

License-Exempt Child Care Providers: A Needs Assessment
for Designing an Implementation Model

by
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Approval Page

This applied dissertation was submitted by Linda Joyce Roseburr under the direction of the persons listed below. It was submitted to the Fischler School of Education and Human Services and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova Southeastern University.



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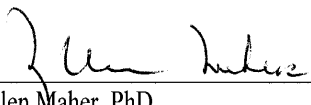
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Abstract

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Many children from low-income families appear to be not receiving quality child care from their license-exempt subsidized child-care providers. The purpose of this qualitative case study was to obtain data from a sample of license-exempt providers/caregivers and parents from a mailed self-administered survey and telephone interview.

Four research questions guided this study:

1. How can information about becoming a child-care provider or hiring a particular license-exempt provider be used to improve the child-care subsidy system?
2. How does a public agency provide services to address the impact on the children's development regarding their emotional health, social development, intellectual development, and physical health?
3. What can a public agency provide to providers or parents to help improve the quality of care?
4. What changes can a public agency make to improve the subsidy system?

The study found that caregivers and parents largely choose this type of care for the child because they are family members and to provide the best care for the child. Data also showed that parents decided to use their exempt caregiver because they trust them. Over 90% of the caregivers and parents, who responded, believe the children's physical, emotional, social and intellectual development are good. Over 85% of those surveyed are satisfied with the services that they are receiving from the public agency that authorizes their subsidized child care. An ethical dilemma is discussed.

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Chapter 1: Introduction

Introduction of Study

Studies have shown that children are entitled to receive quality child care as a path to becoming healthy, happy, and fully developed functioning adults. Despite these findings (Brown-Lyons, Robertson, & Layzer, 2001; Elicker et al., 2005; Fuller, Kagan, Loeb, & Chang, 2004; Kontos, Howes, Shinn, & Galinsky, 1995; Whitebook et al., 2003; Whitebook, Phillips, Bellm, Almaraz, & Jo, 2004), many children appear to not be receiving quality child care from their license-exempt providers. Consequently, a research project of this nature was necessary to address the need to improve the quality of care provided by these caregivers. This research was also needed to fill a gap in the literature that did not address how the quality of child care from license-exempt providers could be improved. According to Kaufman and English (1979), to address this issue a needs assessment needed to be completed in order to identify the “outcome gaps” that needed to be solved between the current situation and the desired situation with this type of child-care provider (p. 213).

Existing research indicated that a large percentage of exempt child-care providers, including from friends and relatives, is only adequate or of minimal quality. In addition, there are over 445,000 children living in poverty nationwide, whose parents are receiving subsidized child care, who are being cared for by exempt providers. According to research (Berk, 2005; Diamond, 1988; Schore, 2000; Witte-Townsend & Whiting, 2003; World Health Organization [WHO], 2004), it is extremely important that the quality of the child care being provided to the children is excellent, in order for the brain, emotional, social, literacy, and physical health and development of the children to be optimized.

Overview of Child Care

The care of the young children takes place in many different kinds of settings and from people having a wide range of relationships to the child. Child care can be provided by parents, relatives, friends, neighbors, child-care professionals, nannies, or strangers. Some of the more common examples of settings are the child's home, friends, or relative's homes, a child-care professional's home or a child-care center.

The majority of children in the United States are now cared for at least once per week by someone other than their parents. The type of child care used varies, depending on family income, household composition, geographic location, and race or ethnicity. For young children under 5 years, more than two thirds of these children experience nonparental care approximately 28 hours per week. The center-based care is the most common nonparental arrangement (30%) for children under 5 years. The next largest type of arrangement for this age group is relative care (22%); then family child care (11%); and nannies or babysitters, including friends and neighbors, have the smallest percentage for care (6%). However, relative care is the most common form of care for infants and toddlers and among Hispanic children. Children from higher income families are more likely to use the center-based care. Another name for the person or people who give the nonparental care is the *child-care provider, provider, or caregiver*. These caregivers can be divided into state-licensed providers, usually the center-based or family day-care providers, and those who are exempt from licensure, or relatives and friends. Researchers (Behrman, 2001; Sonenstein, Gates, Schmidt, & Bolshun, 2002; Tout, Zaslow, Romano Papillo, & Vandivere, 2001) stated that even though relative care is used somewhat more often by low-socioeconomic minority families, it is relied on by parents of all income levels and ethnicities.

Description of the community. This research study took place in a community located in the southwestern region of the United States. This region has a moderate year-round climate and the geographic features range from coastal to mountainous. According to the state's *2005 Child Care Portfolio* (California Child Care Resource and Referral Network, 2005), there are over 811,500 residents currently living in the target county. The mountainous interior and heavily populated coastline is culturally diverse. The economy of the region consists of manufacturing, service, and high-tech industries in the urban areas and agriculture in the rural areas. Many of the families in the region qualify for low-income, subsidized, child-care benefits and approximately 13% of the 90,204 children are living in poverty (California Child Care Resource and Referral Network).

Demographic information. The ethnic distribution in the county is approximately 57% White; 33% Hispanic, 2% African American; 5% Asian; 1% American Indian or Pacific Islander; and 2% designated as multiracial (Community Commission for Ventura County, 2006). The number of children from zero to 13 years of age with parents in the labor force in the county is approximately 90,204, which represents 55% of the total population of 164,722. There are only 25,693 licensed child-care slots for this number of children. Therefore, only 28% of children with parents in the labor force have a licensed child-care slot available (California Child Care Resource & Referral Network, 2005). In the county, a family with one minimum wage earner would use 57% of their annual income of \$14,040 for the care of one infant in a licensed-family child-care home (California Child Care Resource & Referral Network).

The setting of the study. The researcher's agency has over 380 employees and a budget of over \$44 million (California State Senate Office of Research, 2001). It has a

long and proven track record of developing and administering Head Start, Resource and Referral, and Subsidized Child Care Programs. The organization was incorporated in 1980 and it continues to serve children and families with strong partnerships with other community-based organizations who serve the same low-income population.

The organization's vision. The organization's vision is that every child's growth and development will be fully supported to ensure a happy and successful adult life. The state and federal programs that the agency administers serve children from birth to the age of 13 years. The board of directors consisted of doctors, teachers, and administrators from social service agencies whose vision and goals align with the researcher's agency. When making administrative decisions, the board members always keep in mind the agency's most important customers, the children that they serve.

The organization's mission. The organization provides the foundation to build promising futures for its children. It collaborates with parents and community organizations to deliver programs that enrich lives. A goal of the organization is to serve children and families by providing education and referral services to child-care providers in order to improve the quality of the care that is given to the children. Quality consists of maintaining diligent health and safety practices, encouraging oral language development, providing materials and activities that foster learning, providing warm and responsive interactions to the children, and maintaining an environment that is nontraumatic for the children.

The researcher's responsibilities within the organization. The researcher is one of the Child Care Services Managers for the Subsidized Child Care programs. One of the researcher's major responsibilities is to ensure that the state and county laws are followed while administering four state and county programs.

Subsidized Child Care is funded by the federal and state government to assist low-income families with child-care costs for their children up to 13 years of age. Parents, who receive the subsidy, must be current or former cash assistance recipients or have very low income. For parents who qualify, the agency pays the child-care provider or caregiver on behalf of the parent.

History of the subsidy system for child care. Boschee and Jacobs (1998) explained that the need for nonparental care began in the mid-19th century when the family structure began to change; mothers began to go to work in greater numbers and the welfare movement began. Nurseries, as they were called, were established in the 1840s in Boston to care for the children of working wives and widows of the merchant seamen in the area. Settlement houses, established by Adams, also provided care for the children during the day while their newly-immigrated parents worked. The federal government began to subsidize day care during the Great Depression and, during World War II, the federal government subsidized 400,000 children in preschools because the mothers were needed to work in the factories.

In 1965, President Johnson established the Head Start Preschool program for disadvantaged children. Then in 1994, the Early Head Start program for infants and toddlers was added. Both of these Head Start programs included health and parent participation components.

In 1988, the Family Support Act was passed, establishing time limits for welfare, requiring self-sufficiency activities, including employment, training, education and job search; and making subsidized child care for welfare families an entitlement. In 1990, the federal funding expanded with the Child Care and Development Block Grant, also known as the Child Care and Development Fund, and the At-Risk Child Care Grants (Adams,

Holcomb, Snyder, Koralek, & Capizzano, 2006).

Another major increase in the amount of funding provided by the federal government for subsidized child care occurred in 1996 when the federal government passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which included the Temporary Assistance for Needy Families block grant (Hirshberg, 2002). Child care was needed to support families while they participated in activities to help them become self-sufficient (Hirshberg) so the amount of funding increased. The total federal Child Care and Development Block Grant funds available nationwide in 1997 was \$1,986 million. This increase by \$2,817 million over the years, ending with \$4,803 million being spent on subsidized child care under the Child Care and Development Block Grant in 2003 (Butler & Gish, 2003).

After the passage of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the establishment of Temporary Assistance for Needy Families, states were required to provide child care to the families as they moved from welfare to self-sufficiency. The Urban Institute released a report in 2006 (Adams et al., 2006) on a study that looked at how 11 sites throughout the United States implemented these complex child-care laws. One of their main findings was that connecting the child care to the welfare-to-work strategies is very complex and that there are tremendous differences with how the different states implemented the legislation. Some had their welfare-to-work staff complete the paperwork for the child care also and some had two different agencies complete the paperwork eligibility process. Adams et al. suggested that one of the possible results of this complex system is that it may increase the likelihood that parents will select less formal providers, such as friends and relatives, and they stated that it would be interesting to research this further.

Types of providers contracted to give subsidized child care and parent choice.

State and county laws state that parents can select either state-licensed providers, called licensed providers or exempt-from-licensure providers called license-exempt or exempt providers, to care for their children. This is referred to as *parent choice*. License-exempt providers are usually friends or relatives of the children and they are not monitored by the state as are the licensed providers. According to the National Association of Child Care Resource and Referral Agencies (2007) Web site, there are currently 290,466 regulated or licensed-family child-care homes, 117,053 regulated or licensed child-care centers, 804,000 paid and unregulated (license-exempt) relatives, and 298,000 paid unregulated (license-exempt) nonrelatives providing child care nationwide. These numbers include subsidized and nonsubsidized care. Nationwide, approximately 1,782,000 children are receiving subsidized or publicly funded child care and, of those, 445,500 (25%) children per month are receiving subsidized child care from one of the license-exempt unregulated child-care providers (U.S. Department of Health & Human Services, 2005).

At the time of this study, there was a debate about whether government should increase the amount of funding for subsidized child care or pass legislation that would help parents to stay home to care for their children. Parental leave in the United States is unpaid and relatively short in contrast some other nations who offer paid leaves of 10 months or more. Child care in many of the European countries is provided through publicly-funded programs while, in the United States, help to parents is in the form of a subsidy or tax credit. According to the Social Policy Action Network in Washington, District of Columbia, the American public is strongly in favor of parental choice regarding child care and that the best role for government is to guarantee beneficial and safe child-care options for parents (Behrman, 2001).

The target organization for this research study is mandated to allow parent choice when subsidized child-care providers are selected by the parents. All providers selected by the parents to provide child care for their children must sign a contract with the organization. The parent *hires* the provider; which is operationally defined as choosing that individual to care for that parent's child and the subsidy pays for the care, not the parent.

Subsidized license-exempt child care. A report from the California Child Care Resource and Referral Network's Task Force on License-Exempt Child Care (2004) defined child care that is exempt from state licensing requirements or *license-exempt* as any person providing care for the children of only one family, in addition to the operator's own children; any care and supervision of persons by a relative or guardian; certain school-aged, public, and private recreation programs; cooperative nonpaid arrangements between parents and child care on federal lands. This type of child care is also referred to as kith and kin; unregulated family, friend, and neighbor (FFN) or informal. Kreader and Lawrence (2006) identified several themes regarding FFN providers at a symposium that they held on November 2, 2005. One of those themes was that FFN child care is complex and that it has both strengths and weaknesses. A strength of this type of care is that it often helps to provide stability and continuity of care in some situations. A weakness is that the caregiver education level is somewhat low and there are health and safety issues that need to be addressed. Two other themes were that FFN care often transmits the family's language and culture to the children and the caregivers do want support. Many parents choose FFN providers because they trust them; there is often a low child:adult ratio and because they can often provide the care during evening and weekend hours when licensed care is in short supply. According to research conducted by

Vandell and Wolfe (2000), one third of all the working-poor mothers and more than a quarter of working class mothers work weekends. In addition, half of working class parents work rotating shifts while only 10% of the child-care centers and 6% of family day-care home provide weekend care.

Definition of child-care quality. Vandell and Wolfe (2000) conducted a qualitative study in which they examined various studies regarding child-care quality. What Vandell and Wolfe found is that quality is currently measured in two ways: by “process quality . . . [and by] structural quality” (pp. 3-4). Process quality is determined by observing what happens in the child-care setting. The observer looks at children’s interactions with the caregivers and the other children (i.e., language interactions) and health and safety measures are also used. Process quality is widely measured by using the various rating scales developed by Harms and Clifford (1981). They have developed three instruments that measure the process quality for licensed infant and toddler care, licensed early childhood care in centers, and child care in licensed-family day-care homes. Structural quality is evaluated by measuring the characteristics of the child-care setting, including child:adult ratio and size of each group of children, and amount of formal education and training the caregivers have received (Vandell & Wolfe, 2000).

Limitations on the definition of child-care quality. The current ways of evaluating quality in various child-care settings does not take into consideration the depth of the relationship that the child has with the caregiver, such as with a grandmother, compared to the relationship with a teacher or a neighbor. In addition, the instruments used for the process evaluations were designed specifically for licensed child care; therefore, they may not adequately evaluate the more informal license-exempt care.

Another shortcoming with the way quality evaluated at the time of this study is

that the amount of stress, trauma, or exposure to violence for the child in a child-care setting has not been measured in any of the studies that the researcher was able to find while conducting the literature review. However, even though those evaluation methods for quality have limitations, they were the only tools available at that particular time. The studies using those measures were cited in this study. The reader should keep in mind that these studies may not give a totally complete and accurate picture of the quality of license-exempt child care. In this study, the opinions, attitudes, and suggestions were gathered from active license-exempt providers and parents that provided additional insight into the quality issue. These are discussed in the results and discussion chapters of this report.

Nature of the Problem

The problem addressed in this study was that existing research (Brown-Lyons et al., 2001; Elicker et al., 2005; Fuller et al., 2004; Kontos et al., 1995; Whitebook et al., 2003, 2004) indicated that license-exempt caregivers were having difficulties providing the care necessary to maximize the emotional, social, physical, and cognitive development of the children. Because no clear guidance for the improvement of care is provided in the literature, the goal of this study was to determine how best to standardize the child-care practices for all of the license-exempt child-care providers by developing a needs assessment for an implementation model for quality child care. The studies described in this study provide evidence of this significant problem. The problem is that many children from low-income families do not appear to be receiving quality care, as it is currently defined, from their license-exempt subsidized child-care providers. Therefore, it is essential that the caliber of care from these types of providers be improved in certain areas.

Background and Significance of the Problem

In a study that observed 226 license-exempt providers in their homes while caring for the child or children of their friend or relative, Kontos et al. (1995) wrote that “only 9% of the providers were observed to be providing good quality care, whereas 35% were rated as providing inadequate quality care. The remaining providers (56%) were rated as providing adequate or custodial quality care” (p. 206). License-exempt child care is the largest type of child care currently being used for children under 5 years of age (Hirshberg, 2002). Taxpayer-supported child care from friends and relatives (license exempt) was allowed for the first time when the Child Care and Development Block Grant and the Family Support Act were passed in 1994. Prior to that year, this type of child care was a private matter. Now it has become a matter for public concern even though little was known about it (Kontos et al.).

The Family Day Care Rating Scale (FDCRS) developed by Harms and Clifford (1981) is a reliable and valid measurement scale that is commonly used among child-care professionals to determine the quality of care in a family day-care setting. Harms and Clifford evaluated quality in three main areas: health and safety, relationships with others, and opportunities for stimulation and learning by using the 40-item FDCRS rating scale instrument. In addition, there are seven subscales of space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children (Frank Porter Graham Child Development Institute, 2006). There are four levels of quality: inadequate, minimal, good, and excellent (Harms & Clifford).

In a study in which 118 license-exempt providers were evaluated for quality using the FDCRS instrument, the mean scale score was 2.6 where a rating of 1 = *inadequate*

and 3 = *minimal* (Fuller et al., 2004). Fuller et al. found that more license-exempt providers had not completed high school or taken early care and education units than the center-based teachers or licensed family child care home providers.

Elicker et al. (2005) conducted a study in Indiana with 307 children and found that the

. . . average level of child-care quality observed was below good, and just above minimal [using the FDCRS instrument] . . . Overall, licensed settings were of higher global quality than unlicensed settings . . . [and the infant and toddler care was of the lowest quality. They assessed the infants and toddlers in this study on visual reception, fine motor skills, and receptive and expressive vocabulary; and found that the majority of them were less advanced in these areas than average children of the same age. In addition, Elicker et al. reported that the preschool-aged children being cared for in centers scored higher in cognitive competence than did the children in home-based care and] preschool-age children in child-care settings of higher global quality ([ECER-R] or FDCRS) scored higher on early academic skills than children in child-care settings of lower global quality. (pp. 53-59)

Another study by Brown-Lyons et al. (2001) that highlighted research about license-exempt providers found that they “emphasized physical care and keeping children safe and healthy over opportunities for educational or social development [and] overall, there was little creative or expressive play, and little emphasis was placed on activities that promoted literacy” (p. 90).

Whitebook et al. (2003) wrote that some license-exempt providers are also unstable, with “only 31% of providers remaining on the subsidy lists 12 months later . . . [and] a change in child-care provider was more likely to be initiated by the provider than by the parent” (p. 6). This instability of care is not conducive to forming a healthy attachment between the child and caregiver and is, therefore, not of optimal quality. Whitebook et al. (2004) found the agency staff who determined eligibility for those license-exempt providers often expressed concerns that they were unable to guarantee

safe or even adequate care from this type of caregiver because the friend and relative caregivers are not subject to state oversight and are not even required to take health and safety classes.

According to a report (Whitebook et al., 2004) issued by the Center for the Study of Child Care Employment at the University of California at Berkeley,

While we have only been able to scratch the surface in studying the largely unexamined license-exempt sector of child-care services, our case studies of a small sample of providers, in combination with focus groups and a review of local administrative data, raise significant concerns about variability, instability and lack of oversight in the subsidized portion of this sector. (p. 14)

Purpose of the Study

The purpose of this mixed-methods case study was to obtain quantitative and qualitative data reflecting demographic data and current and desired results from a sample of license-exempt providers and the parents who selected these particular caregivers. At the time of the study, the organization had a signed contract with 681 license-exempt subsidized child-care providers (557 relatives and 124 nonrelatives). Ten providers and 10 parents who completed the open-ended questions and returned the written surveys were randomly selected to clarify their viewpoints in telephone interviews, in order to capture a more in-depth understanding of their attitudes and practices.

In the first phase (Kaufman, 1975), quantitative and qualitative research questions in the form of a needs assessment addressed the comparison between current results “what is [for children receiving care from a sample of license-exempt child-care providers and parents and the desired results] or what should be” (p. 95), according to those surveyed. In the second phase, 20 qualitative interviews with providers and parents were conducted to further investigate the current and desired results and how the quality

of care and the subsidy system could be improved (Creswell, 2003). Both parents and providers were surveyed and interviewed in order to compare and contrast their responses to both the quantitative demographic data and the qualitative responses that they gave. Their thick descriptions were provided to the researcher and were used in this report to explain their attitudes and beliefs and to give the reader information to use in their own settings, as applicable (Miles & Huberman, 1994).

The desired results were determined and the outcome gaps discovered. A research-based needs assessment emerged from the data that was collected and analyzed (Kaufman, 1975). This needs assessment was used as a starting point for developing an implementation plan for new quality programs or making quality improvements to the current programs.

Research Questions

Based on the years of experience as a licensed child-care provider and manager for subsidized child care and the knowledge obtained from research on this topic, the following initial research questions were developed for this study:

1. How can information about becoming a child-care provider or hiring a particular license-exempt provider be used to improve the child-care subsidy system?
2. How does a public agency provide services to address the impact on the children's development regarding their emotional health, social development, intellectual development, and physical health?
3. What can a public agency provide to providers or parents to help improve the quality of care?
4. What changes can a public agency make to improve the subsidy system?

As mentioned earlier, license-exempt providers are usually friends or relatives of the

children (license-exempt) and they are not monitored by the state, as are the licensed providers.

Summary

The answers to these questions would give legislators, administrators, parent and provider educators, and the parents and providers themselves, the research-based information on which to base their decisions for improving the quality of care and subsidy system. It was expected that the needs assessment for developing an implementation model could be used in other states or nationwide to increase the quality of care for the large number of children under the supervision of the license-exempt child-care providers. It may also provide insight for licensed child-care providers in these areas.

Definition of Terms

For this study, the following terms are defined for clarity.

Child-care provider or caregiver refers to a male or female who provides care for a child or children in the absence of the guardian of a child or children.

In-home child care refers to child care that is provided in the home where the child resides.

License-exempt or exempt child-care provider, according to California Department of Social Services (2004), refers to “any family day-care home providing care for the children of only one family in addition to the operator’s own children . . . [(i.e., friend or neighbor) or] any arrangement for the receiving and care of children by a relative” (p. 10).

Outside home refers to child care that is provided outside of the child’s home.

Relative is defined by California Department of Social Services (2004) as

“grandparent, aunt, uncle, or adult sibling of at least one of the children in the cooperative” (p. 10).

Chapter 2: Review of Related Literature

Introduction

An in-depth review of the literature was conducted to provide an understanding of the status of the license-exempt child care that children in poverty receive, to determine the gaps in the research, and to develop the research questions for this study. The review of the literature also assisted the researcher in determining the outcome gaps and how to fill those gaps in the services that public agencies can provide.

Child Care for Children in Poverty

At the time of this study, 30% of all children in the United States live in poverty. In 2000, there were 12.1 million children living in poverty and, in the last 5 years, this number has increased by 1.4 million children (Douglas-Hall & Koball, 2006).

Prior to 1996, the federal law required states to provide child-care assistance to families on welfare and families who were recently discontinued from welfare. Funding was guaranteed to the states to cover the cost. However, the 1996 welfare law eliminated this guarantee and left it up to the states to decide which families received child-care assistance (Blank, Adams, Ebb, & Schulman, 1998). Only half of the states have maintained a guarantee for the families on welfare; 27 states cover families who have just left welfare and other states have eliminated all guarantees of child-care assistance, even for families on or leaving welfare (Blank et al.).

The Policy Analysis for California Education (2000) conducted a study in 1998 of 948 single mothers with young children and found that mothers participating in the welfare-to-work program were choosing low-quality child care, that the distribution of subsidized child care was unequal among poor families, which encouraged the use of unlicensed care, and that high rates of maternal depression and uneven parenting was

limiting children's early learning and development. This study found that most of the children of mothers participating in welfare reform were placing their children with relatives and friends in home-based settings rather than in child-care centers. The providers of home-based home care provided fewer educational materials, used television and videos to a greater extent, and had unclean facilities.

In 1991, a longitudinal study (National Institute of Child Health & Human Development [NICHD], 1998) of the first 7 years of 1,300 children's lives was conducted "to determine how variations in child care are related to their development" (p. 5). The findings of NICHD were divided into four main categories, including characteristics of "regulable" child care (i.e., adult:child ratios, patterns of care in the 1st year of life, child care for children in poverty), the role of the family, how child care relates to child development, and how child care affects children's relationship with their mothers (p. 11). This study found that the average number of hours per week of child care in the 1st year of life was 33 hours. This varied, however, with the ethnicity of the child and family. White, non-Hispanics averaged the fewest hours and African Americans the most. Most infants were placed in informal child-care arrangements prior to 4 months of age. Almost 35% of the families in this study were living in poverty or near poverty. According to a report published on the study by NICHD, "Children from families in poverty who were cared for in home settings (by a child-care home provider or family member) received relatively low-quality care" (p. 14).

Enriched Human Relationships are Important

Attachment. Babies and young children are dependent on the care they receive from their caregivers for all of their physical and psychological needs. One of the findings from a WHO (2004) study is that "sensitive and responsive caregiving is a

requirement for the healthy neurophysiological, physical and psychological development of a child” (p. 1).

In 1948, the WHO decided to fund a study of the needs of homeless children due to the widespread dislocation of children after World War II. WHO hired Bowlby (as cited in WHO, 2004) conducted the study and published *Maternal Care and Mental Health Study* in 1952. In that study, Bowlby (as cited in WHO) found that the formation of an ongoing, warm relationship with a caregiver was extremely important to the child’s survival and healthy development.

Poor-quality child care and many hours in child care may contribute to a higher rate of insecure attachment between infants and employed mothers. According to the NICHD (1998) study, when babies were exposed to combined home and child-care risk factors, such as insensitive caregiving or more than one child-care arrangement, the rate of insecurity increased. Therefore, it is crucial to increase the quality of child care for young children.

One of the sources that the writer discovered, while doing this literature review, was a paper written for Head Start’s Fifth National Research Conference in 2000 by Schore. The subject of the paper was based on Schore’s research and related research on the *Parent-Infant Communication and the Neurobiology of Emotional Development*. The main point of the paper was that when a secure attachment occurs between an infant and the primary caregiver, the attachment regulatory system that develops in the right brain during the first 3 years of life is healthy and the child is better able to cope with stress. Schore emphasized that the social-emotional experiences provided by the primary caregiver directly contributes to the development of the limbic areas of the brain needed for processing emotion and adapting to changes in the environment (Schore). Therefore,

quality caregiving should consist of activities that strengthen the emotional attachment between the child and the caregiver.

Literacy-enhancing activities between caregiver and child. During research of the brain, Diamond (1988) discovered that cortical neurons become larger in an enriched and stimulating environment and they decrease in size in a deprived environment. However, Diamond stressed that it is important to not overstimulate the brain because researchers have not yet discovered the limits of the brain regarding stimulation. Therefore, it is important for caregivers to provide a stimulating environment for children at their appropriate developmental level while not overstimulating them.

In addition to fostering healthy brain, emotional, and social development in children, quality child care that is rich in oral language and other literacy-building activities is essential for later success in school. Witte-Townsend and Whiting (2003) emphasized that every instance of oral language heard by a child is important because they affect the development of the areas of the brain that foster literacy development. If these sections of the brain are not developed before the child starts school, it becomes much more difficult for the child to use these language areas of the brain.

One study found that the strongest predictor for ongoing speech difficulties was phonological skill. In this study, a group of 12 preschool children who had participated in a phonological intervention program 3 years before were reassessed. According to Bernhardt and Major (2005), the results showed that

Five of the children had residual phonological impairment. Only two children showed below average reading (decoding and comprehension), although five also showed below average spelling performance. [Bernhardt and Major suggested in the results that the] risk for literacy and ongoing speech impairment can be reduced through early intervention that draws attention to the structure of words. (pp. 1-2)

Activities, such as reading aloud, singing, storytelling and talking, in any language, are examples of activities that draw attention to the structure of speech and words.

Caregivers, parents, and other family members can play an important part in supporting a child's phonological awareness development. A study by Skibbe, Behnke, and Justice (2004) showed that mothers were successful in scaffolding and increasing their children's task performance on phonological awareness skills. According to Skibbe et al., the three children "of mothers who used more scaffolds overall and who decreased their scaffolds over sessions (including directives) were able to perform independently and accurately on more phonological awareness tasks at the end of four sessions than the other two children" (p. 189).

Quality child care that is rich in oral language, reading, and other literacy-building activities is especially important for children living in poverty. Hart and Risley (1995) conducted a longitudinal study of 42 children from the age of 1 year to 3 years. They found that race, ethnicity, gender, or birth order do not matter very much regarding language development; however, how economically advantaged a child is makes a very significant difference. In fact, Hart and Risley found that the children from the welfare families experienced approximately 153,000 fewer words per 100-hour week than the children living in the professional families. In addition, this gap in the number of words experienced continued to widen over time, giving the economically disadvantaged children significantly less experience with language, which hinders literacy development. Hart and Risley recommended making quality child care affordable for all parents as a solution to this problem.

Enriched social interactions. Several studies (Bakermans-Kranenburg, van IJzendoorn, & Bradley, 2005; Shonkoff & Phillips, 2000; Wishard, Shivers, Howes, &

Ritchie, 2003) have found that children exposed to enriched social interactions that are warm, responsive, and harmonious are more likely to form healthy social relationships with peers and adults. According to a study by Tout, de Haan, Kipp Campbell, and Gunnar (1998) on the levels of the stress-sensitive hormone, Cortisol, in preschool children, placing young children in settings away from their homes and in challenging social situations can cause an increase in the amount of this stress hormone.

An Enriched Physical Environment is Important

Quality child care includes opportunities for small and large motor development. Limbs, muscles, and the senses need to be exercised and stimulated by a large variety and number of indoor and outdoor toys, sports equipment, books, and art supplies for proper growth and development to occur (Berk, 2005). Thompson (2001) emphasized that it is also important that caregivers provide a safe and healthy physical environment for a young child that includes protection from harmful exposure to dangerous substances or unsafe situations and a healthy diet that is not deficient in iron or vitamins.

The Absence of Harm to the Child and Exposure to Violence is Important

Besides the quality criteria developed by Harms and Clifford (1981), an absence of trauma is essential for quality child care to exist. This criterion for quality was not part of the evaluation methods used among child-care professionals at the time of this study. However, Perry (1994) stressed the devastating effects that traumatic experiences can have on a child. They can actually alter the physical, emotional, cognitive, and social development of the child. The trauma causes a range of negative emotions, such as fear, pain, and anxiety. Dissociation and hyperarousal are common ways that the child adapts to the memory of this trauma. These children also suffer from posttraumatic stress, such as reexperiencing the event or having nightmares. Because trauma is so harmful to

children, it appears that it is an important consideration for quality. Trauma includes any kind of physical, emotional, or sexual abuse as well as witnessing community or domestic violence, accidents, or even violence on the television. Vessey, Yim-Chiplis, and MacKenzie (1998) stressed that exposure to television violence on fictional and news reports makes the world seem frightening and can lead to nightmares and sleep problems. Viewing violence on television can also lead children to becoming afraid of being victims. The researcher was unable to locate any studies that examined this area of trauma, related to the care being received from license-exempt providers. In fact, even though there are studies (Collins & Carlson, 1998; Elicker et al., 2005; Fuller et al., 2004) that show that the average care given by license-exempt providers, Elicker et al. stated that care is “minimal,” there is very little information about what specifically is needed for total quality child care to be provided, especially with the license-exempt providers (p. 59).

The Conflicting Values of Family Care Versus Business or Governmentally Controlled Care

Parents of young children have to make decisions about the type of child care that is best for their children in the context of society and the public policies that have been put in place. A poll called *Issues in the 2000 Election: Values* (Sylvester, 2001) conducted in 2000 by *The Washington Post*, the Kaiser Family Foundation, and Harvard University, showed that even though the government put millions of dollars into child care since 1990 with welfare reform, tax credits, and family medical leave and private entrepreneurs have begun to invest in the child-care industry, most parents consider child care for their children a personal decision and their responsibility. In fact, Zinsser (2001) stated that even though the percentage of children under 6 years, who are being cared for

in child-care centers, tripled from 1965 to 1994, the percentage of children who spend their days in the home of a relative barely changed over the same time period. This demonstrates that about the same proportion of parents rely on relative care, like their parents and grandparents did. Another poll conducted in 1997 by the Pew Research Center showed that Americans believe that parents should spend more time with their children and that the mother should be the one to stay at home, if there is a choice. However, even though the polls show this parental attitude, demographic trends showed the opposite.

In 1976, only 31% of mothers with babies younger than Age 1 were working; in 1998, this percentage was 59% (Sylvester). More mothers with children under 1 year were working; however, Shonkoff and Phillips (2000) explained that many parents who were working, were also adjusting their hours so child care could be kept in the family. It appeared that it is an economic necessity for both parents to work. In addition, the composition of the American family changed dramatically since 1970. Between 1970, when there were 3.8 million single parents, and 1980, the number of single parents increased by an average of 6% per year, to 6.9 million. By 1990, this number had increased to 9.7 million single parents, increasing by 3.4% per year. In 1994, there were 11.4 single parent families and they continue to increase by about 3.9% per year (Rawlings & Saluter, 1995). Because single parents are usually their only source of support, they need to work for financial survival or they go on welfare and participate in work search or training activity. Therefore, the demand for child care has increased.

Public Policy Debates Regarding Child Care

One of the debates going on between early childhood professionals and proponents of welfare reform was what the primary emphasis for child care should be.

Early childhood professionals emphasized the importance of the educational component of child care in the children's curriculum and for the caregivers. Those interested in welfare reform and employment for single mothers on welfare appeared to be more interested in keeping the cost of child care down. Phillips and Adams (2001) explained that federal subsidies were capped, preventing low-income families from accessing more expensive child care. Also, the states were only spending 4% of the federal child-care funding on quality improvements compared the 25% spent in Head Start.

Waldfoegel (2001) identified a third policy option available for helping parents with child care. The third policy option, besides providing more educational components and limiting the amount spent to encourage cost savings, is parental leave. Parental leave can either be paid or unpaid and it can be used by either the mother or the father. The United States lagged behind in providing parental leave compared to other industrialized countries until 1993, when the Family and Medical Leave Act was passed in the United States. This act provided a 12-week unpaid time period during which the parent cannot lose that parent's job. However, because it was unpaid, many parents did not use it. This coverage was minimal compared to what most other industrialized countries provided. The average childbirth-related leave in other countries was approximately 10 months and most paid a percentage of the salary that the parent was earning. In fact, Norway and Finland provided parental leave for 3 years with a salary and job security.

Summary

There was a 12% increase in the number of children in poverty since 2004 (Blank et al., 1998; Douglas-Hall & Koball, 2006) and families on or leaving welfare were no longer guaranteed subsidized child care. In addition, the quality of care (NICHD, 1998; Policy Analysis for California Education, 2000) for the children in poverty is poor and

might contribute to their insecure attachment with their mothers.

Studies showed that quality child care consists of enriched human and social interactions, literacy-enhancing activities, and an enriched physical environment. Researchers (Diamond, 1988; Schore, 2000; WHO, 2004) reported that the caregiver's healthy relationships to the children contribute to the development of the children's limbic system and areas of the brain needed for processing emotions, facilitating new learning and handling stress. Also, there is only a short time period (Hart & Risley, 1995; Witte-Townsend & Whiting, 2003) of a few years when language and literacy development can occur in a young child. Therefore, the quality of child care that children in poverty receive is extremely important.

It was shown in the literature that quality child care must also have an absence of exposure to trauma (Perry, 1994) and the search revealed a gap in the literature regarding the inclusion of this issue in the definition of quality. In fact, very few research studies were found that addressed any aspect of license-exempt child care, not just the definition of quality. Therefore, the researcher developed a mixed-methods quantitative and qualitative research study that took a case study approach, surveying and interviewing both license-exempt providers and the parents who use them.

In addition, there are larger philosophical questions regarding child care that need to be addressed while forming child-care policies. For instance, are children better off being cared for by their parents and family members, by business or government professionals or a combination? Should education be part of child-care system or should child care be added to the educational system?

Chapter 3: Methodology

Introduction

The problem addressed in this study was that many children from low-income families appear to be not receiving quality care, as it is presently defined, from their license-exempt subsidized child-care providers. Therefore, it is essential that the caliber of care from these types of providers be improved in certain areas.

Participants

The targeted participants were identified through a database containing the names, addresses, phone numbers, type of child care, and the names of the parents and children for both the exempt child-care providers and the parents who hired them. All exempt child-care providers on the database on August 1, 2007, were sent a self-administered English or Spanish survey for them to answer and one English or Spanish survey for the subsidized parents who hired them to complete and return to the researcher. The database of exempt caregivers was divided into four subcategories determined by where the care was provided and if the provider was a relative of the child or not. All of the exempt providers ($n = 681$) in these subcategories were mailed two surveys. The four reports for these subcategories and labels were produced from the database and used for tracking purposes (see Appendix A). In addition, a different report was run from the database to indicate which caregivers were Spanish-speaking. Therefore, the total number of subjects was 1,362 (681 providers and 681 parents). Some of the caregivers may not have given the parent surveys to the parents whose children they cared for, so the total parent population may have been fewer than 681. Follow-up qualitative interviews were conducted with 10 caregivers and 10 parents to clarify the more relevant or interesting responses received to the open-ended questions on the surveys and to explore the types of

activities the caregivers conduct with the children.

The Expert Reviews and the Survey Instruments

The content validity for both surveys was addressed by the researcher e-mailing a draft of the exempt provider and parent surveys to the executive director and the research director of a statewide association of child-care professionals familiar with child-care providers and parents who use subsidized child care. They reviewed the survey instruments to determine if the questions were clearly worded or needed clarification. They recommended that either the name, license-exempt provider, be defined or removed from the survey instrument because that is not how these caregivers refer to themselves. They also suggested that the wording of Questions 1, 2, and 3 be reworded to simplify, clarify, and eliminate the assumption that they have concerns. The researcher agreed with these recommendations and modified the survey instruments. Therefore, the Exempt Provider Survey was then referred to as the Caregiver Survey.

A second expert review of the complete study was obtained from a seasoned child-care researcher at a large university. That expert suggested two additional references and for the researcher to explore the activities that the caregivers conduct with the children to see if process quality exists with the respondents. These references and suggestion were incorporated into the study.

The Caregiver Survey (see Appendix B) and Parent Survey (see Appendix C) were translated into Spanish and verified for accuracy with a second translator prior to mailing. Two unit clerks were asked to translate the responses received in Spanish. A third Spanish-speaking administrator was asked to translate during the follow-up telephone interviews, as required. The survey instruments also underwent a peer review and were pilot tested with five of nonresearch parents and caregivers to increase face and

content validity and reliability after the Institutional Review Board review but prior to the mailing to the target population. The internal consistency reliability of the pilot surveys was determined by entering the pilot demographic data for the five caregivers and five parents into the Statistical Package for the Social Sciences Statistical Software (SPSS) and running an analysis to obtain the Cronbach's alpha score for each. According to Webster (2003), the alpha score for the pilot parent survey appeared to have very good internal consistency, $\alpha = 0.810$ and the pilot caregiver survey showed an acceptable α of 0.784 (p. 7).

SPSS was also used for entering and analyzing the quantitative demographic data for the study group (Questions 7 to 16 on the Caregiver Survey and Questions 7 to 17 on the Parent Survey). The analysis of the quantitative data from each type of survey (caregiver or parent) consisted of a frequency analysis (frequency and percent) and a determination of the measures of central tendency (mean, median, and mode).

A Microsoft Word document, using a table was developed by the researcher and used for entering the qualitative data (Questions 1 to 6 on both surveys) from the surveys and the follow-up interviews. A separate Microsoft Word document was created as a guide for taking notes during the telephone interviews.

To strengthen the validity of the follow-up interviews, copious notes were taken during the interview. Following each interview, the researcher withdrew to a quiet area where the notes were reviewed and amended to reflect the accurate interview data that was captured.

Procedures

Upon the approval of Nova Southeastern University's Institutional Review Board, the researcher had the surveys translated and ran the provider reports from the agency's

software. Labels for all of the exempt providers were printed and put on envelopes. A copy of the informed consent form was also translated to Spanish. The consent form was attached to both the caregiver and parent surveys and mailed to the providers with a 2-week deadline to return them (allowing 1 week for the mail delivery). As previously mentioned on the caregiver survey, the provider was asked to request the parent whose children were cared for by that provider to complete the parent survey. The surveys were coded on the last page of each survey with the provider's vendor number after a "77" to indicate a caregiver survey and an "88" to indicate a parent survey (see Appendix A). The surveys did not contain any identifying names or numbers other than this coded vendor number. The original survey documents were kept confidential and in a locked cabinet at the researcher's residence for a period of 2 years. The researcher was able to identify which provider or parent completed the surveys by comparing the vendor number to the database reports. After this information was obtained, the caregivers and parents were contacted for the follow-up interviews.

As the surveys were returned, the quantitative data was entered into SPSS and the Word document, according to the data codebook that was developed for each survey. Actual quotes from the exempt caregivers and parents were entered into the Word document. The Spanish surveys were translated, as they were received, by two unit clerks who speak and write Spanish. The two unit clerks were asked to review each other's translations to make sure that they agreed on the responses to increase the validity and reliability. They agreed 100% with each other's translations and, therefore, the translations were accepted as valid and reliable. It was anticipated that the response rate would be approximately 20%, which is the normal response rate for a self-administered mailed survey to a cluster sample (Fink, 2003). However, only 140 (10%) of the 1,362

surveys mailed were returned; there were 84 caregiver and 56 parent surveys returned. Possible reasons for the lower than normal response rate could be due to the complexity of the consent form, the education levels of the caregivers and parents, and the fact that the surveys were optional, not mandatory. However, the surveys returned from the cluster sample appear to be representative of the total population due to the consistency of the responses from both the caregivers and the parents.

After the surveys were returned, the vendor numbers from the surveys were entered into a drawing and 30 from each group were selected to receive the educational toy as an incentive gift. Ten caregivers and 10 parents were selected from each of the 30 winners for the follow-up telephone interviews. The researcher looked up the contact information for each potential interviewee and entered the name and contact information on the interview documentation sheet. The informed consent letter informed the caregivers and the parents of the possibility of being selected for a follow-up interview. They were told that it was optional and that it would not affect their subsidized child care in any way. All of the incentive prize winners were notified that they could come into the agency office to pick up the educational toy and thanked for participating in the study.

The researcher called the interviewees and conducted the interviews over a 2-week time span. The caregivers and parents were interviewed separately. During the telephone interviews, a Spanish-speaking translator was present. The researcher was only able to reach one Spanish-speaking caregiver and no Spanish-speaking parents by telephone. However, several of the written surveys returned were from Spanish-speaking only caregivers and parents.

After all of the interviews were completed and the responses transcribed, the data was analyzed. The demographic data was summarized and described in SPSS using the

frequency, percentage, and mode for each applicable variable on both types of surveys. The researcher examined the data for similarities in the responses between the caregivers and the parents and how they compared to the findings in the literature review. The qualitative data was analyzed for patterns of responses, in general, and in relationship to the variables. After the data was analyzed from the surveys and interviews, the researcher determined the outcome gaps between what is and what should be, according to the opinions of the caregivers and parents, and the desired outcomes for the quality of child care and the subsidy system to be improved. Based on the data collected and the literature review, the researcher developed a needs assessment that legislators, administrators, parent-provider educators, or parents-exempt providers themselves could use as a starting point for developing an implementation model for improving the quality of child care or the subsidy system itself.

The time period for conducting the surveys, interviews, analysis, and development of the implementation plan was approximately 16 weeks, beginning immediately after the Institutional Review Board approval was obtained. The survey time frame was 2 weeks for preparation and mailing and 3 weeks for completion of the surveys, allowing for mail time. The data entry occurred during the 2 weeks following the deadline for the surveys to be returned. The scheduling of the interviews began immediately after the data entry had been completed in 1 week. The interview portion of the study lasted approximately 3 weeks, and the analysis and approval phases were completed in 5 weeks.

Limitations

Because the sample population was a cluster of exempt providers from one county in one state, the study will be somewhat limited in its ability to be generalized to other

subsidized populations. In addition, the subsidized programs in other areas or states may have developed different policies and procedures and may not have exactly the same issues as the exempt caregivers and parents expressed in this study. According to Fink (2003), the surveys have a “response bias” because the exempt caregivers and parents that responded to the survey are probably the more conscientious exempt caregivers and parents, and therefore, may not have as many concerns or quality issues to deal with as those who do not respond (p. 27).

Summary

The research design was a mixed-methods quantitative and qualitative study with a case study approach. Data was gathered by self-administered surveys and telephone interviews from license-exempt caregivers and the parents who use them from a sample of the total population at one subsidized child-care agency in one county in one state in the southwestern United States.

The goal of the study was to develop an implementation plan for the exempt child-care caregivers that would increase the quality of child care provided to children in poverty whose families use this type of child care. An additional goal was to add knowledge to the child-care field regarding license-exempt child-care caregivers and the parents who use them.

Chapter 4: Results

Introduction

The problem to be addressed in this study is that existing research (Brown-Lyons et al., 2001; Elicker et al., 2005; Fuller et al., 2004; Kontos et al., 1995; Whitebook et al., 2003, 2004) showed that license-exempt caregivers were having difficulties providing the care necessary to maximize the emotional, social, physical, and cognitive development of the children. Because no clear guidance for improvement of care is provided in the literature, the goal of this study is to determine how best to standardize the child-care practices for all of the license-exempt child-care providers by developing a needs assessment for an implementation model for quality child care.

Results from this mixed-methods case study were included in an analysis of the quantitative and qualitative data reflecting demographic data and current and desired results from a sample of license-exempt providers and the parents who selected these particular caregivers. Quantitative and qualitative research questions were asked of the exempt providers and parents to determine the current results of what is and what should be from a sample of license-exempt child-care providers and parents on the agency's database (Kaufman, 1992). In the second phase of this applied research study, 20 qualitative interviews with providers and parents were conducted to further investigate the current and desired results and how the quality of care and the subsidy system could be improved (Creswell, 2003). Both parents and providers were surveyed and interviewed in order to compare and contrast their responses to both the quantitative demographic data and the qualitative responses that they gave. The open-ended questions on the written survey and an additional telephone survey gathered qualitative data from the caregivers and parents. The quantitative data was analyzed by determining the

frequency, percentage, and mode for each applicable variable on both types of surveys.

Quantitative Data

Caregiver demographic data. The written survey results showed that the vast majority (94%) of the caregivers were female, 54% in their 40s and 50s, 60% were married or living with their partners, 63% were Latino, 74% had a high school degree or less, and 49% had a family income of less than \$20,000. The specific frequencies and percentages for each of these variables are listed in Appendix D.

Parent demographic data. The written survey results showed very different demographic statistics for the age and marital status of the parents compared to the caregivers. The parents were younger (mode of 27 years) and 59% of the parents have never been married, while the majority (60%) of the caregivers were married or living with their partners. The gender (96% female), ethnicity (71% Latino), and education levels (71% had a high school degree or less) for the parents were very closely aligned with the caregivers. A larger percentage of the parents had a yearly income of less than \$20,000year (73%) compared to the caregivers (49%). The specific frequencies and percentages for each of these variables are listed in Appendix E.

In the target county where the study was conducted, the Hispanic population is approximately 33% (Community Commission for Ventura County, 2006). However, the demographic data for the caregivers and parents in this study was 63%. This is consistent with research that indicated that 61% of the Latino children in the United States live in low-income families (Douglas-Hall & Chau, 2007).

The education demographic data of having a high school degree or less (73.9%) was somewhat higher than the norm for children in low-income families in the United States of 25% for less than high school and 36% for high school for a total of 61%

(Douglas-Hall & Chau, 2007). However, this difference can be explained by the fact that these families are not just of the working poor, but some are receiving public assistance and are, therefore, the poorest of the low-income families.

Caregiver Child-Care-Related Data

Number of months caregiver cared for child or children. Eighty-two (98%) caregivers responded to this question and the mean number of months that the caregivers cared for the child or children referred to in the surveys was 42.6 months or 3.5 years. The longest was for 12 years and the shortest was for 1 month. The median amount of time spent caring for the child was 24 months and the mode (most frequent amount) reported was for 6 months.

Caregiver's interest in becoming licensed. Of the 80 caregivers who responded to this question, 30 (37.5%) were interested in becoming licensed. These 30 caregivers expressed this interest even though they are currently legally exempt-from-licensure and the accompanying requirements.

Number of children in care or ratio. The caregivers were asked to fill in the blank on the number of children in their care at any one time, including their own children. Of 83 responses, 42 (51%) caregivers cared for only one or two children and 15 (18%) cared for three children. The rest of the statistics for the ratio of caregiver to children included 13 (16%) caregivers cared for four children; 7 (8%) caregivers for five children; 5 (6%) caregivers with six children each, and one (1%) caregiver cared for eight children. The survey did not gather the ages of the children and the assumption is that several could be school-aged children. Therefore, the ratio of caregiver to child would be lower during the times that the school-aged child is in school.

Location of the care. All 84 caregivers responded to the survey question that

asked them if the child was cared for in the caregiver's home (outside home), the child's home (in-home), or somewhere else (other). Seventy-six (90.5%) caregivers stated that the child care was occurring in the caregiver's home and only eight (9.5%) answered that the care was provided in the child's home. No care was provided in another location.

Relationship to the child. There were 84 caregivers responding to this question. Seventy-four (88.1%) caregivers were the child's relative and 10 (11.9%) were the child's friend.

Parent Child-Care-Related Data

There had been speculation among child-care professionals in the field as to the reasons why parents select exempt-from-licensure caregivers. Some say that is it because the parents need weekend and evening care during times when there is a shortage of available licensed care. The parents that responded to the questions about the days and times needed on the written survey showed that over 96% of the respondents needed child care Monday through Friday and 83.9% needed it on Saturday. Fewer parents (32%) needed child care on Sunday. Only 27% or fewer parents needed child care during the evening, on a swing shift, all night, or at other times. These findings are consistent with the findings (Layzer & Goodson, 2006b; Vandell & Wolfe, 2000) documented in the National Study of Child Care for Low-Income Families.

Qualitative Results

Research Question 1. The first open-ended question on the caregiver survey attempted to gather information from the caregiver about why they decided to care for the child currently under their care. Results from the data analysis indicated that the largest number of responses (58 of 84 surveys or 69%) was that caregivers made the decision to care for the child because the child was a grandchild or great grandchild, or the parent or

child's sibling were helping their daughter, son, or daughter-in-law. The second largest category of reasons for caregiving (15 of 84 surveys or 17%) was to benefit the parent or caregiver, including love of children, schedule of parent, or caregiver needed a job. The third largest by only one response (14 of 84 surveys or 16%) was to benefit the child, including child more comfortable, child know since birth, or did not want strangers to watch. Many of the caregivers gave more than one of the reason listed above and some did not answer the question so percentages cannot be reported accurately. The actual responses to this question are listed in Appendix F.

During the telephone interviews, the caregiver responses to the first question did not offer any new data from what was obtained on the written surveys. Seven were grandparents, one was a sister, and two were friends. All stated that they thought that they could give the best care to the child, that the child knew them, and that they were trying to help the parent. One grandmother whose daughter was attending vocational classes in the evenings stated, "We wanted her to be at home at night." A second grandmother stated that that grandmother had quit a job after 10 years in order to be able to take care of the granddaughter for the daughter. Grandmother said, "Family is more important to me."

The first open-ended question on the parent survey attempted to gather information from the parent about why they decided to use their current caregiver. The first research question corresponded to this survey question. The researcher determined that there were three basic categories of responses to this question and that they were very similar to the reasons that the caregivers gave. The largest number (44 on 56 surveys) of reasons that the parents gave for selecting that particular caregiver was because the person was a close family member and because they trusted that person. The

second highest responded reason (19 on 56 surveys) was because the child benefits from the care received, including the child loves the caregiver, the child is happy with the caregiver, or the child receives better care from that person versus a stranger. The last category of reasons (4 on 56 surveys) for choosing that particular caregiver was to benefit the parent or the caregiver in some way, including caregiver watched before or caregiver is a good friend. These reasons could also have been secondary reasons because many parents gave more than one reason and some did not answer the question. The actual responses to this question are listed in Appendix G.

The telephone interviews for the parents did not yield any new information from the reasons stated on the written surveys (see Appendix H). All but 1 parent of the 10 interviewed, used their mother, mother-in-law, a grandparent, or sister as their caregiver. Trust in the caregiver was an important issue to the parents: “I decided to use her because I trust her and my kids love her.” The parent who was using the mother-in-law stated, “She has been watching them for a long time.” That parent had five children whose ages were 14, 12, 7, 5, and 2 years old. The 10th parent found a caregiver through the church that lives right across the street from her. That parent told the researcher, “The baby does not cry when I leave her with [the caregiver].”

Research Question 2. The second research question, containing four subparts, asked, How does a public agency provide services to address the impact on the children’s development regarding their emotional health, social development, intellectual development, and physical health. The survey questions that corresponded to these research questions were Questions 2a through 2d on both surveys. The results were surprising and consistent among both groups and compared to each other. The vast majority of both the caregivers and parents (92% and 91% respectively) stated that the

children were happy. Some of the “yes” answers were very emphatic (with punctuation and additional words, such as “very”).

The percentages on the question asking if they had any concerns about the child’s ability to talk or play with other children or adults were even greater (93% for both) that they had no concerns. Seven (5%) caregivers and parents did not respond to this question and 3 (2%) caregivers and parents had a concern about the child’s ability to talk or play with other children or adults.

The responses from both groups regarding if the child has been diagnosed with learning problems had lower percentages (caregiver = 71 or 85% and parent = 51 or 91%) of negative responses (no diagnosis). Nine caregivers (11%) and one parent (2%) reported a diagnosis of learning problems. Three (4%) of the caregivers and 4 (7%) of the parents did not respond to this question, put in a question mark, or stated, “Not that I am aware of.”

To the question on both surveys that asked if the child has been diagnosed with any health problems, 82% of the caregivers responded, “No or none.” Five children were reported to have asthma and six had other health problems, such as allergies, a growth problem, Attention-Deficit Hyperactivity Disorder, Lupus, or other special needs not specified. The parental response to this question was 89% who stated that there were no diagnosed health problems. Further research needs to be completed to determine if less than 20% of children with health problems is due to the type of child care received by the children (by friends and relatives) or due to other variables, such as the home environment or heredity.

Research Question 3. What can a public agency provide to providers or parents to help improve the quality of care? The vast majority (over 80%) of the caregivers and

parents were satisfied with the quality of care; however, the suggestions from both groups to improve quality fell into four major categories. The first thing caregivers and providers would like is more information, education and workshops about special needs, medical resources, program resources, after-school programs, nutrition, parenting, discipline, child development, behavioral issues, and the arts so they can teach the children. The second category of requests was for more money for food for the children and extra benefits for the special needs children. The third category of requests was for supplies, such as books, games, and art and craft supplies, be given or loaned to the caregivers. The fourth category of requests was for assistance to the caregivers in organizing field trips, perhaps to the museum, for the children.

Research Question 4. The fourth research question asked for ways that the subsidy system could be improved. Several caregivers and parents did not understand the question and they stated this on the survey. Of those who did understand, over 85% answered that the subsidy system was fine and did not need improvement. An example of a typical response in this category was, “I do not feel that there is any need of improvement at this time.” The suggestions for improvement from the remaining 15% of caregivers and parents fell into four major categories. The most numerous requests (total of 9 from both groups) were for more funds to pay the caregivers more and to expand the number of children or siblings who can be served. The second category of suggestions involved an eligibility regulation. Two parents requested that expenses be considered when determining parental income for eligibility and family fees or the parent’s share of the child-care costs. The third request from both groups (total of 7 from 140 surveys) was improved customer service from the agency, including quicker returned phone calls, better explanations, and improvements to the attendance sheets and less tedious

paperwork. The last category of requests to improve the subsidy system from both groups (4 out of 140 surveys) was to provide additional workshops or education regarding the program's operations, procedures, and requirements.

Information about caregiver-child activities from the interviews. Based on an expert reviewer's feedback, the researcher gave the 10 caregivers and 10 parents interviewed a list of possible activities verbally that the caregiver could conduct with the children, in order to help determine "what is." The caregivers and parents were asked to respond to each activity and to give any details that they wished to give. From the 20 interviews, the following are the numbers of positive responses received for each activity, reading (18), playing games (18), playing outside (17), writing or drawing (17), singing (16), watching television (16), going to the park or beach (15), cooking (15), watching movies or videos (13), telling stories (12), and going to the library or museum (9). Some of the children being cared for were infants so the caregivers and parents believed that a few of the activities did not apply. It appeared that these caregivers and parents were providing quality activities for the children; however, it was unknown to what extent most of these activities were taking place.

Summary. The study found that caregivers and parents largely choose unlicensed care for the child because they are family members and to provide the best care for the child. Data also showed that parents decided to use their exempt caregiver because they trust them. Over 90% of the caregivers and parents who responded believe the children's physical, emotional, social, and intellectual development are good. In addition, over 85% of those surveyed are satisfied with the services that they were receiving from the public agency that authorized their subsidized child care. The implications of these findings will be discussed in the next chapter of this report.

Chapter 5: Discussion

Overview of the Applied Dissertation and Purpose of the Study

Applied research is research that has been identified by practitioners in the workplace to solve identified problems (Gall, Gall, & Borg, 2003). The problem that unlicensed child care appears to be of lower quality was identified by the researcher and the executive director of the agency where the researcher was employed. The researcher was a manager of several large subsidized child-care programs operated in the county.

Over 445,000 children living in poverty in the United States are receiving subsidized child care from unlicensed or exempt-from-licensure caregivers. These exempt caregivers are usually family members or friends of the parent. The problem is that many studies (Brown-Lyons et al., 2001; Elicker et al., 2005; Fuller et al., 2004; Kontos et al., 1995; Whitebook et al., 2003, 2004) had shown that the quality of care from these providers appears, overall, to be of lower quality than licensed care. Because no clear guidance for improvement was provided in the literature, the goal of this study was to determine how best to standardize the child-care practices for all the license-exempt child-care providers by developing a needs assessment for an implementation model for quality child care. A needs assessment was used as a systematic approach where the researcher determined the gaps between the current situation and the desired results and then made decisions about what to change and what to continue (Kaufman, 1992).

The data from this study showed that caregivers and parents largely chose unlicensed care for the child because they were family members and provided the best care for the child. Data also showed that parents decided to use their exempt caregiver because they trust them. Over 90% of the caregivers and parents, who responded,

believed the children's physical, emotional, social, and intellectual development were good. In addition, over 85% of those surveyed were satisfied with the services that they were receiving from the public agency that authorized their subsidized child care.

Elaboration and Interpretation of the Results

Results consistent with the literature. It was shown in the data that over 96% of the parents needed child care Monday through Friday and 84% needed it on Saturday. Fewer parents needed child care on Sunday (32%). Only 27% or fewer parents needed child care during the evening, on a swing shift, all night, or at other times. Consistent with other studies (Layzer & Goodson, 2006b; Vandell & Wolfe, 2000), this data demonstrated that one of the reasons why friends and relatives were chosen as caregivers was because many licensed caregivers did not stay open on the weekends or in the evening. This data corresponds to some of the reasons given by the caregivers and parents to the qualitative survey question that asked why that particular caregiver was chosen. As one caregiver put it, "I am currently caring for my three grandchildren as my son was having difficulty with his varied hours trying to find day care." However, the data from this study showed that even if there were enough licensed centers or family child-care homes that could accommodate these types of work schedules, parents would probably still select friends and relatives for the care due to the other reasons listed, such as trusting the caregiver and feeling that the child receives better care from friends and relatives rather than from strangers.

Results inconsistent with the literature. There were differences in findings regarding the stability of care provided to children using exempt caregivers. Whitebook et al. (2003) evaluated child-care subsidy lists and found that the exempt caregivers were "highly unstable" (p. 10). However, another study found that half of the children studied

who were cared for by relatives had been in the care of one relative besides the parent since birth (Layzer & Goodson, 2006a). The finding in this study that the mean number of months of care was 42.6 or 3.5 years and the longest was for 12 years was inconsistent with the Whitebook et al. (2003) study and consistent with the Layzer and Goodson (2006b) report. Exempt child-care providers appeared to provide stability to the children in their care, which was also in agreement with Kreader and Lawrence (2006). Based on the quantitative and qualitative responses from the caregivers and parents in this study, the majority of the unlicensed caregivers were grandparents, the parent's sibling, or the child's sibling. Therefore, it was logical that relatives with such a close connection to the child, would provide care that was more stable and for longer periods of time in the child's life. An example of this was the following quote from one of the caregivers, "I decided to take care of my two granddaughters because I think that I can take better care of them than anyone else. First of all because they're my granddaughters, and they always have lived here." Many of the children have been cared for by this person since birth. This stability of care by a loving family member was consistent with excellent quality care rather than poor care and also fostered a strong attachment bond between the caregiver and child.

This study found that "structural quality" in the area of a low caregiver:child ratio (over 50% of the caregivers cared for only two children or less) existed in this cluster sample. This seemed to conflict with the Kontos et al. (1995) study, which found that "only 9% of the providers were observed to be providing good quality care." According to Maher (2007), "Without overgeneralizing, family, friend, and neighbor care has some positive attributes that distinguish it from other types of care. First, the typically low adult[:]child ratios can provide for more individualized attention" (p. 4). A low

caregiver:child ratio in unlicensed care is another reason why the quality could be considered good, rather than poor. As stated by Maher (2007), the reason a low ratio equates to better quality is because the child receives more one-on-one time from the caregiver. Examples of this individual attention was expressed by two caregivers in this way, "He tells me stories and I listen," and "We make up our own songs . . . we get silly sometimes." How special for these children to be able to receive this quality attention from someone who cares for them as a family member or friend.

"What is" and "What should be" according to the caregivers and parents. This study found that caregivers largely chose to care for the child that they cared for because the child was a grandchild, their niece or nephew, or their sister or brother, to help the parent and to provide, what they believe, was the best care for the child. By reading the responses that the caregivers gave to this question, it was obvious that they cared deeply for the child and the parent and wanted to provide quality care. These reasons defined "what is" or the current results for why they were providing care for the child. These reasons also reflected "what should be" or the desired results, according to the caregivers.

This study found that parents decided to use their exempt caregiver because they were family members and they trusted them with the care of their child. The researcher was surprised at the strength and consistency of this response from the parents. Forty-four out of 56 (79%) parent surveys indicated that they chose to use that unlicensed caregiver because they either trusted that person or the person was a friend or relative. The majority of these 44 parents made a statement as to why they chose that person because that individual was a grandparent or sister, without any other explanation. The implication was that the parent assumed that the fact that the caregiver was a close relative or friend was reason enough to chose that person and that no other explanation was needed. They

also believed that their child was receiving the best care possible from this provider. This result conflicted with a commonly held belief by many professionals in the child-care field that exempt child care was of lower overall quality than licensed care. Layzer and Goodson (2006a) also found that trust and relationship to the child was important to the parent when making the choice of who would care for them when they could not.

Researchers (Bakermans-Kranenburg et al., 2005; NICHD, 1998; Schore, 2000; Shonkoff & Phillips, 2000; Tout et al., 1998; Wishard et al., 2003; WHO, 2004) believed that trust, attachment, and enriched relationships between the child and caregivers are extremely important for a child's healthy development. Therefore, why do professionals undervalue this benefit of using exempt child care when deciding if quality exists? Is literacy development more valuable to the child than receiving additional attention from a loving relative or friend? Could it be that because it is difficult to measure and quantify, that professionals undervalue its contribution to the child?

A secondary reason that some of the parents gave for using that particular caregiver was because it was convenient or they had used that person before. The fact that the parents added these reasons in addition to the trust and relationship reasons demonstrated that they were not as important to the parents. As confirmed by Kaufman (1975), all of these reasons were both the current ("what is") and required ("what should be") results for the parents.

In the opinion of the vast majority (over 90%) of both the caregivers and the parents, the children were happy in the care of the exempt provider and, therefore, their emotional needs were being met. Fuller (2007) stated, "Sensitive caregiving may be a particularly relevant factor when teachers are serving children from diverse social-class and ethnic backgrounds" (p. 221). This statement could apply to exempt caregivers as

well. Therefore, according to the caregivers and parents in this study, the results were happy children.

According to over 90% of the caregivers and parents who responded, the current and desired results for the children's social and intellectual development and physical health were good and there was not a problem. Therefore, in their opinion, nothing needed to change. According to their responses, the public agency did not need to do anything to improve the quality of the care because the quality already existed. This was an important finding and one that child-care professionals need to explore further. A gap existed between what the caregivers and parents believed to be true and what many of the child-care professionals were willing to accept as true. However, the fact that professionals did not have an instrument in which to measure the quality of the exempt child care (taking into consideration the value of trust and enriched relationships) did not discount or invalidate this finding. Recommendations in the needs assessment section of this report attempted to address this gap.

Over 85% of the caregivers and parents were satisfied with the services that they were receiving from the public agency that authorized their subsidized child care. One caregiver put it this way, "I think this is a wonderful life-saving program. Many women would not be able to make it without this help. Thank you." Another stated, "We are happy family and thank you for all your help!" Caregivers and parents were grateful for the subsidized child care that they received and the fact that parental choice was allowed for them to select friends and relatives for caregivers.

Additional information gained from the interviews. The researcher asked each interviewee if the child was allowed to watch television and for how long. It was surprising how much the children watched television. All but 3 of the 20 interviewees

said that the children were allowed to watch television everyday. However, 9 interviewees said that the television was restricted to only 30 minutes to an hour each day and that the children watched educational programs on certain children's stations. The bad news is that 1 caregiver and 2 parents said the child watched 2 hours per day and 4 said the child watched television 3 to 4 hours per day. One caregiver, who told the researcher that that caregiver had attended some of the agency's provider training sessions, said that that caregiver did not allow any television. The same caregiver also made the following statement, "The 2-year-old is already holding a book and pencil," demonstrating that the caregiver understood concepts of print (a literacy concept). This indicated to the researcher that the caregiver learned something at the literacy workshops attended at the agency. Some of the caregivers and parents made comments during the interview that implied that "process quality" existed, related to the relationship between the caregiver and the child and the extent to which literacy-enhancing activities were taking place. Some caregiver and parent comments follow:

My granddaughter reads a bedtime story to me every day for about 20 minutes (caregiver).

Sometimes we change the story in the English books to Spanish (caregiver).

They (caregiver and four children) sing all the time in English and Spanish (parent).

They write and draw all the time. She keeps paper handy for them and she helps them with their homework (parent).

Implications

Outcome gaps. Even though there were surprisingly few outcome gaps to quality identified in this study, the caregivers and parents did list some ways that the public agency could assist in fostering child-care quality and improve the subsidy system. As mentioned in chapter 4 of this report, caregivers and providers would like more

information, education, and workshops about special needs, medical resources, program resources, after-school programs, nutrition, parenting, discipline, child development, behavioral issues and the arts, so they can teach the children. In addition, they believed that more money for food for the children; extra benefits for the special needs children; and materials, such as books, games, and art and craft supplies, would be very helpful. The last request from the caregivers was assistance in organizing field trips, such as museum, for the children. By looking at what the caregivers were requesting, the researcher concluded that caregivers wanted information and resources that would benefit the children. They were interested in fostering better nutrition, knowledge to assist the special needs of some of the children, and child development knowledge so they can provide better care for them.

Regarding improvements to the subsidy system, both groups wanted more funds to pay the caregivers and to expand the number of children or siblings who could be served. They would also like their expenses taken into consideration during income calculations; improved customer service from the agency; and additional workshops or education regarding the program's operations, procedures, and requirements. Porter (2007) found several studies conducted with exempt caregivers that showed that they wanted to learn more about caring for children and how to keep them safe, healthy, and engaged. Porter also found that they want to get this information through group meetings, newsletters, and videos. The researcher interpreted these results as an indication that caregiving was a difficult, time-consuming, and expensive undertaking for these grandparents, aunts, uncles, sisters, brothers, and friends. For many, this is their sole source of income. As one great uncle put it,

I retired as a correctional officer the same year my great nephew was born. My

niece had no reliable sitter. I decided to help raise my nephew rather than continue the vocational school course I had just started.

Because I love working with children. I think I have plenty of experience taking care of other people's babies, because I had seven children of my own, plus I took child development classes at the college. I used to work in the 'fields' and wanted to get a better job. I like children very much and working with them is very fun for me.

I am caring for my younger sister because my mother returned to work. I decided to leave my office job to care for mine and her children at the same time.

The caregivers probably want the information via group meetings, newsletters, and videos because these methods provide either an opportunity to network and socialize or are easy, quick, and interesting ways to get the information. Sometimes providing child care all day leaves the caregivers with the desire to communicate with other adults after being with the children for several hours per day.

An ethical dilemma. The four research questions for this study were the following:

1. How can information about becoming a child-care provider or hiring a particular license-exempt provider be used to improve the child-care subsidy system?
2. How does a public agency provide services to address the impact on the children's development regarding their emotional health, social development, intellectual development, and physical health?
3. What can a public agency provide to providers or parents to help improve the quality of care?
4. What changes can a public agency make to improve the subsidy system?

The study found that caregivers and parents largely chose this type of care for the child because they were family members and believed they would provide the best care for the child. Data also showed that parents decided to use their exempt caregiver because they trusted them. Over 90% of the caregivers and parents who responded believed the children's physical, emotional, social, and intellectual development were good. Over 85%

of those surveyed were satisfied with the services that they were receiving from the public agency that authorized their subsidized child care. However, during the process of gathering these results and thinking about the implications of them, the researcher began to identify an ethical dilemma related to this child-care issue. Many child-care professionals believed that exempt child care was of lower quality than licensed care, yet the caregivers and parents were saying the opposite. Which viewpoint was correct and what should the recommendations be to fill the outcome gaps?

Prior to the existence of subsidized child care, many mothers or fathers stayed home, extended family members cared for the children, or parents hired someone to watch their children. The government did not interfere with parental choice, unless there was abuse or neglect involved or the children had no one to care for them. An argument could be made that parents would choose what was best for their own children and that government had no right to interfere with those parental decisions. However, another argument could be made that if taxpayer money was going to be spent paying for child care, that government should ensure that quality child care was provided to prevent the negative consequences of poor child care to the children and society. Children who were not fully developed physically, emotionally, socially, or intellectually were likely to be behind other, more fortunate children when they started school. This could lead to higher high school dropout rates, additional welfare costs, and higher crime rates. All of these potential consequences could lead to higher economic costs to the society as a whole.

Does the government have the right to interfere with decisions about how a child is raised and by whom? Is there not a danger in giving government that much power? What if the government thought its approved providers were using “the best” quality child-care techniques, when in reality, they were actually harming the child in some way?

What if a dictatorship came into power? Would the ideas and values taught to the children correspond to the parents' ideas and values? Does society really want to give an impersonal governmental agency jurisdiction into family matters? Should the government interfere only after some kind of harm is done to the child, such as abuse or exposure to trauma? These are all relevant questions that need to be debated and evaluated before major changes in present policy are implemented. Fuller (2007) described the dilemma this way, "Thus, we arrive at an important question: Whether institutions of early learning should act to advance forms of knowledge, language, and social behavior that are valued by reformers, but still feel rather foreign to parents and their local communities" (p. 230).

In this situation, who does the dilemma belong to? Does it belong to the parents, who stand to lose their freedom to choose what they think is right for their child? Does it belong to the child, who is at the mercy of choices from that child's parents, society, or child-care provider? Does it belong to society, in general? Are the schools, the welfare system, the penal system, the mental health treatment system, business, and child development professionals affected? The answer to all of these questions is "yes." This is a broad-based dilemma that needs to be resolved in some manner.

Right versus right. The researcher determined, by examining the facts and available research, that this issue was not a clear-cut right-versus-wrong dilemma because both sides could make valid arguments to support their case. Therefore, the researcher concluded that this dilemma could be described as a right-versus-right one. In other words, it is right that the parent should be able to decide who will care for their child because it is their responsibility, they have the strongest connection to the child and desire for their well-being. On the other hand, the law enforcement, child protection

social workers, and child development professionals know that not all parents make the best decisions for their children. Child abuse and neglect do exist and society has a responsibility to protect defenseless children. In addition, studies have shown that preschool and other quality licensed child care greatly benefits children. It is also right that society ensure quality child care for children, especially because taxpayers are often subsidizing the care.

The resolution principles: How can this dilemma be resolved? Kidder (1995) explained that there are three basic principles that are commonly used by persons making ethical decisions in right-versus-right dilemmas: ends-based thinking, rule-based thinking, and care-based thinking. Other names or explanations for ends-based thinking are “utilitarianism” and the greatest good for the greatest number (p. 155). This method relies heavily on trying to predict how a situation will end and then making a decision based on this prediction. Kidder pointed out that the problem with this kind of reasoning is that sometimes the ending does not turn out as predicted, thus, an incorrect decision could be made.

Rule-based thinking is making a decision based on an established law or rule. The problem with making ethical decisions based on this method is that it assumes that the law is fair or moral. Another problem is that it is rigid and does not take into consideration exceptions to the rule. Care-based thinking is the third way to resolve an ethical dilemma. According to Kidder (1995), this method requires “reversibility . . . [or putting oneself in someone else’s situation, mentally. The problem with this method is that it assumes that someone can accomplish reversibility and that both parties like] moral things” (p. 161).

Taking into consideration these resolution principles, the researcher has taken the

gaps identified by the study between what is, according to the caregivers and parents, and what should be, according to the caregivers, parents, and the literature review, and developed this proposed set of options for filling the outcome gaps. This is the needs assessment that Kaufman (1992) described. These options had been discussed in the child-care field for several years and were not original ideas; however, they have been expanded by the researcher to include exempt caregivers.

Options for Filling the Outcome Gaps or the Needs Assessment

Extended paid family leave. Weston (2006) discussed the need for creativeness in coming up with solutions to ethical dilemmas. Weston suggested that sometimes, a situation that appears to be a dilemma can actually be solved and that the dilemma was merely a “false” one (p. 31). Sometimes, the solution comes down to making tough decisions about spending priorities or being firm with enforcement of regulations. In this situation, there are potential solutions. For instance, in some European countries, child-care assistance is provided through publicly funded programs rather than with subsidies. Some countries offer paid family leave for families with young children for up to 10 months. In Germany, the parental leave is for 3 years. This is the first recommendation that the researcher would include in the needs assessment.

Fund provider education and monitoring. Another recommended solution is to fund provider education or monitoring for all subsidized child-care providers, whether they are centers, family day-care homes, friends, or relatives. The quality standards could be expanded and modified to fit the more informal forms of care, such as friends and relatives, and then parent choice could still be allowed. For this option, a clear definition of quality would need to be developed with measurable goals.

Expand current programs. Expanding the Early Head Start and Head Start

programs is a third recommendation. The Early Head Start program consists of home visits to parents of children from birth to 3 years of age, and counseling on parenting, health, and literacy techniques. The Head Start program is center-based care, for the most part, for 3- and 4-year-olds. The Head Start program could be expanded to a full-day program and additional money could be allocated for expanding the number of children served in the Early Head Start program.

Tiered reimbursement for caregivers. Implementing a tiered reimbursement system for subsidized child-care providers, including exempt caregivers, is a recommended solution for some of the outcome gaps identified by the caregivers and parents in this study. Caregivers who are willing to get additional education in child development or meet specified quality standards would be paid more than those who do not. However, safeguards would need to be built-in to prevent disparities between those providers that could afford to go to school or make improvements to their child care and those who could not.

Parent education. Education for parents would assist them in making the right decision for the care of their child. That education would include what to look for when selecting a child care and how they can help their child to develop in healthy ways, including literacy-enhancing activities, limiting television viewing, health, nutrition, safety, discipline, and parenting.

Limitations

Because the sample population was a cluster of exempt providers from one county in one state, the study was somewhat limited in its ability to be generalized to other subsidized populations. In addition, the subsidized programs in other areas or in other states may have developed different policies and procedures and may not have exactly

the same issues as the exempt caregivers and parents expressed in this applied dissertation study. However, all 50 states have subsidized programs and some form of parental choice involved in the selection of the child-care provider by the parent. According to the National Association of Child Care Resource and Referral Agencies (2007) Web site, there are currently 290,466 regulated or licensed-family child-care homes; 117,053 regulated or licensed child-care centers; 804,000 paid and unregulated (license-exempt) relatives, and 298,000 paid unregulated (license-exempt) nonrelatives providing child care nationwide. These numbers include subsidized and nonsubsidized care. Nationwide, approximately 1,782,000 children are receiving subsidized or publicly funded child care and, of those, 445,500 (25%) children per month are receiving subsidized child care from one of the license-exempt unregulated child-care providers (U.S. Department of Health & Human Services, 2005).

According to Fink (2003), the surveys have a “response bias” (p. 27) because the exempt caregivers and parents that responded to the survey are probably the more conscientious exempt caregivers and parents and, therefore, may not have as many concerns or quality issues to deal with as those who do not respond. This limitation could be minimized by replicating the study or building onto the study with new research. When answering the questions about the activities that the caregivers conduct with the children, the respondents may have told the researcher what they thought the researcher wanted to hear or what they thought was the correct answer rather than what actually occurs. This limitation could be controlled by research conducted in the caregiver’s home using direct observations. Due to the sensitive nature of the topic, it is difficult to determine if the child is suffering from any kind of trauma or exposure to violence; therefore, this is a necessary limitation.

Recommendations for Further Study

Further study is needed that involves home visits in order to determine which activities exempt caregivers conduct with the children and to what extent. It would also be interesting to test the attachment levels between the caregivers and the children. It is suspected that the attachment bond is strong between them. It might also be revealing for an ethnographic study to be completed with a Latino family to investigate ways that language and culture are preserved by keeping child care within the family and how that benefits the child or children.

Recommendations for Further Practice

The researcher recommends that improvements be made to existing quality indicators and measurements to include components that more extensively quantify the relationship between the caregiver and the child. Also, in the opinion of the researcher, any measurement of quality should take into consideration whether the child is being traumatized or exposed to violent situations. Even if all of the other facets of quality exist, if this were present, it would totally negate the overall quality of the care due to its harmful effects on the child. This appears to be a missing piece of the quality evaluation puzzle thus far.

Conclusion

Children are the most precious resource. Parents need to take the responsibility to ensure that they receive the best quality care that parents, caregivers, and society can give them in order for them to develop to their fullest capacity. Ethical decisions need to be made about this care regarding quality and options must be available that do not infringe on parental rights or society's responsibility to children.

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Appendix A
Sample Exempt Provider Report

SAMPLE

10/27/2006

Provider Listings Report:

Service Period: 10/27/2006 - 10/27/2006

VP Clerk: ALL

Type of Care: License-Exempt Outside Home (Relative)

City: ALL

Program: ALL

Zip: ALL

Status: Active

Provider Name	Vendor #	Type Care	Street Address	Zip Code	Phone	Capacity	Number Children
Ab	010058	License-Exempt Outside Home (Relative)	117	93030	(805) 487-	0	1
Ac	010356	License-Exempt Outside Home (Relative)	1925 St. #	93036	(805) 981-	0	2
Ag	P500165	License-Exempt Outside Home (Relative)	2703 Street	93033	(805) 486-	0	1
Ai	P502705	License-Exempt Outside Home (Relative)	1606 #B	93063	(805) 520-	0	1
Al	325970	License-Exempt Outside Home (Relative)	655 Dr.	93030	(805) 604-	0	1
Al	016756	License-Exempt Outside Home (Relative)	1719 Blvd. #324	93030	(805) 760-	0	1
Alv	P502882	License-Exempt Outside Home (Relative)	1000	93033	(805) 486-	0	2
A'	P502612	License-Exempt Outside Home (Relative)	1409	93033	(805) 487-	0	2
Ar	021051 P	License-Exempt Outside Home (Relative)	4016	93033	(805) 486-	0	2
Ap	275010	License-Exempt Outside Home (Relative)	2689 J.	93041	(805) 985-	0	1
Ap	024160	License-Exempt Outside Home (Relative)	2889 J.	93041	(805) 985-	0	2
At	P501872	License-Exempt Outside Home (Relative)	2456 F	93036	(805) 485-	0	1
Ar	P501511	License-Exempt Outside Home (Relative)	921 L #	93033	(805) 486-	0	1
A'ij	P503118	License-Exempt Outside Home (Relative)	712 I	93041	(805) 986-	0	2
A'	P502982	License-Exempt Outside Home (Relative)	1311 E	93035	(805) 204-	0	2
A1	P503205	License-Exempt Outside Home (Relative)	3501	93033	(805) 827	0	4
Br	P502668	License-Exempt Outside Home (Relative)	1293	93021	(805) 857-	0	1
Br	P500185	License-Exempt Outside Home (Relative)	4131	93033	(805) 276	0	3
Bi	P500395	License-Exempt Outside Home (Relative)	94 W.	93001	(805) 642	0	2
Be	041048	License-Exempt Outside Home (Relative)	711	93030	(805) 382-7	0	1
Be	041063	License-Exempt Outside Home (Relative)	3540	93033	(805) 483-	0	1
Be	041067	License-Exempt Outside Home (Relative)	1400	93030	(805) 988-	0	2

Appendix B
Caregiver Survey

Caregiver Survey

A Self-Administered Questionnaire

Please complete the questions on the pages that follow
and submit in person or by mail no later than by _____ to:
Will insert the name and address of the agency
and the researcher's name and title

Dear Caregiver,

The purpose of this survey is to find out what your attitudes and suggestions for improvement are for child care and the subsidy system and why you became a caregiver. I, Linda Roseburr, am a student at Nova Southeastern University and this is a research study to fulfill a requirement for my doctoral degree. All of the friend and relative caregivers on Insert name of the agency database will be asked to complete this survey. Your opinions are important to us!

We are also interested in what the parent who chose you to care for their child(ren) has to say. Please give the parent survey, with the attached consent letter, to the parent for whom you are the caregiver.

Yours and the parent's responses to these surveys will be kept confidential and will not affect your subsidized child-care payment in any way. All surveys that are submitted to *Insert acronym* by the date due will be entered into a drawing for a chance to win one of thirty child's educational toys worth approximately \$20. Please respond to all of the questions and return the survey by ___date(bolded)___ at Insert name and address of the agency, Attention: Insert the name of the researcher. If you have any questions, please call Insert the name and contact phone number of the researcher.

Please answer all of the following questions in your own words. If you need more space, you may write on the back or attach additional sheets.

1) Why did you decide to care for the child you currently care for?

2) Do you have any comments about the following, regarding the child?

If so, please write them in. Please be as specific as possible.

- Does he/she seem happy?
- Do you have any concerns about the child's ability to talk or play with other children or adults (if old enough)?
- Has the child been diagnosed with any learning problems?
- Is the child diagnosed with any health problems?

- 13) My education level is
- Less than High School Degree
 - High School or GED Equivalent
 - Some College or AA Degree
 - BA or BS Degree
 - Master's Degree
 - Doctorate Degree
- 14) My family income per year is
- Less than \$20,000
 - \$20,000 - \$39,000
 - More than \$40,000
- 15) My marital status is
- Married or living with partner
 - Never married
 - Divorced
 - Widowed
- 16) I take care of the children in
- My home
 - The child's home
 - Other: (Please specify) _____
- 17) The relationship that I have to the child(ren) is
- Relative
 - Friend

Thank you for taking the time to complete and submit this survey. Your opinions and information are very valuable to us. Survey # _____

Appendix C
Parent Survey

Parent Survey

A Self-Administered Questionnaire

Please complete the questions on the pages that follow
and submit in person or by mail no later than by _____ to:
Will insert the name and address of the agency
and the researcher's name and title

Dear Parent,

The purpose of this survey is to find out what your attitudes and suggestions for improvement are for child care and the subsidy system and why you chose your current caregiver. I, Linda Roseburr, am a student at Nova Southeastern University and this is a research study to fulfill a requirement for my doctoral degree. All of the parents who use friends or relatives to care for their children on Insert name of the agency and acronym database will be asked to complete this survey. Your opinions are important to us!

Your responses to this survey will be kept confidential and will not affect your subsidized child-care payments in any way. All surveys that are submitted to insert agency acronym by the date due will be entered into a drawing for a chance to win one of thirty child's educational toy worth approximately \$20. Please respond to all of the questions and return the survey by ___date(bolded)___ at insert agency name and address, Attention: insert researcher's name. If you have any questions, please call insert researcher's name and phone number.

Please answer all of the following questions in your own words. If you need more space, you may write on the back or attach additional sheets.

- 1) Why did you decide to use your current caregiver?

- 2) Do you have any comments about the following, regarding the child?
If so, please write them in. Please be as specific as possible.
 - Does he/she seem happy?
 - Do you have any concerns about the child's ability to talk or play with other children or adults (if old enough)?

 - Has the child been diagnosed with any learning problems?

 - Is the child diagnosed with any health problems?

On the following questions, please check off the answer that fits you best:

- 13) I am
- Female
 - Male
- 14) My ethnicity is
- White
 - African-American
 - Latino
 - Asian
 - Other
- 15) My education level is
- Less than High School Degree
 - High School or GED Equivalent
 - Some College or AA Degree
 - BA or BS Degree
 - Master's Degree
 - Doctorate Degree
- 16) My family income per year is
- Less than \$20,000
 - \$20,000 - \$39,000
 - More than \$40,000
- 17) My marital status is
- Married or living with partner
 - Never married
 - Divorced
 - Widowed

Thank you for taking the time to complete and submit this survey. Your opinions and information are very valuable to us.

Survey # _____

Appendix D

Demographic Data for the Caregivers

Demographic Data for the Caregivers

Variable	Group	Frequency	Percentage	Mode
Gender	Male	5	6.0	Female
	Female	79	94.0	
Age	18-29	11	13.0	51 years old
	30-39	9	10.7	
	40-49	25	29.8	
	50-59	20	23.8	
	60-74 (oldest)	15	17.9	
	No data	4	4.8	
Marital Status	Married or living with partner	50	59.5	Married or living with partner
	Divorced	15	17.9	
	Never married	11	13.1	
	Widowed	7	8.3	
	No data	1	1.2	
Ethnicity	Latino	53	63.0	Latino
	White	19	22.6	
	African-American	3	3.6	
	Asian	2	2.4	
	Other	4	4.8	
	No data	3	3.6	
Education Level	Less than High School (H.S.)	36	42.9	Less than H. S.
	H.S. or GED	26	31	
	Some college or A.A.	19	22.6	
	B.A. or B. S.	2	2.4	
	Master's degree	0	0	
	Doctorate	0	0	
	No data	1	1.1	
Family Income/Year	Less than \$20,000	41	48.8	Less than \$20,000/Year
	\$20,000-\$39,000	25	29.8	
	More than \$40,000	13	15.4	
	No data	5	6.0	

Note. $n = 84$.

Appendix E
Demographic Data for the Parents

Demographic Data for the Parents

Variable	Group	Frequency	Percentage	Mode
Gender	Male	2	3.6	Female
	Female	54	96.4	
Age	20-29	30	53.6	27 years old
	30-39	15	26.7	
	40-49	5	8.9	
	50-52 (oldest)	3	5.4	
	No data	3	5.4	
Marital Status	Married or living with partner	8	14.3	Never married
	Divorced	10	17.9	
	Never married	33	58.9	
	Widowed	3	5.4	
	No data	2	3.5	
Ethnicity	Latino	40	71.4	Latino
	White	11	19.6	
	African-American	2	3.6	
	Asian	1	1.8	
	Other	2	3.6	
	No data	0	0	
Education Level	Less than High School (H. S.)	22	39.3	Less than H. S.
	H.S. or GED	18	32.1	
	Some college or A.A.	16	28.6	
	B.A. or B. S.	0	0	
	Master's degree	0	0	
	Doctorate	0	0	
	No data	0	0	
Family Income/Year	Less than \$20,000	41	73.2	Less than \$20,000/Year
	\$20,000-\$39,000	15	26.8	
	More than \$40,000	0	0	
	No data	0	0	

Note. $n = 56$.

Appendix F

Caregiver Responses to Question 1 on the Written Survey

Question 1: Why did you decide to care for the child you currently care for?
1. She is my sister and her old caretaker moved, and we felt better that I would be the one to take care of her.
2. I know them both since they were born.
3. My niece moved into my home with her children and had to go to work. I could not say no.
4. She is my granddaughter.
5. They are my grandchildren and I love to care for them.
6. Because he is my grandson and it gives me time to spend with him and help my stepdaughter.
7. I am caring for my younger sister because my mother returned to work. I decided to leave my office job to care for mine and her children at the same time.
8. Because they are my grandchildren.
9. I enjoy being with children and teaching them how to count, and read to them.
10. To help my sister.
11. They are my grandchildren. Orphans from parent side and my daughter needs me.
12. To help out my sister and her daughter is very special to me.
13. He is my grandson.
14. Because I am her neighbor and it was convenient for her to just drop her off at my house and the child feels comfortable with me.
15. I am currently caring for my 3 grandchildren as my son was having difficulty with his varied hours trying to find day care.
16. No one can take care of them better than I do.
17. The child is a family member and care for the child is too costly elsewhere. I have flexibility in my work hours to care for the varied hours the parent needs to work. Nights, weekend, holidays etc.

18. They are my grandchildren.
19. First and foremost they are my grandchildren and their care is very important to me. I make sure they are fed well and have outside activity.
20. I have 2 children and I love kids.
21. First of all, because they are my grandchildren, and, in my opinion, they are better off in my care than with strangers. Second, because I love children.
22. They are my grandchildren.
23. The child is my grandchild and we did not want her with strangers.
24. She is my grandchild and I'm helping my daughter while she finishes her education.
25. To help out my daughter while she attends school and work and also because Michael (her son) does not adapt that well to new people, places or things, because of being bounced around from home to home. So that is why I decided to help her out and do childcare through you people.
26. Because I think a family member cares and loves a child more than a stranger and as his grandmother I'm the best substitute while his mom is at work.
27. I decided to take care of my grandkids.
28. I love working with kids.
29. Because children are the next generation and I care for my grandchild.
30. Because my sister needed a child-care provider and I was very interest to watch my niece and nephew. I enjoy the job is fun.
31. Because I love him and he is my grandson.
32. She is my granddaughter and I do not trust infant's to outside child-care providers. My daughter was 2 and my son 6 and I found out 7 years later that they were abused at a NY State run child-care provider.
33. I did not want him to stay with someone that would not take good care of him because there are bad child-care providers out there.
34. I was ready to retire, my daughter-in-law asked if I would care for the children and supervise them in their homework and make sure it was completed. School is just

around to corner. My son got full custody of my granddaughter (emergency).
35. Because I needed a job and love children
36. She is my granddaughter and I love her, she also gets to spend more time with others her age because to have young children.
37. They are my lovely family. Because I have no children and I love them like my own child.
38. She is my granddaughter.
39. He's my grandson.
40. Because I'm their granny.
41. It is easier for my grandchildren and daughter.
42. Because I love children.
43. They are my sister's children and they are very attached to me.
44. Because I always had a love for children, and parents should be able to work without having to worry if there children are being loved & cared for.
45. Because she asked me to watch her girls. We are very good friends and the girls love being here. I've been doing day care for a long time for family & friends.
46. Both children are my cousins' children & know me already.
47. They are my grandmother. I have always taken care of them. Know one will take better care of them like I do.
48. My daughter started going to school, and I felt my granddaughter would be safer with me.
49. Laura works at same place my daughter works.
50. I previously watched Serena – when Olivia was born I took them both back.
51. They are my grandkids. They are my pride & joy and I enjoy taking care of them.
52. She is my granddaughter and I wanted to.
53. To help my sister out with child care in the home.

54. Out of necessity. He is my nephew and I love him.
55. It's my granddaughter.
56. Family member
57. Because they're my grandchildren.
58. Because he's my grandson and I love him very much, and I enjoy being with him.
59. Because I love working with children. I think I have plenty of experience taking care of other people's babies, because I had 7 children of my own, plus I took child development classes at the college. I used to work in the "fields" and wanted to get a better job. I like children very much and working with them is very fun for me.
60. They're my grandchildren. I do not trust other people to watch them, I'd rather do it myself.
61. To spend more time with my grandchild and to give her the best care.
62. Because they are my grandchildren, even if they were not, I need the job.
63. The kids I care for are my nephews. I am a stay at home parent and was able to help my sister.
64. Because she is my niece and my sister needed someone to take care of her.
65. I decided to take care of my 2 granddaughters because I think that I can take better care of them than anyone else. First of all because they're my granddaughters and always have lived here.
66. So my daughter could go to work and better their lives.
67. Because they are my grandchildren.
68. I believe that family is safer for my grandchildren than strangers.
69. Because I would not trust anyone else with my grandson.
70. He's my great grandchild.
71. Because she is my granddaughter. With my daughters work and school schedule, her hours can be crazy. They include weekends. I want my grandchild to be put in

a secure place.
72. I retired as a correctional officer the same year my great nephew was born. My niece had no reliable sitter. I decided to help raise my nephew rather than continue vocational school I had just started.
73. Because they are girls and my sisters and I do not trust anybody with my nieces.

Note. $n = 84$. Eleven caregivers did not answer this question.

Appendix G

Parent Responses to Question 1 on the Written Survey

Question #1: Why did you decide to use your current caregiver?
1. I love working with kids.
2. The college has a very reputable child development center & because it is a lab school. They have more resources for Pre-K curriculum available. My mom, Madison's grandmother is the other caregiver.
3. I decided to use her because I trust her and my kids love her.
4. She's family.
5. She is incredible with my son. She makes him happy.
6. Because she is a great babysitter.
7. She's my grandmother of my children and my mom.
8. I felt comfortable with my current caregiver because she take good care of my children by giving them enough food of nutrition vitamin veg. Good hygiene take them places after their school and any other. My babies love her never complain of anything.
9. It's their grandma.
10. Because she is real nice with my children and treat them good.
11. I need to study and work. I trust my provider who is also the grandmother. She is very loveable with children.
12. Because she's my neighbor and I can trust her with my daughter and my daughter likes her a lot.
13. She is the children grandmother.
14. Because she is my mom and she has experience caring for children. Who would be better than their own granny.
15. Because she is my mother and she is very efficient and patient with children. Very disciplined.
16. To help my sister for she could go to school.

17. Because I trust her with my life and kids.
18. Because it is my mother.
19. Grandmother. She cares for my children very well.
20. Because she raise me. It's my mom.
21. Grandmother
22. She used to watch him before and we liked her.
23. She is great with children.
24. I decided to have Mary C. as a caregiver because she is a loving grandmother and I trust her. My son Haydon loves her so much that when I pick him up from her house he cries.
25. Because I know my dad is trustworthy and because my son does not do to good with separation. I wanted someone that would think of my child first instead of looking at is as a job.
26. He's my grandson.
27. She's the right person, trustworthy and because she's their grandmother and she loves them.
28. Because she is my sister and I trust her. I'm sure that my children are well taken care of in all areas.
29. It was easier for my children and work.
30. Because I want more information about a day care. To help me to get a license.
31. She is a very good caregiver she has been my caregiver 7 years ago she work well with my two children and she's a good friend.
32. My mother.
33. It was easier. And I feel safer for them to be with someone they knew. I know that they'll be very well taken care of. If they were to get sick I can leave them with the caregiver that I chose. If I had to take them like to a day care I would not be able to figure out who can watch them.
34. She's my mother and I know how much she loves children. I know how much love

she put into me & my sister and brothers.
35. Because I trust her.
36. Because I need it.
37. Because she is my mom and she takes care of them very well.
38. Because she is my mom.
39. Because she's my mom and I trust her.
40. The reason why I choose my current caregiver is because for one she is my sister, she lives with me and my family and my kids know and love her very much. She's really good with my children and I trust her.
41. She is my mother & I know I can trust her w/my child, also she is willing to watch my daughter on nights and weekends.
42. Because I trust her.
43. I picked my mother because I do not really trust anyone else with my children and it makes it easy for me to go to work and back.
44. She is my sister and I know my children are loved and taken care of with her.
45. I trust her taking care of my children.
46. She is my sister and my daughter would not feel uncomfortable staying with her.
47. Because she is my mom and I know that she really loves my children and I live w/her and I do not have to take them no where for care.
48. Because she is my mom, be more comfortable, satisfied and more confident.
49. Because he is my grandfather and I trust him with my children.

Note. $n = 56$; Seven parents did not answer this question.

Appendix H

Caregiver and Parent Interview Responses That Indicate Process Quality

Caregiver and Parent Interview Responses that Indicate Process Quality

1. From a parent: “They (caregiver and four children) sing all the time in English and Spanish”; “The kids help her bake”; “They write and draw all the time. She keeps paper handy for them and she helps them with their homework.”
2. From a parent: “I like this provider because she cares for only my daughter (1 year old) and her son (2 years old). There is a day care at my college but it is more like school, with a lot of kids, so I want to wait until my daughter is older, three or four.”
3. From a parent: “My sister takes care of my kids (3) and she loves them”; “They take piano lessons and she bought them a microphone” (for singing); “Yes, she has a big board for them to draw on”; “She buys things for them like drawing tools and animal stickers for the wall”; “My baby has a problem that, sometimes when she is crying, she stops breathing. My sister knows what to do when this happens so I am comfortable leaving my baby with her.”
4. From a caregiver: “My daughter goes to school and we wanted her (the child, 4 years old) to be at home at night”; “She is advanced for her age and talked really early”; “She wants to play card games with me”; “We make up our own songs . . . we get silly sometimes”; “She washes the kitchen floor and makes a mess but what can you do?”
5. From a caregiver: “He tells me stories and I listen”; “He talks to me while I am cooking and sometimes we make cookies together.”
6. From a caregiver: “My granddaughter reads a bedtime story to me every day for about 20 minutes”; “The other day I had them (two children) clean their room and they sang Christmas carols”; “I sent them to church camp for two weeks and they had to work at a car wash, bake sale and rummage sale to earn the money. They learned that they have to work to get something”; “Sometimes we go to Griffith Park and the kids ride the bikes while the adults barbeque. In fact, I am waiting for my daughter to get home so we can go today.”
7. From a Spanish-speaking caregiver: “Sometimes we change the story in the English books to Spanish.”
8. From a caregiver: “When I cook, Gabriel (3) likes to sit there and ask ‘what’s that?’ and ‘what’s that?’.” “I take him everywhere with me (errands).”
9. From a caregiver: “We are doing fine. A neighbor brings books for me and leaves them for a few weeks and then replaces them.”