

A COMPARATIVE ANALYSIS OF SUBSIDIZED AND NON-SUBSIDIZED RELATIVE
CHILD CARE HOMES IN KANSAS

by

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B.S.E., University of Central Arkansas, 1995
M.S., Kansas State University, 2004

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

Positive child outcomes are related to high quality child care environments as evidenced through longitudinal studies (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; The National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2005; Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005). These findings are important particularly for young children from low-income families. As these children are commonly the recipients of child care by a relative, high quality relative care is essential (U. S. Census Bureau, 2005; Brown-Lyons, Robertson, & Layzer, 2001; Collins & Carlson, 1998; Ehrle, Adams, & Tout, 2001). Prior research on the quality of care provided by relatives has been limited, inconsistent, and inconclusive due to differing methodological approaches. Previous studies have often grouped relative child care providers along with other home-based care settings; however, they are not the same. Previous studies have also employed a variety of measurement tools to assess quality. This study examined the overall quality of care in relative child care settings using a tool specifically designed for relative child care, comparing the quality of care and motivations for care between subsidized and non-subsidized settings. Overall, findings were consistent with results of previous studies on kith and kin or relative child care providers in that 1) a wide range of quality of care was observed among both subsidized and non-subsidized settings; 2) no differences were observed between quality in subsidized and non-subsidized; 3) no differences were observed between quality of care based on motivation for providing care. The majority of providers will provide care for family regardless of availability of payment; however, subsidized providers were more family-oriented in their motivation compared to non-subsidized who more child-oriented. While all levels of care were observed in both infant/toddler and preschool settings, infant/toddler settings scored higher on all adult-

child interaction variables. These settings were also observed to be safer than preschool settings. Also subsidy status alone does not necessarily increase or affect quality of the care as payment is not the primary motivation for care. Policymakers should, therefore, explore other means by which to enhance quality such as equitable subsidy rates across home-based settings and support programs for this population.

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Dedication

This dissertation is dedicated to the families who gave of their time, opened their homes, and told their stories over the course of this study. Without their generosity, this study would have fallen far short of its goals.

This dissertation is also dedicated to my family: my children, my husband, my parents, and grandparents. I began this study with three children in my life and in my heart and concluded it with eight. Each of you is an amazing addition to my life: Anastasia Elizabeth, Devin Douglas, Catherine North, Gillian Alexandra, Lawrence Caanan-Paul, David Matthew, Hadley Pearl and last, but not least, Mackenzie Rose. You make being a mother a joy!

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Mother and Daddy, all I can say is, "You were right." When I was a child you both told me I could achieve any goal I set my sites upon. There were days I doubted you, but love and support can make anything possible.

Last but not least, this dissertation is dedicated to my grandparents, particularly to my grandmothers: Laverne Payne and the late Rosie Louella Willard. Their impact on my life is immeasurable. I am forever grateful for their love, devotion, and care. Mamaw and Grandma, I love you, both. I am who I am today because of you.

Chapter 1 - Introduction

For more than 4,000,000 U.S. children under the age of five going to grandma's house is more than a visit "over the river and through the woods" (US Census Bureau, 2005). These children are regularly in the care of their grandparent, most often a grandmother, while their parent(s) are working or attending school. "Historically and cross-culturally, the exclusive care of infants and young children by mothers is the exception rather than the rule" (The National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2005, p. xiii). In modern U.S. history, use of non-maternal child care, including child care provided by grandparents and other relatives, has risen since the middle of the 20th century (The NICHD Early Child Care Research Network, 2005). It is within this context that the current study is set.

At the most basic level, child care is designed to provide children with supervision that ensures their safety and health while not in the care of their parents. Recent research, however, has documented a positive relationship between the quality of child care environments and the physical, cognitive, social and emotional development young children. Research involving the Perry Preschool Project stands as a strong testament to the value of quality early childhood environments for at-risk children (Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005). From 1962-1967, the Ypsilanti, Michigan school district operated the Perry Preschool Project. This program was designed to help young children avoid school failure and related problems often experienced by low-income children. The impact of the program on children has been evaluated through various phases of the participant children's lives. In addition to higher cognitive and language development scores during their education, participants in the project were also more likely to graduate from high school (Schweinhart et al., 2005).

The examination of the relationship between the quality of early childhood experiences and child development outcomes was continued into the 1970's by the Carolina Abecedarian Project (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002). Four groups of participants enrolled in the Project from 1972-1977. Participants were enrolled by parents in their infancy then randomly assigned to one of the four groups; 1) those receiving support during the preschool years, 2) those receiving support during the first three years of elementary school, 3) those who received support during both the preschool and school age periods, and 4) those who received no treatment at all. Participants from either the preschool only group or the group of children which received support in both preschool and the primary grades were found to have higher reading and math scores which persisted into their young adulthood (Campbell et al. 2002).

Additionally, various research studies which comprise the National Institute of Child Health and Human Development (NICHD) longitudinal study of early childhood and youth development have found associations between high quality child care and increased school readiness, increased language development, and fewer behavior problems for children at specific points in their development (2005). Investigators found, "With family selection factors and quality of child care controlled, only hours in center care across the time period from 3 to 54 months were related to child outcomes" (The NICHD Early Child Care Research Network, 2005, p. 203). Specifically, increased hours of attendance in center-based care across the studied time were associated with higher incidences of externalizing behaviors (though not at at-risk levels). Increased hours in center-based care during infancy resulted in lower pre-academic test scores, while increased center-based care during the toddler period was correlated with increased language development. Despite the findings of the NICHD's longitudinal study and the success

of the Perry Preschool Project and the proliferation of other programs of this nature, including Head Start, not every child has access to high quality center-based programming, nor does every family seek this type of care for their children out of concerns related to trust or familiarity. In fact, nineteen of the 105 counties in Kansas (18%) do not have a Head Start program (Kansas Head Start Association Member Programs, 2011) while over half (54%) of the state's counties are without an Early Head Start program. Additionally, many counties have limited numbers of licensed or licensed-group family child care homes and licensed center-based programs, often limiting the child care options available to parents, beyond relative child care.

Child care choices for low income families are of particular interest to policy makers and researchers as these children are at-risk for developmental delays due to the indirect and direct effects of poverty without quality early childhood experiences (Duncan & Brooks-Gunn, 2000; The NICHD Early Child Care Research Network, 2005). Policy makers and researchers are also interested in the child care choices of low income families as child care subsidy recipients.

Relative care, “kith and kin,” care or “family, friend & neighbor” (FFN) care are terms used to define informal, unregulated child care environments. The United States Census report, *Who's Minding the Kids: Winter 2002* (U. S. Census Bureau, 2005) along with other survey studies provide strong evidence to suggest that relative care is provided most frequently by grandmothers as compared to other non-parental relatives (Adams, Tout & Zaslow, 2007; Brown-Lyons, Robertson, & Layzer, 2001; Collins & Carlson, 1998; Ehrle, Adams, & Tout, 2001). Nearly 30% of all children in the United States, under the age of five years, experience this form of child care with this being the primary child care arrangement for 17.2% of all children under five years of age (U. S. Census Bureau, 2005). Relative child care is more commonly used by low-income families, as compared to higher-income families with children

and by families children of color (African American and Hispanic children, specifically), as compared to White families (U. S. Census Bureau, 2005). Furthermore it is used more frequently by families with infants and toddlers, as compared to families with preschoolers and by low-income families, as compared to higher-income families with children (Adams, Tout & Zaslow, 2007; U. S. Census Bureau, 2005; Brown-Lyons, Robertson, & Layzer, 2001; Collins & Carlson, 1998; Ehrle, Adams, & Tout, 2001).

Although the United States Census report, *Who's Minding the Kids: Winter 2002* (U. S. Census Bureau, 2005) does not provide specific statistics for individual states, 18.9% of Midwestern children under the age of 5 years are reported to be in the care of a grandparent while 5.4% of these children are in the care of another non-parental relative (U. S. Census Bureau, 2005). Extrapolating these percentages to the population of Kansas children under the age of 5 years of 436,905 children (Kansas State and County Quick Facts, 2009), approximately 106,600 of these children would be in the care of a relative while their parent works, attends school or other training.

With the approval of the legislative branch of the state government, the Kansas Department of Health and Environment Bureau of Child Care Licensing and Registration establishes and enforces child care regulation. Currently Kansas child care regulations identify two types of regulated child care provided in a home setting: Licensed Group Care and Licensed Care (Kansas Department of Health & Environment, 2007, K.S.A. 65-517). Each of these forms of home-based child care is located in the home of the provider and differ in the maximum adult-to-child-ratio, maximum group size, inspection requirements, and provider education/training required. Care by relatives, by blood or marriage, is exempt from compliance with licensing

regulations regardless of the location in which the care is provided (Kansas Department of Health & Environment, 2007, K.S.A. 65-517c) therefore quality of care is not monitored.

The Child Care Subsidy Program is administered by the Kansas Department of Social and Rehabilitation Services. This program is funded by the federal Child Care and Development Fund. Income eligible families receive child care fee assistance when care is provided by a regulated form of child care or by a relative of the child in the provider's home. Some care in the child's home is permitted in this program, but care by a relative in the child's home is not eligible for a Child Care Subsidy. Child care assistance funds are issued to families each month using an electronic bank transfer (EBT) card similar to a debit card. Funds are then transferred, at the families' request, to their child care provider (Kansas Department of Social & Rehabilitation Services, 2011). Child care providers must either be licensed by the Kansas Department of Health & Environment or, if exempt from licensing, child care providers must agree to abide by the Department's discipline policy and must complete a self-evaluation of their setting. During FY 2009, the Kansas Department of Social & Rehabilitation Services spent \$76,786,510 through the Child Care Subsidy Program (Kansas Department of Social & Rehabilitation Services, 2009). Although specific dollar amounts received by relative care providers in Kansas through the Child Care Subsidy Program are not available, using the approximate number of Midwestern children under five years who are in the care of a relative would provide a rough estimated state expenditure towards this form of child care in excess of \$18,000,000.

Context of Problem

Researchers have examined quality of relative child care from a variety of perspectives over the last two decades. Initially viewed by researchers only as an indirect influence on

children, the quality of relative child care has been researched, along with other child care environments, as a direct influence on children in more recent years. Despite this shift, researchers have not reached a general consensus on how to examine this unique form of child care (Kreader & Lawrence, 2006).

Early research on relative child care examined these arrangements the context of larger social support networks, particularly for single and/or economically disadvantaged mothers (Taylor & Roberts, 1995; Unger & Powell, 1980). These studies hypothesized that relative child care arrangements indirectly influenced child development through the support of the mother. Subsequent to the institutionalization of welfare reform policies and programs in 1996, studies on the direct impact of child care environments and early childhood experiences on child development have been conducted. Relative child care arrangements have been included in these studies. Some studies have examined relative child care settings alongside both center-based and regulated family child care homes (Loeb, Fuller, Kagan, and Carrol, 2004; The NICHD Early Child Care Research Network, 2005). Other studies have grouped relative child care providers with regulated family child care homes (Kontos, Howes, Shinn, and Galinsky, 1995), while still others have grouped relative child care providers with other informal child care providers such as friends and neighbors (Layzer & Goodson, 2006; Tout & Zaslow, 2006). Until recently few studies have examined relative child care as a distinct, unique form of child care (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Porter, Rice & Mabon, 2003). In addition to differences in their study populations, these studies employed differing measurements to assess quality in child care environments. Kontos, Howes, Shinn, and Galinsky (1995) and Loeb, Fuller, Kagan, and Carrol (2004) used the Family Day Care Rating Scale (Harms & Clifford, 1989) in their assessments of these environments, while other researchers developed their own

tools (Layzer & Goodson, 2006; The NICHD Early Child Care Research Network, 2005; Tout & Zaslow, 2006). With such methodological variation, it is difficult to obtain consistent findings.

By breaking the term, “relative child care,” into two distinct parts, “relative” and “child care,” it should not be surprising that relative child care has been studied from two distinct perspectives: one which focuses on the relative or family relations and the other which focuses on the child’s experiences and developmental outcomes. A systemic framework can be applied to these distinct perspectives of relative child care, one which focuses on the relative or family relations aspects and the other which focuses on the child care aspects of the situation.

Bronfenbrenner’s Bioecological theory of human development (1979) stresses the importance of the developing individual, the context in which the individual develops, and the interaction between the individual and his/her surrounding environment, including both direct and indirect environmental influences. In *The Ecology of Human Development*, Bronfenbrenner (1979) describes four contextual systems (microsystem, mesosystem, exosystem, and macrosystem) which influence the individual through direct and indirect interactions between the individual and the environment. The biological child is at the center. Around the child is the microsystem, as defined by Bronfenbrenner, “...is a pattern of activities, roles and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (1979, p. 22). The mesosystem is defined as the interaction between two or more elements within the microsystem. Exosystem contains settings in which the developing person is not directly involved, but are affected by the interactions within the system. The macrosystem “...refers to consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies” (1979, p. 26).

Bronfenbrenner later expanded his theory to include the chronosystem which is defined as those environmental and historical events which influence an individual's development over the lifespan (1989). The systems constantly influence one another or are bidirectional as labeled by Bronfenbrenner. Until recently research on relative child care has either taken a mesosystem (extended family microsystem- immediate family microsystem interaction) perspective or a relative as child care microsystem perspective.

This theoretical framework views the individual as developing through direct and indirect bi-directional interactions with various environmental contexts. Individuals experience direct interactions with multiple elements in the microsystem, such as the individual's immediate family, extended family and school or work environments. Mesosystems, interactions between two or more microsystems, have a more indirect influence on the developing individual.

Bronfenbrenner advocated that social science researchers conduct "ecologically valid" studies (Bronfenbrenner, 1979). Using the term, ecological validity, Bronfenbrenner attempted to create a "logical extension of the traditional definition of validity" (p. 29). Ecological validity proposes that researchers include the environmental context of the subject in research design, to include where the research takes place as well as the perspective from which the phenomenon is examined. With regard to this second aspect of ecological validity, Bronfenbrenner states "it is not only desirable but essential to take into account in every scientific inquiry about human behavior and development how the research situation was perceived and interpreted by the subjects of the study" (p. 30). Given the prevalence of relative child care situations, the public dollars paid to relatives providing this form of child care, and potential impact on young children of a high quality early childhood education, the question being asked by researchers, policy makers and practitioners is not whether or not to study quality in relative child care homes.

Rather, the questions being asked of relative child care is from what perspective should these settings be studied and using what measurements?

Significance of the Study

Valid assessments of quality in relative child care setting would allow researchers to better answer questions regarding what factors, such as child characteristics, relative characteristics, family characteristics, and the provision of subsidy, mediate or moderates quality of care provided. Potential outcomes for very young children and low-income children, those most likely to be involved in relative child care situations, could be assessed in relation to child care quality. Intervention programs designed to improve the quality of relative child care could also be further informed by pre-intervention and post-intervention assessments of quality. As a valid assessment of environmental quality has not been readily available until recently, intervention programs have been conducted without valid evaluation tools (Porter & Kearns, 2005). After general levels of child care environmental quality in relative child care settings are ascertained, further research on child outcomes associated with various levels of quality in these settings could then be examined. Given the number of children in relative child care settings and the child care subsidy dollars spent on this form of child care, there is obviously a need for a valid and reliable assessment of the quality of care. This initial assessment of child care quality in relative child care environments will set the stage for further investigation and provide an ecologically valid picture of relative child care from which potential quality initiative programs can be developed.

The purpose of this research study is to assess child care quality in subsidized and non-subsidized relative child care environments. The following research questions will guide this study.

1. What is the overall quality of care in relative child care homes?
2. Does the receipt of a child care subsidy predict higher quality care for children in relative child care?
3. What is the relationship between relatives' attitudes about providing child care and child care quality?
4. What is the relationship between receipt of child care subsidies and the attitudes of relative child care providers regarding the provision of care?
5. What is the process that families utilize to initiate and maintain subsidized and non-subsidized relative child care arrangements?

Definition and Operationalization of Terminology

Center-based child care- “A facility which provides care and educational activities for 13 or more children two weeks to 16 years of age for more than three hours and less than 24 hours per day during day time, evening, and nighttime care” (Kansas Department of Health & Environment, 2007, K.A.R. 28-4-240-d1).

Child care subsidy- A subsidy which compensates a child care provider for the cost of providing child care. These subsidies can be paid to a child care center, family child care home, relative child care provider, or in-home child care provider. Subsidies are paid by and governed by individual states through federal funds allocated as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193). Subsidized child care would include any care environment in which the child care fees are covered, in part or in whole, by a child care subsidy. In some areas of the country the subsidy is paid to the child care provider

directly, while in others it is paid to the parent to pass on to the child care provider. Non-subsidized child care is care in which all child care fees are paid by the parent.

Ecological validity- “The extent to which the environment experienced by the subjects in a scientific investigation has the properties it is supposed or assumed to have by the investigator” (Bronfenbrenner, 1979, p. 29).

Family child care home- “A place maintained for the purpose of providing children with food or lodging, or both, away from such children’s home or homes, for less than 24 hours a day, if: 1) not more than six of the children cared for at such place are less than 16 years of age; and 2) not more than three of the children cared for at such place are less than 18 months of age.” (Kansas Department of Health & Environment, 2007, K.A.R. 65-517-a).

Friends, family & neighbor care (FFN) - See kith & kin care.

In-home child care- Child care provided to a child within the child’s own home, for example, a nanny.

Kith & kin care- Child care provided by friends, family, or neighbors. Depending upon state regulations this care may or may not be exempt from licensing regulations. Synonym used in some literature: friends, family & neighbor care (FFN).

License-exempt child care- Child care which is exempt from licensing regulations and requirements.

Licensed child care- Child care which is governed by licensing regulations and requirements at the state level. Also known as **Regulated child care**.

Mesosystem- “The interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and

neighborhood peer group; for an adult, among family, work, and social life)” (Bronfenbrenner, 1979, p. 25).

Microsystem- “A pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (Bronfenbrenner, 1979, p. 22).

Process features of child care quality- Features of a child care environment which can be observed within the context of the child’s daily experiences. Examples of process features would include adult/child interactions, responsive caregiving techniques, cognitive and language stimulation (Dowsett, Huston, Imes, & Gennetian, 2008; The NICHD Early Child Care Research Network, 2005).

Relative child care- The provision of child care by a relative of the child. The relation to the child can be by virtue of blood, marriage, or legal adoption. In Kansas, this form of child care is exempt from licensing.

Structural features of child care quality- Features of a child care environment which can be regulated by program standards or statutes. Examples of structural features would include adult-child ratios, group sizes, and teacher education or experience (Dowsett, Huston, Imes, & Gennetian, 2008; The NICHD Early Child Care Research Network, 2005).

Chapter 2 - Review of Literature

Although grandparents and other relatives have been providing child care with increasing frequency since the middle of the 20th century (The NICHD Early Child Care Research Network, 2005), the phenomenon of relatives providing child care was not examined until nearly the end of the century. Initial research on relatives who provided child care tended to view the situation as a form of family support (Jayakody, Chatters & Taylor, 1993; Taylor & Roberts, 1995; Unger & Powell, 1980). Within this context, any impact on the child was indirect and occurred through the direct impact of family support on the mother. More recently, however, researchers have begun to examine the quality of these environments as they directly impact children, i.e. as child care environments (Kontos, Howes, Shinn, & Galinsky, 1995; Loeb, Fuller, Kagan, and Carrol, 2004; The NICHD Early Child Care Research Network, 2005; Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Porter, 1998; Porter & Rice, 2000; Porter, Rice & Mabon, 2003; Porter & Kearns, 2005; Porter, Rice & Rivera, 2006; Porter, Rice, Kearns, & Mabon, 2007; Raikes, Raikes & Wilcox, 2005; and Tout & Zaslow, 2006).

Before examining literature specific to relative child care settings, the relationship between quality of care and child outcomes in any child care setting must be established. This relationship has been studied through controlled, intervention programs including the Carolina Abecedarian Project and The Perry Preschool Project. More recent research on the relationship between quality of care and child outcomes has come in the form of longitudinal correlational studies, most notably the National Institute of Child Health and Human Development (NICHD) Study of Early Child Care and Youth Development. Both controlled intervention studies and correlational research have observed cognitive, language, and social development gains among children who experienced high-quality early childhood experiences (Campbell, Ramey,

Pungello, Sparling, & Miller-Johnson, 2002; The NICHD Early Child Care Research Network, 2005; Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005).

Impact of Quality of Care on Child Outcomes

During the 1960's and 1970's researchers in Michigan and North Carolina sought to examine the impact of the quality of child care on child development outcomes through controlled interventions involving at-risk young children: Perry Preschool Project and Carolina Abecedarian Program. Participants of both of these studies were observed to have gains in cognitive and language development (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005.)

Initiated in 1962, the Perry Preschool Project identified 123 African-American children, 58 of whom were assigned to a high-quality, half-day preschool program for 3 and 4 year old children. Most of these children (75%) participated in the program for two school years (3 and 4 years of age), while the remainder participated during just as 4 year olds. Positive impacts have been observed throughout the lives of the participants (Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005). During their elementary school years, project participants attained higher IQ levels, needed fewer special education interventions, and were rated as having higher academic motivation by their elementary school teachers. These same children were more likely to graduate from high school, a finding which was particularly true for female participants. More than eighty percent of female participants graduated from high school, while less than a third of their peers who did not participate in the Project did so. As young adults, participants experienced fewer months of unemployment, fewer arrests, and teenage births. Most recently, as 40-year-old adults, program participants were less likely to have experienced multiple arrests (5 or more) and more likely to be earning greater than \$20,000 per year. In addition to examining

behavioral and educational outcomes of the program participants, the researchers conducted a cost-benefit analysis of their program. The overall return on investment per program participant was \$16.14, with \$12.90 of that return going to the general public, in terms of social service and justice/corrections savings (Schweinhart et. al, 2005). The cost-benefit at age 40 years showed an increase in return of \$5.74 over the cost-benefit analysis conducted at age 27 (Schweinhart et. al, 2005).

The Carolina Abecedarian Project studied the impact of quality of early childhood experiences on 111 African American children who received from born between 1972 and 1977 in North Carolina. Like the Perry Preschool Project before it, this project is a longitudinal project which continues to assess participants into their adulthood. The project participants were randomly assigned to one of four groups: those who participated in the preschool component only, those who participated in the school-age component only, those who participated in both the preschool and school-age components of the project, and those who did not participate in any educational components of the study. In contrast to the Perry Preschool Project, participants of the Carolina Abecedarian Project were selected in infancy and participated in a high-quality, full-day, full year program. Additionally, one-half of the participants from the preschool group received support and services through the first three years of elementary school.

Campbell et. al (2002) found that those children who were enrolled in the preschool component of the project scored higher on math and reading scores than did those who were not enrolled in any component of the project or were enrolled only in the school-age component. These findings were consistent for children who participated in the preschool component alone or in conjunction with the school-age component of the project. Participation in the school-age component of the project was found to reinforce skills reading skills gained during the preschool

component, but did not significantly impact reading skills in isolation (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002).

More recently, the National Institute of Child Health and Human Development (NICHD) embarked on the largest longitudinal study of children, to date (The NICHD Early Child Care Research Network, 2005). Since 1991, the NICHD Study of Early Care and Youth Development has followed the experiences of over 1,300 children at 10 sites across the United States. The first phase (1991-1994) of the study examined the children's first three years of life. The second phase (1995-1999) of the study examined the children's preschool and early elementary experiences, through first grade. Additional phases of the study go beyond the scope of this study and will not be addressed here. Positive caregiving (such as positive regard, sensitivity, and responsiveness toward the child) and frequency of language stimulation were positively associated with cognitive and language development gains during the children's first three years of life. More specifically, children who experienced positive caregiving scored higher on both the MacArthur Communicative Development Inventory (CDI) and the Reynell Developmental Language Scales (RDLS) at 15 and 36 months. At 24 months of age, children who had experienced positive caregiving and frequent language stimulation scored higher on components of the Bayley Scales of Infant Development and the CDI (The NICHD Early Child Care Research Network, 2005).

The NICHD study also examined the family characteristics, child care experiences, child health, and child development characteristics of children living in poverty as compared to children just above the poverty line and those whose families were considerably above the poverty level. This component of the NICHD study found that cognitive and socioemotional development of the children "bore a strong relation to poverty and its factors" (p. 137). After

accounting for income in their analysis, researchers found that quality of care was positively related to cognitive and language development at three years-of-age for those children whose families lived at or near the poverty level. Although center-based care was the most frequent child care arrangement experienced by children of all three income levels, 30% of children from families at the poverty level experienced relative child care. Relative child care was utilized nearly half as frequently for children near the poverty level (18%) and even less for those above the poverty level (11%). In summary, this research in general demonstrates a long term relationship, both through controlled interventions and naturalistic observations between the quality of the child care environment for the infant and preschooler and the child's subsequent development from elementary school through young adulthood. Thus given the funds invested in child care for children at or below the poverty level, the benefits of experiencing quality child care environments prior to formally entering school, and the prevalence of relative child care usage among low-income and families of color, the impact of relative child care is an area of concern for researchers and policy makers.

Relative Child Care: An Overview

Across the United States, over 45% of children in a regular child care arrangement of some kind are in the care of a relative other than their mother, father or a sibling, while their parent(s) are at work or at school (U. S. Census Bureau, 2005). In concrete numbers, that percentage of children equates to nearly 5.5 million children under the age of five, with over 4 million of those children in the care of a grandparent. In contrast, 55% of children regularly experience non-relative care, including center-based care, family child care, or individual in-home care, such as a nanny. The percentage of children who are regularly in the care of a grandparent (36.04%) is nearly identical to that of children who are regularly in the care of a

center-based care facility (36.20%). While a child can experience multiple care arrangements, these demographics attest to the prevalence of relative child care among children prior to their entry into kindergarten.

A closer examination of the demographics of these children is possible by looking at the National Survey of America's Families (NSAF). The NSAF was conducted by the Urban Institute in three rounds; 1997, 1999, and 2002 and gathered information from 40,000 families across 13 states in an effort to allow researchers to identify and follow trends among low-income families and their children. Findings from various waves of this multi-wave survey have informed two major papers in the area of informal child care. The 1997 NSAF findings were included, among other survey studies, in *Kith and Kin- Informal Child Care: Highlights from Recent Research* (Brown-Lyons, Robertson, and Layzer, 2001). The 1999 NSAF findings resulted in a discussion paper written by Kathleen Snyder and Sarah Adelman, *The Use of Relative Care while Parents Work*. Brown-Lyons et al.'s examination of the 1997 NSAF data revealed that 76% of children under the age of 6 were in some form of non-parental child care during the course of the survey, 30% of which were in the care of a relative. Snyder and Alderman's analysis of the 1999 NSAF data found infants and toddlers (children under the age of 3) to be more likely to experience relative care than older children (35%), either alone (28%) or in combination with other forms of child care (7%). Preschool aged children (those at least 3 years of age, but not yet having entered school) were only slightly less likely to experience relative child care (32%) but more likely than infants and toddlers to experience relative child care in combination with another form of care (13%) (Snyder & Alderman, 2004). Additionally, while there were no statistically significant differences between the percentage of infants and

toddlers in exclusive relative care based upon family income, there were significant differences based on family income for preschoolers, 6-9 year olds and 10-12 year olds.

Furthermore, statistically significant differences were found between white children and families of color for all age groups experiencing any relative child care, exclusive or otherwise (Snyder & Alderman, 2004). African-American and Hispanic infants and toddlers were more likely to be in any amount of relative care (43% and 43%, respectively) and exclusive relative care (35% and 39%, respectively) than their white counterparts where 32% of white children under three were in any form of relative care and 25% in exclusive relative care. The racial and ethnic differences among parents who utilize relative child care may account for the 1997 data which revealed the use of relative child care varied from state to state, with 18% of Minnesota families responding to the survey reporting the use of relatives for the care of their young children as compared to 39% of California families. Single parents were also more likely to utilize relative child care than families with two parents in all age groups and amounts of care (exclusive or otherwise) with one notable exception; the trend for families with younger children to use exclusive relative care ameliorated any statistical differences based upon number of parents in the household for those children under 3 in exclusive relative care (Snyder & Alderman, 2004).

The National Survey of Families did not gather data on the relatives who provide care to the children of families who participated in the survey; therefore two studies will be examined in an effort to identify key characteristics of these providers. In a groundbreaking examination of informal in-home based child care settings the relative care study participants as predominantly of color (37% African American and 33% Latino), most often without a high school education (46%), low-income themselves (65% with less than \$20,000 annual household income), and

most frequently married or living with a partner (Kontos, Howes, Shinn & Galinsky; 1995). These providers were also significantly older than their regulated and non-regulated, non-related study peers with a mean age for relative caregivers of 52.9 years and a mean age of the overall participant sample of 42.4 years. During field tests of a new assessment instrument, the Child Care Assessment Tool for Relatives (CCAT-R), Porter, Rice & Rivera (2006) conducted observations in 92 relative child care settings in four states; California, Arizona, Illinois and New York. Over half of the field test participants (52%) were Latino, while 26 and 21% identified their ethnicity as European American or African American, respectively. Most of the relative care providers observed were grandparents (55%), while 36% were aunts or uncles of the children in care. When compared to participants of the 1995 Kontos et al. study, more participants of the CCAT-R field tests reported having completed high school or the equivalent (85% of those reporting education levels).

Beyond these studies of caregivers who provide relative child care, additional studies provide data on the motivating factors for those who provide relative child care. In Porter's initial qualitative research (1998) on this population identified a variety of reasons given by the 45 focus group participants from Bronx, New York. Helping their daughters or sons (or other relative) and watching the children as they grew were among the most common motivational factors. In their research on Family, Friend and Neighbor (FFN) care providers in Washington, Brandon (2005) found that the primary motivation for a majority of caregivers (57%) was helping out family members, while 24% reported enjoying being with children as a motivating factor. Few participants (4%) in this study identified earning money as their primary motivating factor, though 40% received payments from some source.

In terms of organizational structure or licensure status, states establish independent standards regarding which levels of home-based child care require licensure. In Kansas child care in the child's home never needs licensure and is considered a private matter between the child's parents and the child care provider. Child care in the provider's home is also exempt from licensure if all of the children in care are the relatives of the child care provider (Kansas Department of Health & Environment, 2007, K.S.A. 65-517).

The unique nature of relative child care was summarized best by Kontos et al. in their seminal study on home-based child care. In examining the participant demographics, motivation and organizational structures of the participants in their study the researchers state, "These data confirm the existence of three distinctively different types of providers: regulated providers, non-regulated providers, and relative providers" (Kontos et al., 1995, p. 61).

Research Perspectives on Relative Child Care

Research on relative child care arrangements has typically followed one of two distinctly different viewpoints: a family support perspective (Jayakody, Chatters & Taylor, 1993; Taylor & Roberts, 1995; Unger & Powell, 1980) or a developmental, quality of care perspective (Kontos, Howes, Shinn, & Galinsky, 1995; Loeb, Fuller, Kagan, and Carrol, 2004; The NICHD Early Child Care Research Network, 2005; Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Porter, 1998; Porter & Rice, 2000; Porter, Rice & Mabon, 2003; Porter & Kearns, 2005; Porter, Rice & Rivera, 2006; Porter, Rice, Kearns, & Mabon, 2007; Raikes, Raikes & Wilcox, 2005; and Tout & Zaslow, 2006). Early research on relative child care situations focused on family support or social network aspects of these arrangements. More recent research on relative child care situations have focused on the provision of child care and child care quality in these settings. Bronfenbrenner's ecological systems theory of development, in which the individual

develops through the direct and indirect influence of various systems, has frequently been applied to understand these relationships (1979). Based on Bronfenbrenner's theory, it is also not surprising that difficulties in examining these settings have arisen.

Family Support Perspective

Early research on the topic of relative child care focused on the influence of social support networks in general, with child care described as one of many forms of support provided to families in need by other family members (Jayakody, Chatters & Taylor, 1993; Taylor & Roberts, 1995; Unger & Powell, 1980). Although the child is in the direct care of the relative, studies of relative child care conducted from the family/social support network perspective examine the indirect influence of, or support to the child's development, through the relationships between relatives and the child's family of origin. Applying Bronfenbrenner this direct form of developmental support for the child is found in the mesosystem (the system that contains the relationships between elements of the microsystem).

Applying the Family Stress Theory, originally conceptualized by Hill (1949) to their research, Unger & Powell (1980) identified three main support mechanisms provided by family support networks: instrumental, emotional, and referral. Instrumental support consists of "material goods and services" (Unger & Powell, 1980, p. 569), while emotional or social support involves the transfer of feelings of love, affection and esteem between network members. The third form of support identified by the study revolved around the dissemination of information or advice from the older members of the family to the younger generation.

Although on the surface it would appear as though the provision of child care is a strictly instrumental form of assistance, two studies suggest that relative child care also serves as a potential emotional support to mothers and children. In the literature review for their study,

Unger & Powell (1980) cite Unger's unpublished master's research in which "mothers who experienced high levels of stress were found more likely to be actively involved with their infant when they had weekly contact with kin and friends than when they were infrequently in contact" (p. 567). Furthermore, in a study involving 51 economically disadvantaged African American families with adolescents (ages 15-19 years) Taylor & Roberts (1995) tested a conceptual model depicting the hypothesized relationship between kinship support and maternal and adolescent well-being. Although not early childhood, the effects of kinship support on adolescent well-being were found to be mediated by maternal well-being and positive parenting practices. Follow-up research based upon these studies regarding the impact of family support on child outcomes is warranted.

Furthermore, using data from the National Survey of Black Americans, Jayakody, Chatters and Taylor (1993) examined the financial, emotional and child care assistance provided to the single and married African American mothers who participated. The National Survey of Black Americans (NSBA) data used in this study was gathered in 1979-1980 through a multistage probability sample of African Americans in the continental United States who were 18 years and older at the time of the survey. The data analysis conducted by Jayakody et al. (1993) examined a subset of the survey responses provided by mothers of at least one minor child who resided with the respondent mother at the time of the survey. These mothers were grouped by their marital status for analyses as follows: currently married, divorced/separated, widowed, or never married. Most mothers reported living in close proximity to their families, having daily contact with kin, and feelings of closeness to their family. In contrast to emotional support which most mothers reported receiving regardless of their marital status, never married mothers were more likely to receive financial and child care support, though at lower levels than

researchers had initially expected (24.2% and 18.8%, respectively). In summary, this research exemplifies the family support perspective which viewed relative child care as an indirect influence on the lives of young children, through the direct support of their mother.

Child Care Quality Perspective

Research on relative child care conducted since the enactment of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193) has shifted from that of a family support perspective to relative care as a separate and unique form of child care. The child care quality perspective was adopted primarily as a consequence of an increasing concern regarding school readiness nationwide examining of all forms of pre-kindergarten experiences including informal child care settings, such as relative child care homes, particularly those serving low-income families (Porter & Kearns, 2005; Kreader & Lawrence, 2006; Maher 2007). Several key studies have attempted to directly measure quality of care in relative care settings or have measured quality as a means of evaluating support programs serving the low income. The methodologies used across these studies have varied, most notably in terms of the breadth of populations included in the studies and the measurements used within the studies.

Methodologies

Study populations

Research studies involving relative child care providers vary in terms of the composition of the study population; that is, whether or not relative child care providers are examined alongside center-based care, regulated family child care and/or informal, unregulated family child care environments. Loeb, Fuller, Kagan, and Carrol (2004) and the authors of The NICHD Early Child Care Research Network (2005) examined center-based and home-based child care.

Relative child care settings were included within their sample of home-based care. In contrast, Kontos, Howes, Shinn, & Galinsky (1995) separated relative care by comparing regulated and unregulated (relative) home-based care in their landmark study of home-based child care quality. Raikes, Raikes, and Wilcox (2005) also examined both regulated and unregulated home-based child care settings in their study of care in four midwestern states. Both studies assessed relative child care providers within the same context as unregulated homes operated by caregivers unrelated to the children in their care. The National Study of Child Care for Low-Income Families also assessed relative child care settings within the same study as regulated family child care homes and unregulated, unrelated home-based care settings. More recently, kith and kin care (unregulated care, provided by either a caregiver that is either related to or unrelated to the child in care) has been studied in Tout & Zaslow's examination (2006) of family, friend and neighbor providers in Minnesota and the evaluation of the Early Head Start Enhanced Home Visiting Pilot Project conducted by Paulsell, Mekos, Del Grosso, Rowand, & Banghart (2006).

Measurement of quality

The measurements used to assess quality of care in relative care settings varied across studies provoking questions about the validity of the instrumentation when applied to relative child care. Kontos, Howes, Shinn, & Galinsky (1995), Loeb, Fuller, Kagan, and Carrol (2004) and Raikes, Raikes & Wilcox (2005) each used the Family Day Care Rating Scale, (Harms & Clifford, 1989) in their examinations of child care settings. The Family Day Care Rating Scale (FDCRS) was developed to assess the quality of care in *regulated home-based care settings*. Although the FDCRS has been revised in recent years and is now known as the Family Child Care Environment Rating Scale-Revised (Harms, Clifford, & Cryer, 2007) the original scale when these studies were conducted included 40 structural and process items divided into 8

subscales; space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children. Each item was rated using a seven point, criterion-referenced scale. Subscale scores ranging from 1 to 7 are averaged to find an overall score. Settings in which the average score is 1 are described as providing inadequate care. Average scores of 3 and 5 are found in settings providing adequate/custodial care and good care, respectively. A child care setting with an average score approaching the maximum score of 7 is described as providing excellent care (Harms & Clifford, 1989).

Another measurement tool used in early research on the quality of child care in relative child care homes is the Child Care Home Observation Measurement of the Environment (HOME). The first phase of the NICHD study utilized the Child Care HOME to assess the quality of all home-based child care homes. This tool is itself an adaptation of the Home Observation Measurement of the Environment (HOME) (Caldwell & Bradley, 1984). Since its initial development, the HOME has been adapted for use in homes of infants and toddlers (0-3 years), young children (3-6 years), middle childhood (6-10 years), early adolescents (10-15 years), homes with children with disabilities, and in child care homes (HOME Inventory, 2009). The HOME consists of an observation of the child's home or caregiving environment and an interview with the parent or caregiver. The two components of the instrument (observation and interview) are conducted over a 45-90 minute period. During the observation, items are scored using a yes/no format based on observed interactions, behaviors, and materials. The Infant/Toddler version of the instrument includes six subscales: responsiveness, acceptance, organization, learning materials, involvement, and variety in activities. The Early Childhood version of the tool includes eight subscales: learning materials, language stimulation, physical

environment, responsiveness of parent to child, academic stimulation, modeling, variety in daily stimulation and enrichment, and acceptance. The Child Care adaptation of the tool is also age specific and utilizes the same subscales as the home-based Infant/Toddler and Early Childhood tools (U.S. Department of Health & Human Services, 2011).

After using the Child Care HOME during the first phase of the NICHD Study of Early Child Care and Youth Development the study authors developed the Observation Record of the Care Environment (ORCE) for the second and subsequent phases of the longitudinal study. The authors' developed the ORCE as a means of assessing quality from the perspective of an individual child stating, "the best evaluation of quality of care comes from observations of the child's actual experiences in the care arrangement" (NICHD, 2005, p. 80). The ORCE consists of frequency counts of caregiver and child behaviors and a rating scale used for coding the caregiver's behavior. As the tool was developed for the NICHD study, it is not yet readily available for use by researchers outside of the study.

Other researchers have also developed assessment tools for the specific needs of their study. The National Study of Child Care for Low-Income Families (Layzer & Goodson, 2006) developed a child care quality assessment tool for use in regulated and unregulated child care homes serving low-income families. Influenced by the accreditation standards of the National Association for Family Child Care and recommendations for out-of-home care by the National Research Center for Health and Safety in Child Care, the tool includes observations of the environment, caregiver-child interactions, and a caregiver interview.

Tout & Zaslow (2006) encountered difficulties utilizing the Family Day Care Rating Scale (Harms & Clifford, 1989) in their examination of kith and kin care providers in Minnesota. Pilot observations revealed that the FDCRS was "capturing many of the concerns but few of the

strengths in FFN care settings.” In response, the researchers developed their own assessment tool based on tools used in the National Study of Child Care for Low Income Families (Layzer & Goodson, 2006).

During the summer of 2004, the Office of Head Start provided funding to 24 Early Head Start programs for the implementation of the Enhanced Home Visiting Pilot Project. This project aimed to support the quality of care provided to infants and toddlers enrolled in Early Head Start. The evaluation of the pilot project focused on assessing quality of care in kith and kin settings, as well as other project specific components such as strengthening parent-child relationships (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006).

In an attempt to evaluate the pilot project and answer the associated research questions, the Paulsell et al. conducted individual interviews with program staff members, parents and caregivers. Additionally researchers conducted in-home observations in a random subset of the kith and kin caregivers at 12 of the 23 pilot sites (N=74) using the Child Care Assessment Tool for Relatives (CCAT-R) and completed 78 thirty-minute individual interviews with these caregivers. The CCAT-R, described in more detail in this and subsequent chapters, was developed by researchers at Bank Street College of Education in response to their qualitative research with family, friend and neighbor caregivers (Porter, 1998; Porter & Rice, 2000; Porter, Rice & Mabon, 2003; Porter & Kearns, 2005; Porter, Rice & Rivera, 2006; Porter, Rice, Kearns, & Mabon, 2007).

In order to obtain the sample population for the Early Head Start Enhanced Home Visiting Pilot Project, eight caregivers were randomly selected from 10 of the 23 pilot sites. At an additional 2 pilot sites, only seven caregivers were enrolled therefore all eligible providers were invited to participate. Alternate caregivers were then selected as necessary to replace those

from the original list who refused to participate in the in-home observations. In fact, the refusal rate was high (45% of providers initially selected for participation) despite \$40 incentive. Those who refused justified this decision to observers that they felt they were too busy to participate or that the observations would be an intrusion into their daily routine.

Similar to the population of the child care field, in general, the overall caregiving population of the pilot project was predominantly female (84%). In terms of racial and ethnic representation, more than 70% of the pilot project participants were white, 15% were Hispanic and 6% were African American. Socioeconomically, not all caregivers lived in poverty, though many did have low incomes. Researchers did report some notable demographic differences between the entire pilot project population and the providers who participated in the in-home observations. Two-thirds of caregivers enrolled in the entire pilot project were relatives with nearly half of those being grandparents, while over three-fourths of the in-home observation participants were relatives. The in-home participants were also older ($M = 44$ years of age) than the full population ($M = 41$ years of age).

With regards to the caregiving arrangements of the entire pilot project population, care was most often provided at the caregiver's home (64%) with care occurring at the child's home (19%), both homes (13%), or at multiple locations (4%) less frequently. Of the nearly 30% of participants who received some type of compensation, the most common form of payment was a child care subsidy (69%). Cash payments from the parent were received by only five percent of those receiving payments. Providers also reported receiving reciprocal child care (10%), some other form of trade (2%), or other compensation (14%). Over a quarter of providers cared for children in excess of 40 hours per week, while nearly half of providers cared for children less than 20 hours per week.

Results from the in-home interviews and focus groups were that few of the caregivers who were not already licensed or registered expressed interest in becoming licensed or registered. Most reported that they did not view themselves as “Child care providers, but as grandparents or other relatives who were helping their families” (p. 73). While most unregulated caregivers expressed little interest in licensing or registration, they did express a desire to continue caring for children with half expecting to continue to provide care as long as they were needed by the child’s parents and were physically able to do so. Participants of both in-home and focus groups expressed affection for the children in their care, with “most citing the need to help their families and their desire to spend time with the EHS child and other children as their reasons for providing care” (p. 73).

Child Development Findings

In two studies mentioned previously (Loeb, Fuller, Kagan, and Carrol, 2004; The NICHD Early Child Care Research Network, 2005) researchers have examined the link between child outcomes and quality of child care environment across the spectrum of possible child care settings. The child care environments examined for these studies included center-based settings, family child care homes, and unregulated home-based settings, such as relative child care. Loeb, Fuller, Kagan, and Carrol (2004) assessed quality of child care available to low income children and the relationship between the quality of child care and cognitive and social development. Lower levels of quality were found in home-based settings compared to center-based settings using the Early Childhood Environmental Rating Scale (ECERS) and the Family Day Care Rating Scale (FDCRS), though the authors do specify that there may be problems associated with using the FDCRS to assess kith and kin care settings. Children were assessed in two waves, with the first wave occurring when the mean age of participants was 2.5 years and

the second wave being conducted when the mean age of participants was 4 years. Cognitive gains were found in children who entered center-based care before the second wave of their assessments. These gains were also associated with stability of care (months in the setting) prior to the Wave 2 interview. However, social development between Wave 1 and Wave 2 were less stable. Researchers reported, “Point estimates indicate that children participating in FCCHs [family child care homes] exhibited more behavioral problems than those in other types of care settings, but the only statistically significant effect was that children attending FCCHs had more aggressive behaviors than children cared for by kith or kin in both waves” (Loeb et al., 2004, p. 57). The authors of this study go so far as to recommend, “as government invests more resources in child care, greater attention should be paid to the quality of care and ensuring center-based options for more families” (p. 63).

Phase I results of the National Institute of Child Health and Human Development (NICHD) study found that at 24 months of age children who were cared for in child care centers and family child care homes scored better on cognitive and language measurements than children who were cared for in other settings, such as by a relative or by someone within the child’s own home. By 36 months, when quality of care was comparable, children with early experience in child care homes and more overall experience in center-based care settings scored better on cognitive and language measures. Interestingly, positive caregiving (associated with cognitive and language gains in children) was least frequently observed in center-based settings in Phase I while in-home settings (including relative child care environments) offered the highest levels of positive caregiving. Between 15 and 36 months, however, ratings of positive caregiving rose for center-based providers and decreased for home-based caregivers. Authors theorize that children who experienced more center based care may score higher on cognitive & language measures

due to characteristics of setting (same-age grouping, for example) rather than results indicating that center based care is of higher quality than home based care, but these scores are of obvious concern given the importance of positive cognitive and language development.

Relative Child Care Quality Findings

Quality of care findings are reported in four separate categories: global quality, adult-child interactions, activities and materials, and health and safety. These categories necessary due to variation in assessment tools used in the cited studies. Only those studies which assessed quality using the Family Day Care Rating Scale (Harms & Clifford, 1989) report findings in terms of global or overall quality ratings. The remaining studies report their findings in terms of adult-child interactions, activities and materials found within the environment, and health and safety observed within the environment.

Global Quality

Relative child care providers have historically not scored well compared to other care settings on global ratings of quality, a difference likely due to the instruments used to evaluate quality. Kontos, Howes, Shinn, & Galinsky (1995) examined regulated family child care homes, non-regulated family child care homes, and relative child care providers. In the context of this study, regulated family child care homes were defined as those child care homes licensed by the state to care for related and unrelated children within their home. Non-regulated family child care homes were defined as those homes which were exempt from licensing regulations and provided care for children who were related to and/or unrelated to the child care provider. Relative child care providers were defined as those providers who care only for relatives and who are exempt from licensing regulation. Using the FDCRS, Kontos et al. (1995) found

quality levels ranging from inadequate (35%) to good (9%), with a majority of settings providing adequate/custodial care (56%). When FDCRS scores for different types of home-based settings within the study were examined independently, both regulated and non-regulated family child care providers were more likely to provide adequate/custodial care when compared to relative care providers. While regulated family child care providers were found to provide higher quality care than both non-regulated, non-relative providers and relative child care providers. In examining the processes of quality of these three different types of providers, relative care providers were found to be less sensitive, less responsive, and more restrictive than their non-relative peers. Regulated care providers cared more for children overall and more children per caregiver, therefore process quality ratings were not found to be significantly impacted by components of structural quality such as total number of children and number of children per provider. As previously mentioned, Loeb, Fuller, Kagan, and Carrol (2004) assessed the quality of care available to low income children using the ECERS and FDCRS nearly a decade after the research of Kotos et al (1995). Of the three types of care assessed (center-based care, family child care homes, and relative care providers), the lowest levels of global quality were observed in relative care provider settings.

Adult-child Interactions

Examinations of the interactions between relative care providers and the children in their care reveal both strengths and areas of weakness. In examining the processes of quality, the three different types of participants in their study Kontos et al. (1995) found relative care providers to be less sensitive, less responsive, and more restrictive than their non-relative peers. Regulated care providers cared more for children overall and more children per caregiver, therefore process quality ratings were not found to be significantly impacted by components of

structural quality such as total number of children and number of children per provider (Kontos et al. 1995).

Layzer and Goodson (2006) found generally positive caregiver-child interactions in all care settings involved in their study. Those providers who cared only for relative children scored 2.7 (on a 3 point scale) on both “caring and responsive behaviors” and “positive guidance and discipline” (p. 83). Use of positive guidance techniques was slightly more frequently observed in these settings than in the overall population (average score 2.6). Relative providers scored 2.8 on supervision and monitoring of children’s behaviors, though this was slightly lower than the overall average score of 2.9. Providers were rarely observed causing harm, scoring 2.8 out of 3.0 on the “causes no harm” quality indicator.

Observations of family, friend & neighbor (FFN) providers in Minnesota (Tout & Zaslow, 2006) identified both strengths and areas of weakness in the interactions between providers and the children in their care. Findings were aggregated, with no differentiation between non-related providers and relative child care providers. Participants were observed using adequate supervision for the focus child’s age and were not observed using harsh words. Furthermore, these providers were found to be responsive, affectionate and warm. However, providers also missed opportunities to engage children in talking about their feelings (particularly when the child was upset) and missed opportunities to promote and facilitate pro-social behaviors such as sharing and turn-taking.

In their evaluation of the Early Head Start Enhanced Home Visitor Pilot Project, Paulsell, Mekos, Del Grosso, Rowand, & Banghart (2006) describe their findings on the CCAT-R observation measures “as a percentage of the total observation periods (up to 60 20-second observation periods)” (p. 84) in which that type of interaction was observed. The researchers

took this approach) because the CCAT-R is a new measure and there is no clear consensus in the child care research field on how to assess quality of these settings. Their analyses focused on four types of interactions: caregiver and child language, caregiver engagement, child engagement, and caregivers' nurturing and harsh behaviors. Observations of caregiver and focus child interactions were positive. Caregivers were observed speaking to the focus child in almost 70% of observation periods, while the focus child talked or vocalized to the caregiver in over 45% of observation periods. Children were also observed engaging in self-talk and talking or vocalizing with other adults or other children equally (11% of observations each). Furthermore, in a majority of observation periods (85%) the caregiver's predominant tone was engaged. The most commonly observed caregiver behaviors were encouraging concept learning during 41% of observation periods. A high proportion of observation periods included caregiver activities such as encouraging experimentation with an object (34%), encouraging independence or autonomy (32%), and demonstrating how to do something (32%). In the area of nurturing and harsh behaviors, caregivers were observed engaging in nurturing behaviors such as kissing or holding the focus child in 50% of observation periods. Conversely, caregivers rarely (5% of observation periods) interacted with children harshly. Of those negative interactions, the most common classification was ignoring the child (4.1%). The researchers qualify their findings by stating that as a descriptive evaluation, the evaluation "cannot provide estimates of the pilot's impact on the quality or other characteristics of the kith and kin child care arrangements" (p. 68). The observed homes were randomly selected, not selected to be representative of the population, but selected homes had the right to refuse to participate in the in-home observation. Therefore, the results of the observations may overestimate quality as those who provide lower quality care may be more likely to have refused to participate in the observations.

Activities and Materials

In their examinations of family, friend and neighbor care environments, Tout & Zaslow's observations revealed children engaged in one or more of the following: making music, dancing, or moving to music and exploring shapes and sounds in one-third of all settings. Basic art materials were consistently observed in almost half (46%) of settings (Tout & Zaslow, 2006). Children were consistently encouraged to look at or read books on their own in nearly half (46%) of settings; however, only 32% of settings were found to display consistent evidence of at least 10 age-appropriate children's books. In addition to concerns regarding the availability of age-appropriate literacy materials, Tout & Zaslow's observations raised concerns regarding the use of television in care settings. Although inappropriate programming was not observed, the television was frequently on (21-100% of the Snapshot Intervals) in 55% of care settings. While the number of settings in which the children were actively watching the television was 27.6%, researchers reported great concern over participant providers' inattention to limiting screen time among the children in their care. These findings are echoed by the National Study of Child Care for Low-Income Families (Layzer & Goodson, 2006) where less than half of homes had at least 10 children's books and only 57% had basic art materials. These findings were consistent regardless of type of child care home. In examining ratings for interactions which supported cognitive skills, those participants who cared only for children related to them were slightly less likely to be involved with children (2.2 on a 3 point scale compared to the overall average of 2.3) and less likely to provide learning activities (2.0 compared to the overall average of 2.2).

Paulsell et al. (2006) found more than half of homes which participated in the Early Head Start evaluation process contained all of the materials on the Child Care Assessment Tool for Relatives (CCAT-R) Infant/Toddler Materials checklist. Soft materials and soft toys like

dolls or stuffed animals were available in nearly every home observed (99% and 96%, respectively). Toys that promote motor development were found in 90% of homes, while pretend play materials and push/pull toys were each found in 88% of homes. One concerning finding, beyond health and safety issues, was the lack of literacy based interactions between caregivers and children. While nearly all (96%) of homes were observed to have at least one children's book and project participants had access to lending libraries of children's materials and books, caregivers and children interacted with printed materials in only 15% of observation periods and told stories/rhymes or sang in only 11.6% of observation periods.

Health and Safety

The National Study of Child Care for Low Income Families found the family child care homes (both regulated and unregulated) to be safe, on average. For providers who were related to all children in their care, observations revealed the most common safety concern was the lack of posted fire emergency procedures (95%). The next most common safety concern for relative providers was lack of sufficient numbers of fire extinguishers. Other notable safety concerns included the presence of unsafe materials in unlocked, lower kitchen cabinets (66%) and insufficient numbers of smoke detectors (40.7%) and first aid kits (35%). Minnesota family, friend & neighbor care providers homes were observed to have the same types of safety problems (Tout & Zaslow, 2006). The most concerning health/safety observations from this study included children's access to hazardous materials in lower kitchen cabinets or shelves, electrical outlets without safety covers, or inconsistent or non-existent hand-washing on the part of the provider and/or the children. Using the Infant/Toddler Health & Safety Checklist component of the CCAT-R, Paulsell et al. found only 11% met all criteria for "red flag" items (no immediate threats). Three red flag items were commonly observed: only 40% of observed

homes had secured electrical cords, while only 30% had safety caps on electrical sockets, and 23% had dangerous substances (such as cleaning supplies) locked up or out of reach of children. Ironically, these same red flag items were the most commonly observed red flag items during the CCAT-R field tests (Paulsell et al., 2006).

These studies provide some evidence to suggest that the quality of the environment and interactions within relative child care is lower than that of other forms of care, however, there is some question regarding the validity of the application of scales designed to assess quality in home-based environments to the relative child care environment. Such instruments as the FDCRS and HOME may not capture the unique elements of the relative care and thus may not be valid in such circumstances. Despite the potential instrumentation discrepancies, such findings are of concern, particularly when research has clearly demonstrated the quality of experiences prior to entry into kindergarten affect child progress in kindergarten and through early elementary years.

Relative Child Care and Child Care Subsidies

One of the questions of this research is whether or not the presence of the subsidy payment impacts the quality of the child care environment, therefore an overview of child care subsidies provides additional context to the question. Child care fees paid by parents were subsidized under the federal law, Aid to Families with Dependent Children (AFDC), the predecessor to the current child care subsidy program. As interest in family, friend, and neighbor child care (to include relative child care) providers as a form of child care emerged with the passage of 1996's Temporary Assistance to Needy Families (TANF), this overview will limit itself to TANF child care subsidies.

Under the auspices of the Temporary Assistance to Needy Families (TANF), the federal government passes money to each state through block grants. States have broad discretion to distribute those funds to needy families through programs and services that achieve the law's purposes. The two purposes most closely related to child care subsidies are to provide assistance to needy families so that "children may be cared for in their own homes or in the homes of relatives" and "to end needy parents' dependence on government benefits by promoting job preparation, work, and marriage" (Greenberg, Levin-Epstein, Hutson, Ooms, Schumacher, Turetsky, and Engstrom, 2002, p. 28). Each state authorizes an agency or government department to administer funded programs. In the state of Kansas, TANF is administered by the Department of Social and Rehabilitation Services (SRS).

Through Temporary Assistance to Needy Families (TANF), the Department of SRS funds child care subsidies and quality improvement initiatives. States are required to allocate at least 4% of their funds on child care quality measures (Greenberg et al., 2002). The subsidy itself is not intended to increase quality, but rather is intended to assist low-income parents with paying for safe and developmentally appropriate child care (Kansas Department of Social & Rehabilitation Services, 2011). For the 2012-2013 fiscal year, SRS has allocated nearly \$60,000,000 child care subsidies alone. An additional \$3,000,000 has been budgeted for quality improvement projects in the state. Proposed family income guidelines for the 2012-2013 fiscal year set the upper income limit for the receipt of a child care subsidy at 185% of the federal poverty level (Kansas Department of Social & Rehabilitation Services, 2011). Low income parents may apply for a child care subsidy through the SRS website or in person at an SRS office. The subsidy may be paid to licensed child care facilities with a contract with the agency. Relative child care providers are license-exempt in the state of Kansas and may contract with the

agency upon completing a health and safety self-assessment and agreeing to abide by the agency's discipline policy.

Although the authors of the National Study of Child Care for Low-Income Families do not examine quality of care as related to the receipt of child care subsidy or payment, they do provide valuable data regarding the receipt of child care subsidy on the provision of child care. Of the 613 focus children in the study, more than three-quarters (78%) of families received a child care subsidy. Of the remaining 134 families, one-third had applied for a subsidy in the past with half of those families ($n = 27$) having received and lost their child care subsidy. Authors noted that the most common reason for the loss of a subsidy was related to the child's age and eligibility requirements related to child age. Additionally, parents, generally speaking, did not change their child care arrangements in response to the receipt of or the loss of child care subsidy suggesting that the relative arrangement was preferred form of care, regardless of subsidy.

In their assessment of child care quality in home-based care settings across four Midwestern states (Kansas, Nebraska, Missouri, and Iowa), Raikes, Raikes and Wilcox (2005) examined the impact of distal and proximal variables on the quality of care provided. Both regulated and unregulated home-based care settings were included in the 120 randomly selected sample population. Due to variations in state licensing standards, determining the number of relative child care providers across the four states is not possible, though this type of provider was not among the Kansas participants. Distal variables included child care regulations and child care subsidy density, defined as the concentration of children in care who received a child care subsidy. Proximal or provider level variables included providers' levels of education and reported annual training hours. Lower subsidy density and higher levels of provider education were positively related to sensitive caregiving, assessed using the Arnett Caregiver Interaction

Scale. Results are not analyzed by type of care due to the variety of care settings eligible for the study across the four states. Nonetheless, the finding that subsidy density was related to lower levels of caregiver sensitivity is of note given the population studied.

In contrast to the findings of Raikes, Raikes, and Wilcox (2005), results from field tests of the newly developed Child Care Assessment Tool for Relatives (Porter, Rice, Kearns, & Mabon, 2007; Porter, Rice & Rivera, 2006) indicated that caregivers who were reimbursed by the government (21%) had higher scores on caregiver engagement and nurturing than those who were not. Conversely, those who were paid by the child's family (33.7%), but not by other sources or not at all (42.4%), had higher scores on caregiver/child bidirectional communication (Porter, Rice, & Rivera, 2006). This initial research suggests that there may be a relationship between receiving a subsidy and providing care by relatives although earning money was not a primary stated motivation for care from previously cited studies.

Based on the results of two studies involving different populations (regulated and unregulated home-based settings versus unregulated family, friend and neighbor settings) and different operational concepts regarding receipt of subsidy (subsidy density versus analysis of payment), clear conclusions on the impact of the receipt of a child care subsidy on the quality of care experienced by at-risk children. Inconsistent results point to the need for further research on the impact of child care subsidies on child care quality and the unique characteristics of relative caregivers and the care they provide.

Ecological Validity and the Dual Roles of Relative Child Care Providers

In his Bioecological theory of human development, Bronfenbrenner defined the concept of ecological validity as “the extent to which the environment experienced by the subjects in a scientific investigation has the properties it is supposed or assumed to have by the investigator”

(1979, p. 29). The influence of roles, as incorporated by this theory, further complicates the examination of relative child care. According to bioecological theory a role is a “set of activities and relations expected of a person occupying a particular position in society, and of others in relation to that person” (Bronfenbrenner, 1979, p. 85). Furthermore, roles are typically identified by social position labels and are differentiated by such characteristics as age, sex, kinship, relationship, or other social position. Although research has been done on the impact of role perception on custodial grandparents, those grandparents who have assumed custody of their grandchildren (Hayslip & Goldberg-Glen, 2000; Hayslip, Henderson & Shore, 2003; Hayslip, Shore, Henderson, & Lambert, 1998), little work has been done on the role perception of grandparents (or other relatives) who provide day-to-day child care for grandchildren. In their study on characteristics of grandmothers from the United States who provide some form of child care for their grandchildren, Baydar & Brooks-Gunn (1998) used cluster analysis to identify a “typology of grandmothers” (p. 385). Two types of grandmothers, “homemaker” grandmothers (19%) and ‘young and connected” grandmothers (23%) were found to provide child care, while “remote” grandmothers (32%) and “frail” grandmothers (26%) did not. In their qualitative study of thirty Italian grandmothers who provided regular child care to grandchildren from 12 to 48 months of age, Gattai & Musatti (1999) refer to grandmothers providing child care to their grandchildren as strongly related to “social and personal expectations” (p. 35). The grandmothers of this study reported that their involvement in the daily care of their grandchildren was natural or “ultimately voluntary” (p. 39) while caring for their own children had been “naturally compulsory” (p. 39). Gattai & Musatti state, however, that “when the grandmother’s commitment rests on substantial economic grounds, it is enhanced by the fact that it corresponds to a useful role that is acknowledged within the family. It thus becomes a job” (p. 39). These

studies illustrate that relative child care providers, grandmothers in these studies, identify themselves as relative or grandmother first. This perception, on the part of the relative, is likely shared by other members of the family (the child and the child's parent), though these perceptions have not been studied to date. Gattai & Musatti's study, however, indicates that grandmothers who provide child care and receive remuneration may report viewing their role as a job as well as a relationship. The role of child care provider, potentially enhanced through remuneration, could be conceived as being embedded within the role of grandparent or relative.

Beyond these studies of the role perception of adults who provide relative child care, other studies provide additional data on the motivating factors for relatives who care for children. In Porter's initial qualitative research (1998) on this population identified a variety of reasons given by the 45 focus group participants from Bronx, New York. Helping their daughters or sons (or other relative) and watching the children as they grew were among the most common motivational factors. In their research on Family, Friend and Neighbor (FFN) care providers in Washington, Brandon (2005) found that the primary motivation for a majority of caregivers (57%) was helping out family members, while 24% reported enjoying being with children as a motivating factor. Few participants (4%) in this study identified earning money as their primary motivating factor, though 40% received payments from some source. The findings of Anderson, Ramsburg, and Scott's (2005) study of license-exempt child care settings in Illinois echoes the findings of Porter (1998) and Brandon (2005). Providers in this study included 230 relative providers and 71 non-relative providers. When the entire study population was asked to identify three major reasons for providing care the most frequently chosen reasons were: help the focal family (89.4%), enjoy caring for the child (88.8%) and help the child and family learn (87.5%). Furthermore, employment needs or desires as motivating factors were strikingly lower than

family and/or child-centered motivations. Just over a quarter of the full study respondents (26.7%) gave the need to earn money as the major reason for providing child care and 36% identified it as “somewhat of a reason.” Examining the responses of relative care providers specifically, 20% of relatives cited wanting children cared for by a family member as the most important reason they were caring for the children of the focal family. Another 18.7% of relative participants wanted to help out the focal family, while 10.9% and 8.7% cited an enjoyment of helping children in the focal family and enjoying caring for the children as their most important reason for providing care, respectively. Quality of care in relative child care homes has not been examined in relation to the provider’s motivation for providing such care.

In summary, higher levels of child care quality have been linked with positive child outcomes in studies such as the Carolina Abecedarian Project, The Perry Preschool Project and the National Institute of Child Health and Human Development study. These outcomes are of particular importance for at-risk children, such as those from families with low incomes. Younger children and at-risk children are more likely to be in the care of a relative as compared to a center-based setting. Relative care has been studied as a form of family support as well as, more recently, as a form of child care directly influencing child outcomes. It is through this recent research that researchers have developed an interest in relative child care as a unique form of child care. Concerns regarding the measurements used to evaluate quality among relative child care settings have arisen among researchers. In response to these concerns and her own qualitative research involving relative child care providers, Porter developed the Child Care Assessment Tool for Relatives (2007). Recent research on relative child care providers motivations for providing care indicate these providers are more motivated to help their family and the child than by money or other monetary benefits. Relative child care providers can and

do, however, receive payments from parents and government child care subsidies. These subsidies are not intended to affect the quality of care provided to the child directly. Researchers have begun to question whether receipt of these subsidies may enhance the quality of care received by low-income children. Initial research regarding the impact of child care subsidies on quality of care in relative child care settings has been inconclusive, however.

It is within this context that this research study examines the following questions:

1. What is the overall quality of care in relative child care homes?
2. Does the receipt of a child care subsidy predict higher quality care for children in relative child care?
3. What is the relationship between relative's attitudes about providing child care related and child care quality?
4. What is the relationship between receipt of child care subsidies and the attitudes of relative child care providers regarding the provision of relative child care?
5. What is the process that families utilize to initiate and maintain subsidized and non-subsidized relative child care arrangements?

Chapter 3 - Methods

The primary purpose of this research was to assess relationship between subsidy status and quality in relative child care environments and the process of establishing the care relationship. It is intended that the results of this study will inform policy makers, researchers & practitioners regarding the unique characteristics and perspectives of relative child care providers.

Study Design

A mixed-methods approach was chosen to gather and analyze data to address the research questions. Mixed-method designs are, as the name suggests, study designs which combine quantitative and qualitative methodology and procedures. Creswell (2003) describes six forms of mixed-method approaches differentiated by the implementation of the quantitative and qualitative procedures (sequentially or concurrently), the priority given to the two types of procedures (quantitative and qualitative), and to the timing of the integration of the two types of data. The six forms of mixed method approaches are: sequential explanatory, sequential exploratory, sequential transformative, concurrent triangulation, concurrent nested, and concurrent transformative (Creswell, 2003). This study utilized a sequential transformative research strategy.

Two distinct phases of data collection occurred. Phase One included in-home observations and interviews within the relative care environment. Phase Two included focus groups of relative child care providers conducted at public venues. Using two distinct phases of data collection is a characteristic of the sequential research strategies identified by Creswell (2003). Neither methodological approach (quantitative or qualitative) received more priority in this study than the other, indicative of the sequential transformative research strategy. The

methods of data collection implemented in this study were reviewed and approved by the Institutional Review Board of the Kansas State University Research Compliance Office prior to implementation.

Phase One

Participants

Participants were relative child care providers providing care for a child under six years of age while the child's parent(s) was at work or school (N = 24; 22 females). Participants were solicited using two different approaches. Potential subsidized relative child care providers (RCP) were identified through a process of random selection. The Kansas Department of Social & Rehabilitation Services (SRS) maintained lists of all child care providers who receive a child care fee subsidy. The Department provided lists of relative child care providers for each county included in the study. Using computer generated random numbers, providers were randomly selected based upon identification numbers included in the lists as provided by SRS. Subsidized RCPs in the sample counties received an introductory letter from SRS detailing the department's knowledge of the study. The letter also explained that the study was conducted on behalf the agency and that participation or non-participation would not impact the receipt of child care subsidies by the RCP or the child's family.

Non-subsidized RCPs are not required to be registered or licensed by the State of Kansas thus no master list of all providers in the state was available. Providers for this sample were recruited using convenience sampling methods. Recruitment flyers were distributed to local health departments, libraries, Parents as Teacher's programs, and other venues frequented by families with young children. One of these recruitment flyers prompted a reporter from the Wichita Eagle to write an article about the study, bolstering recruitment efforts. Subsequent

“letters to the editor” were published in the Manhattan Mercury, the Wamego Smoke Signal, the Junction City Daily Union, and the Marysville Advocate furthering recruitment efforts.

Snowball sampling in the form of word-of-mouth advertising among non-subsidized RCPs, subsidized RCPs and community members, was utilized to increase the pool of possible non-subsidized RCP participants.

Overall participants ranged in age between 16 to 72 years ($M = 54.5$ years); the majority (79.2%) were white/Caucasian, 16.7% were African American and 4.2% were Asian/Pacific Islander. More subsidized providers than non-subsidized providers were of African American descent, while the pool of subsidized providers contained no Asian/Pacific Islander providers. Overall, 79.2% had not earned a college degree, with 12.5% without a high school diploma, 25.0% with only a high school diploma, and 41.7% having completed some college education, but not a full degree. More subsidized providers did not complete high school than non-subsidized providers although providers with college and graduate school degrees were found in both sub-samples. The majority of the participants (88%) were either the grandparent or great-grandparent of the child for whom they were providing care, with 64% of participants maternal grandmothers. Full demographic details are provided in Table 3.1.

Characteristics of the child care setting and arrangements are detailed in Table 3.2. Care was provided most frequently in the home of the relative care provider (70.8%), although care was also observed in the child’s home (20.8%), or other locations (8.3%). Other locations included the relative child care provider’s place of employment. For example, one provider was employed as a bookkeeper for a local business and cared for her grandchildren on the business’s premises. All subsidized care was provided within the relative’s home as care by a relative cannot be subsidized if the care occurs in the child’s home. A majority of care settings (87.5%)

involved three or fewer children with the average number of children in care of 2.08 for all participant settings. Subsidized settings cared for slightly more children ($M = 2.33$) than non-subsidized settings ($M = 1.93$). Among the full sample, most focus children (74.9%) were in full time care (at least 30 hours per week) with an average of 37.6 hours in care per week. The average time spent in care for subsidized focus children was 32.9 hours while non-subsidized children were in care an average of 40.5 hours per week. Half (50.0%) of the full sample of participants received no payment for their services from any source for care provided. While 6 participants (24% of the full sample and 66.7% of the subsidized sample) were currently receiving a child care subsidy from the state of Kansas Department of Social & Rehabilitation Services (SRS), three (36% of the full sample and 33.3% of the subsidized sample) had received previously, but were not currently receiving, child care subsidies. Of those providers who received payment, those who reported government subsidy as their only form of payment received the smallest average weekly payments ($M = \$71.88$; range = \$50.00 to \$100.00) with those receiving payments from the government and the family reporting the largest average weekly payment ($M = \$143.25$; range = \$47.00 to \$239.50).

Table 3-1*Selected Demographic Characteristics of On-Site Observation Relative Care Providers*

Demographics	Full Sample	Subsidy	No Subsidy
		History	History
	N= 24	n=9	n=15
Age of relative care provider			
Under 40 years	4.3%	0.0%	6.7%
40 – 49 years	25.0%	33.3%	20.0%
50 – 59 years	33.4%	44.4%	26.7%
60 – 69 years	29.1%	22.2%	33.4%
70 – 79 years	4.2%	0.0%	6.7%
Missing/refused	4.2%	0.0%	6.7%
Gender			
Male	8.3%	11.1%	6.7%
Female	91.7%	88.9%	93.3%
Ethnicity			
White/Caucasian	79.2%	55.16%	93.3%
African American	16.7%	44.4%	0.0%
Asian or Pacific Islander	4.2%	0.0%	6.7%

Table 3-1 (continued)*Selected Demographic Characteristics of On-Site Observation Relative Care Providers*

Demographics	Full Sample	Subsidy History	No Subsidy History
	N= 24	n=9	n=15
Relationship of provider to child			
Maternal grandmother	66.7%	66.7%	66.7%
Maternal grandfather	8.3%	11.1%	6.7%
Paternal grandmother	12.5%	0.0%	20.0%
Great grandmother	4.2%	11.1%	0.0%
Other	8.3%	11.1%	6.7%
Highest level of education			
Less than a high school diploma	12.5%	22.2%	6.7%
High school diploma	2.5%	22.2%	26.7%
Some college	41.7%	33.3%	46.7%
4 year degree	8.3%	11.1%	6.7%
Graduate degree	12.5%	11.1%	13.3%

Table 3-2*Characteristics of the child care setting or arrangement*

Characteristics	Full Sample N= 24	Subsidy History n=9	No Subsidy History n=15
Location of care			
Relative care provider's home	70.8%	100.0%	53.0%
Child's home	20.8%	0.0%	33.3%
Other location	8.3%	0.0%	13.3%
Total number of children in care during observation			
1	41.7%	22.2%	53.3%
2	20.8%	33.3%	13.3%
3	25.0%	33.3%	20.0%
4	12.5%	11.1%	13.3%
Hours in care during typical week			
Less than 30	25.1%	44.4%	13.8%
30 - 50	50.1%	33.3%	60.2%
Greater than 50	12.6%	11.1%	13.4%
Missing/Refused	12.5%	11.1%	13.3

Table 3-2 (continued)*Characteristics of the child care setting or arrangement*

Characteristics	Full Sample	Subsidy	No Subsidy
	N= 24	History n=9	History n=15
Current source of monetary payment			
None	50.0%	22.2%	66.7%
Government child care subsidy	16.7%	44.4%	0.0%
Family	25.0%	11.1%	33.3%
Both government subsidy & family	8.3%	22.2	0.0%

During initial telephone call contact with randomly selected subsidized RCPs and volunteer non-subsidized RCPs, participants who verbally assented to participate were asked about the number of and ages of children in care. Information gathered about children in care during these phone calls was used to assign “focus child” status to one child. The interactions of the RCP and the focus child were the focus of the CCAT-R observation. When two or more children were in care, the focus child was intentionally selected to create two roughly equal age-specific groups of focus children, children 0-2 years-old and those 3-5 years-old. The creation of these two distinct groups was based on the different developmental needs of children in these two age groups and the potential for differences in the quality of care given to children in these two age groups. These age group differences are recognized by other valid assessment tools for child care environments such as the Infant/Toddler Environment Rating Scale-Revised (Harms, Cryer & Clifford, 2003), the Early Childhood Environment Rating Scale-Revised (Harms, Clifford & Cryer, 2004), The Home Observation Measurement of the Environment (HOME)

(Caldwell & Bradley, 1984) which has infant/toddler and early childhood versions of the original HOME and the Child Care HOME.

Measures

Quality of Care.

Quality was assessed using the using the Child Care Assessment Tool for Relatives (Porter, Rice, Kearns, & Mabon, 2007; Porter, Rice, & Rivera, 2006). In recognition of the unique qualities of the relative care environment and the need for a valid measure of this environment, Porter designed and tested the Child Care Assessment Tool for Relatives (CCAT-R) (Porter, Rice & Rivera, 2006). The CCAT-R's development is the result of the qualitative research on family, friend, and neighbor caregivers' characteristics and motivations conducted by Porter and her colleagues at Bank Street College of Education in the late 1990's and early 2000's (Porter, 1998; Porter & Rice, 2000; Porter, Rice & Mabon, 2003; Porter & Kearns, 2005). The instrument contains both process (analysis of caregiver-child language interactions) and structural (health/safety and materials checklists) components of quality. Validity for the CCAT-R was determined through observations conducted in 92 homes in four communities: Bakersfield, California; Tempe, Arizona; Chicago, Illinois and New York City (Porter, Rice, & Rivera, 2006). Participants in their study were Latino (52%) than Caucasian (26.1%) and African American (20.6%). Most caregivers who participated in the field testing of the tool were grandparents (55.4%), the majority of whom were grandmothers (95.7%). A majority of those observed had at least a high school diploma (84%), while just over a quarter had at least an associate's degree or higher. Slightly more than half (53%) were caring for a child under the age of three and 60% were caring for one or two children. Additionally, 16.5% were caring for children with special needs.

The CCAT-R includes four distinct components to assess quality: an in-home observation of behaviors, two environmental checklists, and an interview with the relative provider. Observations are conducted over a 2-3 hour time frame and involve three methods of data collection: Time sampling, environmental checklists, and an interview. Process aspects of quality related to the interactions between the caregiver and child(ren) in care “that support language, cognitive, physical and socio-emotional development” (Porter & Kearns, 2005, p. 2) are assessed through the completion of six 6-minute 40-second time sampling cycles. Structural aspects of quality related to available materials and health and safety concerns are assessed through two checklists completed in between time sampling cycles during the observation, the Health & Safety and Furnishings & Materials Checklists. Each of the six time sampling cycles includes 20 alternating periods of observing and coding. For example, during the first time sampling cycle the observer would observe for 10 seconds, then record his/her observations for 10 seconds and so on for a total of 10 observation periods. The interactions observed during the ten observation periods in the time sampling cycle are recorded on the CCAT-R Action/Communication Snapshot. The scores for each interaction item range from 0 to 10. A summary of behaviors observed over the course of the entire time sampling cycle are then recorded on the CCAT-R Behavior Checklist. The behavior items summarized on the Behavior Checklist are scored as either present or absent. Positive behaviors, such as “caregiver comforts child”, are scored as +1. Negative behaviors, such as “caregiver handles child roughly”, are scored as -1. If a behavior is not observed at all over the course of the time sampling cycle it is scored as 0.

Scores for each Action/Communication Snapshot and Behavior Checklist item are combined from each of the six time sampling cycles for an overall item score. Therefore a

minimum score of 0 and a maximum score of 60 are possible using the Action/Communication Snapshot. A minimum score of -1 and a maximum score of 0 is possible for a negative Behavior Checklist item, while a minimum score of 0 and a maximum score of +6 is possible for each positive Behavior Checklist items.

Unlike other, more commonly utilized, child care quality instruments, the Child Care Assessment Tool for Relatives does not provide a global measure of child care quality. Instead, the authors of the CCAT-R have identified four factors of quality of care: 1) Child Nurturing, 2) Caregiver engagement in activity with focus child, 3) Caregiver/child bi-directional communication with the focus child, and 4) Caregiver unidirectional communication with the focus child. Scores for each of these factors are based on independent behaviors recorded on the Action/Communication Snapshot and/or the Behavior Checklist across the six time sampling cycles. For the purposes of this study, these quality factors will be referred to as composite variables as they comprise the overall variable, quality of care.

Child nurturing.

This indicator of quality is related to the social/emotional development of young children. *Caregiver Nurturing* scores are based individual cycle totals for four Behavior Checklist items on the CCAT-R: 1) caregiver does own activity without regard for child's interests (negative behavior), 2) caregiver kisses or hugs child, 3) caregiver holds, pats or touches child, and 4) caregiver comforts child. The minimum score possible on this indicator is -6, while the maximum score possible is 18. No reliability indicator has yet been published on this scale.

Caregiver engagement.

Engaging caregiver-child interactions enhance the child's cognitive and physical development. Caregiver Engagement scores are based on individual cycle totals for five

Action/Communication Snapshot items: 1) caregiver names/labels items, 2) caregiver engages in other talk, 3) caregiver does activity with focus child alone or with other children, 4) caregiver directs focus child's activity without regard for child's interests, and 5) focus child interacts with safe materials. Three Behavior Checklist item totals across the six cycles are also included in the Caregiver Engagement score: 1) caregiver tone is smiling/laughing, 2) caregiver tone is engaged, and 3) caregiver tone is not engaged. The minimum score possible on this indicator is -6, while the maximum score possible is 123.

Caregiver/focus child bidirectional communication.

Bi-directional communication is related to language and social/emotional development of children. Scores for this indicator are based on individual cycle totals for nine

Action/Communication Snapshot items: 1) caregiver responds to focus child language, 2) caregiver requests language, 3) caregiver verbally directs focus child action, 4) caregiver repeats or builds on what child says, 5) caregiver names/labels items, 6) caregiver engages in other talk, 7) caregiver does activity with focus child alone or with other children, 8) focus child speaks to caregiver, and 9) focus child interacts with caregiver. Five Behavior Checklist items are also assessed over the six time sampling cycles and their presence or absence included in the scoring for this factor. Those checklist items are 1) caregiver tone is smiling/laughing, 2) caregiver tone is engaged, 3) caregiver tone is not engaged, 4) caregiver holds, and 5) caregiver comforts child). The minimum score possible on this indicator is -3, while the maximum score possible is 279.

Caregiver unidirectional communication with focus child.

Scores for unidirectional communication, related to language development, are based on individual cycle totals for eight Action Communication Snapshot items: 1) caregiver responds to focus child language, 2) caregiver requests language, 3) caregiver verbally directs focus child

action, 4) caregiver repeats or builds on what child says, 5) caregiver names/labels items, 6) caregiver directs focus child’s activity without regard for child’s interest, 7) focus child engages in self-talk, and 8) focus child interacts with caregiver. The minimum score possible on this indicator is -3, while the maximum score possible is 216.

The authors of the CCAT-R have identified three levels of quality of care for each factor for children 0-2 years of age (infants/toddlers) and preschoolers (children 3-5 years of age). Separate quality scales were identified through field testing of the CCAT-R. The practice is consistent with other quality assessments, for example the CC-HOME has an infant/toddler version and an early childhood version (HOME Inventory, 2009). The age-specific quality levels associated with each factor are detailed in Tables 3.3 and 3.4.

Table 3-3

CCAT-R Levels of Quality for Infants and Toddlers (0-2 years)

Quality of Care Factor	Poor	Acceptable	Good
Child Nurturing	< 7.0	7.0-11.0	> 11.0
Caregiver engagement	< 47.0	47.0-57.0	> 57.0
Bidirectional communication	< 79.0	79.0-107.5	> 107.5
Unidirectional communication	< 48.5	48.5-68.5	> 68.5

Table 3-4*CCAT-R Levels of Quality for Preschool Children (3-5 years)*

Quality of Care Factor	Poor	Acceptable	Good
Child Nurturing	< 3.0	3.0-5.0	> 5.0
Caregiver engagement	< 44.0	44.0-56.5	> 56.5
Bidirectional communication	< 77.0	77.0-108.5	>108.5
Unidirectional communication	< 39.0	39.0-61.0	>61.0

Health/Safety and Materials

The CCAT-R also includes two environmental checklists for each age group: The CCAT-R Materials Checklist and the CCAT-R Health & Safety Checklist. The Materials Checklists identify the presence of developmentally appropriate materials for children in the child care environment. The infant/toddler version for children birth up to 3 years contains 17 items: six items related to furnishings and 11 items related to materials. The preschool version for children 3-years-old and older contains 15 items: three items related to furnishings and twelve items related to materials. Items are scored as either present or absent. The Health/Safety checklist assesses generally accepted health and safety guidelines and practices, including potentially dangerous “red flag items” in the child care environment. The infant/toddler checklist for children under 3-years-of-age contains 42 items: six related to food preparation, twenty-two related to the environment, nine related to routines, and five related to outdoor play. The preschool version for children over 3-years-of-age contains a total of 33 items: three food preparation items, seventeen environmental items, eight routines items, and five outdoor play items. Items are scored as either present or absent.

Caregiver motivation

Attitudes of the relative care provider toward child care were assessed through quantitative and qualitative measures. The CCAT-R includes a 63 item interview through which the attitudes of the RCP toward child care can be examined. The interview is completed at the conclusion of the observation. In addition to the CCAT-R Caregiver Interview, individual semi-structured interviews were conducted with all participants directly observed by the researcher. The questions contained within the semi-structured interview were written by the researcher. The individual semi-structured allowed the participant to expand upon answers given during the administration of the CCAT-R Caregiver Interview providing depth and explanation to the data. Specific emphasis was placed upon caregiver perception of quality of care provided, the initiation and maintenance of the child care arrangement, participant's views of providing relative child care, participant's views of the subsidy (where applicable) and the participant's views regarding the current license-exempt status of relative care providers. These semi-structured interviews were audio-taped and subsequently transcribed by either the researcher or a senior undergraduate student participating in a research intern program. Individual interview participants were identified only by an identification number. The interview questions for these semi-structured can be found in Appendix A.

Subsidy. Payment sources were self-reported through the CCAT-R caregiver interview. Categories of payment include current state subsidy, received subsidy in the past but not currently, parent payment, other source of payment, no payment. No attempt was made to further verify receipt of payments.

Procedure

The initial plan for on-site observation/interview data collection involved using four observers, the researcher and at least three additional trained observers from local Child Care Resource & Referral Agencies (CCR&RA) servicing the counties included in the study. The researcher was trained in July 2005 on the quantitative instrument, the Child Care Assessment Tool for Relatives (CCAT-R), at Bank Street College of Education and established inter-rater reliability (above the 80% level) with the authors of the instrument. After obtaining inter-rater reliability with the authors of the CCAT-R, the researcher conducted a one-day training session on the instrument for all potential outside observers on this study. Inter-rater reliability (at or above the 80% level) between the researcher and potential outside observers was through joint observations in relative child care homes in the study area. Due to scheduling conflicts and difficulty with achieving inter-rater reliability with three potential outside observers, only one additional observer assisted in data collection. This outside observer completed only one observation. The outside observer completed all components of the CCAT-R, but the caregiver interview of that participant did not include the researcher generated interview questions. Consequently the researcher conducted all remaining observations.

In-home observations, typically lasting 2-3 hours, were scheduled at the convenience of the relative care provider during typical hours of care. Upon arriving at the home, the researcher introduced herself, reminded the participant of the purposes of the study and reviewed the informed consent documentation. Prior to the start of the first time sampling period and in between time sampling cycles, the researcher interacted casually with the caregiver and focus child in order to alleviate any apprehension regarding being observed. During time sampling periods, the observer used an audio tape player with one ear phone to listen to previously

recorded cues regarding the timing of observation and coding periods. During time sampling cycles, the researcher positioned herself in such a way as to be able to see and hear both the caregiver and the focus child. When this was not possible, the researcher positioned herself closest to the focus child in order to be able to accurately record their interactions with materials and any instances of self-talk.

Phase Two

This mixed methods study involved collection of both quantitative and qualitative data. Qualitative data was gathered on participants who consented to in-home observations in Phase One through the interview portion of the CCAT-R. Additional qualitative data was sought through focus group interviews to which all subsidized relative child care providers within the identified geographic region of the study and all Phase One participants. The purpose of these focus groups was to elicit and record the thoughts and opinions of providers who might not have felt comfortable participating in an in-home observation. Additionally, focus groups offer participants the opportunity to expand their thoughts and opinions in response to the comments of others in similar situations.

Participants

Five relative child care providers participated in the focus groups. All were currently receiving child care subsidy payments and were female. Four of the five were Caucasian, while the fifth was African American. Four were grandmothers and one was a great-grandmother. No further demographic data were collected.

Measures

Focus groups were semi-structured in nature and utilized the same semi-structured interview questions used with Phase One participants.

Procedures for Phase Two Data Collection

Five focus groups were scheduled between September 25, and October 6, 2007 in Kansas. Flyers advertising the nearest focus group session were sent to all observation/interview participants in the study, as well as all providers on the June 2007 SRS relative child care providers list. From this recruitment effort, three focus groups were conducted.

Focus groups were held in the local public libraries. Each group interview was approximately 1 hour in duration. Informed consent was obtained prior to the start of the focus group discussion. Video and audio equipment were used to record the sessions. These devices were monitored during the groups by an assistant who accompanied the researcher. Audio tapes were transcribed verbatim for later qualitative analysis, with video tapes being available for clarification. By having two formats from which to derive transcripts, the potential for missing data is reduced and reliability or credibility is increased. Focus groups were transcribed by the researcher. While focus group participants were identified by their first names during the discussion and on transcripts, pseudonyms were given for inclusion in this document.

Procedures for Phase Two Data Analysis

The researcher conducted a narrative analysis of transcribed individual and focus group sessions using NVIVO 7 (QSR International, 2006) to search for common themes in participant responses. The use of computer software designed to examine qualitative data enabled the researcher to code data efficiently. This approach also allowed the researcher to develop themes, examine frequency of identified themes, and identify connections between various themes in a manner similar to the methods used to analyze quantitative data. Outside review should not be seen as the equivalent of replication. Different researchers could identify different themes in the

same set of qualitative data, but the potential for more feasible outside review increases credibility.

Creswell recommends a number of techniques to ensure the accuracy of qualitative data analysis. To that effort, this study employ triangulation, peer debriefing, and an examination of researcher bias and positionality. Triangulation, the use of differing data sources to verify themes identified in the qualitative data, was employed through the bidirectional comparison of individual and group qualitative data collected during the study. Peer debriefing involves the use of an outside reader to review and ask questions about the qualitative data “so that the account will resonate with people other than the researcher” (Cresswell, 2003, p. 196.)

The researcher and two additional professionals served as transcript reviewers. The researcher’s major professor, an associate professor in the Kansas State University School of Family Studies and Human Services, served as one of the additional reviewers. The second additional reviewer was a professional in the field with a master’s degree in early childhood special education. Peer debriefing was used with the focus groups as those discussions were less structured than individual interviews. Individual interviews were conducted using the CCAT-R Caregiver Interview, with additional questions added by the researcher on a case-by-case basis. During peer debriefing, each reviewer read the focus group transcripts identifying common themes until consensus was reached. If consensus could not be reached, the majority view (two of the three) was used and the disagreement noted.

Lastly, the researcher recognizes her own potential bias and positionality in the study. The researcher acknowledges her own positive experiences as a child in a relative child care environment may bias her views of the topic in favor of relative child care providers, while her previous professional experiences as a child developmentalist may cause her to view relative

child care settings with a critical eye, to include reporting child abuse or neglect should these be observed.

Chapter 4- Results

The purpose of this study was to examine the quality of care in subsidized and non-subsidized relative child care environments in Kansas using a mixed methods approach. The following research questions were examined:

1. What is the overall quality of care in relative child care homes?
2. Does the receipt of a child care subsidy predict higher quality care for children in relative child care?
3. What is the relationship between relative's attitudes about providing child care related and child care quality?
4. What is the relationship between receipt of child care subsidies and the attitudes of relative child care providers regarding the provision of relative child care?
5. What is the process that families utilize to initiate and maintain subsidized and non-subsidized relative child care arrangements?

Quality of Care in Relative Homes

The first research question examined overall quality of care in relative child care. During field tests for the CCAT-R mean scores were higher for those providers caring for children under three than those who cared for children three and older (Porter, Rice, & Rivera, 2006). As a result, separate levels of quality were identified for these two age groups by the authors of the instrument. Therefore, mean scores were calculated separately for each composite variable for settings in which the focus child was 0 to 36 months (infant/toddler) and settings in which the focus child was 37 months to 6 years of age (preschool). Children who had reached their sixth birthday were not eligible to be observed as a setting focus child, but may have been in care during the observation.

Settings Caring for Infant/Toddler Focus Children

Fifteen of the 24 total settings observed involved infant/toddler focus children. When compared to the suggested ranges for poor, acceptable and good care established by the authors of the CCAT-R (refer to Table 3.3), the mean score for settings in which the focus child was under 36 months of age were commensurate with the highest level of quality on one composite variable of child care quality, caregiver engagement in activity with focus child (M = 68.7). The mean score for these settings corresponded to the “Acceptable” range on two composite variables, caregiver/child bi-directional communication (M = 105.3) and caregiver unidirectional communication with the focus child (M = 59.2). However, the mean score for these settings fell within the “Poor” level on child nurturing (M=5.1).

Table 4-1

Quality of care Scores for Settings Caring for Infant/Toddler Focus Children

Composite Variable	Score Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	1.0 -13.0	4.0	5.1	4.1
			Poor	
Caregiver engagement	49.0 - 90	69.0	68.7	12.4
			Good	
Bidirectional communication	55.0 – 152.0	99.5	105.3	27.0
			Acceptable	
Unidirectional communication	26.0 – 88.0	54.5	59.2	18.3
			Acceptable	

n = 15

An examination of individual setting scores provides a clearer picture of the range of quality of care experienced by infant/toddler focus children for all composite variables (Table 4-2). While the mean score for child nurturing was observed at the Poor level, slightly more than one quarter of settings (26%) scored at the Acceptable or Good level. All infant/toddler focus children received care commensurate with the Acceptable or Good levels for caregiver engagement. A majority scored at the acceptable or good level for both caregiver/child bi-directional communication with focus child (87) and caregiver unidirectional communication with the focus child (67).

Table 4-2

Percentage of Settings Caring for Infant/Toddler Focus Children Observed at each Level of Quality as Identified by the CCAT-R

Composite Variable	Poor	Acceptable	Good
Child Nurturing	73.0%	13.0%	13.0%
Caregiver engagement	0.0%	13.0%	87.0%
Bidirectional communication	13.0%	40.0%	47.0%
Unidirectional communication	33.0%	27.0%	40.0%

n = 15

Using the CCAT-R Materials Checklist for children under 3 years of age, 60% of settings caring for infant/toddler focus children were observed to have 9 of 11 materials identified on the checklist (Table 4-3). Eighty percent (80%) of settings were observed to have 6 of the 11 identified materials. Of note, nearly all (93%) of settings were observed to have books available for the children in their care. The only materials not consistently observed in settings caring for

infant/toddler focus children were sand & water materials and construction toys. While sand and water materials were found in 47% of infant/toddler settings, the most common use of these materials was in relation to bathing children in care.

Table 4-3

Materials Present in Settings Caring for Infant/Toddler Focus Children

Checklist Materials	Settings with items observed
Painting, coloring, and/or writing materials	60.0%
Pretend play materials	87.0%
Sand & water materials (e.g. cups, funnels, pots, spoons)	47.0%
Push/pull toys	60.0%
Gross motor toys (e.g. ball, crib gym, rocking horse)	87.0%
Fine Motor Toys (e.g. shape sorters or puzzles)	80.0%
Construction toys	40.0%
Dolls or stuffed animals	87.0%
Books	93.0%
Toys with music or sound	80.0%
Ride on toys	60.0%

n = 15

Most settings were found to be free of the common age-specific, potentially fatal health hazards identified by the CCAT-R Health/Safety Checklist for Children Under 3. The most common observed hazards were uncovered electrical outlets and unsecured cords for window coverings (Table 4-4). These hazards were observed in 40% of settings. Other common hazards

were less frequently observed. For example, stairways were not gated in only 13% of observed settings and infants were never observed being put to sleep on their back.

Table 4-4

Potentially Fatal Health Hazards Present in Settings Caring for Infant/Toddler Focus Children

Potentially fatal health hazards	Settings with observed hazards
Pot handles not turned to back of stove	13.0%
Electrical outlets are not covered or made inaccessible	40.0%
Electrical cords are not secured	13.0%
Relative care provider cannot see or hear children age 5 and under at all times	13.0%
Dangerous substances are not out of reach for mobile infants, toddlers, & preschoolers	7.0%
Blind cords not out of infant' reach	40.0%
Stairway gates not in use with mobile infants/toddlers	13.0%
Crib slats are not more than 2 inches apart	0.0%
Choking hazards are not kept away from infants & toddlers	7.0%
Infants under one year of age are not put to sleep on their backs	0.0%

n = 15

Settings Caring for Preschool Focus Children

Nine of the 24 total settings observed involved preschool-aged focus children. Compared to the suggested ranges for poor, acceptable and good care established by the authors of the

CCAT-R (refer to Table 3.4), the mean score for settings in which the focus child was 3 – 6 years of age corresponded to the “Acceptable” range on two composite variables, caregiver engagement with focus child (M = 47.2) and caregiver unidirectional communication with the focus child (M = 47.1). These mean score for these settings fell within the “Poor” quality of care level on both child nurturing (M = 0.1) and caregiver/child bi-directional communication with the focus child (M = 76.7).

Table 4-5

Quality of care Scores for Settings with Preschool Focus Children

Composite Variable	Score Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	-5.0 – 5.0	0.0	0.1	3.0
			Poor	
Caregiver engagement	25.0 – 81.0	47.5	47.2	17.2
			Acceptable	
Bidirectional communication	45.0 – 148.0	71.0	76.7	33.0
			Poor	
Unidirectional communication	25.0 – 108.0	42.5	47.1	25.9
			Acceptable	

n = 9

Again, an examination of individual setting scores provides additional data on the overall quality of care experienced by preschool focus children for all composite variables (Table 4-5). Unlike settings caring for infant/toddler focus children where a wider range of quality was observed, settings caring for preschool-aged children were slightly homogenous. For two composite variables (child nurturing and caregiver/child bi-directional communication), at least

two-thirds of settings scored at the Poor level. Only on caregiver engagement in activity with the focus child and caregiver unidirectional communication with the focus child did over half of settings score at or above the Acceptable level of care. One-third of settings scored at the Poor level on every composite variable, while two of the nine settings scored at the Acceptable or Good level for every composite variable.

Table 4-6

Percentage of Settings Caring for Preschool Focus Children Observed at each Level of Quality as Identified by the CCAT-R

Composite Variable	Poor	Acceptable	Good
Child Nurturing	78.0%	22.0%	0.0%
Caregiver engagement	44.0%	33.0%	22.0%
Bidirectional communication	67.0%	22.0%	11.0%
Unidirectional communication	44.0%	33.0%	22.0%

n = 9

While overall, the interactions between caregivers and preschool-aged focus children were not indicative of high quality care, children in half of all observed settings had access to ten of twelve materials identified on the age-specific CCAT-R Materials Checklist, see Table 4-7. Children in nearly three-fourths of all observed settings had access to five of twelve materials identified on the checklist. Materials most frequently observed included painting, coloring, and/or writing materials (80%), pretend play materials (100%), and fine motor toys (80%). Three of five potentially fatal health and safety concerns for preschool-aged children were identified through in-home observations, see Table 4-8. In half of all settings observed electrical cords were not secured and dangerous materials were within reach of children. In more than three-fourths of all observed homes, uncovered electrical outlets were accessible to young

children. Compared to homes in which the focus child was under the age of 3, homes with older focus children were more likely to have potentially fatal health and safety concerns.

Table 4-7

Materials Present in Settings in for Preschool Focus Children

Checklist Materials	Settings with items observed
Painting, coloring, and/or writing materials	80.0%
Pretend play materials	100.0%
Sand & water materials (e.g. cups, funnels, pots, spoons)	30.0%
Fine Motor Toys (e.g. shape sorters, stringing beads, hammer/pegs)	80.0%
Construction toys	50.0%
Books	70.0%
Toys with music or sound	70.0%
Ride on toys	20.0%
Toys that teach color, size, or shape (e.g. sorting cubes, pegboards)	60.0%
Free expression toys (e.g. play dough, clay, paints, colors)	50.0%
Toys that teach numbers (e.g. puzzles with numbers, blocks, games)	70.0%
Puzzles	50.0%

n=9

Table 4-8

Potentially Fatal Health Hazards Present in Settings: Focus Child 3-6 Years-of-Age

Potentially fatal health hazards	Settings with observed hazards
Pot handles not turned to back of stove	40.0%
Electrical outlets are not covered or made inaccessible	80.0%
Electrical cords are not secured	60.0%
Relative care provider cannot see or hear children age 5 and under at all times	20.0%
Dangerous substances are not out of reach for mobile infants, toddlers, & preschoolers	50.0%

n=9

Impact of Subsidy on Quality

The second question was: Does the receipt of a child care subsidy predict higher quality care for children in relative child care? For the examination of this question, participants were separated into four groups based upon the age of the focus child (infant/toddler versus preschool) and subsidy status (subsidized versus non-subsidized). Subsidized care settings were defined as those settings which were currently receiving or had received a child care subsidy in the past. Conversely, non-subsidized care settings were defined as those settings which were not currently nor had ever received a child care subsidy.

Settings caring for Infant/Toddler Focus Children

Descriptive statistics for subsidized and non-subsidized settings in which the focus child was an infant or toddler are provided in Tables 4-9 and 4-10. Independent sample T-tests were conducted. No statistically significant differences were found between mean scores for subsidized and non-subsidized infant/toddler care settings on any of the four composite

variables; child nurturing, caregiver engagement, bidirectional communication, or unidirectional communication (see Table 4-11). However effect sizes, as measured by Cohen’s *d*, were moderate for three of the four composite variables for infant/toddler care, caregiver engagement, bidirectional communication, and unidirectional communication.

Table 4-9

Quality of care Scores for Subsidized Settings for Infant/Toddler Focus Children

Composite Variable	Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	1.0 – 9.0	4.0	4.5	2.8
Caregiver engagement	49.0 – 86.0	65.3	64.4	14.2
Bidirectional communication	55.0 – 152.0	95.8	97.5	39.3
Unidirectional communication	26.0 – 85.0	50.8	54.3	21.8

n=6

Table 4-10

Quality of care Scores for Non-Subsidized Settings for Infant/Toddler Focus Children

Composite Variable	Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	1.0 – 13.0	4.0	5.6	4.8
Caregiver engagement	58.0 - 90.0	69.0	71.6	11.0
Bidirectional communication	82.0 – 146.0	119.0	110.4	22.8
Unidirectional communication	43.0 – 88.0	64.0	62.6	16.2f

n=8

Table 4-11

Independent Samples T-Test Comparing Subsidized and Non-Subsidized Settings for Infant/Toddler Focus Children

Composite Variable	t	df	Sig. (2-tailed)	Mean Difference	Std Error Difference	95% CI		Cohen's <i>d</i>
						Lower	Upper	
Child Nurturing	0.48	13	0.64	1.06	2.20	-3.69	5.80	0.27
Caregiver engagement	1.10	13	0.29	7.14	6.48	-6.86	21.12	0.56
Bidirectional communication	0.91	13	0.38	12.94	14.31	-17.96	43.85	0.40
Unidirectional communication	0.85	13	0.41	8.31	9.77	-12.80	29.41	0.43

n=16

Settings caring for Preschool Focus Children

Tables 4-12 and 4-13 detail the descriptive statistics for subsidized and non-subsidized settings in which the focus child was between three and six years of age. Independent sample T tests were conducted. No statistically significant differences were found between mean scores of subsidized and non-subsidized preschool care settings on any of the four composite variables (see Table 4-14.) Effect size was moderate for unidirectional communication and strong for child nurturing.

Table 4-12*Quality of care Scores for Subsidized Settings for Preschool Focus Children*

Composite Variable	Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	-5.0 – 5.0	-1.0	-0.7	3.3
Caregiver engagement	25.0 – 81.0	42.8	47.0	19.6
Bidirectional communication	45.0 – 148.0	67.8	76.5	37.6
Unidirectional communication	26.0 – 108.0	45.5	52.8	29.6

n= 6

Table 4-13*Quality of care Scores for Non-Subsidized Settings for Preschool Focus Children*

Composite Variable	Range	Median	<u>M</u>	<u>SD</u>
Child Nurturing	0.0 – 3.0	2.0	1.7	1.5
Caregiver engagement	31.0 – 61.0	52.0	47.7	15.0
Bidirectional communication	52.0 – 109.0	71.0	77.2	28.8
Unidirectional communication	25.0 – 52.0	30.5	35.8	14.3

n= 3

Table 4-14

Independent Samples Test Comparing Subsidized and Non-Subsidized Settings for Preschool Focus Children

Composite Variable	t	df	Sig. (2-tailed)	Mean Difference	Std Error Difference	95% CI		Cohen's <i>d</i>
						Lower	Upper	
Child Nurturing	-1.13	7	0.30	-2.33	2.07	-7.23	2.56	0.90
Caregiver engagement	-0.05	7	0.96	-0.67	13.03	-31.48	30.15	0.04
Bidirectional communication	-0.03	7	0.98	-0.67	24.94	-59.63	58.30	0.02
Unidirectional communication	0.92	7	0.39	16.92	18.50	-26.82	60.66	0.73

n=9

All Settings

The sample population was aggregated (i.e., infant/toddler with preschool subsidized homes) in an attempt to identify potential statistically significant differences in quality of care composite variables between subsidized and non-subsidized care settings that had not observed previously. A multivariate analysis of variance (MANOVA) was performed for the full sample, comparing subsidized and non-subsidized care settings for each of the quality of care composite variables. Despite the potential for increased power with an increased sample size, no statistically significant differences were observed (see Table 4-15). Thus, the sample was combined in further analyses.

Table 4-15*MANOVA Comparing Subsidized and Non-Subsidized Settings for All Settings*

Composite Variable	R²	Adjusted R²	df	Mean Square	F
Child Nurturing	0.00	0.04	1	1.34	0.07
Caregiver engagement	0.01	0.04	1	47.31	0.15
Bidirectional communication	0.01	0.04	1	212.37	0.20
Unidirectional communication	0.06	0.01	1	622.78	1.33

n=24; *p < .05

Impact of Relative's Attitudes on Quality

The third question focused on the relationship between relative's attitudes about providing child care related and child care quality. The Caregiver Interview component of the Child Care Assessment Tool for Relatives addresses caregiver motivations and attitudes with a series of questions. In the first set of questions, the caregiver is asked to identify all of the motivating factors which apply to their reasons for providing care from among a list of motivating factors. An examination of participant responses (infant/toddler and preschool combined) to this series of questions indicated that all providers identified wanting to be a part of the child's life and wanting to help their family as reasons that they provide care for the focus child. The least frequent reason given by the full sample for providing care was that the provider didn't have anything else to do. Only 29% of providers stated that needing money was among their reasons for providing care for the focus child (Table 4-16).

Table 4-16*Distribution of Motivations for Providing Care*

Care Attitude	Number of Affirmative Responses	Percentage of Providers Responding Affirmatively
“Want to be a part of their life”	24	100.0%
“Family asked”	13	54.0%
“Better job than another child care provider”	15	62.5%
“Want to help out family”	24	100.0%
“Nothing else to do”	3	12.5%
“Like children”	21	87.5%
“Need money”	7	29.0%
“Love the child and want to spend as much time with him/her as possible”	23	95.8%
“Other”	9	37.5%

n=24

Participants were then asked to select their main reason for providing care for the focus child from among the care attitudes they had previously selected as among their overall reasons for providing care for the child. The most common main reason, among all participants, for providing care was “I love (focus child) and want to spend as much time with him/he as possible” (36%).

Table 4-17*Distribution of Participants' Main Reasons for Providing Care*

Main Care Attitude	Number of Affirmative Responses	Percentage of Providers Responding Affirmatively
“Want to be a part of their life”	6	25.0%
“Better job than another child care provider”	2	8.0%
“Want to help out family”	4	16.0%
“Love the child and want to spend as much time with him/her as possible”	9	37.5%
“Other”	3	12.5%

n=24

In order to examine potential differences in quality of care composite variables based on caregivers' motivating factors, main motivation choices were grouped into two categories based on perceived orientation of their choice: family-oriented or child-oriented. The family-oriented group included the response, “I want to help out family.” Similarly, three main motivation choices were attributed to the child-oriented group: “I want to be part of their life,” “Better job than another child care provider” and “I love the child and want to spend as much time with him/her as possible.” Three caregivers identified “Other” as their main motivation for providing care. A review of the field notes and transcripts from these providers enabled the researcher to ascribe one response to the family-oriented group (“We want the mother to finish college”), and two responses to the child-oriented group (“She’ll only be little once,” and “I want her to know that I’m her grandmother and for that to be an important relationship for her.”). Most providers’ responses (75%) were among those attributed to the child-oriented focus.

The distribution of caregiver’s motivations across the three levels of quality (poor, adequate, and good) for each of the four composite variables (Child Nurturing, Caregiver Engagement, Bidirectional Communication, and Unidirectional Communication) is illustrated in Table 4-18. Notably, most family-oriented (66%) and child-oriented (78%) caregivers were observed demonstrating poor child nurturing. Most family-oriented caregivers (66%) were also found to have poor levels of bi-directional communication with the focus child. In contrast, child-oriented caregivers were found to display adequate or good levels of care in the areas of caregiver engagement with the focus child, bi-directional communication with the focus child, and unidirectional communication with the focus child.

Table 4-18

Distribution of quality of care levels for each composite variable by motivation orientation

Composite Variable	Poor		Acceptable		Good	
	Family	Child	Family	Child	Family	Child
Child Nurturing	4.0	14.0	2.0	2.0	0.0	2.0
Caregiver engagement	2.0	2.0	1.0	4.0	3.0	12.0
Bidirectional communication	4.0	4.0	1.0	7.0	1.0	7.0
Unidirectional communication	3.0	6.0	3.0	4.0	0.0	8.0

N=24

In order to determine if the caregiver’s motivation orientation (family-, child-oriented) impacted quality of care, as identified by the Child Care Assessment Tool for Relatives’ pre-determined levels of quality, a Chi square goodness of fit analysis was conducted for each of the four composite variables. The results of these cross-tabulations are provided in Tables 4-19 through 4-22. For the child nurturing (Table 4-19), more providers who cited a family-oriented main motivation scored at the “acceptable” level expected. More child-oriented providers were

observed in both the “poor” and “good” categories than expected. No significant differences were found between observed and expected frequencies, however $\chi^2 = 2.074$, $p > .05$).

Table 4-19

Chi-Square Goodness of Fit Analysis for Child Nurturing Composite Variable by Motivation Orientation

Motivation Orientation		Level of Quality			Total
		Poor	Acceptable	Good	
Family	Count	4.0	2.0	0.0	6.0
	Expected	4.5	1.0	0.5	6.0
Child	Count	14.0	2.0	2.0	18.0
	Expected	13.5	3.0	1.5	18.0
Total	Count	18.0	4.0	2.0	24.0
	Expected	18.0	4.0	2.0	24.0

Pearson Chi-Square = 2.07 Asymp. Sig. (2-sided) = 0.36

In the area of Caregiver Engagement with the focus child (Table 4-20), more family-oriented providers were observed at the “poor” level of care for this composite variable than expected, while more child-oriented providers were observed at the “acceptable” and “good” levels of care than expected. Again, no significant differences were identified between observed and expected frequencies $\chi^2 = 1.600$, $p > .05$).

Table 4-20

Chi-Square Goodness of Fit Analysis for Caregiver Engagement in Activity with Focus Child Composite Variable by Motivation Orientation

Motivation Orientation		Level of Quality			Total
		Poor	Acceptable	Good	
Family	Count	2.0	1.0	3.0	6.0
	Expected	1.0	1.3	3.8	6.0
Child	Count	2.0	4.0	12.0	18.0
	Expected	3.0	3.8	11.3	18.0
Total	Count	4.0	5.0	15.0	24.0
	Expected	4.0	5.0	15.0	24.0

Pearson Chi-Square = 1.60

Asymp. Sig. (2-sided) = .45

Similar results were noted in the area of caregiver/child bidirectional communication with the focus child ($\chi^2 = 4.000, p > .05$). More family-oriented providers were observed at the “poor” level of care for this composite variable than expected, while more child-oriented providers were observed at the “acceptable” and “good” levels of care than expected however the differences were not significant.

Table 4-21

Chi-Square Goodness of Fit Analysis for Caregiver/child Bidirectional Communication with Focus Child Composite Variable by Motivation Orientation

Motivation Orientation		Level of Quality			Total
		Poor	Acceptable	Good	
Family	Count	4.0	1.0	1.0	6.0
	Expected	2.0	2.0	2.0	6.0
Child	Count	4.0	7.0	7.0	18.0
	Expected	6.0	6.0	6.0	18.0
Total	Count	8.0	8.0	8.0	24.0
	Expected	8.0	8.0	8.0	24.0

Pearson Chi-Square = 4.00 Asymp. Sig. (2-sided) = 0.14

No significant differences were observed in caregiver unidirectional communication with the focus child ($\chi^2 = 4.190, p > .05$). It is noted that more family-oriented providers were observed displaying “poor” or “acceptable” levels of this composite variable than expected. In contrast, more child-oriented providers were observed at the “good” level of care than expected.

Table 4-22

Chi-Square Goodness of Fit Analysis for Caregiver Unidirectional Communication with the Focus Child Composite Variable by Motivation Orientation

Motivation Orientation		Level of Quality			Total
		Poor	Acceptable	Good	
Family	Count	3.0	3.0	0.0	6.0
	Expected	2.3	1.8	2.0	6.0
Child	Count	6.0	4.0	8.0	18.0
	Expected	6.8	5.3	6.0	18.0
Total	Count	9.0	7.0	8.0	24.0
	Expected	9.0	7.0	8.0	24.0

Pearson Chi-Square = 4.19 Asymp. Sig. (2-sided) = 0.12

Child Care Subsidies and Caregiver Attitudes

What is the relationship between receipt of child care subsidies and the attitudes of relative child care providers regarding the provision of relative child care? This question was analyzed using both qualitative and quantitative data analyses. This question does not involve quality of care component variables which are evaluated according to differing levels of quality according to the Child Care Assessment Tool for Relatives (CCAT-R) therefore data was not segregated by age group.

As previously described in this chapter, participants were asked to answer a series of questions regarding motivation and attitudes. This series of questions is a component of the Child Care Assessment Tool for Relatives Caregiver Interview. In the first set of questions, the caregiver is asked to identify all of the motivating factors which apply to their reasons for

providing care from among a list of motivating factors. The caregiver is then asked to identify one main motivating factor. Responses included the following: “I want to be a part of the child’s life,” “My family asked,” “I can do a better job than another child care provider,” “Want to help out family,” “Nothing else to do,” “Like children,” “Need money,” “Love the child and want to spend time with them,” or “Other.” More (66.7%) subsidized child care providers selected wanting to help their family as a motivating factor as compared to non-subsidized providers (46.7%). Similarly, more subsidized providers (66.7%) indicated they could do a better job than another child care provider than their non-subsidized counterparts (60%). A greater number of subsidized providers also indicated they needed payments (44.4%) associated with caring for the child than non-subsidized caregivers (20%).

Table 4-23*Distribution of motivations for providing care for the full sample and by subsidy status*

Care Attitude	Affirmative Responses		
	Full Sample	Subsidy History	No Subsidy History
	N=24	n=9	n=15
“Want to be a part of their life”	24 (100.0%)	9 (100.0%)	15 (100.0%)
“Family asked”	13 (54.0%)	6 (66.7%)	7 (46.7%)
“Better job than another child care provider”	15 (62.5%)	6 (66.7%)	9 (60.0%)
“Want to help out family”	24 (100.0%)	9 (100.0%)	15 (100%)
“Nothing else to do”	3 (12.5%)	1 (11.1%)	2 (13.3%)
“Like children”	21 (87.5%)	8 (88.9%)	13 (86.7%)
“Need money”	7 (29.0%)	4 (44.4%)	3 (20.0%)
“Love the child and want to spend as much time with him/her as possible”	23 (95.8%)	8 (88.9%)	15 (100.0%)
“Other”	9 (37.5%)	6 (66.7%)	3 (20.0%)

Participants selected the main reason for providing care for the focus child from among the care attitudes they had previously selected as among their overall reasons for providing care for the child. The most common primary reason, among all participants, for providing care was “I love (focus child) and want to spend as much time with him/he as possible” (36%) (Table 4-

24). A greater number of non-subsidized caregivers (46.7%) identified this response as their main motivating factor than subsidized caregivers (22.2%).

Table 4-24

Distribution of Participants' Main Reasons for Providing Care

Main Care Attitude	Affirmative Responses		
	Full Sample	Subsidy History	No Subsidy History
	N=24	n=9	n=15
“Want to be a part of their life”	6 (24.0%)	2 (22.2%)	4 (26.7%)
“Better job than another child care provider”	2 (8.0%)	1 (11.1%)	1 (6.7%)
“Want to help out family”	4 (16.0%)	2 (22.2%)	2 (13.3%)
“Love the child and want to spend as much time with him/her as possible”	9 (36.0%)	2 (22.2%)	7 (46.7%)
“Other”	3 (16.0%)	2 (22.2%)	1 (6.7%)

As described earlier, main motivation choices were then grouped into two categories based on perceived orientation of their choice: family-oriented or child-oriented. The family-oriented group included the response, “I want to help out family.” Similarly, three main motivation choices were attributed to the child-oriented group: “I want to be part of their life,” “Better job than another child care provider” and “I love the child and want to spend as much time with him/her as possible.” Three caregivers identified “Other” as their main motivation for providing care. A review of the field notes and transcripts from these providers enabled the

researcher to attribute responses to the family-oriented or the child-oriented group. More providers selected child-oriented motivations than family-oriented motivations among subsidized (55.5%) and non-subsidized providers (86.7%). Subsidized providers were more likely to identified family-oriented motivations for providing care (44.4%), than their non-subsidized counterparts (13.3%).

Table 4-25

Distribution of Participants' Motivation Orientation

Motivation Orientation	Affirmative Responses		
	Full Sample	Subsidy History	No Subsidy History
	N=24	n=9	n=15
Family-oriented	6 (25.0%)	4 (44.4%)	2 (13.3%)
Child-oriented	18 (66.7%)	5 (55.5%)	13 (86.7%)

In order to examine differences in motivation orientation based on subsidy status, a Chi square goodness of fit analysis was conducted (Table 4-26.) This analysis did not reveal significant differences in two areas ($\chi^2 = 2.904$, $p > .05$). More subsidized providers were observed to have family-oriented motivations than expected, while more non-subsidized providers were observed to have child-oriented motivations than expected.

Table 4-26*Chi-Square Goodness of Fit Analysis for Motivation Orientation by Subsidy Status*

Motivation Orientation		Subsidy Status		Total
		Subsidized	Non-Subsidized	
Family	Count	4.0	2.0	6.0
	Expected	2.3	3.8	6.0
Child	Count	5.0	13.0	18.0
	Expected	6.8	11.3	18.0
Total	Count	9.0	15.0	24.0
	Expected	9.0	15.0	24.0

Pearson Chi-Square = 2.904 Asymp. Sig. (2-sided) = 0.088

Motivations of Relative Care Providers and Subsidy Status

Analysis of individual and focus group interview responses indicated the presence of two primary motivations for providing care. The first was to establish and maintain a relationship with the child. Quantitative analysis of participants' answers to the CCAT-R interview indicated a clear desire to spend time with the child. Qualitative analysis of these answers revealed two major factors for those responses: the desire to replicate positive past experiences and the desire to compensate for past negative experiences. Two respondents identified the child care arrangement as a way to repeat positive experiences from their life or the lives of their children. A focus group participant and subsidized provider stated, "I just loved being a mom, myself. I loved being a stay at home mom as many years as I did it. The grandkids are a high, high priority for me." In addition to repeating positive experiences, participants expressed a desire to compensate for experiences that may have been lacking in their life or the lives of their

children. Another subsidized participant commented that her lack of a relationship with her own grandparents motivated her to want to care for her grandchild, “When I was growing up, both sets of my grandparents died when I was a year old. My parents never really spent a lot of time with my kids, neither did their dad’s parents. I’ve never known what it was like to have a grandparent, but I want to make sure my kids know what it’s like.” A non-subsidized participant stated that he had missed much of his children’s early years due to his military career and caring for his grandson provided him the chance to enjoy those experiences while bonding with his grandson and supporting his daughter’s new life, “when I was in the military I was gone 200 to 250 days out of the year. . .missing all the holidays, missing all the important things. Kids grew up so fast and I missed so much of that. This is kind of like turning the clock back 25 years. I get the chance to do it again.”

The second motivation for relatives to provide care was to support their family, either the parent of the child in their care or the child, him or herself. An examination of the CCAT-R interview responses of Phase One participants (N=25) and responses obtained during the focus groups of Phase Two (N=6) revealed that forty-six percent of participants in both phases of data collection (cumulative N=31) reported that support of the parent of the child in their care was a major motivating factor. Of these respondents, 30% reported supporting parents who were attending school, while 23% reported supporting parents with alternative work/school schedules which would have made obtaining more traditional forms of child care difficult. This motivating factor may have best been illustrated by the parents of a disabled veteran whose child care subsidy had been rescinded after she began receiving disability benefits from the Department of Veterans Affairs and returned to school. The child in this situation was in care sixty-five hours

per week due to her mother's school and work schedule. The grandparents provided that care at no cost to their daughter, the child's mother, in order to support her goal of finishing college.

“Are there any other reasons that you may be caring for her that...um... haven't been mentioned, that you would like to mention.

IT 109A: Mom can't afford day care.

**IT 109B: And we want to make sure she finishes her education. {unintelligible}
Right Grandpa?**

IT 109A: That's right.

And of those that we just talked about to include the one you added. Which one would you pick as your main reason for providing care for her?

IT 109A: I think the one that she...

That she just mentioned?

IT 109B: That we really want to make sure that Julie finishes college.”

Ten respondents identified supporting the child as a motivating factor in their decision to provide child care. Most of these respondents reported feeling that the care they provided was at least as good as, if not better than, the care the child would receive in other potential care arrangements. Three of these ten respondents identified specific past experiences with negative, negligent, or abusive care experiences in more traditional child care arrangements as motivating factors in their decision to provide child care to the child currently in care. A grandmother who cares for three of her grandchildren reported of the focus child in her care, “When I first got him, I mean it was so messed up, that they were sitting at the table and I went to serve the girls first and he started to scream like he wasn't going to get any food.”

Role Perceptions of Relative Care Providers and Subsidy Status

In an attempt to determine if subsidy status impacted role perception, participants were asked to describe the role they most closely identified with, that of child care provider or of grandparent. Of the 31 providers who participated in either Phase One (N = 25) or Phase Two (N = 6) of the study, only two participants (6%) identified him or herself as a professional child care provider and as a relative. Both of these participants were currently receiving a child care subsidy and expressed an interest in becoming licensed to care for non-relative children or to become a professional child care provider. At the time of her in-home observation and interview, one of these participants was an education major at a local university. The second, a focus group participant, has a daughter who currently works in a child care facility. This participant also commented on the difference between subsidy rates paid to regulated child care providers and those paid to relative care providers.

“FGP1.1: For me, it’s just a little bit different. The daughter that I’m living with is trying to get into operating a licensed day care, so it would be. . .the difference that you get for regular day care kids is a lot of money, I mean that’s a lot of money. She’s had three or four years into that, so I might really like that.

So, it is something that you might consider?

FGP1.1: Yes. I’ve already got my foot in the door. She’s already gone to all of the classes. All she’s lacking is mailing the licensing fee, so it a thought.”

All other participants identified themselves as a relative who was providing care, most commonly as a grandparent, whether they received a child care subsidy, payment from the family, both, or neither.

The role perception of grandparent was so strong among participants that even participants with previous experience as a regulated child care provider caring for non-relative children identified themselves as a relative, first. A subsidized relative care provider commented, “I’m his grandma. I don’t look at it as child care. I look at it as my grandkids. Also, there are a lot of people out there who do things to kids that you don’t know and it’s scary. It’s scary for me as a grandparent and for her as a mom. So we just . . . I just look at it as I’m not a daycare provider, I’m their grandma.” This grandmother had previously operated a licensed family child care (FCC) home in another town and received child care subsidies for non-related children as an FCC provider, yet she still saw herself as a grandparent, not as her grandchild’s child care provider. Another former licensed and subsidized provider specifically chose to care for relatives only after having negative experiences with non-relatives regarding payment. She stated that by viewing her services as a gift, a support family, she was able to relinquish expectations regarding payments. She asked only that relative parents pay what they could, when they could do so. These comments illustrate the absence of connection to between previous child care experiences and relative care providers self-identifying as their role in the children’s lives as a professional rather than relationship-based role.

Initiation and Maintenance of Arrangements Among All Subsidized and Non-subsidized Relative Child Care Arrangements

The final research question asked, “What is the process that families utilize to initiate and maintain subsidized and non-subsidized relative child care arrangements?” Analysis of individual and focus group interviews with all relative care providers (subsidized and non-subsidized) revealed three common, often overlapping, themes regarding the initiation of the care

arrangement and one overarching theme regarding the maintenance or stability of the care arrangement.

Initiation of Child Care Arrangements

Two initiation of child care arrangement themes were identified equitably among subsidized and non-subsidized providers: 1) whether relative care providers volunteered or were asked by family members to care for the child, and 2) sacrifices required of the relative care provider in the initiation of the child care arrangement. A third theme emerged among providers with a current or past child care subsidy, the timing of the child care arrangement in relation to the receipt of a subsidy or payment.

Forty-four percent (n = 31) of all study participants reported volunteering to provide child care for the child in their care with 24% of those participants having a history of subsidy receipt. A subsidized focus group participant who stated that her granddaughter was an unwed mother with little support from her immediate family therefore she, "couldn't see not participating, so they lived with me for a while before she found a job. Her wages are very minimal so it was a matter of economics for her and I just volunteered."

Of the non-subsidized volunteers, one grandmother of one-year-old triplets commented that she had volunteered to care for the children four days per week for a smaller amount of money than her daughter would pay for other child care arrangements, helping both the grandmother and the children's mother. "I was going to do it two days a week without pay and she was going to try to find somebody two days a week and pay them. I said if you pay me the money, I'll just do it four days a week. We just moved back to Wichita, just months before she got pregnant. I'd been busy getting the house settled so I hadn't had time to find a part time job anyway. I figured that this'll help out both of us." Another non-subsidized grandmother who

cares for the infant son of an assistant county attorney commented that she volunteered to care for her daughter's child because many of her own friends had "wonderful experiences" caring for their grandchildren.

A second theme which emerged regarding the initiation of the child care arrangement is the sacrifices relative care providers often face in these situations. As mentioned earlier, one in-home observation participant was providing care for his grandchild while her mother, a disabled veteran, worked part-time and attends college. The child care subsidy was rescinded for this family after the mother began receiving disability payments from the Veteran's Administration. Despite the loss of the subsidy and the financial burdens placed upon the family as a result, the grandparents were committed to caring for their grandchild. The child is in the care of her grandparents nearly fifty hours per week over four days though her grandparents receive no payments whatsoever. A great-grandmother who received a subsidy to care for her great-granddaughter and participated in a focus group revealed that the subsidy she receives offsets some of the financial sacrifices she has made for her granddaughter and great-granddaughter:

"She kept asking if I wanted to be paid through SRS and to me that was like, "People just don't do this. You're family." We'd been providing financially for them for a long time, but we're on retirement and we have in the past, and still continue to, buy most of her clothes. I provide breakfast and pack lunches for my granddaughter because she makes \$9.00 an hour. I thought that if I were to do this. I think I was eligible in May and I don't think my granddaughter transferred the money over to my account until September, so I just recently began receiving the stipend. I hate to take it and it's just such a minimal amount. I was just shocked. The amount that I get doesn't even begin to cover what I spend on her food and diapers, let alone anything else. I still provide clothing and two meals a day for not only my granddaughter, but one of her co-workers. Then I provide for Kenzie."

One grandmother, who had no history of receiving a child care subsidy but whose daughter & son-in-law pay for her to care for their 2-year-old granddaughter, commented that she and her husband had relocated in order for her to care for the child. "My husband and I were

in New Mexico when she asked us. She was obviously pregnant and she'd been thinking about it a lot and she asked if there was any way that Dad, my husband, could transfer back this direction if that was possible because she really wanted me to watch Tatiana, because she didn't really trust anybody else. We moved back, we did." The mother in this situation is a case-worker for the Department of Social and Rehabilitation Services, the agency in Kansas which oversees child care subsidies and child abuse charges.

The sacrifices of another non-subsidized provider were evident in the child care arrangement itself. The provider works part-time in the accounting office of a business in the 'college shopping district' in the area. The grandmother brought her two grandchildren (at the time a toddler and a preschool-aged child) to her office with her and provides care in the accounting office. The provider commented that she provides care to offset the "cost of outside child care" for her own daughter despite the need to juggle the care of the children and her own work. She stated that her employer allows the children to be on-site while she works, but that she would have left the position if he had not allowed her to do so.

A final theme, expressed specifically among those relative care providers who received a subsidy from the government, was the child care arrangement preceding the receipt of the subsidy. When asked about the child care arrangement and subsidy arrangements, one focus group participant commented, "The twelve- year-old I've cared for him or helped care for him almost his entire life. I haven't been supplemented by SRS for that care until just this past spring (2006)." She further commented that she hadn't started receiving a subsidy for providing care until she began providing care for her daughter's youngest child, an infant at the time of the focus group interview. An in-home observation/individual interview participant who received a child care subsidy echoed these sentiments in the following comment, "I was already doing for

her. It's just I wasn't getting paid for this. I think my daughter just found out about it last October, I think."

Maintenance of Child Care Arrangement Beyond the Subsidy

Due to the fluid nature of the receipt of child care subsidies, participants were asked about maintaining the child care arrangement in individual and focus group interviews. Analysis of focus group and individual interview responses revealed that providers were either currently providing care beyond the receipt of the subsidy or anticipated that they would continue to do so.

Two participants were continuing to provide care after the child in their care was deemed ineligible for subsidized care or after the child care subsidy was diverted to another child care provider. One of these providers cared for his grandchild after she was deemed ineligible for a child care subsidy due to funds her mother received from the Veteran's Administration. Another in-home observation/individual interview participant no longer received a child care subsidy for caring for her two-year-old granddaughter, despite continuing to providing care for more than 20 hours per week. At the time of the participant's in-home observation, the child had recently been enrolled in a child care center as a supplementary child care arrangement. The child's parent opted to use the child care subsidy to reduce the fees she was required to pay to the child care center.

When asked how long they anticipated providing care, few providers stated a definitive point at which they would stop providing care, short of physically being unable to do so. For example, one subsidized focus group participant stated, "*As long as she needs the help, I will be there and that's indefinite. I'm not going to put a time table on it. I'm trying to help her to get herself together. I don't know how long that's going to take, but as long as I'm here I'll help with the kids.*" A subsidized provider who participated in Phase One of the study commented

that she would “find a way” to continue providing care for the child if the child became ineligible for a child care subsidy. This sentiment was also echoed by a subsidized provider who was seeking an Associate’s degree in early childhood education from a nearby community college. This provider stated that she would “do it on her own” if the two relative children in her care were no longer eligible for a child care subsidy.

Chapter 5 - Discussion

The purpose of this exploratory study was to examine the quality of care in subsidized and non-subsidized relative child care environments using a mixed methods approach. The research questions were examined through in-home observations, individual interviews, and focus group interviews. In-home observations were completed using the Child Care Assessment Tool for Relatives (Porter, Rice, Kearns, & Mabon, 2007), a child care quality assessment designed specifically to capture the strengths of this unique form of child care, as well as to illuminate potential limitations which could negatively impact child outcomes.

Summary of Findings

In-home observations conducted in two dozen subsidized and non-subsidized relative child care homes revealed child care quality at all levels identified by the Child Care Assessment Tool for Relatives: poor, acceptable, and good. This breadth is consistent with previous studies of child care settings, in general (The NICHD Early Child Care Research Network, 2005), and home-based child care settings, specifically (Kontos, Howes, Shinn, & Galinsky, 1995). Infant/toddler relative caregivers had higher levels of quality than their preschool counterparts. Additionally, infant/toddler settings were observed to have fewer potentially fatal health and safety concerns. These findings were consistent with those of the CCAT-R field testing done by Porter and her colleagues (Porter, Rice, & Rivera, 2006) and other studies involving either kith and kin care providers or relative child care providers (Layzer & Goodson, 2006; Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Tout & Zaslow, 2006).

One major finding is that among infant/toddler and preschool settings alike, the quality composite variable of Caregiver Nurturing was “poor.” An examination of the effect sizes between infant/toddler and preschool settings on both child nurturing and unidirectional

communication suggests the magnitude was much stronger, that is the presence of a subsidy made no difference in care in these areas, for preschoolers as compared to infants and toddlers (where effect sizes were small to medium). Caregiver Nurturing promotes social-emotional development in children and can be evaluated as “good” through interactions such as hugging, kissing, holding, or comforting the child. Conversely, relative caregivers observed engaging in their own activity without regard for the child’s interest display “poor” caregiver nurturing. Lack of interaction is potentially detrimental to the social-emotional development of young children (Bowlby, 1982). This finding is again consistent with those of the CCAT-R field testing (Porter, Rice, & Rivera, 2006). With the exception of Caregiver Nurturing, the levels of care observed reflect more positive caregiving situations than those examined in the groundbreaking examination of home-based settings conducted by Kontos, Howes, Shinn, & Galinsky (1995) where 35% of caregivers provided inadequate care and in other studies where relative care was examined in conjunction with regulated home-based settings (Loeb, Fuller, Kagan, and Carrol, 2004.)

While definite health and safety concerns were noted, most care settings were observed to have many developmentally appropriate materials. More than half (60%) of infant/toddler care settings were observed to have nine of eleven types of developmentally appropriate materials, with 80% having six of eleven types of developmentally appropriate materials. These findings are consistent with previous studies in terms of the availability of materials (Layzer & Goodson, 2006; Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Tout & Zaslow, 2006). Though Layzer & Goodson, Paulsell et al. and Tout & Zaslow expressed concerns regarding the lack of literacy interactions between caregivers and children in their studies, the use of materials was not an area examined for this study.

The remaining research questions examined the potential relationship between subsidy receipt and quality. No significant differences in quality were found between subsidized and non-subsidized settings and while the sample was relatively small, the effect sizes measured by Cohen's *d* were large for preschool nurturing and medium for caregiver unidirectional communication with the focus child and for caregiver engagement and caregiver bidirectional communication with the focus child and caregiver unidirectional communication with the focus child among infants and toddlers. This finding is in direct contrast with findings reported by Raikes, Raikes, and Wilcox (2005) in their examination of regulated and unregulated home-based settings in Kansas, Nebraska, Iowa and Missouri where increased subsidy density (define again?) was correlated with lower levels of quality. This finding is also in direct contrast with that of the CCAT-R field testing (Porter, Rice & Rivera, 2006) where subsidized relative providers were observed to have higher scores on items related to cognitive-language development, such as caregiver bidirectional communication with the focus child and caregiver unidirectional communication with the focus child.

An examination of caregivers' main motivations revealed that a majority of relative care providers' motivations were family-oriented or child-oriented rather than employment-oriented. While these findings were not surprising, they do corroborate findings from multiple previous studies of kith and kin or relative child care providers (Anderson, Ramsburg, and Scott, 2005; Brandon, 2005; Kontos, Howes, Shinn, & Galinsky, 1995; Porter, 1998). Interestingly, though, subsidized providers were more likely to identify with family-oriented motivating factors than their non-subsidized peers who were more likely to identify child-oriented motivating factors. Although the sample was small, an examination of the potential relationship between child care

quality, in terms of the four composite variables identified previously in this chapter, and caregivers' motivations for providing care did not reveal significant relationships.

Qualitative analysis of individual and focus group interviews with relative care providers found the receipt of child care subsidies to have little influence on the attitudes of relative child care providers regarding the provision of relative child care, specifically on relative care providers' motivations for providing care and their role perceptions. Relative care providers rarely reported receipt of child care subsidy or payment from the family as a predominant motivating factor for providing care.

Qualitative analysis of individual and focus group interviews indicated that many relative care providers volunteered to provide child care for the focus child, prior to any awareness of the child care subsidy program and/or despite the need to make sacrifices in order to do so. Furthermore, analysis revealed several child care arrangements that extended beyond the receipt of child care subsidies. This revelation prompted the expansion of the study's definition of subsidized provider. This finding corroborates the findings of the National Study of Child Care for Low-Income Families (Layzer & Goodson, 2006) which found that few parents changed their child care arrangements in order to receive or in response to the loss of child care subsidies.

Limitations of Study

The primary limitation of this study is the small sample. Initially, sample pools of 30 subsidized and 30 non-subsidized relative child care providers (RCPs) were planned through two separate recruitment processes. These sample sizes were selected in order to maximize the ability of the statistical analysis to identify an effect size of 0.30 (Cohen & Cohen, 1983; Salkind, 2004). Counties were selected to provide a potential population representative of the demographics of the state, as a whole. These pools of providers were to have been utilized for

both phases of data collection including on-site observation/interviews and focus group interviews.

Despite the provision of monetary incentives for both in-home observations and focus group participants, difficulties in participant recruitment resulted in reduction of the sample sizes for both phases of data collection, though the geographic scope of the study remained stable. Other studies of this population have also encountered difficulties in recruitment of participants (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Raikes, Raikes, and Wilcox, 2005).

Second, the results regarding the quality of care of non-subsidized providers may have been influenced by the use of convenience and snowball sampling as these providers sought to participate in the study rather than simply agreeing to participate after being contacted by the researcher. Due to the characteristics of the study population, two different sampling approaches were necessary in order to secure both subsidized and non-subsidized relative child care providers. Although the Kansas Department of Social and Rehabilitation Services (SRS) maintains a database of all child care subsidy recipients, no such database of non-subsidized relative child care providers exists. Potential subsidized providers were randomly selected from the SRS database, while potential non-subsidized providers were secured through convenience and snowball sampling thus introducing a volunteer bias to the study. It would be of great interest to understand the differences between those who volunteered and those who did not want to participate with implications for designing potential support systems.

Third and finally, the racial and ethnic diversity may limit the external validity of these results; however, the sample nearly represents the demographics of the geographical area. The large percentage of white participants is congruent with demographics of region (Kansas State and County Quick Facts, 2009): however, the lack of Latino participants in the study is not

representative of the region or of some other studies involving this population. Relative child care providers in the other studies of informal, home based settings, including relative care providers, were more likely to be of color (Kontos, Howes, Shinn, & Galinsky, 1995; Porter, Rice, & Rivera; 2006). The demographics of this study's population most closely resembled that of Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006, with regards to race, location of care, economic status of provider, and payment receipt . The overall caregiving population of the Early Head Start pilot project was predominantly white (70%), while 15% were Latino and 6% were African American. Care was most frequently provided at the caregiver's home (64%) with care occurring at the child's home (19%), both homes (13%), or at multiple locations (4%) less frequently. Socioeconomically, not all caregivers lived in poverty, though many did have low incomes. Only thirty percent of the Early Head Start pilot project providers reported receiving compensation of some type (Paulsell et al., 2006.) Of those who received some type of compensation, the most common form of payment was child care subsidy. Cash payments from the parents were received by only five percent of those receiving payments. Over a quarter of providers cared for children in excess of 40 hours per week, while nearly half of providers cared for children less than 20 hours per week.

Limitations of the Child Care Assessment Tool for Relatives

Limitations of the CCAT-R measurement tool were also identified over the course of the study. Major limitations were observed during implementation, scoring, and interpreting data using the tool. First, achieving inter-rater reliability was both difficult and too time consuming for collaborating agency staff. At the onset of the study, the researcher was trained by the authors of the CCAT-R during a 2.5 day training session in New York City. Training included 8 hours of classroom instruction on the tool and two observation/debriefing sessions lasting

approximately 6 hours each. At the conclusion of this training, the observer was able to achieve an inter-rater reliability at the 80 percent level with the authors of the instrument. Following this training, the researcher attempted to train three potential observers locally to assist with in-home observations. The researcher found it difficult to obtain inter-rater reliability with these potential observers without extensive training and multiple practice sessions using the tool. Due to the extensive amount of time required to achieve inter-rater reliability with the researcher, potential additional observers were withdrawn from the study by their sponsoring agencies despite initial letters of support for the project. Eventually, the researcher trained and obtained inter-rater reliability with a graduate student, although this observer conducted only one observation due to conflicts between her schedule and that of potential participants.

A second challenge with the Child Care Assessment Tool for Relatives was the complex scoring system which results in non-standard raw scores. These raw scores can be difficult to interpret for two main reasons: the potential for negative scores and the inconsistent maximum score for composite variables. As discussed in Chapter 3, each composite variable is based on the number of positive behaviors observed over the course of the six time sampling periods and the number of negative behaviors observed over the same periods. Instances of negative behaviors are scored as a negative number and deducted from the overall total for each composite variable. For most composite variables the total number of observed behaviors is large enough to offset the potential for negative observed behaviors. However, for Child Nurturing, the score is based on the number of observed instances of three behaviors which are scored positively (caregiver kisses or hugs child, caregiver holds or touches the child, and caregiver comforts the child) and one behavior which is scored negatively (caregiver does own activity without regard for the child's interests) consequently a negative overall score is possible.

A negative raw score for a variable based on observed behaviors is confusing for those unfamiliar with the scoring system. Additionally there is a vast difference in the maximum raw scores for the different composite variables. For example, the minimum raw score for Child Nurturing is -6 and the maximum score is 18. In contrast, the maximum raw score for Caregiver-focus child Bidirectional Communication is 279. It is difficult to interpret these raw score results without extensive understanding of the scoring system, thus raw scores must be associated with a quality label (Poor, Acceptable, or Good) before they can be interpreted.

Third, the overwhelmingly “poor” results on Child Nurturing indicate probable issues related to construct validity for this composite variable. Distinct differences were identified between infant/toddler caregivers and preschool caregiver scores within this study. Also, the variation in child nurturing scores between Porter, et al.’s field test subjects, upon which the levels of quality for the instrument were based, and the participants of this study highlight potential cultural, ethnic, and geographic influences on observable behaviors the instrument associates with nurturing relationships. Assigning value-based labels such as “poor,” “acceptable” and “good” to behaviors which may not be culturally representative in terms of the construct they purport to measure may be unfair and potentially harmful to relative child care providers. The authors have developed a functional, albeit complex, system of measurement. However, the tool may not be ecologically valid across cultures and contexts. While the tool does assess relative child care as a unique form of child care, separate from other home-based settings, at least one composite variable does not appear to recognize the cultural differences in caregiving and consequently may not yet fulfill the needs of the field for an instrument to study this form of care.

Implications for Policy

In terms of the impact of the receipt of child care subsidy on child care quality, the results of this study stand in contrast to those of previous researchers (Porter, Rice, & Rivera, 2006; Raikes, Raikes, & Wilcox, 2005.) While Porter, et al. found subsidized providers to provide higher quality of care and Raikes, et al. found providers with higher subsidy density, this study found no significant relationships between subsidy and quality. The inconsistent results among these studies suggest that child care subsidies may not be an effective quality improvement strategy across all relative child care providers. To view subsidies as a means by which quality of care can be impacted is not supported by this research and may run counter to the intent of the law governing Temporary Assistance to Needy Families (Greenberg, Levin-Epstein, Hutson, Ooms, Schumacher, Turetsky, and Engstrom, 2002). Each state is required to designate funds for child care quality improvement projects. The development and implementation of quality improvement projects targeted specifically towards relative child care and kith and kin care providers would likely be a more effective means by which to impact the quality of care particularly care provided to at-risk children in these settings. Input from researchers, support program practitioners, and those involved in relative child care systems would provide a wealth of information in the development phase of such quality improvement programs.

In their report of a national symposium on the development of strategies to improve family, friend and neighbor (FFN) care, Kreader & Lawrence (2006) reflect on two states' approaches towards this population, Kansas and California. The report detailed the legal boundaries, subsidy rates, and quality initiatives in these states as they apply to FFN and relative child care. Both Kansas and California consider relative child care providers to be exempt from

licensing, but require criminal and child abuse background checks be completed on family members as a component of subsidy eligibility.

In terms of subsidy rates, California FFN providers can receive “up to 90 percent of the maximum rate for licensed family child care” (Kreader & Lawrence, 2006, p. 9.) Although most relative child care providers receive less than 90 percent of the maximum rate, their rates are reported to be competitive. In contrast, Kansas employs a tiered rate system in which relative child care providers are paid less than all other forms of home-based child care, even less than unregulated, unrelated caregivers who provide care in the child’s home (Kreader & Lawrence, 2006). Although the results of this study suggest that receipt of the subsidy is not a main motivating factor for relative child care providers, the implementation of more level subsidy rates among similar forms of child care should be investigated. Among subsidized providers in this study, those who reported government subsidy as their only form of payment received the smallest average weekly payments ($M = \$71.88$; range = \$50.00 to \$100.00). Differences in findings between this study and Porter, Rice and Rivera’s findings from the field testing of the CCAT-R (2006), completed California, Arizona, Illinois, and New York may be related to the differing approaches to establishing subsidy rates across child care settings. In light of the quantitative and qualitative results, it is possible that the minimal subsidy amounts received have a negative impact on motivation levels and, indirectly, on quality of care. Clearly, additional research in this area is needed.

These two states also report differing approaches to quality improvement programs (Kreader & Lawrence, 2006). At the time of the report, California was in the process of developing a program designed to “engage, connect with, and support FFN care” (p. 9) as an extension of the Comprehensive Approaches to Raising Education Standards (CARES) Plus

program which was launched during the 2000-2001 fiscal year. The CARES Plus program, along with the FFN component, continues through the First 5 campaign with funding for 2010-2013 of up to 36 million dollars (First 5 California, 2011). In contrast, Kansas's initial efforts to impact the quality of care in relative care settings involved tying subsidy receipt to participation in mandated training sessions. The report states that this approach "did not work; relative providers did not come" (p. 9.) This training approach is consistent with the approach taken with licensed family child care providers. Licensed family child care providers are required to complete a minimum number of training hours annually in order to maintain their license. Those who are not licensed, cannot receive a subsidy.

This research was initiated at roughly the same time that the Kansas Department of Social & Rehabilitation Services linked receipt of child care subsidy with attendance at mandatory training, ostensibly in an attempt to positively impact quality of care in subsidized settings. Given the lack of research tying subsidy receipt and quality of care (Raikes, Raikes, & Wilcox, 2005) this study attempted to examine the issue and to contribute to research literature upon which quality improvement programs might be based in the future.

The comments of relative child care providers who participated in this study provide evidence to suggest that this initial approach was not effective, especially comments of those participants who were previously licensed family child care providers yet who now more closely identify themselves as relatives who provide child care. A subsequent attempt to reach this population in Kansas involved providing a support program for parents and providers for which incentives were provided (Kreader & Lawrence, 2006) This approach was more successful, but budgetary limitations prevented the expansion of this program. One of the sites in this pilot project was located in Kansas, though the specific location is not available. This more family-

centered approach is more consistent with support programs such as home visiting through programs such as, Parents as Teachers or Head Start and Early Head Start.

While investments in early childhood, such as those implemented in California, may be initially challenging from an economical standpoint research on the positive impacts of such programs on child development have been seen to pay personal and financial dividends in the long-term (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005). Given the limitations of this study including the suggested limitations of the tool, it is imperative that policy makers use these results only as a means of developing future quality improvement projects, not as a means of determining the efficacy of child care subsidies in terms of increasing the affordability of child care for parents and providers. *The positive impact of child care subsidies on affordability is in keeping with the original intent of the law (Greenberg, Levin-Epstein, Hutson, Ooms, Schumacher, & Turetsky, 2002), while any potential link between subsidies and quality would simply augment an important support for low-income families.*

Additional research using ecologically valid measures on support programs for families in relative child care would be an appropriate next step towards supporting children and their families.

Future Research Directions

Given the importance of quality early childhood experiences for all children and prevalent use of relative child care among low income families, future research on quality care in this unique setting is essential. Research must focus more innovative methods of reaching relatives who provide care to support development of high quality care environments. Further, confirmation of the reliability and validity of the Child Care Assessment Tool for Relatives or

other evaluative measures specific to informal, home-based child care arrangements such as relative child care homes is an important next step in this research field. Over time researchers must arrive at some consensus regarding the most appropriate tools with which to evaluate these unique child care settings.

Replication of this and other studies with larger and diverse samples would provide stronger, more generalizable results. As evidenced by the difficulties associated with securing participants in the current study, relative child care providers may be reluctant to participate in these programs due to the closed nature of family systems. Relatives who receive a subsidy may be more reluctant to participate than non-subsidized relatives due to what could be perceived as an existing government involvement (the process through which the subsidy is obtained) in the family's life. In order to overcome potential reluctance, future studies could be undertaken in wider or more densely populated geographic regions but also must be attentive to addressing these concerns of those hesitant to participate. Future studies should also be implemented within the context of support programs for the families utilizing these child care arrangements. Additionally, researchers must recognize cultural and geographic differences among families and, by extension, relative child care providers. For example, what works in an urban area may not work in rural areas. Researchers must be attentive to and attempt to understand and address possible differences.

Absent the availability of a larger pool of willing participants, future researchers would be wise to focus on one age group at a time rather than to divide their research pool into multiple age groups, such as infants and toddlers, preschoolers, and potentially school-age children. An argument could be made in favor of focusing on infants and toddlers as the sole age group from which to obtain focus children as these children are more likely to be in the care of a relative

than their preschool-aged counterparts (Ehrle, Adams, & Tout, 2001). An examination focusing on the experiences of preschool age children in relative child care might provide avenues through which to provide support services as children in this age group are more likely to experience relative child care in conjunction with some form of group care, such as a preschool or Head Start program (Adams, Tout, & Zaslow, 2007; Collins & Carlson, 1998). The Early Head Start Home Visitors Pilot Project (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006) is an example of a potential quality improvement project that could be adapted or replicated by other agencies or states.

Support programs for kith and kin or relative child care providers are becoming more prevalent (Kreader & Lawrence, 2006) as state child care leaders attempt to incorporate these settings into the formal child care continuum. Support programs should reflect the ecology of the system of care (Bronfenbrenner, 1979) and incorporate all members of these triangular relationships: children, parents, and providers in respectful, responsive, educational, and relationship-based home- and community-based experiences have the potential to positively impact the lives of low-income families and their children.

Given the possible link between child-oriented motivations for providing care among relatives and higher quality of care provided, programs which aid relative care providers in identifying more closely with the needs of the child (in addition to the needs of the family) might also be explored. The National Parents as Teachers Organization offers a home-visiting curriculum, “Supporting Care Providers through Personal Visits,” that can be used with family, friend and neighbor (FFN) care. This relationship-based curriculum highlights the developmental needs of young children and attempts to address areas of care in which relative child care and FFN providers have been found lacking, specifically language development and

health/safety. The incorporation of traditional Parents as Teachers curriculum (Parents as Teachers, 2011) with children's parents and its informal child care curriculum counterpart with relative child care providers is one potential support program that could prove effective in terms of raising child care quality, focusing relative and parent attention on the child's needs. A program of this nature could also produce a positive impact on child outcomes in social/emotional skills, such as problem solving, and language development such as literacy skills, two areas of child outcomes in which relative child care providers have been found to struggle (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Tout & Zaslow, 2006). Support of strength-based and relationship-based quality improvement programs and equitable subsidy rates may have the potential for greater impact on quality child care as it does not appear that subsidy receipt alone impacts quality of care.

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Appendix A - Semi-Structured Interview Questions

1. Can you tell me a little bit about {focus child}?
 - a. What are some of his/her likes?
 - b. What are some of his/her dislikes?
2. How long have you cared for this child?
3. How did you become a caregiver for this child?
4. Can you tell me about a typical day with this child?
 - a. What are some of your favorite moments with this child?
 - b. What are some of the not so fun moments? Challenges?
5. How long do you anticipate providing care for this child? What events or situations might cause the current situation to change?
6. Compared to other child care or early education options available to this child, how would you describe the care you provide?
7. Currently, relative child care providers do not have to be licensed to provide care.
 - a. What do you think about relative care providers not having to be licensed?
 - b. How would you feel (or what would you think) if the state asked you to become licensed?
 - c. Would you still care for the child if the state asked you to become licensed? Why or why not?
8. Can you tell me what experiences you've had with the local child care resource & referral agency {insert name}?
 - a. Do you receive their newsletter?
9. If RCP receives child care subsidy from SRS ask:

- a. According to the information SRS has shared with me for this study, you receive payment from SRS for providing care for this child? Is that correct?
 - b. Can you tell me about that?
 - i. How did you or the child's parent become aware of the subsidy program?
 - ii. What difference has the receiving a child care subsidy made for you, personally?
 - iii. What difference has the receiving a child care subsidy made for the child/family?
 - iv. What difference has the receiving a child care subsidy made for the care you provide?
 - v. Would you care for this child if SRS were not able to provide a child care subsidy for the care?
10. If I were to ask you which role you most closely identify with, relative/grandparent or child care provider, which would you choose and why?
11. Can you tell me about how do you and the child's parents balance your family relationship with the child care relationship?
12. Can you tell me about your work history?
- a. Did you work before your children were in school?
 - i. *If yes:* Can you tell me about the child care arrangements you used?
13. Are there other aspects of caring for relative children that you'd like to share with me?

Appendix B - Focus Group Interview Questions

Request participant introductions:

Relationship to child (grandparent, aunt, etc.)

Age of child(ren) in care

1. How long have you cared for this child?
2. How did you become a caregiver for this child?
Motivation- help for parent/bond with child; voluntary/necessary
3. How long do you anticipate providing care for this child? What events or situations might cause the current situation to change?
4. Compared to other child care or early education options available to this child, how would you describe the care you provide?
5. Currently, relative child care providers do not have to be licensed to provide care.
 - a. What do you think about relative care providers not having to be licensed?
 - b. How would you feel (or what would you think) if the state asked you to become licensed?
 - c. Would you still care for the child if the state asked you to become licensed? Why or why not?
6. If RCPs receives child care subsidy from SRS ask, “According to the information SRS has shared with me for this study, you receive payment from SRS for providing care for this child? Is that correct?”
 - a. Can you tell me about that?
 - b. How did you or the child’s parent become aware of the subsidy program?

- c. What difference has the receiving a child care subsidy made for you, personally?
For the child/family? For the care you provide?
 - d. Would you care for this child if SRS were not able to provide a child care subsidy
for the care?
7. If I were to ask you which role you most closely identify with, relative/grandparent or
child care provider, which would you choose and why?
8. Can you tell me about how do you and the child's parents balance your family
relationship with the child care relationship?