

# strengthening families

## almost like family: family child care

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## ALMOST LIKE FAMILY: FAMILY CHILD CARE

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The Center for the Study of Social Policy is a nonprofit (501(c)3) organization based in Washington, DC, that helps states and localities implement creative and effective strategies that strengthen disadvantaged communities and families and ensure that children grow up healthy, safe, successful in school, and ready for productive adulthood.

Strengthening Families™ is an approach to work with children and families that build five research-based Protective Factors with families to prevent child abuse and neglect and promote optimal child development. Strengthening Families is an initiative of the Center for the Study of Social Policy and is supported by the generous support of the Doris Duke Charitable Foundation.

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## background of the family child care programs study

Between 2001 and 2003, the Center for the Study of Social Policy (CSSP) developed an approach to preventing child abuse and neglect by building family strengths, called Strengthening Families™, which evolved from review of existing literature and field research with exemplary center-based early care and education programs across the country. This extensive research resulted in the identification of five Protective Factors, when they are present and prominent in a family, that reduce the likelihood of child abuse and neglect and contribute to excellent outcomes for young children: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children (Center for the Study of Social Policy, 2004). Another valuable outcome of this research was the development of a practical self-assessment tool designed to help early care and education programs identify concrete and practical ways of incorporating strategies that build the Protective Factors into their day-to-day work.

Although home-based child care was not studied in the original research, it is a valued option within the early care and education system in the United States. For the purposes of this report, the terms “family child care” and “home-based child care” will be used interchangeably to discuss the type of care described above. The report does not apply to “family, friend, and neighbor care.” Rusby (2002) reported that approximately 26% of children under age 6 who attend child care receive their care in a home-based setting. “Because they provide a home-like atmosphere, and typically smaller group sizes than many center-based programs, family child care is the first choice for many parents of infants and toddlers” (Buell, Pfister, & Gamel-McCormick, 2002, p. 215). As Strengthening Families has been adopted in early childhood programs around the country, strong interest in using the Strengthening Families approach in home-based child care settings has emerged. The purpose of this Home-Based Early Care and Education Programs Study was to learn how home-based early care and education professionals can build the Strengthening Families Protective Factors with the families and children they serve. The results of the study were used to inform the development of a self-assessment tool appropriate for use by home-based providers. An extensive review of the literature on home-based programs is presented here first, followed by the results of the study.

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## defining family child care

Twenty-five years ago, family child care was just coming to the attention of policy-makers and researchers. At that time, there was general agreement that family child care (known then as family day care homes or by other names) was the care of one or more children unrelated to the provider, in the provider's home. Family child care was viewed as the sharing of a family with other children for part of a day while the children's own mothers were working or otherwise not available to them. A small family child care home typically cared for six or fewer children, and a larger family child care home, usually called a "group" family child care home, cared for 7-12 children.

Today, much of the field still uses these general parameters when discussing family child care even though the quality and professionalism of home-based care has increased. States have developed wildly differing definitions of family child care in their licensing provisions but there is no singularly accepted definition of home-based/family child care (Morgan et al., 2001; Morrissey, 2007; Morrissey & Banghart, 2007). "Given that state regulations vary for licensing and registration, the definition of family child care is not always precise in policy or the research literature" (Morrissey, p. 2; Morrissey & Banghart, p. 2). This has complicated the work of researchers who seek to compare family child care across the states and policymakers who seek to improve quality for children (Morgan, Azer, & Lemoine, 2001, p. 1).

Yet, there are some common components within various state and research-based definitions that, taken together, provide a framework for conceptualizing this category of child care (cf. Atkinson, 1988; Atkinson, 1992; Bromer & Henley, 2004; Buell et al., 2002; Chalfie, Blank, & Entmacher, 2007; Hegland, Peterson, Jeon, & Oesterreich, 2003; Helburn, Morris, & Modigliani, 2002; Layzer & Goodson, 2006; McGaha, Snow, & Teleki, 2001; Morgan et al., 2001; Morrissey, 2007; Morrissey & Banghart, 2007; National Child Care Information Center, 2007; Nelson, 1988; Nelson, 1989; Oliveira, 2007).

1. Home-based child care is non-parental for the most part, although some of the children may be the provider's own.
2. Home-based child care is offered in the residence of the provider.
3. Home-based child care is a business; thus, providers are compensated.

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4. There is one full-time home-based child care provider per residence; however, some providers may employ a full- or part-time assistant.
5. Only a few children are enrolled in a home-based program at one time. The maximum number varies from state-to-state and may be related to the age of the children.
6. Mothers of children in home-based child care are employed or attend school.
7. Children in home-based child care are mixed-age groups and may include siblings.
8. Home-based child care programs serve a greater proportion of infants and toddlers than center-based programs.
9. Children in home-based child care attend the program on regular days or hours.
10. Mothers learn of home-based programs through informal networks (e.g., friends).
11. Home-based child care programs serve demographically diverse families.
12. The quality of care in home-based programs is highly variable, as with center-based programs.

The component that varies most in both state and research-based definitions of home-based/family child care is state regulatory requirements (cf. Atkinson, 1988; Bromer & Henly, 2004; Center for the Child Care Workforce and Human Services Policy Center, 2002; Chalfie et al., 2007; Cornell Early Childhood Program, 2006; Divine-Hawkins, 1981; Etheridge, McCall, Groark, Mehaffie, & Nelkin, 2002; Hegland et al., 2003; McGaha et al., 2001; Morrissey, 2007; Morrissey & Banghart, 2007; National Child Care Information Center, 2007; Nelson, 1989; Oliveira, 2007; Tuominen, 2003). In some cases, home-based/family child care programs are defined as only those that have met state regulations (whether through licensing, registration, or certification procedures), while unregulated programs are regarded as “family, friend, and neighbor care.” In other cases, both regulated and unregulated programs are included in the definition and study of home-based/family child care.

## characteristics of providers

Although regulatory requirements for home-based programs may differ from state to state, the characteristics of home-based providers tend to be similar across states (cf. Center for the Child Care Workforce and Human Services Policy Center, 2002; Chalfie et al., 2007; Freeman & Vakil, 2007; Helburn et al., 2002; Kryzer, Kovan, Phillips, Domagall, & Gunner, 2007; Layzer & Goodson, 2006; Morrissey, 2007; Morrissey & Banghart, 2007):

1. They are overwhelmingly female.
2. They are parents themselves.
3. They work long hours.
4. Their income is low relative to those holding similar skill-level jobs. The earnings of providers with unregulated programs may be less than their peers with regulated programs.
5. They have little or no employment benefits (e.g., health insurance and retirement) through their business.
6. Their ethnicity reflects the ethnicity of most of the families they serve.
7. There is much variation within states in the age, educational level, socioeconomic level, training in child care, years of experience in child care, and marital status of home-based providers.

Since home-based providers primarily serve children of employed mothers or mothers who are enrolled in school (Bromer & Henly, 2004; Fuller, Kagan, Loeb, Chang, 2004; Loeb, Fuller, Kagan, & Carrol, 2004; Morrissey, 2007; Morrissey & Banghart, 2007), the workday of the providers mirrors that of the mothers plus the amount of time mothers need to travel to and from their workplaces or schools. Thus, in addition to having a long workday five days a week, providers tend to offer flexible—and sometimes personalized—scheduling; this may be particularly important for low-income working mothers who may have variable or late evening work schedules (Bromer & Henly; Center for the Child Care Workforce, 2002; Chalfie et al., 2007; Layzer & Goodson, 2006; Morrissey; Morrissey & Banghart; Oliveira, 2007).

## family child care providers' work with children

Historically, the “care” of young children has been conceived of as not requiring specialized training and meant (a) responding to young children’s basic physical needs (e.g., feeding, diapering), (b) responding to their basic emotional needs (e.g., showing affection, comforting when distressed), and (c) providing a safe and secure environment. In contrast, the “education” of young children historically has been conceived of as requiring specialized training and meant the systematic planning and implementation of specific goals, objectives, and activities that resulted in enhanced physical, social, emotional, cognitive, and linguistic development. Freeman and Vakil (2007) stated:

Of the many changes that have shaped the field of early childhood, one salient issue now recognized is that care giving and education are inseparable dimensions in early childhood programs. This premise comes to light...when examining family child care programs which have historically been conceptualized by images of mothering rather than teaching. As these programs become more professional, providers begin to see their work as educate and their role as involving both teaching and care giving. (p. 269)

The term “educare” was coined to challenge the longstanding false dichotomy and hierarchy between education and care often suggested in the early childhood education field and to communicate the interrelated nature of education and care in quality early childhood education programs (Caldwell, 2002; Freeman & Vakil, 2007; Smith, 1992). Caldwell asserted, “One cannot educate without offering care and protection, and one cannot provide true care and protection without also educating” (p. 192).

In the context of her work, the home-based/family child care provider is responsible for all aspects of child care and early education experiences—from encouraging an infant’s first steps, to toilet training, to encouraging prosocial behavior, to modeling language skills, to reinforcing children for appropriate responses.

The provider is the critical determinant of the children’s experiences. How she interacts with children, how she structures their activities and experiences, her emotional tone and the content of her spoken interactions are what primarily define the child’s daily experience in [home-based] care. (Layzer & Goodson, 2006, p. 10.1)

Furthermore, in settings with mixed-age groups, the provider must “juggle the developmental needs of a wide age range of children” (Kryzer et al., 2007, p. 460).

The unique characteristics of home-based/family child care (e.g., small adult-child ratio, mixed-age groups, inviting home settings) would make it easy to conceptualize this type of care as a program that also “educates” children. “Educare is provided in caring, responsive social contexts where adult-child and child-child interactions and opportunities for play and exploration promote children’s social and intellectual development” (Smith, 1992, p. 4). Some home-based providers, however, have been doing this all along. That is, “whether intentional practice or intuitive understanding of child development guides these providers” (Freeman & Vakil, p. 275), some already establish meaningful relationships with the children and the families they serve which ultimately facilitate children’s physical, social, emotional, cognitive, and linguistic development.

### the provider-parent relationship

Both parents and providers understand that a pleasant and respectful adult-to-adult relationship between families and caregivers is very important in home-based child care. “Effective parent-caregiver partnership and communication is beneficial for children in care, and a satisfying parent-provider relationship is associated with stronger parent-provider attunement and better child adjustment to child care” (Morrissey, 2007, p. 18). However, Nelson (1989) suggested that the nature of home-based child care creates unique factors that make the formation of wholesome provider-parent relationships more complex than it at first seems:

Because this kind of childcare remains in a private domain, these relationships have a different context than those between institutional employees and their clients. Yet, because they are based on an exchange of services for money, these relationships also may differ from those between family members and friends who informally exchange goods and services. (p.7)

### RECONCILING SHARED PARENTING

Parents tend to choose home-based child care because they desire a small, more intimate setting in which their child will more likely receive individualized care and attention. Home-based providers tend to choose this line of work because, for one reason, they love children. The relationship between parents and providers in a home-

based program, then, revolves around a shared concern for meeting the needs of children. Providers must reconcile two key elements in their “shared parenting” relationship with parents: (a) common agreement on “care characteristics” cited by parents (Britner & Phillips, 2003) and (b) the level of their emotional attachment to others’ children (Nelson, 1990).

### Care Characteristics

Both parents and providers bring to the home-based care experience beliefs, attitudes, and values about parenting. Care characteristics include (a) child rearing styles (e.g., authoritarian versus permissive), (b) disciplinary methods (e.g., reinforcements and punishments), (c) what is appropriate child play (e.g., allowing pretend play with guns), (d) the experiences across the child’s day (e.g., amount of time spent watching television), (e) attributes of the home-based facility (e.g., space, materials, resources), and (f) early childhood development priorities (e.g., focus on teaching the alphabet versus teaching manners).

Britner and Phillips (2003), Owen, Ware, and Barfoot (2000), as well as Pence and Goelman (1987), suggested that agreement between parents and providers on care characteristics was a key component in parents choosing and remaining with a particular home-based child care provider. Britner and Phillips concluded, “To the extent that parents and providers value the same structural and functional care characteristics of the arrangement, the continuity of goals across settings may translate into favorable child outcomes and satisfaction for parents and providers” (p. 6-7). Similarly, Morrissey (2007) reported, “Mother-caregiver agreement in childrearing attitudes helped to foster greater partnership and higher quality caregiver-child interactions in family child care” (p. 18).

### Emotional Attachment

Another aspect of shared parenting involves the provider’s level of emotional attachment to the children in her care. Some researchers (e.g., Katz, 1988; Scarr, 1984) have suggested that teachers should have an emotional distance from students in order to avoid biased judgments about them, as well as to maintain professionalism. Nelson (1990) proposed that the level of emotional closeness or distance should be a concern of home-based providers, as well. That is, if providers assume a parenting role too strongly and become too emotionally engaged with other peoples’ children, this may compromise or interfere with their ability to maintain a businesslike relationship with parents.

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Providers must decide...how close they should become to these children, how much physical affection they should express, what is acceptable and unacceptable behavior from a child, [and] what kind of discipline should be used....In sum, the provider must determine how to act...like a mother toward children who are not her own. This is difficult....Family day-care providers become enormously attached to the children in their care and, in some respects, giving them good care means treating them like their own. Yet these feelings cannot be allowed to flourish because [providers] lack the privileges of motherhood and because they must commodify caregiving [i.e., to treat as a commodity]. (Nelson, 1990, p. 587-588)

Based on the responses from providers in his research, Nelson (1988) concluded that "Genuine caring is not easily transformed into a commodity on which any price can be placed" (p. 86). Providers in his research reported that, although they understood the necessity of assuming an emotional detachment with the children in their care, it is easier said than done and even more difficult to sustain. Indeed, both the concept of caring and the work that home-based providers do on a day-to-day basis create strong emotional attachments. Thus, it may be more prudent and realistic for providers to seek "to find the proper balance between attachment to, and distance from, each child in her care" (Nelson, 1989, p. 29).

### RECONCILING THE TRANSACTIONAL RELATIONSHIP

A second factor that home-based child care providers deal with in the provider-parent relationship is the nature of their transactional relationship with parents: whether it will be in the form of a "market exchange" versus a "social exchange" (Nelson, 1989; Nelson, 1990). In a market exchange, there are clearly specified (a) obligations (e.g., parents should pay the provider on Friday for services for the next week), (b) rules (e.g., parents must pick-up children by 6:30 p.m.), and (c) social distance (e.g., parents should not call the provider after 9:00 p.m. unless there is an emergency).

It is easy to understand why providers have at least some commitment to a straightforward market perspective. At one level, the provision of daycare is a job. Providers have to charge enough to make a living and want to be able to predict their incomes. Thus, they set rates and try to hold clients to a fixed fee. Providers also want to regulate their clients to make their own lives as easy as possible. They want to offer care for limited and inflexible hours, have advance

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notice of exceptions to the schedule, and avoid caring for children who are sick. (Nelson, 1989, p. 12)

On the other hand, in a transactional relationship that is based in a social exchange there are (a) diffuse obligations, such as flexible or personalized scheduling; and (b) negotiated decision-making such as the provider and parent jointly developing goals for the child (Nelson, 1989; Nelson, 1990). These obligations and joint decision-making suggest that social exchange transactions are rooted in trust and intimacy (Nelson, 1990). However, parent-provider trust can be compromised and exploited by parents who frequently pick-up children late, who assume "overtime" should be free since the provider is "at home anyway," who do not consistently follow agreed-upon child care strategies at home (e.g., using toilet training methods on the weekend), and who do not pay on time (Nelson, 1989).

Some providers say [social exchange] relationships can work to their benefit. When the provider has close and intimate relationships with the parents it is easier to agree on how to regulate a child's behavior. Her work is easier. But personal relationships can also intensify the difficulty of negotiations and further reduce the provider's control over her work. Friendships complicate the work by making it more difficult to request rate changes or to put into effect regulations concerning hours. (Nelson, 1990, p. 84-85)

However, the very nature of "family child care is characterized by the intimacy of the relationship between the parent and the provider" (Layzer & Goodson, 2006, p. 7.1).

### RECONCILING PROVIDER PROFESSIONALISM

A third factor that home-based child care providers must reconcile regarding the provider-parent relationship is how they conceive "professionalism." Bromer and Henley (2004) pointed out:

Professionalism in the early childhood field has been characterized by the following tenets: emotional distance from the client, limit-setting on personal involvement and helping, use of formal resources and instruction, and ability to translate child development theory and research into practice. Proponents of these standards maintain that providers and teachers who adhere to them are more likely to offer high quality care and education. Others challenge these traditional definitions of professionalism claiming that they limit the caregiving capabilities and effectiveness of early care and education workers. (p. 950)

As with the issues of shared parenting and the type of provider-parent transactional relationship, understanding professionalism as maintaining emotional distance from the child and the parents creates a dilemma for home-based providers because it is incompatible with the close and personal relationships that characterize home-based child care programs. "Broader definitions of professionalism that emphasize the emotional and relational aspects of child care work and that view the family rather than the child as the target of attention" (Bromer & Henley, 2004, p. 952) may better serve home-based child care providers.

### family and home-based program linkages

Several researchers (e.g., Britner & Phillips, 2003; Bromer & Henly, 2004; Owen et al., 2000) have focused on the importance of the connections between home and child care settings. Two critical points are (a) provider-parent interaction and communication and (b) provider provision of family social support.

#### PROVIDER-PARENT INTERACTION AND COMMUNICATION

Current thinking in the early childhood field emphasizes the importance of provider-parent interaction and communication as a means of enhancing child outcomes (Britner & Phillips, 2003; Owen et al., 2000). "The child's quality of experience in each environment may be enhanced when parent and child-care provider bridge the distance between the two social worlds of child care and home and work together as partners in the child's care" (Owen et al., p. 426).

In general, provider-parent interaction and communication can occur at different levels on a continuum: from infrequent and very brief (e.g., polite greetings or small talk at drop-off); to sharing information about the child at specified times (e.g., weekly reports, provider-parent meetings); to frequent conversations about child, parent, or family matters. Home-based child care is particularly conducive to high levels of provider-parent interaction and communication. Nelson (1989) asserted, "Because [home-based] providers have to know what is happening in the children's lives, they learn about the whole family. Daily interaction provides the basis for warm friendship" (p. 15). Pence and Goelman (1987) found a difference in the amount and forms of provider-parent interaction and communication between home-based and center-based settings. "Family care parents were much more apt to exchange various types of information beyond 'in a business way' with caregivers and often shared a 'good friend' relationship" (p. 114).

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Owen et al. (2000) pointed out that, in addition to benefitting the child, regular and engaging provider-parent interaction and communication is related to mutual positive regard:

When a mother seeks and shares information with her child-care provider about her child, she demonstrates an investment in her child's well-being. These communications may also convey the mother's positive regard for the caregiver's skill and appreciation for the caregiver's role in the child's early experiences. . . . The parent-caregiver interactions that take place when information is sought and shared are likely to reinforce a positive relationship between parent and caregiver. . . . Such possible benefits are in keeping with . . . research findings of caregivers' positive regard for parents with whom they communicate. (p. 425)

### PROVIDER PROVISION OF FAMILY SOCIAL SUPPORT

Strong connections between a child's home and child care settings also can be forged by the home-based provider offering the family social support. Bromer and Henly (2004) studied family social support and concluded, "The fact that so many child care providers across settings reach out to families beyond the direct care of children suggests the urgent need of families for support in a variety of areas" (p. 958). Bromer and Henly defined family support as:

Both formal and informal social supports that child care providers offer parents and families beyond the direct care of children, including help and advice with child-rearing, personal and family matters, as well as assistance with and information about employment, housing, education, and financial matters. (p. 943)

*Formal* social support structures can be observed in many Head Start programs that focus on two generations—children and their parents—as a "holistic approach to early care and education... [In such cases] separate service providers are used for child care and family support activities and child care providers and teachers do not participate in the direct delivery of family support services" (Bromer & Henly, 2004, p. 945).

Home-based early care and education programs, in effect, are two-generation programs. As such, "some researchers suggest that as local and trusted experts in early childhood, family care providers can serve as vehicles for providing family support to their clients" (Morrissey, 2007, p. 18-19). The *informal* social support offered by a

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home-based provider, however, is actualized differently than that in formal social support structures. With informal social support, the home-based provider singularly assumes the dual responsibilities of child care and family support.

“...Some child care providers report informally offering parents a range of supports in addition to the direct caregiving they provide children.... Providers sometimes customize their care schedules to meet parents’ work schedules and budgets, offer emotional guidance and advice on employment as well as a range of instrumental supports such as grocery shopping and transportation. (Bromer & Henly, 2004, p. 945)

Bromer (2001) reported the findings from several studies which examined the help-giving that home-based providers extended to the parents of the children they serve:

1. Home-based providers serve as important family resources for parents with few social supports.
2. Home-based providers are perceived by some mothers as a “safety net.”
3. Home-based providers offer financial advice, marital counseling, and general emotional support to parents, in addition to sharing information about childrearing and parenting.

In addition, “family child care can provide increased contact with people of the same cultural and ethnic background, potentially minimizing stress, and for new immigrants, can ease adjustment and provide the opportunity to make social contacts” (Morrissey, 2007, p. 19).

Although providing informal social support may be an important dimension of the home-based provider’s work, Bromer and Henley (2004) cautioned that several concerns should be addressed before promoting it as an obligatory part of the home-based provider’s work:

Many providers report feeling burned out by the intensity of their work with children, their long hours, and low wages. Incorporating family support responsibilities into these providers’ job descriptions may increase feelings of burnout and decrease the stability and quality of child care programming. . . . [Furthermore] to the extent informal caregivers are untrained and overburdened

with other responsibilities, they may not be the best prepared to take on these additional roles. (p. 957-958)

Although providing support may increase parental satisfaction with their children's child care arrangements and parental perceptions of quality child care, and may be consistent with a holistic approach to early care and education (Britner & Phillips, 2003; Bromer & Henly, 2004; Morrissey, 2007; Morrissey & Banghart, 2007), little is known about the effects of family support offered to parents directly by child care providers themselves because empirical studies have been limited to programs in which child care and family support functions are separate. The broader social support and social network literatures have not examined the role of non-relative child care providers in parents' social networks or the effects of family support delivered by child care providers. (Bromer & Henly, 2004, p. 946). Additional research is also needed to better understand the impact of the dual responsibilities—child care and family support—on the home-based provider.

### what about the father's role in family child care?

In most of the research on the provider-parent relationship in home-based/family child care, the parent is usually defined as the mother. In one of the few studies that focused on fathers, Atkinson (1987) found that middle- and upper-middle income fathers were involved with home-based child care in several ways: (a) talking with providers about their child, (b) talking with their child about the child's experiences, (c) engaging in discussion with the mother about the home-based program, (d) getting their child ready in the morning, (e) taking their child to the home-based program, (f) visiting their child in the program, (g) providing supplies and equipment, (h) attending parent meetings, and (i) caring for their child when the child was too sick to attend the program.

Of these various ways in which fathers participated, the most frequent types of participation involved communication and transportation: talking to the provider, the child, and the mother, as well as driving the child to the program in the morning. The least frequent type of father-participation was attending parent meetings.

## provider stress

Research has shown a relationship between the mental health of the parent and child mental health outcomes, as well as a relationship between nurturance of the child care center provider and the mental health of children in her care (Buell et al., 2002).

Unfortunately, “there is little published research addressing how the mental health of nonparental caregivers, such as family child care providers, is related to the infant and toddler mental health of those in their care” (Buell et al., p. 215).

Several researchers (cf., Atkinson, 1988; Atkinson, 1992; Buell et al., 2002; Goelman, Shapiro, & Pence, 1990; Hamre & Pianta, 2004; Nelson, 1988; Nelson, 1989; Rusby, 2002) have suggested that the very nature of home-based child care lends itself to numerous sources of stress for the home-based provider that could have a negative impact on mental health. The following are suggested in the literature as potential sources of stress:

1. Working long hours with a lot of responsibility, and receiving low pay.
2. Lacking social, instrumental, and problem-solving support over a long workday as the only adult in the setting.
3. Having to play multiple roles, often without support. That is, being the care-provider, the teacher, the behavior monitor, the cook, the janitor, the nurse, the business manager, and perhaps being the social worker for the family and the confidante and advisor to the parent(s).
4. Preparing materials and activities for different age groups of children and responding to varying developmental needs.
5. Balancing the role of a businesswoman with the role of a friend/confidante if one has personal relationships with parents.
6. Dividing one’s home into business/child care space and private/family space.
7. Being taken advantage of by parents in such ways as not paying on time or frequently picking-up children late.
8. Managing competing demands for attention, as well as feelings of jealousy, between one’s own children and the children in care.

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9. Having constricted opportunities for social connections since home and place of work are the same.
10. Having very little time for self reflection or activities, given the length of the workday (as many as 12 hours) plus one's own family and household responsibilities.
11. Being perceived with low prestige (e.g., as a babysitter) by the workforce, in general, and by individuals in the education and child care fields, in particular.

In their national study of family child care, Layzer and Goodson (2006) asked providers about various sources of job-related stress. The most frequently cited sources were:

Insufficient time for themselves; being unable to get everything done that they wanted to; and feeling "used up" at the end of the day.... Many providers said that they experienced conflicts between their responsibilities to their families and to the children they care for. More than 60 percent of all providers reported needing to do their own housework or errands while caring for children. More than a third of providers had problems with parents picking up their children late, and more than a quarter of providers had problems with parents who leave sick children with symptoms such as a rash or fever. Further, providers reported resentment from their own family, including resentment from their own children of the children in their care... and resentment among other family members about the disruption in household activities caused by the child care in the home. (p. 8.8)

It should be noted that the *presence* of one or more sources of stress—in and of itself—is not sufficient to result in the *experience* of stress. The experience of stress occurs when one or more sources of stress or high level of demands strain an individual's resources or exceed an individual's ability to cope with the demands. "If the quality of home day care is linked to the emotional well-being of providers, then the importance of understanding the sources of stress is crucial" (Atkinson, 1992, p. 386). It follows, then, that it is crucial to understand the many kinds of resources that could enhance the provider's ability to cope with various sources of stress, as well.

## provider use of support services and provider intentionality

Several researchers have described the positive relationship between the delivery of higher quality child care and (a) the level of caregiver education and ongoing specialized training in child care and child development (e.g., DeBord & Sawyers, 1996; Gable & Halliburton, 2003; Kontos, Howes, & Galinsky, 1996; Morrissey, 2007; Morrissey & Banghart, 2007; Walker, 2002) and (b) a provider's use of support services and the intentionality they bring to their work (e.g., DeBord & Sawyers, 1996; Doherty, Forer, Lero, Goelman, & LaGrange, 2006; Fischer & Eheart, 1991). In addition to contributing individually to higher quality child care, these variables—provider education, ongoing training, use of support services, and intentionality—have been found to be interrelated. Morrissey (2007) reported, "Providers who seek opportunities for advanced training and credentials have been found to be more committed to the field and to offer higher-quality care and training" (p. 16). Similarly, Fischer and Eheart (1991) stated:

We have observed that providers engaged in training are likely to establish a degree of mutual support among themselves during the training, and are more likely to be informed of available support, such as professional associations. . . . As a result of the training, they are more likely to appreciate and participate in support networks. (p. 560)

### PROVIDER USE OF SUPPORT SERVICES

Doherty et al. (2006) defined "provider use of support services" as membership in professional child care associations and/or involvement with the local child care community. Oliveira (2007) stated, "Family child care associations and family care community-support networks have as their core purpose providing peer support, sharing resources, and enhancing professionalism" (p. 9). Oliveira cited findings from an older study:

Home-based providers are more likely to be rated as having higher global quality scores when they "seek out the company of others who are providing care and are more involved with other providers." Unfortunately, most home-based child care providers may function in almost total isolation, lacking support or the opportunity to share ideas and learn new skills. (p. 9)

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Buell et al. (2002), as well as DeBord and Sawyers (1996), suggested that membership in professional associations and seeking support from a local child care network can benefit the home-based provider in the following ways:

1. Technical assistance - receiving information and instrumental support that is designed to increase program quality.
2. Technical assistance relationship - forging an interpersonal relationship with an individual that enables emotional support for the provider.
3. Colleague linkages - becoming affiliated with other home-based providers.
4. Continuing education - being inspired and encouraged to seek ongoing educational and training experiences.

In addition, Walker (2002) suggested that some home-based providers may view professional "association activities as social outlets for support and information; others may also see them as a context for professional identity and further enhancement" (p. 229).

### PROVIDER INTENTIONALITY

Another factor said to be related to the delivery of higher quality child care is "provider intentionality," described by Doherty et al. (2006) as a provider's motivation for and commitment to continuing to provide child care, as well as her purposeful approach to child care and education. They found that the six characteristics of provider intentionality could be organized and described as follows:

#### *A Commitment to the Occupation*

- Describing family child care as one's chosen occupation
- Identifying family child care as a long-term career rather than a temporary job

#### *A Professional Approach to the Work*

- Seeking out opportunities to learn about child care and child development
- Networking with other providers

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### *A Child-Related Motivation for Engaging in the Work*

- Planning purposeful experiences for the children
- Having child-related motives for providing family child care

In examining the role of personal motivation and professional identity as they relate to quality in family day care, Pence and Goelman (1991) concluded:

It becomes clear that both personal factors motivating an individual to provide care and the degree of professional "pride" taken in assuming the responsibility of caregiver are critical factors associated with the quality of the caregiving environment. Higher quality caregivers see themselves and their work from a more "professional" perspective: they are more likely to have undertaken specific educational training, they are more likely to be licensed, they are more likely to belong to a [family day care] association, they will continue providing care for a longer period of time, they gather information on their children in care more systematically, and they speak with parents about those parents' children more often. (p. 97)

It is around this group of women who are committed to working with young children, who see this as a personally rewarding and a socially desirable activity, who are prepared to be licensed, who are prepared to be educated specifically in [family day care], and who are committed to the establishment of support networks of other caregivers that our hopes must rest for a better start for our young children in family day care. (p. 99).

## purpose of the family child care and programs study

It is apparent from this literature review that, over the years, much has been learned about the structural and functional aspects of home-based/family child care programs, as well as the characteristics and work of providers. It is apparent, also, that much needs to be learned.

Early childhood professionals have known for decades that they play an important role in protecting and nurturing young children and promoting their social and emotional development. In addition to the role they can play with all

parents and children, there is evidence to suggest that an early childhood program that reaches out to parents also may be the best child abuse and neglect prevention strategy. (Center for the Study of Social Policy, 2004, p. 5)

Thus, given that home-based/family child care is a significant presence in the lives of many children and families, the purpose of this study was to learn how home-based early care and education providers build the Strengthening Families Protective Factors that reduce the likelihood of child abuse and neglect, that strengthen families, and that contribute to excellent outcomes for children: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children (Center for the Study of Social Policy, 2004) .

### design and delivery of the study

The original Strengthening Families field research design was adapted for the home-based programs study and was implemented in four states—Georgia, Illinois, New Jersey, and Wisconsin. The activities by which the study purpose was achieved in each of the four states were as follows:

1. Identification of a study coordinator.
2. Identification of 10 home-based early care and education providers.
3. Completion of a survey by each home-based early care and education provider.
4. Conduct of a focus group with the providers from the identified programs.
5. Conduct of a focus group with two parents from each identified program.
6. Conduct of a structured site visit at each of the identified programs.

This final report is a synthesis of the survey, focus group, and site visit findings from the four jurisdictions.

CSSP identified a study coordinator for each jurisdiction: Charlyn Harper Browne, Georgia; Tanveer Coelho, New Jersey; Jamilah Jor'dan, Illinois; and Jane Robinson, Wisconsin. Charlyn Harper Browne is a Senior Associate with the Center for the Study of Social Policy. Jamilah Jor'dan is the founder and president of the Partnership for

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Quality Child Care. Tanveer Coelho is the president of the New Jersey Family Child Care Providers' Association and a member of the Board of Directors of the National Association for Family Child Care. Jane A. Robinson is a child advocate and an administrator at Harmony Montessori School. Study coordinators formed study teams who conducted the focus groups and the site visits.

### **NOMINATION OF HOME-BASED PROVIDERS**

Study coordinators solicited the assistance of various child care agencies in their state (e.g., The Wisconsin Child Care Improvement Project; Quality Care for Children/Georgia), as well as relevant individuals (e.g., the Executive Director of the Illinois Association for Family Child Care; the New Jersey State Child Care Administrator) to identify and nominate home-based child care programs in at least two cities within their state. The primary criteria for being nominated were (a) the program was regarded as the provider's business rather than informal family, friend, and neighbor care, irrespective of regulatory or accreditation status; and (b) the program was regarded by the nominator as exemplary in its delivery of care. The following documents were mailed to the nominated providers: (a) an invitation to participate, (b) a consent to participate, (c) a home-based survey, and (d) general information for all parents.

### **INVITATION TO PARTICIPATE**

A letter of invitation to participate in the home-based study that explained the expectations of participants, as well as the benefits of participating, was mailed to the 10 nominated providers from each jurisdiction. In addition, nominated providers were assured that the study team would not interrupt their program's daily routine and activities. Nominated providers were expected to (a) complete a survey, (b) agree to and participate in a site visit of their program, (c) notify all parents about the study and site visit and distribute a parent information sheet prior to the site visit, (d) participate in a focus group with the other home-based program providers, and (e) identify and invite parents from different families to participate in a focus group.

Nominated providers were informed that the benefits of participating in the study included furthering the body of knowledge about home-based programs, supporting the Center for the Study of Social Policy (CSSP) in advancing its Strengthening Families initiatives, and, most importantly, contributing to the overall understanding about the prevention of child abuse and neglect. In addition, providers and parents who participated in the focus groups received an honorarium.

### CONSENT TO PARTICIPATE

As a condition of participation, nominated providers were required to sign a consent form that outlined the purpose, procedures, and potential benefits of the study. Also, the consent form indicated that there were no foreseeable risks to study participants. Nominated providers were assured of confidentiality in the study and of their ability to refuse to respond to any questions or withdraw from the study without penalty.

### SELF-REPORT HOME-BASED PROVIDER SURVEY

Providers who elected to participate in the study (see Appendix H) were required to complete a survey which solicited (a) contact and background information on the provider (e.g., educational/training credentials), (b) information on the program (e.g., accreditation and licensing status), and (c) information on the children and families served (e.g., number of children in different age categories; ethnic/cultural background of families). These data are described in the results section and are summarized in Tables 1, 2, and 3.

In addition to the demographic data requested, study participants were asked to expound on the following items:

1. What is the underlying philosophy of your program?
2. What does your program do to prevent child abuse and neglect?
3. Describe specific key strategies that value and nurture parents or caretakers.
4. Describe specific key strategies that help families make connections with each other.
5. Describe specific key strategies that build knowledge of parenting and child development.
6. Describe specific key strategies you use to help families in a crisis.
7. Describe specific key strategies you use to promote children's social and emotional development.

Responses to items two through seven are summarized in the results section of this report.

## FOCUS GROUPS

Study teams in each state led separate focus groups with home providers and parents. CSSP staff—Judy Langford, Nilofer Ahsan, Jean McIntosh, Susan Kelly, and Kate Stepleton—co-facilitated some of the focus groups. Focus groups were scheduled for 90 minutes. The questions that guided the providers’ and parents’ focus groups are listed in Appendix I and Appendix J, respectively. The responses are summarized in the results section of this report.

## SITE VISITS

Study coordinators scheduled site visits with each participating home provider; all were facilitated by study team members and, in some cases, co-facilitated by CSSP staff. Site visits were scheduled for 90-120 minutes during drop-off or pick-up times so that the study team would have an opportunity to observe and briefly talk with parents as they entered the home, observe the child care setting, and interview the provider and any staff. Questions posed to providers and parents are listed in Appendix K and Appendix L, respectively. These data are summarized in the results section of this report.

# results from the family child care programs survey

Due to the nature of the data collection methods, simple descriptive statistics were used to analyze the data.

## CHARACTERISTICS OF THE HOME-BASED PROVIDERS

### Number of Participants

The total number of home-based/family child care providers who participated in the study was 39: 10 from Illinois, New Jersey, and Wisconsin, and 9 from Georgia (one of the nominated providers withdrew). Table 1 provides a summary of self-reported demographic information on the participating home-based providers, organized by individual and combined jurisdictions.

### Gender and Ethnic Distribution

All study participants were female and of diverse ethnicities. The combined ethnic distribution is as follows: (a) Caucasian/White = 15 (38%), (b) African American/Black =

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14 (36%), (c) Hispanic/Latino = 5 (13%), (d) Greek = 2 (5%), (e) Indian = 1 (2.5%), (f) Pakistani = 1 (2.5%), and (g) Nigerian = 1 (2.5%).

**Table 1. Characteristics of Home-Based Providers**

Note: All data are based on aggregated survey responses submitted by home-based providers

CHARACTERISTICS	GA	IL	NJ	WI	Totals
Number of Providers	9	10	10	10	39
<b>Gender</b>					
Female	9	10	10	10	39
Male	0	0	0	0	0
<b>Ethnic Distribution of Providers</b>					
Caucasian/White	3	0	4	8	15
African American/Black	5	4	4	1	14
Hispanic/Latino	1	3	0	1	5
Greek	0	1	1	0	2
Indian	0	0	1	0	1
Pakistani	0	1	0	0	1
Nigerian	0	1	0	0	1
<b>Educational Credentials*</b>					
CDA**	6	4	7	2	19
Bachelor's Degree or Beyond	2	5	3	5	15
Associate's Degree	1	3	1	4	9
Currently Enrolled in College	1	0	1	1	3
Family Child Care Certificate	1	0	0	0	1
Non-Education Certificate	1	0	0	0	1
No Answer	0	1	0	0	1
<b>Range of Years as a Provider</b>					
2 - 6 years	4	3	1	2	10
7 - 10 years	2	2	3	3	10
11 - 14 years	0	1	3	0	4
15 - 30+ years	3	3	2	5	13

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No Answer	0	1	1	0	2
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\* Note: Individuals may have a degree and a CDA.

\*\* Child Development Associate Credential.

### Education and Training

Nineteen (49%) of the 39 home-based providers reported having a Child Development Associate (CDA) certificate: 7 providers in New Jersey, 6 in Georgia, 4 in Illinois, and 2 in Wisconsin (it should be noted that some providers listed both a CDA certificate and some level of postsecondary education). Fifteen (38%) of the providers reported having a bachelor's degree or higher: 5 providers in Illinois, 5 in Wisconsin, 3 in New Jersey, and 2 in Georgia. Nine (23%) of the providers reported having an associate's degree: 4 providers from Wisconsin, 3 from Illinois, and 1 each from Georgia and New Jersey. Three providers—1 each in Wisconsin, New Jersey, and Georgia—reported being currently enrolled in a postsecondary program. Thus, 27 of the 39 providers (69%) reported having at least some college education, with 24 of the 27 reporting to have some level of postsecondary degrees, including post-baccalaureate degrees.

### Years of Operation

It was not possible to determine the median or modal length of operation of the participating home-based programs because many providers gave inexact responses (e.g., "more than 10 years"). However, the range for the length of operation was two years to more than 30 years. Twenty (54%) of the home-based providers who responded to this question reported operating a program for 10 years or less: 6 providers from Georgia, 5 from Illinois, 5 from Wisconsin, and 4 from New Jersey. Seventeen (46%) of the providers reported operating a program for more than 10 years: 5 providers from Wisconsin, 5 from New Jersey, 4 from Illinois, and 3 from Georgia. Two providers did not respond to this item.

## CHARACTERISTICS OF THE HOME-BASED PROGRAMS

Table 2 provides a summary of selected self-reported demographic information on the participating home-based programs, organized by individual and combined jurisdictions.

### Geographical Location

The majority (87%) of the 39 programs are located in either urban areas or suburban areas. Only 2 programs (one in Georgia and one in New Jersey) were reported as being in a rural area.

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**Table 2. Selected Characteristics of Home-based Programs**

Note: All data are based on aggregated survey responses submitted by home-based providers

CHARACTERISTICS	GA	IL	NJ	WI	Totals
<b>Ethnic Composition of Community</b>					
Multi-Ethnic (3 or more ethnic groups)	4	3	6	4	17
Predominantly/Exclusively Caucasian	2	0	2	3	7
Mixed Hispanic and Caucasian	0	2	1	0	3
Mixed African American and Caucasian	2	0	0	1	3
Predominantly/Exclusively African American	0	2	0	0	2
Mixed African American and Hispanic	0	1	0	0	1
Predominantly/Exclusively Hispanic/Latino	0	1	0	0	1
No Answer	1	1	1	2	5
<b>Community Location of Program</b>					
Urban	3	7	2	6	18
Suburban	4	3	6	3	16
Rural	1	0	1	0	2
No Answer	1	0	1	1	3
<b>Income Level of Community</b>					
Low (<\$30,000)	0	3	0	0	3
Middle (\$30,000 - \$90,000)	5	3	3	3	14
Upper (>\$90,000)	0	0	2	0	2
Mixed	3	4	5	0	12
No Answer	1	0	0	7	8
Number of Licensed Programs	9	10	9	9	37
Number of Accredited Programs	6	5	5	9	25
Number of Programs w/Addt'l Staff	4	9	4	2	19

### Community Socioeconomics

Fourteen (36%) of all participating programs were reported as being in a community with family incomes in a middle range (\$30,000 - \$90,000) and 12 (31%) in a community with mixed family incomes; the survey instrument did not solicit an explanation of the type of mixed income (e.g., low and middle; middle and upper). Only 3 (8%) of the 39 programs—all in Illinois—were reported as being in a community with low family incomes (<\$30,000). At the opposite end of the continuum, only 2 (5%) of the 39 programs—both in New Jersey—were reported as being in a community with upper family incomes (>\$90,000).

### Community Ethnic Composition

The home-based providers described the ethnic composition of the communities in which their programs are located as follows (five providers did not answer): (a) multi-ethnic (composed of three or more ethnic groups) = 17 (44%); (b) predominantly/exclusively Caucasian/White = 7 (18%); (c) mixed African American/Black and Caucasian/White = 3 (8%); (d) mixed Hispanic/Latino and Caucasian/White = 3 (8%); (e) predominantly/exclusively African American/Black = 2 (5%); (f) predominantly/exclusively Hispanic/Latino = 1 (2.5%); and (g) mixed African American/Black and Hispanic/Latino = 1 (2.5%).

### Program Staff

Almost half (49%) of the home-based providers reported that they have staff in addition to themselves; the survey instrument did not solicit from respondents an indication of whether additional staff were full- or part-time. With respect to the individual jurisdictions, 9 of the 10 home-based providers from Illinois reported having additional staff, whereas only 4 providers from Georgia, 4 from New Jersey, and 2 from Wisconsin reported having additional staff.

### Licensing

Thirty-seven (95%) of the home-based providers indicated that their programs were licensed; one provider indicated that her program was not licensed and one provider did not respond to this question.

### Accreditation

Combined, 25 (64%) of the 39 participating providers reported having accredited programs: 9 of the 10 programs in Wisconsin, 6 of the 9 programs in Georgia, and 5 programs each in Illinois and New Jersey. The two accrediting bodies reported were the National Association for Family Child Care and the National Association for the Education of Young Children.

### CHARACTERISTICS OF FAMILIES IN THE HOME-BASED PROGRAMS

Table 3 provides a summary of selected demographic information, reported by the home-based providers, on the children and families served by the participating home-based programs, organized by individual and combined jurisdictions.

**Table 3. Selected Characteristics of Families in Home-based Programs**

Note: All data are based on aggregated survey responses submitted by home-based providers

CHARACTERISTICS	GA	IL	NJ	WI	Totals
<b>Age Distribution of Children Served</b>					
Number, ages 0 – 2	32	31	26	30	119
Number, age 3	18	23	14	13	68
Number, age 4	3	24	3	12	42
Number, age 5	0	7	0	1	8
Number, above age 5	0	12	5	0	17
<b>Ethnic Composition of Families</b>					
Multi-Ethnic (3 or more ethnic groups)	0	5	6	1	12
Predominantly/Exclusively Caucasian	2	0	0	5	7
Mixed Hispanic and Caucasian	1	1	2	1	5
Mixed African American and Caucasian	3	0	1	2	6
Predominantly/Exclusively African American	3	3	0	0	6
No Answer	0	1	1	1	3

### Ethnic Distribution of Families

In organizing the reported ethnic/cultural backgrounds of the families in the participating programs, some ethnic/cultural descriptions were grouped together. For example, designations of “Italian” and “Canadian” were counted within the category “Caucasian/White.” Similarly, designations of “Black Muslims” and “Caribbean Islander” were counted within the category “African American/Black.” Thus, the aggregated ethnic/cultural backgrounds of the families attending the participating programs are as follows: (a) multi-ethnic (three or more ethnic groups) = 12 (31%); (b) predominantly/exclusively Caucasian/White = 7 (18%); (c) predominantly/exclusively African American/Black = 6 (15%); (d) mixed African American/Black and Caucasian/White = 6 (15%); (e) mixed Hispanic/Latino and Caucasian/White = 5 (13%); and (f) no answer = 3 (8%).

### Number and Ages of Children Served

The reported total number of children served across jurisdictions is 254—an average of seven children per program, disaggregated in the following age categories: (a) birth to 2-year-olds = 119 (47%), (b) 3-year-olds = 68 (27%), (c) 4-year-olds = 42 (17%), (d) 5-year-olds = 8 (3%), (e) 5+ -year-olds = 17 (7%). With respect to the individual jurisdictions, the Illinois providers reported the largest combined number of children served (97), whereas providers in the other three states reported lower combined enrollments: Wisconsin = 56, Georgia = 53, and New Jersey = 48. Participating providers in these same three states disproportionately serve children ages 0-3: Georgia = 94%, Wisconsin = 77%, and New Jersey = 83%; the percentage among the Illinois providers = 56%. For all jurisdictions combined, 74% of the children served are ages 0-3.

### DESCRIPTIVE SURVEY ITEMS

Tables 4-9 provide summary groupings of the home-based providers’ responses to six of the descriptive survey items, as well as the number and percentage of providers who gave responses within each grouping. The first item solicited specific information about what home-based programs/providers do to prevent child abuse and neglect while the other five items solicited key strategies home-based providers use that are related to each of the Protective Factors identified in the Strengthening Families approach.

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Table 4. Program Strategies/Activities to Reduce Child Maltreatment (N = 39)

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
<b>Strategies/Activities Used with Parents</b>		
Provide resources/information/referrals/workshops for parents (e.g., brochures, CDs, web links, state agencies) as requested or as needed and in times of family crisis.	23	58%
Talk a lot with parents; keep lines of communication open; assure parents they can talk with me in confidence about anything/anytime; provide an opportunity for parents to talk with me about their child, daily and via parent conferences.	22	56%
Inform parents about child development, developmentally appropriate expectations, positive approaches to discipline, and other parenting matters via literature and class observations.	12	31%
Provide a warm, respectful, caring, and comfortable environment for parents.	4	10%
Create family networking through social gatherings; offer parents a night out.	3	8%
Ask parents questions if I see a "boo-boo."	2	5%
Observe how parents treat and talk to their child and the child's behavior around parents.	1	2.5%
Look out for signs of parental distress.	1	2.5%
<b>Strategies/Activities Used with Children</b>		
Observe or check each child daily for marks or scars; observe children when changing them to note any unusual reaction my touching; observe how clean children are and how they are dressed.	14	36%
Teach children about never letting anyone touch their private parts except their parents, and home provider; use dolls to make sure children know what their private parts are.	3	8%
Teach children about respect for others, self-respect, and kindness.	3	8%
Teach children to keep their hands to themselves; teach hitting, pushing another child is not acceptable; teach them to solve problems with words and not by hitting.	2	5%
Listen to the children and ask open-ended questions, especially during circle time; look for changes in children's emotional expressions and behavior.	2	5%

Strategies/Activities for Self		
Take classes/attend trainings so I can stay informed; I try to stay current about federal and state rules and regulations about child abuse.	9	25%
Report any type of abuse or neglect to the proper authorities.	5	13%
Pray	1	2.5%

### What does your program do to prevent child abuse and neglect?

As can be seen on Table 4, home-based providers gave responses to this question that related to strategies used with parents, strategies used with children, and strategies related to their own personal edification and responsibility. A little more than half (58%) of the home-based providers cited providing print or electronic resources to parents or connecting parents to relevant social service agencies as a strategy they use to reduce child maltreatment. A similar percentage (56%) of the providers cited maintaining open lines of communication and assuring confidentiality as strategies.

Thirty-six percent (36%) of the home-based providers cited strategies related to regularly observing or checking children for physical signs of abuse or neglect (e.g., bruises, scars, poor hygiene). In contrast, only 2 of the 39 home-based providers (5%) indicated that they make an inquiry directly to parents, “if I see a ‘boo-boo,’” and only 1 (2.5%) acknowledged that she closely monitors how parents “treat and talk to their child and how the child behaves around the parent.” In the same vein, only 3 of the 39 providers (8%) indicated that they teach children about not letting anyone touch their genitals (“private parts”) except their parents and the provider. Five of the providers (13%) acknowledged that, if necessary, they would “report abuse or neglect to the proper authorities.” Additional strategies used by the participating home-based providers to prevent child abuse and neglect include (a) sharing information with parents about child development and parenting issues (31%) and (b) staying abreast of information including regulations regarding the identification and reporting of child abuse and neglect (25%).

### Describe specific key strategies that value and nurture parents or caretakers.

Table 5 lists nine groups of strategies and activities home-based providers reported they use to value and nurture parents. The highest percentage of providers (64%) cited strategies related to having parents feel comfortable and confident that they can

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turn to and talk to the provider for guidance and assistance about numerous matters. Forty-four percent of the providers cited strategies related to being considerate of parents (e.g., giving tuition discounts to families if they are experiencing financial problems) and doing things to make parents feel special (e.g., helping children make Mother’s Day cards).

Table 5. Program Strategies that Value and Nurture Parents (N = 39)

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
Talk with parents a lot about anything and everything; interact daily in morning and evening with parents; maintain atmosphere of open communication with parents; tell parents to consider me an extension of their family so they can feel comfortable sharing things with me and when they are in need; be available to parents when they need to talk; parents can call me 24/7; listen to parents.	25	64%
Do things for parents to make them feel good/special like having miniature candies sitting out for them at pick-up time or coffee/tea available in morning; if I see something small that reflects a parent, may purchase it for them; have children make things for parents on special holidays; I always have extra essentials (e.g., hats, food) so if a parent forgets something, I use my things so parents won't have to leave work to bring the forgotten item; giving discounts to parents when they have financial challenges; complimenting parents about how they are working with their child; expressing appreciation to those who pay on time.	17	44%
Share information about child with parents; during day, email pictures of children to parents while they are at work; tell parents cute things child did during day; keep daily log of children's activities and routines and share this with parents; post pictures of children and parents on board; keep video records of children's' activities.	12	31%
Have information board for parents; share ideas about children with parents; share information regarding resources, child development, parenting; send newsletter to parents and other family members.	11	28%
Facilitate relationships between parents (past and present); help parents network; provide family outings; involve parents in program; form partnerships with parents; stress "we are a team."	9	23%
Respect parents' views and opinions; ask parents about how they handle situations with children at home; ask "Do you have any suggestions for dealing with this or that?"; discuss child strategies; honor parents' requests regarding the way their child is cared for (e.g., eating restrictions); set goals for child with parents' input.	9	23%
Offer a parents' night out by extending my hours one evening per quarter; offer parents a day-out on Saturday.	3	8%
Build life-long relationships; children return as parents.	1	2.5%
Make home visits.	1	2.5%

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Similarly, 23% of the providers described the importance of showing respect and regard for parents' points of view (e.g., religious differences, attitudes about spanking) and of honoring parents' special requests regarding the care of their child (e.g., serving vegetarian meals). Other strategies that providers indicated they use to demonstrate that they value parents were (a) sharing information with parents about their child using various formats such as electronic photographs and daily logs (31%); (b) disseminating information to parents about child development, parenting issues, and relevant community resources (28%); and (c) encouraging parents' involvement in the program and facilitating relationships/forming networks between families, including families who had previously participated in the program (23%).

### **Describe specific key strategies that help families make connections with each other.**

The strategies cited by the participating home-based providers to help families make connections with each other are designed to foster mutual appreciation and positive relationships between all family dyads: adult to adult, adult to child, family to family, and child to child. The majority of the providers reported strategies that fall into two general groups (see Table 6): (a) hosting or helping to plan social gatherings outside of the workday—evenings or weekends—that enable parents to get together in a relaxed, fun setting (72%); and (b) highlighting children in the program operation (e.g., sharing each child's accomplishments with all parents) and hosting program site activities (e.g., birthday parties) and outings (e.g., a field trip to the local library) that are child-centered (64%).

Another strategy cited by 31% of the providers related to both informal and formal ways of facilitating connections between families, such as making introductions at drop-off and pick-up and convening parent meetings and conferences. Almost one-fourth (23%) of the providers cited fostering communication among parents by sharing family phone numbers (with the family's permission). Fifteen percent of the providers indicated that building connections between families begins at enrollment (e.g., reception for new families to meet families of currently enrolled children) or even before (e.g., open house for interested parents).

Almost one-fifth (18%) of the home-based providers indicated that the relationships among children, as well as children's feelings of connectedness to the program, are central to helping families make connections. Some providers pointed out that parent friendships evolve as their children become friends, not only through children's

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program involvement but by children attending each others' birthday parties, having play dates, and participating in sports together; some children even maintain long-term friendships. Also, in adulthood, some former attendees display an intergenerational connection to the home-based provider by enrolling their own children in the same home-based program they once attended.

**Table 6. Program Strategies that Help Families Make Connections (N = 39)**

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
Host "family nights" where families have a chance to get together; fun family gatherings/ parties; have a "mom's night out" or "parents night out" for families to get together; pot-luck dinners, picnics, shows; parents are involved in planning social gatherings.	28	72%
Have programs that involve all children; have birthday parties at my establishment; organize field trips/school outings for children and families; ask parents to be field-trip helpers; have sleepovers for children at least once a year; display family photos; share children's accomplishments with all families.	25	64%
Introduce parents to each other at drop-off or pick-up if they have not met; host parent meetings and workshops; when parents get together, I make sure to facilitate the conversation so that every parent has a chance to share.	12	31%
I make a phone number list so parents can contact each other; parent-provider communication book; parent information sheets to allow parents to learn about each other (with permission); get permission to share phone numbers.	9	23%
Families develop friendships as their children become friends; parents invite program children to each other's birthday parties; parents tend to keep their children in contact with each other even after they leave the program, mostly through community sports; after having social gatherings, parents set up play dates with each other, exchange clothing, do sporting activities.	7	18%
Connections begin even before child even starts in care because I invite new parents to come at pick-up time so they can meet everyone; have a function to renew contracts and that way old parents can meet new parents; host parent information sessions; host an open house at beginning of year.	6	15%
Create relaxed areas for stress-free departures and arrivals; keep a friendly atmosphere; provide coffee and muffins in morning at drop-off.	4	20%

**Describe specific key strategies that build knowledge of parenting and child development.**

Although 1 provider emphasized that parents do not have the time to do a lot of reading, 26 (67%) of the 39 providers reported making printed/reading resource materials available and accessible to parents at the program site—including books, brochures, conference handouts, and developmental charts—as the strategy they use for building knowledge about parenting and child development (see Table 7).

**Table 7. Program Strategies that Help Build Knowledge on Parenting and Child Development (N = 39)**

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
Parent resource library; parents can borrow books; articles are available for taking; give parents information about "normal" development and milestones; give reading materials on specific behavioral challenges; satellite loan libraries; provide information in their own language; share brochures/handouts from conferences and agencies; post developmental charts and developmental profile checklist parents can refer to; put information in parents' mailboxes; newsletter that includes parenting tips; I buy each new family a book called "Touchpoints" by T. Berry Brazelton.	26	67%
Parents can call me and ask questions as needed; recommend books and websites; connect parents with outside groups or agencies to receive appropriate information; parents trust my judgment.	22	56%
Daily information sheets about own child; parent conferences; periodic written progress reports; I keep a picture memory book on each child that shows growth/ accomplishments over the year.	18	46%
I regularly attend workshops, conferences, trainings; I attend monthly family child care association meetings; have my own database of "how to do's"; participate in a network of child care professionals to exchange strategies/ideas; staying abreast of current news; surfing the net.	10	26%
Model child strategies in front of parents like age-appropriate discipline; share personal experiences--success and failures--in working with children.	8	21%
Inform parents about workshops/trainings and encourage them to attend.	7	18%
Parents can hang-out at program during day to observe strategies; allow parents to observe children to ensure them their child acts like other same-age children.	4	10%
Parent meetings; parents are invited to share their ways of caring for children; host workshops/conferences for parents; connect parents with parents of older children who have lived through developmental phases.	4	10%

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Twenty-two (56%) of the providers reported that parents trust providers' judgment. As such, parents tended to turn to their home-based provider for answers to questions, recommendations for community and "people" resources, and referrals for social services. In addition to providing general information to parents, almost half (46%) of the providers cited sharing specific developmental information with a child's parents about their child via such formats as daily information sheets, periodic progress reports, and parent conferences.

In order to be informed about current child development issues and parenting strategies, a little more than one fourth (26%) of the providers reported that they regularly attend workshops, conferences, and trainings, as well as network with other home-based providers, family child care associations, and resource and referral agencies. Likewise, 18% of the providers reported that they inform parents about relevant workshops and conferences and encourage them to attend. Only 8 of the 39 home-based providers (21%) explicitly mentioned "*modeling*" and "*sharing my successes and failures in rearing children*" as strategies to help build knowledge of parenting and child development.

### **Describe specific key strategies you use to help families in a crisis.**

Twenty-five (64%) of the 39 providers cited two interrelated groups of strategies they use to help families in a crisis: (a) having an empathic, non-judgmental relationship with parents which results in (b) being perceived as a primary source for providing support or for directing families to appropriate resources (see Table 8). Other strategies reported by providers include acts of support related to specific parental needs, such as (a) keeping a child extra hours when a parent has a late appointment, (b) offering a free night of child care so parents can have an evening out, (c) contacting agencies on behalf of a family, (d) accompanying a parent to an agency when they are nervous about meeting with social service personnel, (e) communicating and maintaining neutrality when there are conflicts among parents or families, and (f) offering reduced tuition when a parent is experiencing a financial crisis.

Table 8. Program Strategies that Help Families in a Crisis (N = 39)

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
Relationships built with parents give them confidence to trust me so they can open up and talk with me when the family is in crisis; ask "How can I help?"; ensure confidentiality; let them know I have a shoulder they can cry on; provide encouragement and support in a non-judgmental way.	25	64%
Take time to listen and offer appropriate resources for solving problems/addressing crisis; provide information--including websites, phone numbers, services; do research on the problem and offer information and community resources; give numbers to appropriate hotlines.	25	64%
Offer to keep their child extra hours if parent is running late or has late appointment; offer to keep a sibling; offer a free night of child care so parents can have a night out.	8	21%
Look for a solution to problems together; offer to go to meetings/access services with them if they are nervous; contact services/agencies on behalf of family; take a team approach/united front in dealing with a crisis related to the child.	7	18%
Watch for signs of family stress or unusual behavior displayed by child.	2	5%
During financial crisis, I offer reduced tuition.	2	5%
Offer my home as a neutral, safe ground; when there are disputes between parents or between families, let them know I will not take sides.	2	5%
Connect them with other parents who may have experienced similar crisis.	1	2.5%
I have hired a person to work with families to address crisis situations.	1	2.5%

### Describe specific key strategies you use to promote children’s social and emotional development.

Providers’ descriptions of strategies used to promote children’s social and emotional development suggested that many providers perceive the social and emotional domains of development as independent of one another. For example, 23 providers (59%) listed physical activities that were designed to teach and reinforce social development (e.g., having children engage in activities that require them to share) rather than emotional development (see Table 9). Other strategies aimed at fostering social skill development included (a) teaching and encouraging children to regularly use polite language and manners (e.g., saying “please” and “thank you”) and (b) praising and otherwise reinforcing children for engaging in prosocial behavior (e.g., helping and cooperating).

Strategies cited by providers that are designed to foster emotional development in children are (a) modeling positive feelings and more appropriate ways of expressing negative feelings (41%); (b) teaching children to identify different feelings through the use of visual aids such as books, puppets, and posters (23%); (c) identifying for children

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the feelings they are experiencing when they are unable to articulate them (e.g., “You’re feeling sad.”) (21%); (d) teaching children to use “I” messages when conflict occurs with another child (e.g., “I feel sad when you take my toy.”) (15%); and (e) teaching children to value different kinds of people (8%).

**Table 9. Program Strategies that Help Promote Social and Emotional Development (N = 39)**

Strategies/Activities Cited by Home-Based Providers on Survey	Frequency	%
Encourage learning through play; provide activities--inside and outside of program—for children to interact; daily opportunities for children to play, share, form friendships; have children to take care of animals and plants; have "partner activities"; have activities in the drama area/pretend play; cooperative play; talking with each other.	23	59%
Model behaviors so children can observe, like showing respect for others; teach children other ways of showing/responding to negative emotions; model display of positive emotions; treat children respectfully; show affection to children.	16	41%
Coach children to talk about how they feel; use specific books to identify emotions; use puppets to show how to express emotions; posters that show different emotions.	9	25%
I verbalize and respond to what child might be feeling when the child can't express it; I talk about how I feel; validate how children feel; observe their behavior.	8	21%
Praise/reward children for showing good and positive behavior and manners.	7	18%
Use age-appropriate activities outlined in my curriculum/daily schedule	7	18%
Teach children to use "I" messages during conflict (e.g., "I feel sad when you . . ."); prompt children to use words to communicate feelings instead of screams/hitting	6	15%
Teach manners/polite language (please, thank you) in words and sign language.	4	10%
Teach children to value differences; read books about different kinds of families.	3	8%

### Results from the Providers’ Focus Groups and Interviews during Site Visits the Nature of Provider-Parent Interactions

With respect to the nature of the provider-parent interactions, providers stated that they create or seize numerous opportunities to interact verbally with parents that span all points of the family’s involvement with the home-based program and range in length from 15 seconds to several hours. These opportunities include:

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1. An open house for interested parents.
2. The initial interview prior to or at enrollment.
3. Gatherings for new parents to meet each other and currently enrolled parents.
4. Receiving children at drop-off.
5. Returning children at pick-up.
6. Parent-provider conferences.
7. Home visitations.
8. Provider-organized whole-family social gatherings (e.g., picnics, barbeques).
9. Parent-organized whole-family social gatherings (e.g., birthday parties, weddings).
10. Individual parent or dyad parent gatherings (e.g., mom's or couple's night out).
11. Field trips with parents as chaperones (e.g., to petting zoo, library).
12. Provider-initiated telephone calls during the day in case of a child emergency.
13. Parent-initiated calls during the day or evening.

Several of the home-based providers mentioned that they invite feedback about the program from parents. Also, providers reported that parents tend to have more time in the evening than in the morning to interact; thus, the nature of morning chat and evening chat tends to differ in content. For example, in the morning, after hearing the provider's general greeting (e.g., *"Good morning. How are you?"*), parents either respond briefly to the provider's inquiry or share information about important child or family circumstances that may impact the child's day. On the other hand, evening conversation tends to begin with the provider's report of the child's day but often transitions to parent-initiated discussions about the parent's day or other personal matters. One provider noted, *"We just chat about everything."* Several providers indicated that, in the evening, some parents occasionally stay a few hours with the provider while relaxing in the den or sitting around the kitchen table.

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Although in the context of the focus groups very few providers indicated that this was an imposition on their personal time, in the one-on-one interviews some providers indicated that they discouraged parents from *“hanging around a long time every time they come for their child. I need some ‘me time’.”* Also, providers noted that female parents/caretakers tended to communicate longer and more personally with them than male parents/caretakers.

In addition to face-to-face or telephone conversations with parents, providers also indicated that they use written methods to interact with parents (e.g., logs, emails, newsletters) and to share information with them (e.g., books, brochures, reminder cards, parent magazines). Many providers indicated they had dedicated areas in their home for sharing printed information with parents, such as a parent resource library and/or a parent information board.

Providers across jurisdictions described a wide variety of information that they typically share with parents that includes (a) information about the provider and the program, (b) trainings, (c) regulations, (d) typical and atypical child development, (e) parenting skills, (f) help agencies, and (g) information specific to their child. More specifically:

1. Verbal assurance that their child is in good hands and will be well cared for
2. Verbal—and sometimes material—expressions of appreciation for entrusting their child to the provider’s care
3. Program license and, if applicable, documentation of accreditation.
4. Program policies and expectations
5. Conferences, workshops, and trainings attended by the provider
6. Workshops and trainings for parents
7. State and national news regarding infants and children (e.g., toy recall)
8. State regulations (e.g., mandated reporting)
9. The nature of their child’s daily routine (e.g., appetite, disposition)
10. New skills their child displays

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11. Funny, cute, or interesting things their child and other children do or say
12. Statements made by their child that the provider believes require follow-up with the parent (e.g., *"My mom pushed me down."*)
13. Behaviors the child displays (e.g., consistently holding one ear) or physical indicators (e.g., one foot turned inward) that suggest the possible need for medical attention
14. Contagious illnesses of other children
15. Child's progress in all developmental domains
16. Preparation for kindergarten; kindergarten readiness
17. Inappropriate or problematic behavior displayed by child (e.g., biting)
18. Pertinent child-oriented websites, parenting websites, and medical websites
19. Medical and social service agencies
20. Resource and referral agencies; parent information exchange agencies
21. Early evaluation and intervention services
22. Age-appropriate play sites and entertainment

### ADDRESSING PARENTS' ISSUES

Many providers indicated that, although they did not consider themselves to be experts, they felt a sense of responsibility to try to answer parents' child-oriented questions or to make a commitment to help parents find answers to questions. There was variation, however, in methods used to actualize this sense of responsibility. One provider expressed the sentiment of many: *"I don't have to know all the answers; I need to know where to go for information."* Another provider indicated, *"I try not to force my opinion or even information on parents."* Other providers approached parents' questions in a different way, as exemplified by the following: *"I listen to them and then I say, 'Well, I have an idea. Maybe this would work, or maybe it wouldn't. What do you think?'"* Finally, one provider reflected, *"My job is to guide them and reinforce good behaviors that I see them demonstrate."*

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The reported child-oriented questions posed to providers by parents can be organized into the following topic areas:

1. Normal/typical developmental expectations and milestones; how to judge if a child's development is "on the right track"; developmental delays.
2. Child routines and patterns (e.g., feeding, sleeping, bathing).
3. Effective discipline strategies.
4. Setting parameters for appropriate and inappropriate behavior.
5. Separating "the behavior" from "the child."
6. Self-help skills (e.g., potty training, brushing teeth, tying shoes).
7. Parenting strategies and skills/child-rearing techniques.
8. Health, safety, and nutrition.
9. Weaning from breast, bottle, or pacifier.
10. Handedness (e.g., "How can I keep Matt from being left-handed?").
11. Parent and child separation anxiety.
12. Spending quality time with children.

Many providers indicated that, as a result of forging a trusting relationship with parents, often they are perceived as confidantes. Thus, many parents even share with providers, and seek advice about, emotionally painful content, such as marital problems, money issues, and grief resulting from a death in the family. There were mixed reactions to being perceived in this role. Many of the providers saw being a confidante as an acceptable extension of their role as a home-based provider. For example, one provider noted: *"At one time or another, my parents have come to me about their adult relationships. They think I am an extension of their family—like an aunt or grandmother—so, they tell me things that sometimes they don't tell their real relatives."*

On the other hand, a few providers indicated that they *"try not to get too involved with their (parents') personal lives. So I push the issue back to them and say, 'You must be a superwoman, handling things so well.'"*

The home-based providers reported that they work with parents on both child-oriented and personal questions by (a) offering reading materials and directions to websites, (b) presenting opportunities to make observations of the children in the program, (c) sharing personal experiences and opinions, (d) making referrals, (e) modeling various strategies, and (f) encouraging conversations with and support from other parents.

### ADDRESSING DIFFICULT ISSUES WITH PARENTS

Many providers noted that they *“usually see problems before the parents.”* The home-based providers shared varying descriptions of difficult parent-child situations which could be organized around four central contributors to the parent-child difficulty: the child’s behavior (contributor 1); the parents’ response to the child’s behavior before and after the provider brought attention to it (contributor 2); the parents’ response to the provider after the provider brought a delicate matter to their attention (contributor 3); and one or both parents’ behavior (contributor 4).

#### Example of Contributor 1 to a Difficult Family Situation (The child’s behavior)

A child was expelled from three different day care centers due to his unruly behavior. The parent appealed to the home-based provider who subsequently allowed the child to enroll in her program. The home-based provider attempted to address the child’s persistent disruptive behavior by consulting with other professionals and agencies for support and suggestions in working more effectively with the child. Although the provider began to see a little evidence of behavioral change, the provider was not entirely successful because the family left the program.

#### Example of Contributor 2 to a Difficult Family Situation (The parents’ response to the child’s behavior before and after the provider brought attention to it)

A 4-year-old was not potty-trained and did not use age-appropriate, articulate speech; what is more, the parents seemed unconcerned about or oblivious to the child’s apparent developmental delays. When the home-based provider brought this to the parents’ attention and invited them to observe their child in the program, the parents removed the child from the program.

### Example of Contributor 3 to a Difficult Family Situation (The parents' response to the provider after the provider brought a delicate matter to their attention)

A child was older and more advanced cognitively and physically than the other children in the program; furthermore, she did not form any peer social relationships. Thus, the home-based provider told the parents that *"the group is not the right fit"* for their daughter and made recommendations to them of home-based programs with older children. The parents perceived this as a rejection of their child and felt insulted, frustrated, and angry with the provider. Eventually, the parents came to understand and accept the provider's recommendation and enrolled the child in another home-based program. The provider indicated that her lesson in this situation was to try *"to understand the other person's point of view."*

### Example of Contributor 4 to a Difficult Family Situation (One or both parents' behavior)

When a parent came to the program to retrieve his child, it was apparent to the provider that the parent was under the influence of alcohol. The provider informed the parent that, per program policy, she could not allow him to drive the child home and that he would have to make alternative arrangements. The father left, and, after some time, returned to pick-up the child. The provider released the child to the father because she perceived him to be sober.

Numerous home-based providers indicated that one of the greatest challenges in addressing difficult situations is coming up with tactful yet explicit ways of discussing delicate issues with parents. Many providers stated that they have encountered a variety of emotional responses from parents—such as anger, hostility, denial, and rejection—that cause providers to be cautious when they bring difficult matters to parents' attention and that tend to impede finding effective solutions. Overall, however, the home-based providers perceived the nature of the relationship between the provider and the parent to be the mitigating factor in influencing how difficult situations were addressed by the provider and received by the parents.

Another challenge in addressing difficult situations with parents is identifying and connecting parents to appropriate resources. One provider suggested that providers should have a *"warm line"* (i.e., rather than a hotline) to which they could call to find the right resources for a particular difficult situation, crisis, or need.

## PROMOTING SOCIAL AND EMOTIONAL DEVELOPMENT

The home-based providers described a number of strategies they use to promote children’s social and emotional development:

1. Modeling appropriate social behaviors such as respect for others and courtesy toward others.
2. Making sure the physical and social environments are ones that promote inclusion (e.g., a provider built a ramp so that a wheelchair-bound child could enroll).
3. Creating opportunities for children to learn how to enter groups and interact cooperatively with peers.
4. Modeling for children how to use words to describe their feelings.
5. Asking children to name or describe how they are feeling.
6. Using praise and other positive reinforcers when children engage in appropriate social behavior and use mannered language.
7. Structuring a physical environment that is well lit, has an area for relaxation or “alone time,” and has an outdoor space for physical activity (e.g., running, climbing).
8. Teaching children relaxation methods (e.g., taking deep breaths) in order to quiet and calm themselves.

Many home-based providers indicated that they had encountered children with only “normal”/age-expected social development issues, such as 2-year-olds not sharing toys. Thus, they had not had much—or in some cases, any—experience working with children who may have emotional or behavioral difficulties. Some providers who have had this experience stated that first they share with the parents observations of their child’s seemingly emotional or behavioral difficulty and may even invite the parents to observe the child in a typical day.

If parents are receptive to their concerns, providers indicated that they assist the parents in identifying appropriate resources and treatment options for the parents and child, as well as resources for the provider to support the corrective recommendations

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for the child. Many of the providers in one jurisdiction indicated that they *"made their homes available to therapists during the day so that parents won't have to take off from work."* The following statement exemplifies a few providers' strategy for addressing children's seemingly emotional or behavioral difficulties: *"I just love them, pray for them, and pray with parents for them."*

While each of these approaches is different, each gives credence to the possibility of a real emotional or behavioral difficulty. In contrast, one provider's approach is to treat the child's behavior as a non-issue: *"If a parent mentions a behavior problem that their child has at home, I remind them it's a phase and to be patient with their child until it passes."*

Most providers reported that very seldom had children been expelled from their program. The few providers who had expelled a child did so for one of the following reasons:

1. The child did not respond to behavior change strategies and continually acted in ways that were harmful to other children (e.g., extreme physical aggression).
2. The child displayed behavior that the provider did not feel qualified to address (e.g., head-banging).
3. The provider discovered that parents had not been forthcoming about a preexisting emotional or behavioral difficulty with their child (e.g., sleep difficulties).

On the other hand, several providers cited situations in which parents initiated the removal of the child from the home-based program after the provider spoke with the parents about the child's physical signs (e.g., abrasions on back or buttocks) or behavioral signs (e.g., preoccupation with masturbation during playtime) that were suggestive of child abuse or neglect.

### **PROVIDERS' TRAINING**

Consistent with the data from the surveys, providers reported much diversity with respect to their education and training. Their highest educational level ranged from a high school diploma, and perhaps a Child Development Associate certificate, to post-baccalaureate degrees. Thus, some of the providers had been exposed to such topics as child development theory, behavior management, and child maltreatment through

graduate and/or undergraduate courses. In contrast, other home-based providers received exposure to these topics through brief professional development experiences (e.g., conference sessions and local workshops) and self-initiated learning activities (e.g., reading books and parent magazines; having conversations with physicians and other professionals; searching the Internet).

Most of the providers considered various state agencies and private organizations in their jurisdictions to be invaluable resources for both training experiences and information about child development, parenting, and child abuse and neglect. Likewise, many of the providers cited the need for more ongoing educational and training experiences in these areas in order to be more effective as home-based providers and to meet the needs of children and their parents. Also, some of the providers considered their local network of home providers, whether formally or informally organized, to be an important source of information and idea-sharing.

### ADDRESSING CHILD ABUSE AND NEGLECT

Across jurisdictions, the question that seemed to be the most difficult one for providers to address was, "How do you try to communicate with parents around issues related to child abuse and neglect?" In some cases, the question resulted in silence for a short time. In other cases, providers suggested that, so far, it was a non-issue. Some of these responses included:

1. *"I have not had to deal with [child abuse or neglect] so far."*
2. *"I have not experienced families that openly abuse or neglect their children."*
3. *"Fortunately, I have never observed any signs of neglect or abuse in the children I've worked with."*
4. *"The parents I deal with are mainly professionals and of high education"* (suggesting that child abuse and neglect was not an issue with parents of a certain educational and professional caliber).

Of the home-based providers who have had to address potential child abuse or neglect concerns, many acknowledged that it is very difficult to discuss these concerns with parents; one provider asserted, *"We've always had to play such an adversarial role around child abuse."* Other providers indicated that they look for red flags of abuse and neglect, such as scars and bruises and drastic changes in a child's behavior and

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mood (e.g., *“If a child is suddenly resistant to a diaper change or if an outgoing child becomes withdrawn.”*). A few providers reported that they attempted to intervene when a parent showed aggression to a child in the provider’s presence. The following example is a verbatim account from a study coordinator based on a provider’s description:

*A parent yanked at the child’s hand in frustration at pick-up. The provider told the parent that she seemed very tired and why doesn’t she leave the child with her while requesting the parent to just go home and relax for a while and pick-up her child later. The parent did so and returned later and thanked the provider.*

When the topic of reporting suspected child abuse and neglect was probed, only a few providers indicated that they had ever filed a report. Others gave a variety of responses, such as:

1. *“Well you know I’m a mandated reporter.”*
2. *“I would not hesitate to follow state regulations and procedures.”*
3. *“When reports are made, the parent suddenly moves! So, what happens to that child?”*
4. *“I deal with this with the belief that the parent is not intentionally doing something to harm the child, so I can be an ally with the parent for the good of the child.”*
5. *“I try to do all I can to help the family before I make a referral.”*
6. *“I don’t want to make the call, because I don’t want to be wrong.”*

### Responding to Personal Stress

The providers cited numerous strategies they engage in to prevent or mitigate their own work-related stress:

1. Taking alternating breaks if full- or part-time staff are present.
2. Incorporating variety in the day-to-day program activities.
3. Getting 6-8 hours of sleep during the work week.

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4. Engaging in physical exercise or meditating before the workday begins.
5. Resting and relaxing while the children nap or even taking a brief “power nap.”
6. Making time for oneself in the evenings or on the weekend.
7. Setting boundaries with parents (e.g., no phone calls after 9:00 p.m. unless there is an emergency).
8. Using close family members, friends, and colleagues as sounding boards.
9. Seeking the perspective, opinions, and honest feedback from trusted others (e.g., staff of relevant state agencies and private organizations).
10. Praying, meditating, tuning into one’s inner/higher self.

### provider intentionality

Although provider intentionality—a commitment to the occupation, a professional approach to the work, and a child-related motivation for engaging in the work—was not directly assessed in the study, these variables can be inferred from survey, interview, and focus group data; explanations; and descriptions reported by some of the providers. For example:

1. Twenty-seven of the 37 providers who responded (73%) indicated that they had operated a home-based program for more than 7 years; 13 (35%) reported 15-25+ years. This can be interpreted as a commitment to the occupation.
2. Survey responses of 10 (26%) of the providers indicated that they attend workshops, conferences, and trainings, and/or attend monthly family child care association meetings, and/or participate in a network of child care professionals. Further, many providers indicated in interviews and focus groups that they turned to local agencies or networks of providers for support and resources. These efforts are indicative of a professional approach to their work.
3. Interview and focus group responses of some providers are suggestive of having a child-related motivation for engaging in the work, as illustrated by the following provider’s reflection: *“Childhood is a journey. I have been a licensed provider since 1996. Childhood is a time for exploring, creating, and discovering*

*the world all around us. It is a time for learning how to learn, for being accepted 'just the way I am.' I respect and respond to the unique needs of children."*

## results from the parents' focus groups and interviews during site visits

### REASONS FOR CHOOSING A HOME-BASED PROVIDER

Parents' responses to the question, "Why did you select a home-based program?" can be grouped into two categories: reasons related to their desired child care experience and reasons related to their perceptions of the home-based provider. Many parents believed that the qualities of a home-based program and of a home-based provider stood in stark contrast to a center-based program and its staff. The reasons cited by parents that are related to their desired child care experience include the following:

1. The nature of the physical environment (e.g., *"I wanted a clean facility that feels like home."; "It's a house made for kids."*).
2. The ambiance created by the provider (e.g., *"It is like a home, not a business, not cold."; "It's like a comfortable incubator with each mother and child in her care."; "It gives me a sense of emotional safety."*).
3. The nature of the program (e.g., *"Kids get more one-on-one attention."; "Family child care has better adult-child ratios."*).
4. The management of the program (e.g., *"She lets me bring my son before she 'officially' opens so I can get to work on time."*).
5. The sense of security engendered by the provider (e.g., *"I am comfortable and can work at peace knowing my child is safe and in good hands."*).
6. The regard for diversity and inclusion (e.g., *"She has materials in Spanish and knows sign language."*).
7. The respect for parents' preferences for their children, as much as possible without changing the basic structure of the program (e.g., *"She supported breastfeeding including using my pumped milk and permitting me to come and breastfeed on my breaks and lunch when I could."*).

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Parents' perceptions of their providers that contributed to the decision to choose a home-based program center on following provider characteristics:

1. Passion for the children.
2. Knowledge of child care, children's needs, and child development, as well as knowledge of resources that address these matters.
3. Willingness to answer parents' questions without making them *"feel stupid or uncaring."*
4. Nurturing and trustful personality.
5. Willingness to be flexible to accommodate an individual family's needs.
6. Willingness to go above and beyond what is typically expected of child care providers (e.g., after a child had surgery, one provider went to the hospital to learn how to change the child's colostomy bag so that he could remain in the program.).
7. Professionalism (e.g., credentials) and years of experience.
8. Validation of a parent's efforts to be a good parent.

The high regard for providers was expressed by one parent in the following way: *"If anything happened to me or my husband, my children would go to my family child care provider."*

Many parents indicated that they sought the home-based provider based on her reputation in the community or upon the recommendation of others. In some cases, the currently enrolled child was the second or third sibling to be in the care of the provider. Some of the parents who had relocated from another state indicated that they viewed the provider as a part of their extended family. One father said, *"It's like having my mother-in-law here."*

### SEEKING SUPPORT FROM THE PROVIDER

Across jurisdictions, most parents gave emphatic affirmative responses to questions regarding seeking support from their home-based provider. In explaining why she did not hesitate to turn to her provider for assistance or advice about *"anything and*

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*everything,” one parent succinctly expressed the sentiment of many, “She is more than my provider. She is my friend.”*

Parents described a variety of child-related and non-child-related issues about which they had sought referrals, assistance, advice, a trusted ear, or comfort from providers:

1. Identifying appropriate medical, dental, psychological, or social services for their child or for themselves.
2. Working with a child who has special needs (e.g., numerous dietary restrictions).
3. Personal parenting skills (“*Am I doing this right?*”) and parenting strategies (e.g., managing children with difficult temperaments).
4. Explaining forms and other paperwork (e.g., legal documents, subsidy applications) in the parent’s native language.
5. Understanding the regulations about and process for receiving child support.
6. Needing flexibility in dropping off or picking-up a child late due to work demands.
7. Coping with marital problems, marital separation, or divorce.
8. Coping with the death of significant others.
9. Balancing family and work responsibilities.
10. Responding to job or school-related issues.
11. Finding housing.
12. Pursuing a postsecondary academic or training program.
13. Being alone/handling children as a single parent.
14. Coping with in-laws (e.g., allowing their child to visit out-of-state grandparents without the mother).
15. Addressing general and specific life demands and life changes (e.g., a second pregnancy in the context of a rocky marriage).

## RELATIONSHIPS WITH OTHER FAMILIES

In responding to questions about the kinds of relationships they had with other families in the program and the program's role in fostering these relationships, parents described relationships on a continuum of familiarity that ranged from aloofness (e.g., simply nodding or giving a short greeting), to strong friendships (e.g., partnering with another parent for delivery or pick-up of children; allowing children to spend the night with each other). Many parents expressed appreciation for their provider's efforts to create opportunities for parents to interact and get to know each other via regular introductions and program sponsored gatherings, such as holiday celebrations and field trips.

One parent stated that, in her hometown, *"Blacks and Whites don't mix. But I've met some of the White parents. We even speak when we run into each other at Wal-Mart. That wouldn't have happened if our children weren't in [Miss Smith's] school."*

Although some parents indicated that they had preexisting or new relationships with families beyond the program context, others emphasized that family interactions were limited to the program context. For example, one parent stressed: *"We know each other in the program; our kids know each other. But outside the program? No, no!"*

## INFORMATION RECEIVED FROM PROVIDERS

Numerous parents reported that their home-based provider was an essential, first-line source of information about general child-related issues (e.g., toilet training, positive discipline, weaning, nutrition, safety, product recall), specific child-related issues (e.g., a particular child's progress or behavioral concerns), and non-child related issues (e.g., housing, job searches). Parents cited four major reasons that they turned to their providers for information:

1. The number of years of experience as a home-based provider (e.g., *"I didn't know anything about raising a child and what to expect; there is no class you take. [Miss Smith] has worked with so many children and has seen what works and what doesn't work."*)
2. The willingness to assist parents in finding answers (e.g., *"If she doesn't know something right away, she'll take the time to find an answer. She even emailed me an article while I was at work."*).
3. The regard providers show for parents' views (e.g., *"When I bring an issue to her about my son, she first asks me, 'What do you do at home that works?'"*).

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4. The non-judgmental way in which providers respond to parents (e.g., *"She made me feel like I didn't suck as a parent."*).

Typically, parents were provided with information as a result of (a) a specific question being posed to a provider or (b) when the provider deemed it timely or necessary to bring information to one parent's or all parents' attention. Information was shared via conversations (e.g., daily interactions and scheduled conferences), printed literature (e.g., magazine articles, books, handouts, newsletters), and electronic sources. Several parents indicated that their providers often ask parents for input and were receptive to unsolicited opinions and suggestions about various matters pertaining to their child and to the operation of the program. One parent noted that her provider *"gently suggests things rather than insisting that I do something."*

### IMPACT OF THE PROGRAM

Regarding the impact of the home-based program on how the parent and child interact, numerous parents spoke of how much their parenting skills and style had improved as a result of their home-based provider's influence. They perceived themselves as much more nurturing, patient, and child-centered. One parent who has both a 19-year-old and a 4-year-old concluded, *"As I have learned better parenting skills, I have learned more about my child and we get along better. I wish I had known then—with my older son—what I know now."* Specific parenting changes cited by parents include:

1. Using more positive reinforcement.
2. Engaging in less spanking; being less harsh and less punitive.
3. Yelling less; changing voice tone and volume.
4. Talking/communicating more with children and asking questions.
5. Listening more to children.
6. Giving the child choices.
7. Serving healthier meals at home.
8. Creating and following a daily routine.

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9. Having behavioral expectations that are more in line with developmental milestones.
10. Modeling appropriate behavior in front of children; being more cautious about saying inappropriate things (e.g., curse words) in front of children.
11. Setting and enforcing limits.
12. Trying to provide consistency in how things are done at home and in the program.
13. Being calmer and more confident as a parent.

Several parents indicated that the program had impacted their parent-child relationship in almost facilitating a role reversal, in that that their child tended to *“bring her learning home and use it on me.”* For example, a parent reported that her 3-year-old commented, *“You have to wait your turn, Mommy.”* Similarly, a parent laughingly acknowledged, *“One day I must have had an angry expression on my face because [her daughter] came to me with a very concerned expression on her face and asked, ‘Do you need to go to the quiet area for a little while?’”* Also, many parents described an increased appreciation for what young children do and an increased understanding of the relationship between playing and learning in early childhood. One mother proudly exclaimed, *“My kid rocks itsy-bitsy spider!”*

## discussion and conclusions

Home-based/family child care is distinguished from other forms of early care and education in characteristics of both structure and process: Typically, home-based/family child care involves paid, non-parental caregiving to a small number of mixed-aged children (disproportionately 0-3 year-olds) of employed or school-going mothers, by one provider (disproportionately female) in the residence of the provider. Accordingly, the work of home-based providers involves a lengthy and flexible schedule during which multiple and divergent responsibilities are performed to meet the care and developmental needs of children, as well as the social support needs of families as perceived by the provider or as requested by the parent, all for relatively low pay. In addition, home-based/family child care is characterized by varying regulations regarding licensing, registration, and/or certification of home-based programs which

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result in much variation—across and within states—in the education and training qualifications of home-based providers.

Home-based child care is a valued option for families in the United States serving about one-quarter of children under age 6 who attend child care (Rusby, 2002). As with other early care and education providers, through their day-to-day work, home-based providers have the potential to play a significant role in the furtherance of young children's optimal development and in the prevention of child abuse and neglect. Thus, the Center for the Study of Social Policy conducted a study to learn more about how home-based providers build the Strengthening Families Protective Factors that reduce the likelihood of child abuse and neglect, that strengthen families, and that contribute to excellent outcomes for children: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children (Center for the Study of Social Policy, 2004).

### LIMITATION AND STRENGTH OF THE STUDY

The characteristics of the participating providers are similar to the general national profile of home-based/family child care workers in that, "family child care providers vary widely in race, age, educational attainment, and socioeconomic status" (Morrissey, 2007, p. 4). However, since the data in this study were generated from a small group of home-based providers, the conclusions which emerge from the data should be generalized with caution.

As the purpose of this study was to learn how home-based providers build the Strengthening Families Protective Factors in their work with children and parents, a strength of the study is the combined methods used to gather data: individual interviews, focus groups, observations, survey instrumentation, and self-reflection on one's practice. Combined, these methods enabled a detailed description of and a telling of stories about the home-based providers, settings, and experiences. "Many teachers and researchers now acknowledge that wisdom can be found in the voices of individuals as they live their own experience, reflect on its meaning, and take action to change what they perceive to be in need of change (Borgia & Schuler, 1996, Appeal for Practicing Teachers section 2, para. 1).

## CONCLUSIONS

The home-based providers in this study and their services are highly valued and appreciated by the parents they serve. As such, the reputations of the home-based providers tend to be considerably positive and consistently strong in their communities as exemplified by the observation that most of the providers never have advertised; they receive new families from referrals and some even have a waiting list. Generally, the services provided by the home-based providers in this study can be conceived as “educare” (Freeman & Vakil, 2007), in that the providers perceive their day-to-day work as involving varying levels of both teaching and caregiving. Furthermore, the overall results of the study suggest that home-based/family child care providers need and are interested in a wide variety of training experiences and that relevant training programs should be developed that address their unique context and provision of care.

The following are more specific conclusions that may be gleaned from the study findings.

**Conclusion I: With respect to building the Strengthening Families Protective Factors, home-based providers should receive introductory and on-going training in the Protective Factors so that their actions and activities move from intuitive practice to intentional practice that is designed to strengthen families.**

The overriding conclusion that can be drawn from this study is that, irrespective of jurisdiction, ethnicity, age, level of training in early care and education, or years of experience, the home-based providers in the study as a whole (a) build close relationships with parents, (b) forge constructive relationships among parents, (c) share child-related and parenting skills information with parents, (d) assist parents with non-child-related matters, as well as with family emergencies, and (e) help children to learn prosocial behavior and to feel good about themselves. In other words, the day-to-day work of the home-based providers in the study serves to build parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children—that is, the Strengthening Families Protective Factors.

The unique characteristics of the home-based/family child care programs make the work of the providers particularly conducive to building the Protective Factors. Furthermore, in the four jurisdictions in this study combined, 74% of the children served

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are ages 0-3. Stated another way, the home-based providers tend to serve the age group of children that research (e.g., Goldman, Salus, Wolcott, & Kennedy, 2003) shows are most vulnerable to child abuse and neglect and are the most frequent victims of child fatalities. However, the study revealed that the home-based providers' work is rarely intentionally designed to strengthen families or build Protective Factors that reduce the likelihood of child abuse and neglect.

Research suggests that the nature of an individual's motivation for and commitment to a career is related to intentionality (Doherty et al., 2006). The study findings reveal evidence of home-based providers who are motivated to pursue early care and education as a career because, as one provider stated, *"I enjoy working with children and I want to be a part of the experiences that enable every child to grow and develop to their fullest potential."* Several providers indicated that home-based child care was their "calling." Child-focused individuals such as these who are committed both to children and to the home-based/family child care profession are a "valuable social resource" (Doherty et al., 2006, p. 310). Thus, home-based providers can become conscientious, empowered allies in the prevention of child abuse and neglect if they are provided with the information, training, and networking that will enable their actions and activities to move from intuitive practice to intentional practice that is designed to build the Strengthening Families Protective Factors.

**Conclusion 2: A continuum of ongoing specialized training in early childhood care and education should be available and accessible to enable home-based providers at all levels of educational attainment, academic backgrounds, and experience to maximize their work.**

"Caregiving training and education have emerged as important predictors of care quality" (Morrissey, 2007, p. 16). Yet, Doherty et al. (2006) concluded, "Our data do not support an assumption that high-quality family child care can only be provided by someone with a college or university credential in ECE or a related discipline" (p. 310). Furthermore, "the lack of training does not mean... caregivers are not interested in improving their caregiving skills" (Drake, Greenspoon, Unti, Fawcett, & Neville-Morgan, 2006, p. 243).

There is much diversity in the educational preparation and training of the home-based providers in this study; some possess high school diplomas only and others have baccalaureate and graduate degrees. Also, the major field of study of some providers with postsecondary education is unrelated to child development. Yet, irrespective of

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their level of education, as a whole, home-based providers are perceived by the parents they serve as having a high level of expertise in child development, early childhood education, and parenting issues: (a) by virtue of their years of experience working with young children, (b) because *"This is their job."*, and (c) due to parents' tendency to perceive themselves as not knowing much about children (e.g., *"I'm not a teacher!"*). However, irrespective of their level of education, there may be a mismatch between parents' perceptions of home-based providers' level of expertise and providers' actual level of expertise in child development, child care, and parenting issues.

As previously described, providers in the study are committed to the home-based/family child care profession and to the children and families they serve. It follows, then, that these individuals would support the need for ongoing professional development for themselves and other home-based providers because they "perceive early care and education in their community as a system and that by strengthening their system, they are strengthened" (Buell et al., 2002). In other studies (e.g., Doherty et al., 2006; Drake et al., 2006; Walker, 2002), home-based providers have indicated that the barriers to formal education and training include (a) cost, (b) time intensive training, (c) single-language delivery of training, (d) lack of training opportunities within an easily accessible distance, (e) lack of transportation, (f) lack of opportunities for training outside of the workday, (g) need for their own child care during training hours, and (h) competing work-family-training responsibilities. In addition, Walker asserted, "As long as child care work is characterized by low wages and is of limited public value, the people who work in it will see little reason to find resources to achieve more training, credentials, or degrees" (Walker, p. 230).

Thus, given the diversity of education and training of home-based providers, as well as the child-related and parenting questions that parents pose to providers, varying levels of on-going education and training should be made available to home-based providers in such general topics as (a) child growth and development, (b) best practices in early care and education, (c) effective parenting, and (d) effective discipline with young children (both reinforcement and punishment). Furthermore, strategies must be developed to mitigate barriers to education and training, to ascertain the most effective length and breadth of training for individuals with diverse educational backgrounds, and to determine the best modes of delivery of education and training (e.g., classroom workshops, distance education, site-based coaching, etc.). These strategies would serve to support the professional development needs and challenges of home-based providers; to incentivize the acquisition of training; to raise public awareness and appreciation of home-based providers and their much needed work; and, ultimately, to

more effectively meet the needs of children and families served by home-based/family child care providers.

### **Conclusion 3: Home-based providers should receive training aimed at specific caregiver behaviors.**

Study providers who spoke about their own training needs primarily focused on topics parents asked of them, as indicated above. Much diversity could be observed among the providers with respect their (a) caregiving style, (b) deliberate interactions with children, and (c) levels of sensitivity and responsiveness to children; yet, very few providers identified these issues as training needs. Dowsett, Huston, Imes, and Gennetian (2008) concluded, "Because simply increasing the overall level of caregiver education does not appear to be sufficient, the next step in child care research is to examine how training programs can target specific types of caregiver behaviors in order to improve caregiving quality" (p. 90). Dowsett et al. identified the following as "specific areas in which caregivers could be better trained" (p. 90):

1. Responding to and expanding on a child's verbalizations or vocalizations (e.g., asking and answering questions; identifying feelings).
2. Providing sensitive caregiving by taking an active interest in the child's activities (e.g., commenting on successes; redirecting when interest wanes).
3. Being appropriately responsive to children's emotional states and needs (e.g., encouraging alternative routes before frustration sets in; offering calm reassurance when the child is upset).
4. Helping children to manage both positive and negative peer interactions (e.g., learning to share toys; expressing anger).

It should be noted that these training suggestions also are caregiver behaviors that serve to build the Strengthening Families Protective Factor "social and emotional competence of children."

Child abuse and neglect issues were found to be the most difficult matters for the home-based providers in this study to address—whether the issue is regularly checking children for physical signs of abuse or neglect, or making direct inquiries to parents about red flags of abuse or neglect, or teaching children about "good touching" and "bad touching," or reporting suspected abuse or neglect. In fact, asking questions

about how they broached child abuse and neglect issues with parents seemed to evoke a range of emotions in home-based providers, from being at ease, to displaying discomfort, to showing dread, to dismissing the matter because *“my parents are educated.”*

Thus, other specific areas in which home-based providers could be better trained include: (a) the identification of child and family risk factors with respect to child abuse and neglect; (b) typical prevention strategies and Strengthening Families Protective Factors as prevention strategies; (c) the meaning of “mandated reporter” and the attendant state regulations and procedures regarding reporting suspected child abuse and neglect; (d) how to broach the subject of child abuse and neglect with parents without creating a judgmental and hostile atmosphere; (e) being a single caretaker and having the responsibility of addressing child abuse and neglect issues, and the consequences thereof oneself; and (f) managing the fear of being wrong about one’s observations and suspicions about child abuse and neglect.

**Conclusion 4: Since the mental health of the provider is related to the mental health of children in her care, then home-based providers also should receive training in strategies to promote their own personal and emotional well-being.**

Although “there is little published research addressing how the mental health of nonparental caregivers, such as family child care providers, is related to the infant and toddler mental health of those in their care” (Buell et al., 2002, p. 215), there is research that points to the mental health of the parent as a significant predictor of the child’s mental health (Buell et al., 2002; Heinicke, Fineman, Ruth, Recchia, Guthrie, & Rodnig, 1999). Similarly, “research has shown that nurturance of the provider is related to the mental health of the children in care” (Buell et al., 2002, p. 215).

Numerous providers in this study cited the need for more quality time for themselves both during the workday and afterwards. In addition, providers cited numerous strategies they engage in to prevent or reduce their own work-related stress. Yet, very few providers expressed feelings of personal or job-related demands or stress beyond their current ability to cope. Still, in order for home-based providers to provide sensitive and responsive nurturance to the children in their care, as well as to maintain their own optimal mental health, it is important for providers to receive training and social support in mitigating potential sources of stress and managing experienced stress (Atkinson, 1992; Buell et al., 2002; Hamre & Pianta, 2004).

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One potential source of stress for home-based providers relates to characteristics that are, paradoxically, considered to be the cornerstone of effective family child care and were cited by parents in the study as the major strengths of home-based providers: (a) close, open, and trusting relationships between home-based providers and parents; and (b) providers' tendency to offer care and support to parents beyond what may be expected of a child care provider. While *"being there"* and *"bending backwards"* for parents may help home-based providers to forge close, trusting, and personally supportive relationships, and thereby to build Protective Factors, there are potentially problematic implications of these characteristics:

1. Some home-based providers may not have the professional skill and psychological wherewithal to assist parents with certain types of issues or problems.
2. Continual *"above and beyond care"* by the home-based provider may become taxing—physically and emotionally—beyond the provider's own self-care and resiliency resources.
3. *"Above and beyond care"* can lead to enmeshed relationships (i.e., blurred boundaries) which may, at least, interfere with the home-based provider enforcing the business aspects of the home-based program, or at worst, contribute to an exploitative relationship on the part of the parent.
4. While *"above and beyond care"* may help to fulfill some home-based providers' emotional needs, becoming so involved with parents' lives may result in providers not spending time with their own friends and, ironically, may result in feelings of social isolation.

Thus, another specific area in which home-based providers could be better trained is *"caring for the caregivers"* (Buell et al., 2002, p. 213), in regards to their own emotional well-being, as well as to the emotional well-being of those they give care and support.

**Conclusion 5: Membership in and affiliation with professional family care associations, as well as strong partnerships with child care community support agencies and networks, should be strongly encouraged of all home-based providers.**

The connection to and use of support services—both local child care community agencies and professional child care associations—has been found to be a valuable asset for home-based providers (cf. DeBord & Sawyers, 1996; Doherty et al., 2006;

Fischer & Eheart, 1991; Oliveira, 2007; Rusby, 2002). Doherty et al. cited the assertions of the author of a working paper on quality improvement in family child care in which the author:

Notes that providers tend to be isolated and recommends that each community have an organization for family child care providers to facilitate networking and peer mentoring and provide training and on-going professional development. To be effective, such organizations must be accessible in terms of location and/or other means. (p. 310)

Fischer and Eheart (1991) went a step further in their study and concluded that, “where participants had access to a variety of support services, it was providers’ affiliation with support networks—not merely access to them—that was predictive of quality of care” (p. 559).

Numerous providers in this study spoke of the value of various agencies in their state that they turn to for consultation, continuing education opportunities, technical assistance, resources, and mentorship. On the other hand, very few referred to membership in professional organizations. Many home-based providers reported feelings of isolation with respect to having a colleague with whom to share ideas and solve problems, even if they have a full- or part-time person in their employ. Thus, home-based/family child care providers could benefit from actively seeking membership in and affiliation with professional associations and informal networks of providers, as well as regular or as-needed communication with established community support agencies. In addition, professional associations should “make concerted efforts to be more accessible and available for family child care providers” (DeBord & Sawyers, 1996, p. 8).

### **Conclusion 6: Home-based providers should be included as integral contributors in the planning and implementation of a state’s comprehensive early care and education system.**

Despite parents’ demand for and valuing of home-based child care, “the field remains disorganized with no shared vision or delivery” (Oliveira, 2007, p. 12). Furthermore, in addition to regulatory differences from state-to-state, there are differences among states in the type and level of support provided to home-based providers in such areas as mental health consultation, availability of resources, and interagency linkages to services for children and families. Thus, home-based providers should be included in

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the planning and implementation of a state's comprehensive early care and education system in order to (a) ensure that home-based programs are included as viable child care options, (b) participate in an analysis of a state's support of providers, (c) encourage the inclusion of funds in a state's budget to assist providers' efforts to improve the quality of service delivery, and (d) contribute to the development of recommendations of how early childhood systems could more effectively support home-based providers.

The findings and conclusions from this study suggest that, whether they are called home-based providers or family child care providers, it is abundantly clear that the participants in this home-based program study are not "babysitters" and that their work is not menial. Generally, the results of this study reveal that the services offered by the participating providers are broad-based and reach both the adults and children in the family. Home-based/family child care providers are, by and large, those individuals who provide care for America's youngest and most vulnerable population. Home-based providers, like others who provide early care and education to young children, deserve the public respect and regard afforded those who help to build strong families, communities, and society as a whole.

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