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REVIEWS OF RESEARCH
LITERATURE REVIEW

Quality in Family, Friend, and Neighbor Child Care Settings

Amy Susman-Stillman
Center for Early Education and Development, University of Minnesota

Patti Banghart
National Center for Children in Poverty
Mailman School of Public Health, Columbia University

May 2011

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

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What We Know

FFN caregiver characteristics

- Education: Family, friend, and neighbor (FFN) providers generally have lower levels of education than licensed providers (a high school education compared to some college or a college degree).
- Experience: FFN providers exhibit a range of experience caring for children, some gained by virtue of their own parenting experiences, and some by caring for children who were not their own.
- Motivation: FFN providers cite consistent, similar reasons for providing care including: wanting to help the child's parent; wanting to help the child grow and learn; fostering intergenerational ties; and staying home with their own child.
- Stability: the extent to which caregiver turnover is a problem in the license-exempt sector is unclear; however, relative providers self-report a remarkable degree of stability of FFN care arrangements – ranging from 12 months or more.

Quality in FFN care

- Quality ratings in FFN care tend to vary by the assessment tool used. For example, studies using the Family Day Care Rating Scale (FDCRS) to assess quality consistently show that the quality of FFN care was rated as inadequate to minimal. Studies using the QUEST – a new quality assessment tool designed for home-based child care – found that caregiving settings received at least adequate ratings for space and comfort, outdoor materials and safety, supervision and monitoring, and caregiver warmth and responsiveness.
- Research findings consistently show low adult:child ratios (for example, 1:2) in FFN care; lower than ratios generally found in licensed caregiving settings.
- Overall, the quality of caregiver-child interactions is a strength of FFN care. Most FFN studies found acceptable levels of warmth and support for children.
- Studies were mixed on whether the development of children in license-exempt settings lags behind that of children in licensed settings. The Three City Study suggests that child care quality rather than child care setting affects child development (Li-Grining & Coley, 2006). The Growing Up in Poverty Study however, found that children in centers showed significantly higher cognitive and school readiness skills than children in FFN settings. At the same time, children in family child care had higher rates of behavioral problems than children cared for in FFN settings (Fuller, et al., 2004).
- Findings on the quality in FFN care should be viewed cautiously however, as researchers are wrestling with whether the concept of quality and the measurement of quality should be the same in license-exempt settings as it is in licensed settings.
- FFN providers reported wanting to learn how best to support children's development. They also expressed interest in health/safety, child development, and business and financial information, as well as in community resources and activities particularly low-cost ones. At the same time, the majority of FFN providers did not express interest in becoming licensed. More research is needed to understand the most effective strategies for educating and supporting FFN providers.

Parental satisfaction

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

Parent-FFN provider relationships

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

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Introduction

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

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

New understanding of how the quality of various early childhood settings affects child outcomes has led to increased attention regarding quality at the state and federal levels and prompted policymakers, researchers, and parents to ask more careful questions about the quality of care across settings, including FFN care. To date, much of the research on the quality of child care has explored the quality of care offered in licensed child care settings (that is child care centers and family child care homes). Given that FFN caregivers are generally exempt from state regulation (depending on the state), only need to meet basic health and safety requirements to receive CCDF payments for providing care, and therefore not required to meet defined program standards, the quality of the care children are receiving in FFN care is of primary importance.

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

- What are some of the difficulties in defining quality in FFN?
- What are the structural characteristics related to quality of FFN care (for example, provider education and training, adult:child ratio, etc.)?
- What is the quality of care in FFN settings, including interactions between children and their FFN caregivers?
- To what extent do parental perspectives regarding FFN care shape our considerations about quality?
- What do we know about FFN care and children's developmental outcomes?
- What evidence supports strategies to improve the quality of FFN care?
- What are some of the methodological concerns with studying the quality of FFN care?

What is Family, Friend and Neighbor Care?

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

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

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

Background on Child Care Quality and FFN Care

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

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

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

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

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

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

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

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

In an effort to include findings from the older and newer theoretical frameworks, this review organizes the literature to-date on quality in FFN care around the frameworks of structural and process quality and child development. Summaries of findings in each of these areas are presented. Relevant findings from the family-sensitive caregiving perspectives (e.g., parental perceptions of care) are also included. Throughout, the review raises questions about the methodological adequacy of measures used in both licensed and FFN care settings, and the extent to which the different frameworks appropriately capture the important conceptual and practical dimensions of FFN care. It also offers suggestions for conceptual and methodological consideration.

Criteria for Selection of Studies for Review

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

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

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Table 1: Methodology of Studies Reviewed and Topics Examined

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

Description of Studies

Methods

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

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Multi-site studies

Parent and provider interviews/ questionnaire; quality observations

Li-Grining & Coley, 2006; Votruba-Drzal, et al., 2004; Fuller, et al., 2004; Loeb, et al., 2004; Layzer & Goodson, 2006; NICHD, 1996; Paulsell, Mekos, DelGrosso, Rowand, & Banghart, 2006

Parental perceptions of FFN care, Structural characteristics, Caregiver characteristics, Process quality, and FFN care and children's development

State survey studies

Illinois – linked surveys of parents and their license-exempt providers participating in the state subsidy system. Longitudinal analysis of statewide subsidy administrative data.

Washington – telephone survey of families and FFN caregivers

Minnesota – telephone survey with randomly selected households acrossthe state

Anderson, Ramsburg, & Scott, 2005

Brandon, Maher, Joesch, & Doyle, 2002

Chase, 2005; and Chase, Arnold, & Schauben, 2006b

Parental perceptions of FFN care, Structural characteristics, Caregiver characteristics, and FFN provider interest in quality improvement

Smaller-scale studies

Focus groups, interviews, and/or surveys with providers and/or parents; and/or quality observations

Bromer, 2006; Jaeger & Funk, 2001; Porter, 1998; Porter, Rice, &Mabon 2003; Porter & Vuong, 2008; Reschke & Walker, 2006; Maxwell, 2005; Shivers, 2005; Shivers & Kim, unpublished; Todd, Robinson & McGraw, 2005; Tout & Zaslow, 2006; Whitebook, et al., 2003; Whitebook, et al., 2004; Maher, Kelly, & Scarpa, 2009; McCabe & Cochran, 2008

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TUDIES

Methods

The literature reviewed here uses a variety of meth- ods, including observations and child assessments, to measure quality and child outcomes of care settings as well as interviews and focus groups with parents and providers to understand parent satisfaction of care and provider perceptions of care and interest in for- mal professional development or informal education and support. Some studies (multi-site and smaller-

scale) have conducted observations and assessments across child care settings (Li-Grining & Coley, 2006; Votruba-Drzal, et al., 2004, Fuller, et al., 2004; Jaeger & Funk, 2001; Loeb, et al., 2004; McCabe & Cochran, 2008; NICHD, 1996; 2000), while others have exclusively examined FFN care (Anderson, et al., 2005; Brandon, et al., 2002; Bromer, 2006; Chase, et al., 2005; Maher, et al.., 2008; Maxwell, 2005; Paulsell, et al., 2006; Porter & Vuong, 2008; Shivers, 2005; Shivers & Kim, unpublished; Todd, Robinson, & McGraw, 2005; Tout & Zaslow, 2006; Whitebook, et al., 2003; Whitebook et al., 2004).

Measures

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

The FDCRS was used in the majority of the reviewed studies to observe quality in FFN child care (Li-Grining & Coley, 2006; Fuller, et al., 2004; Loeb et al., 2004; Jaeger & Funk, 2001; Maxwell, 2005; McCabe & Cochran, 2008; Shivers, 2005; Shivers & Kim, unpublished). It is designed for use in licensed family child care settings and adapted from the original Early Childhood Environmental Rating Scales (ECERS), used in center-based settings. The FDCRS assesses quality – both structural and process – on seven aspects of care: space and furnishings, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children. Despite its wide use in evaluating FFN care, there are questions about how accurately the FDCRS can measure the quality of FFN caregiving considering how certain scales favor licensed settings with more resources.[4] The FDCRS developers explicitly distinguish between family child care settings and the child's home environment, which may be more aligned with family, friend, and neighbor care. Therefore, there has been some concern that the FDCRS will automatically produce higher quality ratings in licensed settings (Maher, 2007).

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

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

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

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

Emerging Themes

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

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

Structural Features

Adult: Child Ratio

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

Education of FFN Providers

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

Training and Experiences Caring for Children

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

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Caregiver Characteristics

Motivation for Caregiving

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

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

Stability of FFN Caregiving

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

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

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

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

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

Physical Environment

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

Process Quality

Process Quality in FFN Studies

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

Quality of Caregiver-Child Interactions

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

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