

# Home-Based and Family Child Care: Characteristics and Quality Issues

## 6

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The importance of regulating home-based and family child care and improving the quality of these services is clear. The National Child Care Survey (Hofferth, Brayfield, Deitch, & Holcomb, 1991) suggests that the majority of children under five years of age whose mothers work full time are cared for in the homes of a neighbor, friend, family child care provider, or relative. Thirty-eight percent of children are cared for in home-based care versus thirty-five percent in center-based care.

### CATEGORIES OF HOME-BASED FACILITIES

There are three basic categories of home-based providers who care for young children: regulated, legally unregulated, and illegally operating.

#### Regulated Providers

*Regulated* providers follow state laws, which determine a threshold of children allowed to be served at any one time and the standards child care providers must meet. These providers are licensed, registered, or certified, depending on the state, and include family child care home providers (one

adult cares for six or more children, two adults care for

#### Legally Unregulated

These providers are not required for licensing and are exempt from regulatory standards that a neighboring neighbor can take is regulated by a state. The

#### Illegally Operating

Illegally operating though they serve includes providers not licensed, registered,

Most home-based (Hayes, Palmer, & Zuckerman, 1995). 81% of the nonregulated number of children (1995).

#### CURRENT QUALITY

Little is known about report that families the mothers' jobs, a quality child care (Goel, 1995). Approaches to study have been under-researched have sought to characterize regulated providers and Approaches to study (ratios and growth) examine factors such as outcomes (Kontos et al., 1995).

Studies have examined child care (Fiene et al., 1990). In each, the Day Care Environment

adult cares for six or fewer children) and group child care home providers (two adults care for 7–13 children).

### **Legally Unregulated**

These providers serve a number of children less than the threshold required for licensing or registration, or they are relatives of the child and exempt from regulation. Family child care homes usually have additional standards that caring for children in one's home does not. A relative or neighbor can take in one, two, or possibly three children and not be regulated by a state. These providers are considered legally unregulated.

### **Illegally Operating**

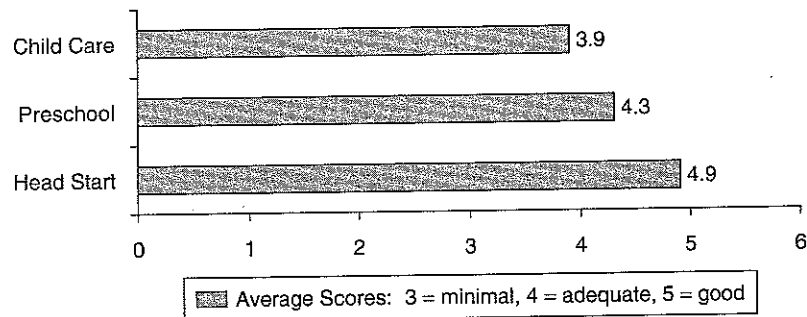
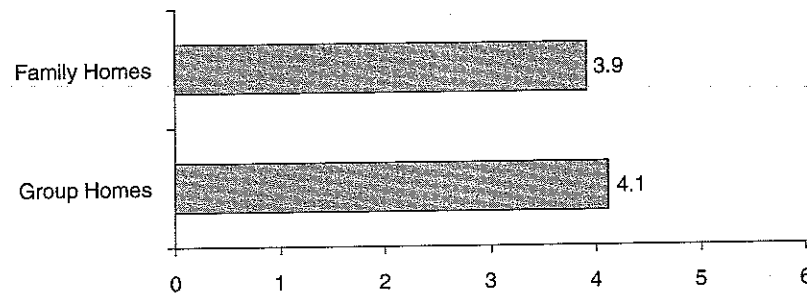
Illegally operating providers are not licensed or registered even though they serve the threshold number of children. This category also includes providers serving more children than allowed, even if they are licensed, registered, or certified.

Most home-based caregivers are unregistered and unregulated (Hayes, Palmer, & Zaslow, 1990; Kahn & Kamerman, 1995). In one study, 81% of the nonregulated providers were illegally caring for more than the number of children their state allowed (Kontos, Howes, Shinn, & Galinsky, 1995).

## **CURRENT QUALITY OF HOME-BASED FACILITIES**

Little is known about the quality of these arrangements. Some studies report that families who are the least well educated, have less income from the mothers' jobs, and have higher levels of stress tend to have lower quality child care (Goelman & Pence, 1987a, 1987b). Family child care has been under-researched (Kontos et al., 1995). A number of recent studies have sought to characterize family child care quality, focusing on regulated providers and using observations as primary data sources. Approaches to studying quality include examining regulated characteristics (ratios and group size) and more process-oriented approaches that examine factors such as provider behavior and type of children's experiences (Kontos et al., 1995).

Studies have also compared home-based child care to center-based child care (Fiene et al., 2002; Fiene & Melnick, 1991; Melnick & Fiene, 1990). In each, the overall quality of homes as measured by the Family Day Care Environmental Rating Scale (FDCRS; Harms & Clifford, 1990)

**Figure 6.1** ECERS-R Mean Scores by Type of Center-Based Facility**Figure 6.2** FDCRS Mean Scores by Type of Facility

scored at or lower than center-based care when compared to the Early Childhood Environment Rating Scale (ECERS), which are similar scales for two different early childhood environments (Harms & Clifford, 1980). For more information on these rating scales, see Appendix 1 at the end of this chapter. In a recent study (Fiene et al., 2002), centers and homes scored about the same (see Figures 6.1 and 6.2), but lower than Head Start and nursery school programs.

Family Child Care (FCC) is generally perceived as “informal,” implying a less structured environment lacking in curriculum, a less educated provider, and a lower quality program. However, quality varies widely among family child care homes. Melnick and Fiene (1990), Fiene and Melnick (1991), and Fiene and colleagues (2002) found that the variation in the FDCRS scores of homes was much greater than it was in the ECERS scores of center-based facilities. Home-based facilities offered some of the best child care, but also some of the worst.

The primary incentives that lead family child care homes to become licensed include public subsidies, the possibility for referrals from resource

and referral agencies, access to the professional development and training provided by states, and the ability to obtain liability insurance. Providers who see their services as a business or career are often more eager to gain the visibility that licensing and registration offers. However, many others do not approach home-based care as a business or career and tend to care for children only while their own children are of preschool age (Hayes et al., 1990).

### **OBSTACLES TO IMPROVING THE QUALITY OF FAMILY CHILD CARE**

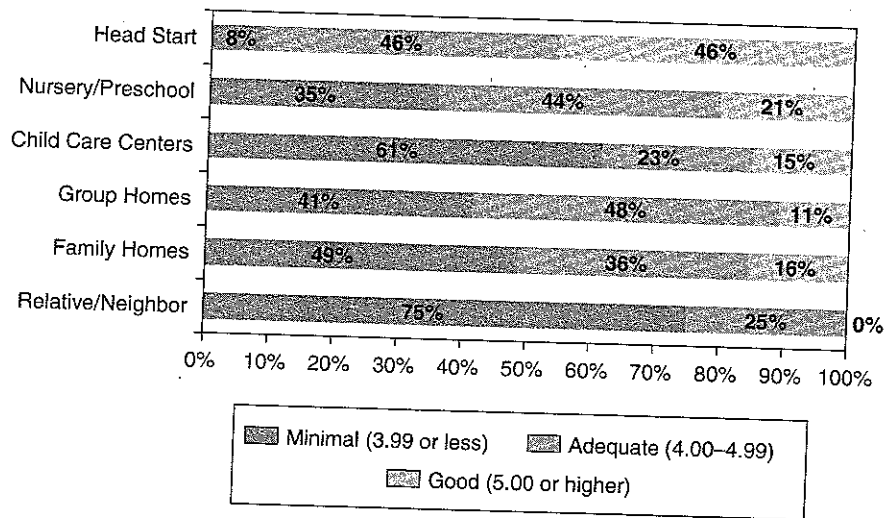
It is far more difficult to study quality in family day care (home-based facilities) than in centers. The definition of quality varies across communities and among researchers, parents, and providers. Many providers do not want to be evaluated and are not accessible to researchers (Fiene et al., 2002). These and other factors suggest the few studies available may depict family child care as better than it is. This is a concern considering that legally exempt care homes serve the most children, but offer the lowest quality (Fiene et al., 2002).

Fiene and colleagues (2002) found the quality of regulated homes to be roughly comparable to that of child care centers, but not to the quality of Head Start or nursery schools. Poor quality was common in nonregulated homes (see Figure 6.3 on the next page). Children in informal settings are much less likely to engage in activities promoting literacy and learning than children in centers and regulated FCC homes (Zinsser, 1991).

The following section discusses research that may help to improve the overall quality of care in home-based child care.

### **CHARACTERISTICS OF IMPROVED HOME-BASED AND FAMILY CHILD CARE PROGRAMS**

Several characteristics of homes have been found to be related to quality. They include the intentionality of the caregiver to view the care as a professional business and the caregiver having more education, utilizing a curriculum, and taking advantage of training and mentoring programs. Some characteristics are regulated, such as educational level, utilizing a curriculum, and the amount of training or mentoring. Others are not amenable to regulation, such as viewing a program as a business, but can be encouraged through training and mentoring.

**Figure 6.3** Percentage of Facilities With Minimal, Adequate, and Good Scores on Environmental Quality

### Intentionality

Intentionality is an important factor in determining quality (Brandon, Maher, Joesch, & Doyle, 2002) and is defined as being committed to caring for children, seeking out child development learning opportunities and other professionals, and creating environments where children can be nurtured and learn. Intentional providers offer the high quality, warm, and more attentive care associated with better growth and development. These providers are found more frequently in family child care than in relative care.

The issue of intentionality is critical to the overall quality of care provided by a caregiver.

Fiene and colleagues (2002) found a significant relationship between the education of the home-based provider and the overall quality of the home as measured by the FDCRS. Family child care homes, which cared for 4–6 children, and group child care homes, which cared for 7–11 children, were observed. The more education that the primary caregiver had, the greater the quality scores were. Having a college degree made a distinct difference in quality. These caregivers viewed themselves as professionals, had more administrative safeguards in place for parents, and more programmatic items in place, such as a curriculum for the children. The majority of those without a college degree saw themselves in the child care business short term, while their children were of preschool age.

**Curriculum**

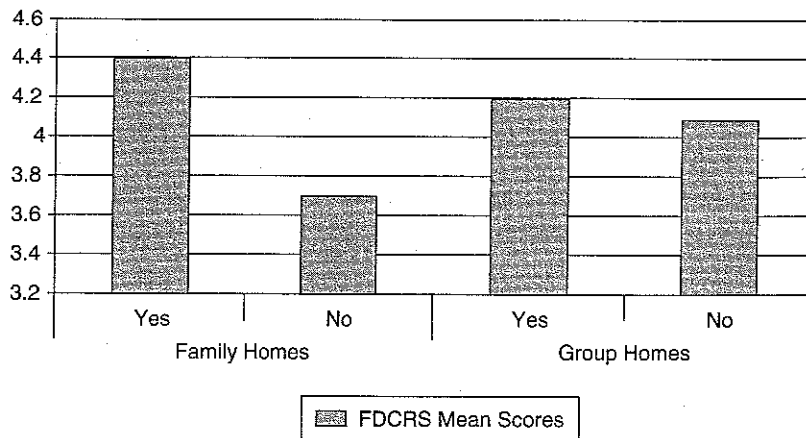
Another way to improve the quality of home-based child care is to have family child care home providers utilize a curriculum (see Figure 6.4). Substantially higher quality scores were earned by family child care homes that utilized a curriculum, but a curriculum earned only slightly higher scores among group child care homes. In this study, the variation in educational levels was not as great in group child care homes as in family child care homes because the group child care homes were licensed and the educational requirements were more stringent than in family child care homes, which operated under a registration system.

Caregivers with a college degree provided care on an average of seven to eight years, while those without a degree had tenures of two to three years (Fiene et al., 2002).

**Training and Mentoring Programs**

A few experimental studies have examined ways to improve family child care. A quasi-experimental study (Galinsky, Howes, & Kontos, 1995) of a short-term training program, "Family to Family," indicated that the training increased global quality but not process quality (e.g., interactions between caregiver and children). The Quality Early Learning Evaluation (Bagnato & SPECS Program Evaluating Team, 2002) identified key elements that enable low-income children to enter school prepared, learn early, and begin to succeed.

**Figure 6.4** Curriculum Use in Type of Home Setting and FDCRS Scores



Findings suggest that when quality standards are met in family child care homes, children achieve at the same rate as those in center-based care (Bagnato et al., 2002).

High quality standards, ongoing mentoring (quality assurance), and the expectation that quality standards will be maintained were essential to achieving and sustaining high quality. The study also reported that mentoring ensures program quality, community leadership breeds program success, and parents learn to help their children succeed.

The findings are consistent with an Infant Caregiver Mentoring Study (Fiene, 2002), which found that mentoring of infant caregivers produced positive behavioral change. Caregivers who received the mentoring intervention (see Box 6.1) were more sensitive and responsive to infant cues. The study is one of the few randomized control trials of a mentoring intervention. In the fall, 20 caregivers received mentoring, and 20 were assigned to a control group, which received the usual workshop training offered by the state. In the spring, the control group received mentoring, and the intervention group became the control. In each semester, those who received mentoring scored significantly higher on all quality measures, and the gains lasted at least through the following summer.

The National Association for Education of Young Children (NAEYC, 1987) has identified common program features related to quality:

- weekly mentoring to improve quality based on NAEYC and the National Association for Family Child Care (NAFCC) standards and practices;
- parent participation;
- ongoing child assessment and feedback to guide instruction and care; and
- community leadership and interagency partnerships, especially with schools.

### **Box 6.1 Capital Area Early Childhood Training Institute's Caregiver Mentoring Program**

This program offers intensive onsite technical assistance and mentoring to directors and caregivers. The program has been effective in making caregivers more sensitive and responsive to children's cues. It is supported by Commonwealth of Pennsylvania and foundation funds, and the unit cost is about \$40.00/hour. Mentors visit weekly with protégés in their individual programs. The ratio of protégés to mentor is 10:1. Protégés receive 70–80 hours of mentoring and technical assistance during an academic year.

NAFCC has set quality standards for accreditation in six domains: relationships, environment, activities, developmental learning goals, safety and health, and professional and business practices.

In one study of health and safety, regulated family child care providers had higher levels of compliance than unregulated family child care and relative providers (Galinsky, Howes, Kontos, & Shinn, 1994). It also reported that home caregivers provided higher quality care when they cared for relatively more children—three to six children—instead of one to two children. This result is related to intentionality. The caregivers saw themselves as professionals, planned more effectively, and utilized a curriculum.

### RELATIVE AND NEIGHBOR CARE

In the United States, many employed parents depend on relatives to care for their children during work hours. The National Survey of America's Families (NSAF) found that, in 2002, 33% of children under age three and nearly a third of preschool children were cared for by a relative while their parents worked. Over 25% of children under age three were in relative care only as opposed to a combination of care arrangements (Snyder, Dore, & Adelman, 2005). However, there is little research on care provided by relatives and friends. One study (Kontos et al., 1995) found a pattern of behavior among relative providers that suggested less interaction with the relative's children than with unrelated children. Relative care was characterized as less structured, less formal, and less focused on the children. In another study (Brandon, Maher, Joesch, & Doyle, 2002), a majority of relatives and friends who provided child care reported at least some problems in providing care, and two-thirds said they would welcome training or support. However, no wide-scale training programs are available for this group of providers.

### CONCLUSIONS AND RECOMMENDATIONS

Family child care or relative care is widely used by families with young children. Unfortunately, the quality of care in family child care and relative care is generally lower than the quality of center-based care. However, several recommendations to improve the quality of home-based care can be drawn from research. They include the following:

- *Attending an orientation session before the registration application is approved should be required.* Such a session should, at a minimum,



explain that family child care is a business, review regulations and the “how to” of operating a business, explain administrative requirements, and define financial arrangements.

- *Require “registration” for all home-based care receiving public subsidies.* Research shows that unregulated care is much lower in quality than regulated care.
- *High quality preservice training initiatives specific to family child care should be funded.*
- *Mentoring models that involve intensive in-home training for caregivers should be implemented.*
- *A public education campaign should be implemented to inform parents and communities about what registration means and that “intentional” caregivers generally provide higher quality care than those who “watch” children.*
- *All home-based family child care providers should be brought into the regulatory system, which must provide technical assistance that helps providers improve the quality of care they offer.*

### **APPENDIX 1: OVERVIEWS AND DESCRIPTIONS OF THE EARLY CHILDHOOD ENVIRONMENT RATING SCALE (ECERS) AND THE FAMILY DAY CARE RATING SCALE (FDCRS)**

This section provides examples of what constitutes high and low quality by outlining key indicators of several ECERS-R and FDCRS items. These scales have been used in several major child care and early childhood studies over the past 20 years (Cryer, 1999; Galinsky et al., 1994; Helburn & Howes, 1996; Iutovich, Fiene, Johnson, Koppel, & Langan, 1997; Jaeger & Funk, 2001) and are among the most reliable program quality instruments available.

#### **Overviews**

ECERS-R is designed to assess center-based programs for children in preschool through kindergarten (ages two and a half through five). The scale consists of 43 items organized into 7 scales: Space and furnishings, personal care routines, language reasoning, activities, interactions, program structure, parents and staff.

The FDCRS is designed to assess family child care programs. The scale consists of 40 items, including 8 supplementary items for programs serving children with disabilities. The descriptors cover the needs of a range of ages from infancy through kindergarten. The items are organized into

7 subscales: Space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development, adult needs, provisions for exceptional children.

Each is described in four levels of quality: inadequate, minimal, good, and excellent. Inadequate and minimal ratings focus on the provision of basic materials and on health and safety precautions. The good and excellent ratings require positive interaction, planning, and personalized care, as well as good materials.

### ECERS-R Description

A minimal score (3.00–3.99 on the ECERS-R), for example, on the language-reasoning subscale under books and pictures translates into a setting that has some books for children and at least one staff-initiated receptive language activity time (e.g., reading books to children or storytelling). A good or excellent score (above a 5.00 on the ECERS-R) requires more: (e.g., a wide selection of books are accessible for a substantial portion of the day, books are organized in a reading center, staff read books to children informally [e.g., during free play or at naptime], some books relate to current classroom activities or themes [e.g., books borrowed from the library on a seasonal theme], and books and language materials are rotated to maintain interest).

A minimal score on the furnishings for relaxation item indicates some soft furnishings and toys are accessible. However, other indicators would not be observed, such as a cozy area for children for a large part of the day and keeping most soft furnishings clean and in good repair. A minimal score on child-related display means some children's work is displayed, and there are appropriate materials for the predominant age group. But other indicators would not be observed, such as having displays that relate closely to current activities and children in the group or allowing children to do most of the work on the display.

A minimal score on activity items (e.g., fine motor, art, music/movement, dramatic play, nature/science, math/number) means that some developmentally appropriate materials were accessible and in good repair, but the caregiver fell short in other areas, such as not having the materials well organized or available at different levels of difficulty for the children or not providing opportunities to use materials for individual or creative expression.

### FDCRS Description

A minimal score (3.99 or less on the FDCRS) for the child-related display category means that no child related pictures, mobiles, or

children's artwork are put up for children to look at. A minimal score on the active physical play item means that, in some homes, there is little or no safe outdoor or indoor space for physical play. A minimal score on the activity items—art or sand and water play, for example—means that some materials were accessible, but the materials were not organized to encourage self help, the caregiver did not help children develop skills, and the materials were not well organized for independent use.

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