the data generated by our sample also represents those providers who declined to participate, as well as providers in other communities, cannot be determined. As discussed in Chapter 3, Section 3.3, overall our sample was reasonably comparable with a Canada-wide sample of regulated providers obtained in an earlier survey.[4] However, both studies required completion of a questionnaire and it is likely that both under-represent providers who are not fluent in English or French, or who are less comfortable than others in responding in writing to written material.

One safeguard that can raise confidence in the representativeness of a sample is to increase sample size. More participants generate more data and reduce the possibility that a few extreme cases will seriously distort the results. However, on-site data collection is time-consuming, costly and, especially in a person's home, intrusive. As a result, obtaining large samples is challenging. While our sample was large relative to those used in other research, we still did not have sufficient numbers to do focused analyses in individual jurisdictions.

Limitations of the *Family Day Care Rating Scale*

The study used two observation instruments: the *Caregiver Interaction Scale (CIS)*[5] and the *Family Day Care Rating Scale (FDCRS)*.[6] Concerns have been expressed that the *FDCRS*, being an adaptation of an instrument originally designed for centres, fails to acknowledge or tap "several important aspects of family child care quality."[7] These include the provider's ability to capitalize on the presence of a mixed-age group of children as an opportunity for children to learn from other children, and the quality of the communication and interaction between provider and parent. We acknowledge as major limitations in our study the fact that we did not assess the provider's ability to successfully relate to, and engage children in, mixed-age groups, or the provider's relationship with parents. There is clearly a need to develop an observational instrument that would access these skills and other important aspects of family child care quality, such as the provider's ability to address the isolation typical of this occupation, her ability to ensure some personal time for herself, and the family child care situation as an adult work environment. There is equally clearly a need for research on these as yet unexplored aspects of family child care provision. Nevertheless, the high correlation

that we found between the *CIS* and the *FDCRS* (see Table 6.6) in addition to the findings of previous research (see Appendix A) allows us to have some confidence in the ability of the *FDCRS* to identify the basic health and safety of the homes and those homes most likely to provide the type of experiences that support and stimulate children's development.

The Time of Day When the Observations Were Conducted

Most of the observations were done between the time of arrival and the end of lunch. As a result, in most cases we did not observe when school-aged children were present, which is also usually the time when the provider has the maximum number of children. Thus our study, like previous family child care research, did not pay adequate attention to the experiences of school-age children in family child care. There is a need for future studies to explore this issue specifically.

Implications for Future Research

Sampling

We know that many family child care providers in Canada, especially in large urban areas, come from diverse language and cultural backgrounds. Future studies must use multiple approaches to reach out to these providers so that their perceptions and needs can be identified.

While our sample was large relative to those used in other research, we did not have sufficient numbers to do focused analyses in individual jurisdictions. Future studies that hope to address specific policy questions within a given jurisdiction will need to recruit larger samples than were possible on an individual province basis in this study.

The Appropriateness of Existing Measures of Quality in Family Child Care

One of the instruments we used, the *Family Day Care Rating Scale*, has been criticized for failing to acknowledge or assess critical aspects of family child care. As was identified in the recent *Caring 'Cross Canada* symposium, which involved providers, family child care agency staff, organizational and government representatives and researchers, there is a need to identify what constitutes quality in family child care and to develop appropriate mechanisms to asses it.

Quality Care and Developmental Outcomes

There are compelling social reasons for conducting research on the effect of the level of child care quality on children's emotional, social, language and intellectual development. Little is known about either the short-term or the long-term consequences of participation in low- or high-quality child care during a child's early years. The current study contributed much to our ability to predict the variables associated with positive child outcomes. The next crucial step for a society that truly values its children is an examination of the short- and long-term developmental implications of child care per se, and child care of different levels of quality.

ERIC

Notes

1. Divine-Hawkins 1981.
2. Kontos et al. 1995.
3. For example, Goelman and Pence 1987, 1988.
4. Goss Gilroy Inc. 1998.
5. Arnett 1989.
6. Harms and Clifford 1989.
7. Modigliani 1990, p. 20.

ERIC Full Text Provided by ERIC

References

Alberta Association for Family Day Home Services. (1996). *Step Ahead: Alberta Family Day Home Provider Training and Certification Program.* Rev. ed. Edmonton, Alberta: Author.

Arnett, J. (1989). "Caregivers in Day Care Centres: Does Training Matter?" *Developmental Psychology* 10: 541-552.

Atkinson, A.M. (1988). "Providers' Evaluation of the Effect of Family Day Care on Own Family Relationships." *Family Relations* 37: 399-404.

Azer, S. and Morgan G. (1998). *Studies Show Positive Changes and Trends in Child Care Regulations.* Boston, MA: Center for Career Development in Early Care and Education, Wheelock College.

Battle, K. and Torjman, S. (2000). *A Proposed Model Framework for Early Childhood Development Services within the National Children's Agenda.* Ottawa: Caledon Institute on Social Policy.

Beach, J., Bertrand, J. and Cleveland, G. (1998). *Our Child Care Workforce: From Recognition to Remuneration: More Than a Labour of Love.* A Human Resource Study of Child Care in Canada. Ottawa: Child Care Human Resources Steering Committee, c/o Canadian Child Care Federation.

Bollin, G.G. (1993). "An Investigation of Job Stability and Job Satisfaction Among Family Day Care Providers." *Early Childhood Research Quarterly* 8: 207-220.

Bronfenbrenner, U. (1979). *The Ecology of Human Development.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. and Morris, P.A. (1998). "The Ecology of Developmental Processes." In R.M. Larner, ed., *Handbook of Child Psychology, 5th ed: Theoretical Models of Human Development,* pp. 993-1028. Toronto: John Wiley.

Burchinal, M.R., Roberts, J.E., Riggins, R., Zeisel, S.A., Neebe, E. and Bryant, D. (In press). "Relating Quality Of Center Care to Early Cognitive and Language Development Longitudinally." *Child Development.*

Caldwell, B. and Bradley, R. (1979). *Home Observation for Measurement of the Environment.* Little Rock, AK: Center for Child Development and Education, University of Arkansas.

Canning, P.M. and Lyon, M.E. (1990). "Young Children With Special Needs." In I.M. Doxey, ed., *Child Care and Education: Canadian Dimensions,* pp. 254-268. Scarborough, Ontario: Nelson Canada.

Canadian Council on Social Development. (1998). *The Progress of Canada's Children, 1998.* Ottawa: Author.

Carew, J.V. (1980). "Experience and Development of Intelligence in Young Children and in Day Care." *Monographs of the Society for Research in Child Development* 45: Serial no. 187, vol. 6/7.

Chang, H. (1993). *Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education.* San Francisco, CA: California Tomorrow.

Childcare Resource and Research Unit. (2000). *Early Childhood Care and Education in Canada: Provinces and Territories 1998.* Toronto: Centre for Urban and Community Studies, University of Toronto.

Clarke-Stewart, A. (1987). "Predicting Child Development from Child Care Forms and Features: The Chicago Study." In D.A. Phillips, ed., *Quality in Child Care: What Does the Research Tell Us?* pp. 21-41. Washington, DC: National Association for the Education of Young Children.

Clarke-Stewart, A. (1999). *How Child Care Relates to Children's Cognitive and Language Development: NICHD Study.* Paper presented at the American Association for the Advancement of Science Meetings, January 21-26, Anaheim, CA.

Clarke-Stewart, A. and Gruber, C.P. (1984). "Day Care Forms and Features." In R. Ainslie, ed., *The Child and the Day Care Setting,* pp. 35-62. New York: Praeger.

Clarke-Stewart, K.A., Vandell, M., Burchinal, M., O'Brien, M. and McCartney, K. (2000). *Do Features of Child Care Homes Affect Children's Development?* Irvine, CA: University of California at Irvine.

Cleveland, G. and Krashinsky, M. (1998). *The Benefits and Costs of Good Child Care: The Economic Rationale for Public Investment in Young Children.* Toronto: Childcare Resource and Research Unit, Centre for Urban and Community Studies, University of Toronto.

Clifford, R.M., Harms, T. and Cryer, D. (1991). *Assessing the Early Childhood Environment for Infants and Toddlers, Family Day Care, and Preschoolers: Three Rating Scales.* Paper presented at the Annual Conference of the National Association for the Education of Young Children, Denver, CO.

Clifford, R.M., Harms, T., Pepper, S. and Stuart, B. (1992). "Assessing Quality in Family Day Care." In D.L. Peters and A.R. Pence, eds., *Family Day Care: Current Research for Informed Public Policy,* pp. 243-265. New York: Teachers College Press.

Council of Ministers of Education, Canada (CMEC). (1998). *Preparation for Learning: Preschool Education.* Discussion paper for the CMEC third national forum. Toronto: Author.

Cummings, E.M. (1980). "Caregiver Stability and Day Care." *Developmental Psychology* 16: 31-37.

DeBord, K. and Sawyers, J. (1995). "Does Membership in a Professional Association Influence Quality of Family Child Care?" *Extension Journal* 33: 1-5.

Dimidjian, V.J. (1982). "Understanding and Combatting Stress in Family Day Care." *Journal of Child Care* 1: 47-58.

Divine-Hawkins, P. (1981). *Family Day Care In The United States: Executive Summary.* Final Report of the National Day Care Home Study. Washington, DC: Administration of Children, Youth and Families. ED 211 224.

Doherty, G. (1997). *Zero to Six: The Basis for School Readiness.* Ottawa: Applied Research Branch, Human Resources Development Canada.

Doherty, G. (1999). *"You Bet I Care!* Moving to the Family Child Care Phase." *Interaction* 13: 31.

Doherty, G. (2000). "Issues in Canadian Child Care: What Does the Research Tell Us?" *Research Connections* 5.

Doherty, G., Friendly, M. and Oloman, M. (1998). *Women's Support, Women's Work: Child Care in an Era of Deficit Reduction, Devolution, Downsizing and Deregulation.* Ottawa: Status of Women Canada.

Doherty, G., Lero, D.S., Goelman, H., LaGrange, A. and Tougas, J. (2000). *You Bet I Care! A Canada-Wide Study on Wages, Working Conditions and Practices in Child Care Centres.* Guelph, Ontario: Centre for Families, Work and Well-Being, University of Guelph.

Doherty, G., Lero, D.S., Tougas, J., LaGrange, A. and Goelman, H. (In press). *Policies and Practices in Canadian Family Child Care Agencies.* Guelph, Ontario: Centre for Families, Work and Well-Being, University of Guelph.

Dunn, L.M. (1979). *Peabody Picture Vocabulary Test.* Circle Plains, MN: American Guidance Service.

Dunn, L. and Dunn, L. (1981). *Peabody Picture Vocabulary Test* (Revised). Circle Plains, MN: American Guidance Service.

Dunster, L. (1994). *Home Child Care: A Caregiver's Guide.* Ottawa: Child Care Providers' Association.

Eheart, B.K. and Leavitt, R.L. (1986). "Training Day Care Home Providers: Implications for Policy and Research." *Early Childhood Research Quarterly* 1: 119-132.

Eliker, J., Fortner-Wood, C. and Noppe, I.C. (1999). "The Context of Infant Attachment in Family Child Care." *Journal of Applied Developmental Psychology* 20: 319-336.

Ferguson, E. (1998). "The Child-Care Debate: Fading Hopes and Shifting Sands," In C. Baines, P. Evans and S. Neysmith, eds., *Women's Caring: Feminist Perspectives on Social Welfare*, pp. 191-217. Don Mills, Ontario: Oxford University Press.

Fiene, R. and Melnick, S.A. (1989). *Licensure and Program Quality in Early Childhood and Childcare Programs.* Paper presented at the American Educational Research Association annual convention, Boston, MA.

Fischer, J.L. and Eheart, B.K. (1991). "Family Day Care: A Theoretical Basis for Improving Quality." *Early Childhood Research Quarterly* 6: 549-563.

Fosburg, S. (1981). *Family Day Care in the United States: Final Report of the National Day Care Home Study.* Vol. 1. Cambridge, MA: Abt Associates.

Foster, L. and Broad, D. (1998). *Flexible Child Care for Flexible Workers.* Regina, Sask.: Social Policy Research Unit, University of Regina.

Galinsky, E., Howes, C., Kontos, S. and Shinn, M. (1994). *The Study of Children in Family Child Care and Relative Care.* New York: Families and Work Institute.

Gardner, M.F. (1979). *Expressive One-Word Picture Vocabulary Test.* Novato, CA: Academic Therapy Publications.

Goelman, H. (1983). *Manual for Child Observation in the Victoria Day Care Home Study.* Unpublished manuscript. Vancouver: University of British Columbia.

Goelman, H., Doherty, G., Lero, D.S., LaGrange, A. and Tougas, J. (2000). *Caring and Learning Environments: Quality in Child Care Centres Across Canada.* Guelph, Ontario: Centre for Families, Work and Well-Being, University of Guelph.

Goelman, H., and Pence, A.R. (1987). "Effects of Child Care, Family, and Individual Characteristics on Children's Language Development: The Victoria Day Care Research Project." In D.A. Phillips, ed., *Quality in Child Care: What Does the Research Tell Us?* pp. 89-104. Washington, DC: National Association for the Education of Young Children.

ERIC Full Text Provided by ERIC

Goelman, H. and Pence, A.R. (1988). "Children in Three Types of Day Care: Daily Experiences, Quality of Care and Developmental Outcomes." *Early Child Development and Care* 33: 67-76.

Goelman, H. and Pence, A.R. (1991). "Talking to Children: The Effects of the Home and the Family Day Care Environment." In Childcare Resource and Research Unit, ed., *Proceedings from the Child Care Policy and Research Forum, 1991*, pp. 63-88. CRRU Occasional Paper No. 2. Toronto: Centre for Urban and Community Studies, University of Toronto.

Goelman, H. and Pence, A.R. (1994). "Play, Talk, Literacy, and the Ecology of Day Care." In H. Goelman and E.V. Jacobs, eds., *Children's Play in Childcare Settings*, pp. 193-213. Albany, NY: State University of New York Press.

Goelman, H., Rosenthal, M.K. and Pence, A.R. (1990). "Family Day Care in Two Countries: Caregivers, Parents and Children in Israel and Canada." *Child and Youth Quarterly* 9: 251-270.

Goelman, H., Shapiro, E. and Pence, A.R. (1990). "Family Environment and Family Day Care." *Family Relations* 39: 14-19.

Golden, M., Rosenbluth, L., Grossi, M., Policare, H. Freeman, H. and Brownlees, E. (1979). *The New York City Infant Day Care Study.* New York: Medical and Health Research Association of New York Inc.

Gopnick, A., Meltzoff, A.N. and Kuhl, P.K. (1999). *The Scientist in the Crib: Minds, Brains and How Children Learn.* New York: William Morrow.

Goss Gilroy Inc. (1998). *Providing Home Child Care for a Living: A Survey of Providers Working in the Regulated Sector.* Ottawa: Canadian Child Care Federation.

Gunnar, M. (1998). "Quality of Early Care and Buffering of Neuroendocrine Stress Reactions: Potential Effects on the Developing Human Brain." *Preventive Medicine* 27: 208-211.

Guy, K. (1997). *Our Promises to Children.* Ottawa: Canadian Institute of Child Health.

Harms, T. and Clifford, R.M. (1980). *Early Childhood Environment Rating Scale.* New York: Teachers College Press.

Harms, T. and Clifford, R.M. (1989). *Family Day Care Rating Scale.* New York: Teachers College Press.

Harms, T. and Clifford, R.M. (1990). *Infant/Toddler Environment Rating Scale.* New York: Teachers College Press.

Harms, T., Clifford, R.M. and Cryer, D. (1998). *Early Childhood Environment Rating Scale.* Revised ed. New York: Teachers College Press.

Harms, T., Clifford, R.M. and Padan-Belkin, E. (1983). *The Day Care Home Environment Rating Scale.* Chapel Hill, NC: Homebased Day Care Training Project, University of North Carolina at Chapel Hill.

Helburn, S.W., ed. (1995). *Cost, Quality and Child Outcomes in Child Care Centers.* Denver, CO: Department of Economics, University of Colorado at Denver.

Home Child Care Association of Ontario. (1994). *Home Child Care: Discussion Guide.* Toronto: Author.

Howes, C. (1983). "Caregiver Behavior in Center and in Family Day Care." *Journal of Applied Developmental Psychology* 4: 39-53.

Howes, C. (1985). "Determinants of Toddlers' Experience in Day Care: Age of Entry and Quality of Setting." *Child Care Quarterly* 14: 140-151.

ERIC Full Text Provided by ERIC

Howes, C. and Norris, D.J. (1997). "Adding Two School Age Children: Does It Change Quality in Family Child Care?" *Early Childhood Research Quarterly* 12: 327-343.

Howes, C. and Rubenstein, J. (1985). "Determinants of Toddlers' Experiences in Day Care: Age of Entry and Quality of Setting." *Child Care Quarterly* 14: 140-151.

Howes, C. and Stewart, P. (1987). "Child's Play With Adults, Toys and Peers: An Examination of Family and Child-Care Influences." *Developmental Psychology* 23: 423-430.

Hughes, R. (1985). "The Informal Help-Giving of Home and Center Childcare Providers." *Family Relations* 3: 359-366.

Jenson, J. and Stroick, S.M. (1999). *A Policy Blueprint for Canada's Children.* Ottawa: Canadian Policy Research Networks.

Jones, K. (1991). *Job Satisfaction, Commitment to Professionalism, and Perceived Support Systems in Family Day Care Providers.* Wheeling, IL: National-Louis University. ED 353 038.

Jorde-Bloom, P. (1996). *Improving the Quality of Work in the Child Care Setting.* Wheeling, IL: Early Childhood Professional Development Project, National Louis University.

Katz, L.G. (1993). *Five Perspectives on Quality in Early Childhood Programs.* Urbana, IL: ERIC Clearing House on Elementary and Early Childhood Education, Monograph Series No. 1.

Kent, T. (1999). *Social Policy 2000: An Agenda.* Ottawa: Caledon Institute of Social Policy.

Kerr, M.K. and Polyzoi, E. (1996). "Issues and Concerns of Licensed Family Day Care Providers." *Canadian Journal of Research in Early Childhood Education* 5: 39-45.

Kohen, D., Hertzman, C. and Wiens, M. (1998). *Environmental Changes and Children's Competencies.* Ottawa: Applied Research Branch, Human Resources Development Canada.

Kohen, D., Hunter, T., Pence, A. and Goelman, H. (2000). "The Victoria Day Care Research Project: Overview of a Longitudinal Study of Child Care and Human Development." *Canadian Journal of Research in Early Childhood Education* 8: 49-54.

Kontos, S. (1992). *Family Day Care: Out of the Shadows and into the Limelight.* Washington, DC: National Association for the Education of Young Children.

Kontos, S. (1994). "The Ecology of Family Day Care." *Early Childhood Research Quarterly* 9: 87-110.

Kontos, S., Howes, C. and Galinsky, E. (1996). "Does Training Make a Difference to Quality in Family Child Care?" *Early Childhood Research Quarterly* 11: 427-445.

Kontos, S., Howes, C., Shinn, M. and Galinksy, E. (1995). *Quality in Family Child Care and Relative Care.* New York: Teachers College Press.

Kontos, S., Hsu, H.C. and Dunn, L. (1994). "Children's Cognitive and Social Competence in Child-Care Centers and Family Day-Care Homes." *Journal of Applied Developmental Psychology* 15: 387-411.

Kontos, S. and Riessen, J. (1993). "Predictors of Job Satisfaction, Job Stress, and Job Commitment in Family Day Care." *Journal of Applied Developmental Psychology* 14: 427-441.

Kyle, I.J. (1997). "Private and Public Discourses: The Social Context of Child Care." *Canadian Journal of Research in Early Childhood Education* 6: 203-222.

ERIC Full Text Provided by ERIC

Kyle, I.J. (1998). "The Politics of Home Child Carework: Transcending Contradictory Public and Private Discourse." *Canadian Journal of Research in Early Childhood Education* 7: 51-69.

Kyle, I.J. (1999). *Rethinking Carework in Home Child Care: Providers' Perspectives in Context.* Unpublished PhD dissertation. Guelph, Ontario: Department of Family Relations and Applied Nutrition, University of Guelph.

Kyle, I.J. and Kellerman, M. (1998). *Case Studies of Canadian Family Resource Programs.* Ottawa: Canadian Association of Family Resource Programs.

Lamb, M.E., Hwang, C.P., Bookstein, F.L., Broberg, A., Hult, G. and Frodi, M. (1988a). "Determinants of Social Competence in Swedish Preschoolers." *Developmental Psychology* 24: 58-70.

Lamb, M.E., Hwang, C.P., Broberg, A. and Bookstein, F.L. (1988b). "The Effects of Out-of-Home Care on the Development of Social Competence in Sweden: A Longitudinal Study." *Early Childhood Research Quarterly* 3: 379-402.

Larner, M. (1996). "Parents' Perspectives on Quality in Early Care and Education." In S. L. Kagan and N. E. Cohen, eds., *Reinventing Early Care and Education,* pp. 21-42. San Francisco, CA: Jossey-Bass.

Lero, D.S. (1981). *Factors Influencing Parents' Preferences for, and Use of Alternative Child Care Arrangements for Preschool Children.* Guelph, Ontario: University of Guelph, College of Family and Consumer Studies.

Lero, D., Goelman, H., Pence, A.R., Brockman, L.M. and Nuttal, S. (1992). *Parental Work Patterns and Child Care Needs.* Ottawa: Statistics Canada, Cat. 89-529.

Long, F., Garduque, L. and Peters, D. (1983). *Continuity between Home and Family Day Care.* Paper presented at the biennial meeting of the Society of Research in Child Development, Detroit, MI.

Lyon, M. and Canning, P. (1995). *The Atlantic Day Care Study.* St. John's, Nfld: Memorial University of Newfoundland.

McCain, M.N. and Mustard, J.F. (1999). *Reversing the Real Brain Drain: The Early Years Study.* Toronto: Canadian Institute for Advanced Research.

McConnell, B. (1994). *Family Day Care Providers' Perceptions of Support and Levels of Job Satisfaction.* Unpublished MSc thesis. Winnipeg, Manitoba: Department of Family Studies, University of Manitoba.

Modigliani, K. (1990). *Assessing the Quality of Family Child Care: A Comparison of Five Instruments.* New York, NY: Bank Street College of Education.

Modigliani, K. (1994). *Promoting High-Quality Family Child Care.* New Haven, CN: Quality 2000 Initiative, Yale University.

National Council of Welfare. (1999). *Preschool Children: Promises to Keep.* Ottawa: Author.

National Crime Prevention Council. (1996). *It Takes a Whole Community to Prevent Youth Crime.* Ottawa: Author.

National Family Day Care Training Project. (1999). *Synthesis Report.* Ottawa: Canadian Child Care Federation.

National Forum on Health. (1997). *Canada Health Action: Building on the Legacy.* Ottawa: Author.

Nelson, M.K. (1988). "Providing Family Day Care: An Analysis of Home-Based Work." *Social Problems* 35: 78-94.

Nelson, M.K. (1990). "A Study of Turnover among Family Day Care Providers." *Children Today* 19: 8-13.

Nelson, M.K. (1991). "The Regulation Controversy in Family Day Care: The Perspective of Providers." In J.S. Hyde and M.J. Essex, eds., *Parental Leave and Child Care: Setting a Research and Policy Agenda*, pp. 354-372. Philadelpia, PA: Temple University Press.

NICHD Early Child Care Research Network. (1996). "Characteristics of Infant Child Care: Factors Contributing to Positive Caregiving." *Early Childhood Research Quarterly* 11: 269-306.

Norpark. (1989). *A Survey of Private Home Day Care Services in Ontario, 1988.* Toronto: Queen's Printer for Ontario.

Palys, R. (1997). *Research Decisions: Quantitative and Qualitative Perspectives.* Toronto: Harcourt Brace Canada.

Pence, A.R. and Goelman, H. (1987). "Who Cares for the Child in Day Care? An Examination of Caregivers from Three Types of Care." *Early Childhood Research Quarterly* 2: 315-334.

Pence, A.R. and Goelman, H. (1991). "The Relationship of Regulation, Training and Motivation to Quality of Care in Family Day Care." *Child and Youth Forum* 20: 83-101.

Pepper, S. and Stuart, B. (1992). "Quality of Family Day Care in Licensed and Unlicensed Homes." *Canadian Journal of Research in Early Childhood Education* 3: 109-118.

Phillips, D., McCartney, K. and Scarr, S. (1987). "Child Care Quality and Children's Social Development." *Developmental Psychology* 23: 537-543.

Ontario, Government of. (1997). *Day Nurseries Act* and *Regulation 262.* Toronto: Queen's Printer for Ontario.

Read, M. and LaGrange, A. (1990). *Those Who Care: A Report on Approved Family Day Home Providers in Alberta.* Red Deer, Alta: Child Care Matters.

Rosenthal, M.K. (1994). "Social and Non-Social Play of Infants and Toddlers in Family Day Care." In H. Goelman and E.V. Jacobs, eds., *Children's Play in Child Care Settings*, pp. 163-192. Albany, NY: State University of New York.

Rubenstein, J. and Howes, C. (1983). "Adaptation to Infant Day Care." In. S. Kilmer, ed., *Advances in Early Education and Day Care*, Vol. 3, pp. 13-45. Greenwich, CN: JAI Press.

Stith, S.M. and Davis, A.J. (1984). "Employed Mothers and Family Day Care Substitute Caregivers: A Comparative Analysis of Infant Care." *Child Development* 55: 1340-1348.

Stuart, B. and Pepper, S. (1988). "The Contribution of Caregivers' Personality and Vocational Interests to Quality in Licensed Family Day Care." *Canadian Journal of Research in Early Childhood Education* 2: 99-109.

Tabachnick, B.G. and Fidell, L.S. (1996). *Using Multivariate Statistics.* 3d ed. New York: HarperCollins.

Taylor, A.R., Dunster, L. and Pollard, J. (1999). "... and This Helps Me How? Family Child Care Providers Discuss Training." *Early Childhood Research Quarterly* 14: 285-312.

Thorndike, R.L., Hagen, E.P., Sattler, J.M. and Delaney, E.A. (1986). *Quick Battery of the Stanford-Binet Intelligence Scales.* 4th ed. New York: Riverside.

Todd, C.M. and Deery-Schmitt, D.M. (1996). "Factors Affecting Turnover Among Family Child Care Providers: A Longitudinal Study." *Early Childhood Research Quarterly* 11: 351-376.

Trawick-Smith, J. and Lambert, L. (1995). "The Unique Challenges of the Family Child Care Provider." *Young Children* 50: 25-32.

Vandell, D.L. (1999). *Cognitive, Linguistic and Social Consequences of Early Experience: Child Care and Social Competence: NICHD Study.* Paper presented at the American Association for the Advancement of Science Meetings, Anaheim, CA, January 21-26.

Vandell, D.L. and Wolfe, B. (2000). *Child Care Quality: Does It Matter and Does It Need to be Improved?* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Western Canada Family Child Care Association of B.C. (1996). *Good Beginnings.* Delta, BC: Author.

Whitebook, M., Howes, C. and Phillips, D. (1990). *Who Cares? Child Care Teachers and the Quality of Care in America.* Final Report of the National Staffing Study. Oakland, CA: Child Care Employee Project.

Wormeli, C.T. and Carter, D.E. (1990). *Canada Quick Individual Educational Test.* White Rock, BC: Canadian Edumetrics.

Glossary of Abbreviations

CCAAC	Child Care Advocacy Association of Canada
CCCF	Canadian Child Care Federation
CCRRP	Child care resource and referral program
CCV	Child Care Visions Program, Social Development Partnerships Division, Human Resources Development Canada
CIS	*Caregiver Interaction Scale*
C/QPP	Canada/Québec Pension Plan
ECCE	Early Childhood Care and Education
ECERS	*Early Childhood Environment Rating Scale*
ECERS–R	*Early Childhood Environment Rating Scale–Revised*
FDCRS	*Family Day Care Rating Scale*
FRP	Family resource program
HOME	*Home Observation for Measurement of the Environment*
NICHD	National Institute of Child Health and Human Development (U.S.)
NLSCY	National Longitudinal Survey of Children and Youth (Canada)
SD	Standard deviation
SES	Socio-econonomic status

Notes

ERIC

ERIC Full Text Provided by ERIC

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

EFF-089 (3/2000)

PS029277