PREDICTORS OF QUALITY CAREGIVING IN THE "FAMILY CHILD CARE PARTNERSHIPS" HOME VISITATION PROGRAM

Except where reference is made to the work of others, the work described in this dissertation is my own or was done in collaboration with my advisory committee. This dissertation does not include proprietary or classified information.

---

Ellaine Bailey Miller

Certificate of Approval:

| | |
|---|---|
| Marilyn Bradbard<br>Professor<br>Human Development and Family Studies | Ellen Abell, Chair<br>Associate Professor<br>Human Development and Family Studies |
| Dorothy Cavender<br>Professor<br>College of Human Sciences | Brian Vaughn<br>Professor<br>Human Development and Family Studies |

Stephen L. McFarland
Acting Dean
Graduate School

# PREDICTORS OF QUALITY CAREGIVING IN THE "FAMILY CHILD CARE PARTNERSHIPS" HOME VISITATION PROGRAM

Ellaine Bailey Miller

A Dissertation

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Doctor of Philosophy

Auburn, Alabama
December 16, 2005

PREDICTORS OF QUALITY CAREGIVING IN THE "FAMILY CHILD CARE PARTNERSHIPS" HOME VISITATION PROGRAM

Ellaine Bailey Miller

Permission is granted to Auburn University to make copies of this dissertation at its discretion, upon request of individuals or institutions and at their expense. The author reserves all publication rights.

*Ellaine Bailey Miller*
Signature of Author

December 16, 2005
Date

# VITA

Ellaine Kimbrough (Bailey) Miller, daughter of Dr. William H. Bailey, Ph.D., and Sue (Chapman) Bradley, was born June 3, 1971, in Knoxville, Tennessee. She graduated from Rabun County High School in the top ten percent of her class in 1989. She attended the University of Georgia in Athens, Georgia, and graduated with a Bachelor of Arts degree in Psychology in June 1993. She married Peter Charles Miller, son of Leo and Gene (Slaughter) Miller, on August 3, 1991. After the birth of their son, Peter Charles Miller, Jr., born December 24, 1993, and working in various University of Georgia offices, Ellaine entered Graduate School, Auburn University, in September 1995. After the birth of her daughter, MaryAynne Kathryn Miller, born August 10, 1997, she obtained her Master of Science in Family and Child Development in March 1998. Ellaine continued her graduate studies in the Department of Human Development and Family Studies in the doctoral program and will graduate December 16, 2005.

DISSERTATION ABSTRACT

PREDICTORS OF QUALITY CAREGIVING IN THE "FAMILY CHILD CARE PARTNERSHIPS" HOME VISITATION PROGRAM

Ellaine Bailey Miller

Doctor of Philosophy, December 16, 2005
(M.S., Auburn University, 1998)
(A.B., University of Georgia, 1993)

224 Typed Pages

Directed by Dr. Ellen Abell

The primary focus of this study is to describe the Family Child Care Partnerships (FCCP) program and examine the possible relations among key features and processes of the FCCP training program in an attempt to identify predictors associated with quality caregiving for program participants. Participants in this study included 203 family child care providers in Alabama and 15 of the home visitors (mentors) working with them. Providers were observed by their mentors during their first month of participation in the program and quarterly thereafter for purposes of collecting quality care information as assessed using the Family Day Care Rating Scale (Harms & Clifford, 1989) and the Caregiver Interaction Scale (Arnett, 1989). Providers and mentors completed demographics surveys as well as a modification of the Helping Relationships Inventory (Young & Poulin, 1998). Each provider was also assigned a rating for accreditation status. Hypothesized models were tested to determine the causal relationships among the

study variables. A direct-effects model predicting provider accreditation status was the only plausible model fitted which met all conventional model fit tests.

ACKNOWLEDGEMENTS

The author would like to thank Dr. Ellen Abell for assistance with completion of this degree program and her unwavering support. Appreciation is also given for the assistance of many of the faculty in the department of Human Development and Family Studies. Special thanks go to the family child care providers of Alabama and the mentors employed throughout the years with Family Child Care Partnerships as well as the many student and support workers involved in the FCCP program. Thanks also go out to immediate and extended family members Peter, Charles, MaryAynne, Daddy, Mom, and Kathryn for their support, encouragement, and patience during the many years devoted to this endeavor.

Style manual used:

APA Handbook

Computer software used:

MSWord

MSExcel

MSAccess

SPSS

MPlus

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

# I. INTRODUCTION

Family Child Care Partnerships (FCCP) is a statewide in-home mentoring program funded by the Alabama Department of Human Resources. Since the program's inception in 2000, the primary goal of the program has been to help family child care providers increase the quality of care they offer and to assist them in attaining national accreditation standards. Participants in the program are licensed caregivers who provide in-home care to young children for a fee. They receive weekly in-home training and technical assistance from trained program personnel (mentors) and have the opportunity to participate in monthly group trainings on subjects relevant to the challenges of providing quality child care in the home setting. In addition, FCCP participants are given an opportunity to apply for and receive up to $500 in equipment and a $495 scholarship to pay for the cost of applying for accreditation from the National Association of Family Child Care.

In the five years during which FCCP has been in operation, the number of nationally accredited family child care providers in Alabama has increased from none to 35. Other indications of success include the establishment of a statewide professional family child care provider association and annual conference, recognition of FCCP as a leader in quality enhancement training in family child care, and on-going annual funding of over $1 million awarded through a competitive grant process. In spite of these successes, research-based evidence is absent that would explain the processes responsible

for the quality improvements a child care provider enrolled in FCCP makes. The purpose of the current study is to propose and examine a set of relationships among characteristics of program participants and features of the FCCP program that could predict providers' achievement of the quality outcomes that FCCP promotes.

Published studies examining the effectiveness of training programs are rare in the family child care field. However, most of the research available evaluates quality of care with the Family Day Care Rating Scale (FDCRS; Harms & Clifford, 1989) and Caregiver Interaction Scale (CIS; Arnett, 1989). Correlational studies looking at factors contributing to quality of care indicate provider regulation, training, group size, adult-child ratio, work commitment, and motivations for being providers are key correlates of high quality care in the family child care setting (Galinsky, Howes, Kontos, & Shinn 1994; Kontos, 1994; Kontos , Howes, & Galinsky, 1996). Researchers have concluded that, in general, providers who seek out and receive specialized family child care training are more sensitive and responsive in their caregiving, receive higher scores on global indicators of family child care quality (i.e., FDCRS and CIS), and report being more committed and intentional than less trained caregivers (Galinsky et al., 1994; Kontos et al, 1996; Taylor, Dunster, & Pollard 1999).

Looking beyond the research literature on family child care, studies evaluating training programs designed to enhance or improve quality of caregiving are found primarily in the nurse home visiting literature and, to a lesser extent, the Head Start home visiting literature. The nurse home visiting literature provides a rich body of information that describes the components of home visiting programs; details the effectiveness of intense, one-on-one, hands-on technical assistance types of training programs; and offers

explanations for why and how these training programs work by evaluating the processes involved in these programs.

Key studies in the nurse home visiting research literature come from the Nurse Home Visiting Program (NHVP) started in Elmira, NY, and replicated in Memphis, TN (see Kitzman, Cole, Yoos, & Olds, 1997), and Denver, CO (see Hiatt, Sampson, & Baird, 1997). These studies describe in detail the relationship process involved in an intensive, structured, home visiting program designed to improve the quality of care new mothers would offer their infants. Home visitors in these studies were professionals and paraprofessionals. Similar to FCCP, home visitors scheduled visits with volunteer participants on a weekly basis, had a limited caseload, documented their activities during visits, and had curricular guidelines and materials provided to them to use with clients but were allowed flexibility to address other issues that came up during their visits.

The programs were evaluated at the implementation, process, and outcome levels. At the Elmira site, mothers in the home visiting program were found to have a higher sense of mastery and control over their lives compared to mothers not receiving home visits. Program effects were greatest for children of unmarried, lowest-income mothers and were most prevalent four to fifteen years after the program ended (Olds, Hederson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998). Further research to determine the reasons for better results being found in the Elmira site compared with the Memphis site revealed that characteristics of the mothers, the nurse home visitors, and the relationships between them were important for successful maternal outcomes. Home visitor variations in program delivery, based on their sensitivity to the individual mother's culture, environment, needs, and personal context increased maternal receptiveness and supported

relationship building and maintenance (Hiatt et al., 1997; Kitzman et al., 1997). Subsequent research focusing on the mother-home visitor relationship suggests that program effects were mediated by the quality of this relationship (Korfmacher & Olds, 1998).

While home visiting program research has identified participant characteristics, home visitor characteristics, relationship quality variables, and program features as possible explanation points for successful program outcomes, none of the research available takes a comprehensive view of all of these variables. This is also true in the limited family child care literature. The current study attempts to take a more comprehensive approach and has two objectives. The first objective is to describe the program in detail. The literatures in the fields of family child care, child care in general, and home visiting offer little evidence of educational training programs designed for family child care providers and delivered in the home setting. A description of the development of the program, its implementation, evaluation tools, and outcomes should add significant information to the field of public service programming and child care.

The second objective is to examine the possible relations among key features and processes of the FCCP training program in an attempt to identify predictors associated with quality caregiving in the homes of caregivers participating in this mentoring program. A model will be tested to understand the processes involved with improving quality of care using the home-visiting service delivery model. Specifically, independent variables include provider characteristics (e.g., ethnicity, education, and years of experience in the child care field), mentor characteristics (e.g., ethnicity, education, and experience with family child care), evaluation of the provider-mentor relationship from

both the providers' and the mentors' perspectives, and other relevant program characteristics (e.g., number of mentors working with a provider and number of contact hours with mentor). Dependent variables to be analyzed will be mentor-reported scores of providers on the FDCRS and CIS--well-established, reliable assessments of child care quality--as well as provider accreditation status.

The current study will provide a meaningful addition to the limited amount of literature on family child care and the growing body of literature on home visiting programs as it seeks to explain why some providers make quality improvements in the family child care setting and others do not. The current study attempts to bridge the gap between descriptive information about programs and explanatory research concerning program processes.

# II. LITERATURE REVIEW

The purpose of this literature review is to examine previous research about factors that contribute to the quality of child care practices in family child care as well as about programming methods designed to increase caregiving quality. Because the literature focusing on the practices and training programs used by family child care providers is limited, the review will also examine research on home visitation programs designed to improve parental caregiving practices, since this educational delivery model employs programming features similar to the service delivery model used by FCCP. (Note: Additional information and details about the studies reviewed in this chapter can be found in Appendix A.)

## Quality Family Child Care

As increasing numbers of mothers of preschool-aged children have entered the workforce and need formalized care for their children over the past 20 years, quality child care has been a main topic of interest. Past research has found that children experiencing high quality care have been shown to have better social, emotion, and cognitive functioning compared to children in low quality care settings (e.g., Howes, 1997a; Kontos, S., & Wilcox-Herzog, A., 1997; Peisner-Feinberg, E. S., & Burchinal, M. R., 1997). While much of the research on quality of care tends to focus mainly on center-based child care settings, a few researchers have focused on describing and evaluating quality in the family child care setting. Seminal work in the ecology and quality of family

child care is provided by the Families and Work Institute's *Study of Children in Family Child Care and Relative Care* (Galinsky et al., 1994; Kontos, 1994; & Kontos, 1996).

In their examination of provider characteristics associated with high quality care, Galinsky et al., (1994) found that family child care providers who were observed to offer the highest global quality and showed the most sensitive, responsive and warm interactions with the children in their care tended to have higher levels of education (77% with more than high school education), offered multiple planned activities each day, and actively sought out and participated in professional organizations and specialized training. Those providers who attended specialized child care training were found to offer higher levels of care than those without training, even when controlling for years of experience as a provider.

Most professionals in the child care field recognize that education and training are important aspects of quality in child care; however, little published information on effective training programs can be found. Kontos and associates (1996) examined provider characteristics related to change in quality of care offered as a result of participating in two to four group training sessions a year totaling 12 to 25 hours of training. Providers participating in the training group (n=130) and comparison group (n=112) were observed in their natural caregiving environment. Prior to the training, no significant differences between groups were found to be related to the quality of care provided or with regard to demographic characteristics, business practices, commitment to the job, or group size. After the training, program participants were observed to offer higher quality of care and to use slightly more business and safety practices than the comparison group. Kontos et al., (1996) concluded that participating in the training had a

small but positive effect on quality of care offered by provider completing the training program which was not influenced by provider characteristics including education and prior experience.

In an effort to promote quality standard compliance and determine whether or not specialized training would facilitate that compliance, the state of Georgia implemented a low-level assistance training program (Wilkes, Lambert, & VandeWiele, 1998). Half of the randomly selected providers were assigned to receive a 1 ½ hour in-home technical assistance visit by a trained technical assistance data collector while the other half were used as a control group. Wilkes et al., (1998) found that providers who received a technical assistance visit were more likely to be in compliance with state regulations at follow-up compared to the control group, and those at the lowest quality levels before the training had the greatest change in compliance after the assistance visit.

From the perspective of the providers themselves, the effectiveness of a training program depends on its capacity for meeting relevant educational and training needs. In their nation-wide assessment of the specialized training needs of Canadian family child care providers, Taylor and associates (1999) conducted interviews with 298 caregivers and collected survey data from 258 organizations about the family child care training they offered. Providers' reports about their past experiences with training suggested that training content too often is focused on child care center-related concerns rather than the special needs and circumstances of family child care homes, their child care experience and expertise is not recognized, and the needs of caregivers who have been in the business for several years are not met (Taylor et al., 1999). Barriers to attending training included geographical distance from training facilities, inability to see how the training

will impact their ability to care for children, the cost of attending training, inability to see a financial benefit to attending, and the lack of time or ability to fit training into already busy schedules.

Providers reported wanting training that contains relevant content, is delivered in an accessible manner, and does not underestimate the skills and knowledge base of the providers in attendance and saw training as a way to improve their caregiving and business skills as well as boosting their self-esteem and self-concept. Taylor et al., (1999) asked providers who reported actively seeking out and attending trainings what their motivations were for accessing and taking advantage of these training opportunities as well as how they overcame the barriers previously mentioned. Providers reported that they are interested in improving the quality of care they offer, want more credibility in the field and community, and are looking for new ideas and supports for challenges they face in their businesses. These providers also suggested that training be designed to respect their experience and education levels, link to tangible results in their business, and recognize their attendance and excellence in the community.

In conclusion, Taylor et al., (1999) recommends that training programs be designed to meet the needs of the clients they serve. The training must be relevant to family child care needs. The training must be accessible to the target audience. The training must be designed to build on the strengths of the providers attending the training. The training must have networking time built into it to foster the support system providers can come to rely on between trainings.

While participating in child care training programs is seen as important to quality practice by professional and providers, published research describing actual training

programs designed for family child care providers and evaluated for their effectiveness is sparse. Previous research examining specific provider characteristics and effectiveness of training programs that contribute to why some providers offer higher quality care than others does not clearly explain what exactly those characteristics are or how they interact with their participation in training programs.

## Home Visiting Training Programs

The literature focusing on the practices and training programs used by family child care providers is limited; however, the nurse home visiting literature provides a rich body of information that describes the components of home visiting programs, details the effectiveness of intense, one-on-one, hands-on technical assistance types of training programs, and offers explanations for why and how these training programs work by evaluating the processes involved in these training programs. Key studies in the nurse home visiting research involves the Nurse Home Visiting Program (NHVP) started in Elmira, NY, and replicated in Memphis, TN (see Kitzman et al., 1997), and Denver, CO (see Hiatt et al., 1997). Outcome measures for all three program sites focused on children's health and development and mothers' life course trajectories.

The program protocol had specific lessons built in that each nurse was to teach each mother -- through direct instruction or modeling -- concerning specific caregiving skills (e.g., quieting a crying baby or redirecting toddler behaviors). Nurses or paraprofessionals were instructed and trained to deliver these lessons in a way that would promote the self-efficacy of the mothers. The idea was to create an atmosphere of trust and competence in caregiving that would allow the mothers to exhibit appropriate caregiving behaviors and feel competent, willing, and able to continue those behaviors

when the nurse was not present in the home (Cole, Kitzman, Olds, & Sidora; 1998; Hiatt, et al., 1997; Kitzman et al., 1997; Olds & Korfmacher, 1998).

The nurses in the NHVP sites were trained to work with participants using a solution-focused, strength-based approach while working with the participants (O'Brien & Baca, 1997). This approach was assumed to be at the root of the process by which mothers changed their attitudes, beliefs, and behaviors with their children. Nurses used this idea to promote mothers' self-efficacy and self-sufficiency. This approach is hallmarked by understanding that the participating mothers have the most information about their own lives and situations. Nurses were trained to recognize participants' strengths and capitalize on them. Using the mothers' strengths as a springboard for instigating change was expected to allow for the most success in the program.

Each nurse carried a caseload of 20 to 25 families. The home visits included structured curriculum-type lessons that were prescribed for each session. However, nurses were given great latitude in implementing those lessons considering a primary emphasis of the program was to create a close relationship between the nurses and the mothers participating. Nurses were instructed to take individual needs and participant goals into consideration (Campbell, 1994; Kitzman et al., 1997).

Program process was operationalized as the ways the nurse home visitors worked with the mothers to enhance, improve, and change their parenting behaviors and competencies. Other processes examined in assessments and analyses were the influences of psychological and family resources on the mothers and the interactions and influences of the child on the mothers. The effect of the program on mothers' context was hypothesized to be mediated by mothers' behaviors. The program was designed to

change both the behaviors themselves and the contexts that affect those behaviors (Olds et al., 1997 & 1998; Olds & Korfmacher, 1998).

In all three sites of the NHVP, data collection methods consisted of interviews, assessments, and follow-ups. In-home observations and interviews were conducted to assess mother-child interactions (looking at maternal warmth, control, and involvement) and home safety hazards including seat belt and car seat use and control of poisonous substances in the home. Information on client characteristics such as age, SES, and education were included as variables involved in differential program outcomes. At the Elmira site, program effects were greatest for children of unmarried, lowest-income mothers, were most prevalent in the 4 to 15 years after the program ended and were correlated with mothers' sense of mastery and control in their caregiving and life circumstances. Mothers in the home visiting program were found to have a higher sense of mastery and control over their lives compared to mothers not receiving home visits. This implies that the nurse visitation helped poor, young mothers feel more competent and confident in their caregiving skills.

Results from the Memphis study were different from the Elmira study. There were no program effects on new-born health, but as children got older and mothers participated in the program longer, children's health and well-being was more positive. The most significant difference between the Memphis and Elmira programs involved mother-child interaction patterns. In contrast to the Elmira mothers, mothers in the Memphis program were not observed to be more sensitive or responsive during interactions at the laboratory observation when compared to mothers not receiving home visits (Olds, et al., 1998).

Why the Elmira program "worked" and the Memphis program did not have similarly dramatic effects is not clear. For both programs, the content, service delivery method, and client base were similar. For both programs, mothers in the most dire conditions (youngest, poorest, least efficacious at enrollment) changed their lifestyles and caregiving practices the most in a positive direction. Successful participants and their children were seen in both programs to improve their environments and life courses well after the program had ended. However, not every participant had a positive outcome, and in Memphis, the effects of the program are more difficult to see.

Subsequent research was undertaken to determine differences in program efficacy and to identify and evaluate specific program implementation and service delivery processes as they related to differing characteristics of the persons delivering the program (Hiatt et al., 1997; Kitzman et al., 1997). Characteristics of the nurses were identified and included ethnicity, age, and whether or not they had their own children. Researchers collected data on characteristics of the mothers, the nurse home visitors, and the relationships between them, as well as the larger social context in which these interactions take place (Kitzman et al., 1997). Data were gathered about service delivery processes and outcomes between mothers working with professional nurses and those receiving services through a paraprofessional. Parenting status of the home visitor was also noted (Hiatt et al., 1997). Qualitative analyses suggested that those who were flexible and creative in their service delivery methods and sensitive to the individual culture, environment, and personal context and needs of each participant were more successful in obtaining desirable maternal outcomes. When nurses had different backgrounds as compared to participating mothers, nurses reported having to make

adjustments to their program delivery style and work hard to understand the context in which the mother lived. Understanding that context allowed the nurse to modify her style to maximize mother receptiveness (Kitzman et al., 1997). Paraprofessionals were found to be as competent as professional nurses in administering the program and obtained similar maternal outcomes, when provided with appropriate supervision and specialized training in relationship building and maintenance (Hiatt et al., 1997).

In addition to the effects of mother-reported characteristics (demographics, sense of control, mastery, knowledge, etc.), nurse characteristics (demographics), and aspects of program delivery (e.g., frequency of home visits), Korfmacher, Kitzman, and Olds (1998) chose to explore, explain, and discuss how variations in how nurses delivered program services may mediate program effects. Utilizing the participants from the Memphis site (n=228), these researchers operationalized program involvement as length of time participating, level of services addressing parenting specifically, and the emotional quality of the nurse-mother relationships. Program success was measured with parenting assessments such as attitude toward parenting, home environments, and parenting behaviors as observed during mother-child interactions. Mothers were asked to assess the nurse-client relationship at the end of the program (2 years after the child's birth) using a 27-item "Helping Relationships Inventory," designed to tap how much mothers thought the nurses understood their individual circumstances and how much acceptance and sensitivity the nurses offered. Results suggest that mothers with the lowest levels of psychological resources and who received high levels of caregiving instruction during visits had higher scores on the HOME inventory at the end of the program. Korfmacher et al., (1998) concluded that the program's effects were mediated

by the nurse-mother relationship and the mothers' psychological resources. In addition, when the nurse-client relationship was strong and positive in nature, participants were more actively engaged in the program and had more successful outcomes regardless of contact. It appears that quality versus quantity of contact is most important in program success (Korfmacher et al., 1998).

In summary, research designed to assess the differential success of mothers participating in the Nurse Home Visiting Program has gone beyond the standard approaches used to evaluate program success (examining participant characteristics and program features, such as intensity and frequency of visits) to also consider evaluating program processes, in this case, by evaluating the emotional quality of the relationship from both the home visitor and the client's perspective. The attention given to this aspect of program evaluation has led to further research efforts designed to understand program process in other relationship-based interventions.

In a recent review article, McNaughton (2000) examined fourteen home visiting programs in an attempt to explain what the mechanisms are in the nurse-client relationship that effect change. Relevant information about the nurse-participant relationship, nurse role during the visit, participant role during the home visit, and expected results from the interactions were explored. The data analyzed include information from 142 nurse home visitors and their interactions with participants across 59 home visits (McNaughton, 2000). McNaughton identified four stages involved in the nurse-participant relationship – (1) pre-entry; (2) entry; (3) working; and (4) termination. Nurse-mother relationships could be dichotomously categorized as either "collaborative" or "difficult." In collaborative relationships, nurses and mothers were able to work

successfully toward mutual goals; mothers were receptive to the program's methods and content; they trusted the nurses; and they showed general interest, openness, and improvement in caregiving skills throughout the course of the program. In difficult relationships, mothers would open their doors to the physical entry of the home visitors, but were not receptive to the goals of the program and refused to create a relationship with the nurses; they were observed or reported to be closed to the ideas presented by the nurses; and they did not keep appointments or utilize referrals to outside agencies.

Nurses were found across programs to focus primarily on creating and maintaining a collaborative relationship. Relationship maintenance was the primary objective, and delivery of program content was the secondary objective. The mother's role was identified as making a choice of whether or not to be open to and make changes in her behaviors based on the information and instruction offered by the nurses. As such, she controls the entry, intensity, and frequency aspects of the home visits themselves as well as controlling the level of information reception and behavioral change that results (McNaughton, 2000).

McNaughton (2000) concluded that the relationship between the nurse and the participant is the key to success in home visiting programs. She suggests that aspects of this relationship maintenance in combination with the nurses' goals for these mothers (self-esteem and self-efficacy) are mediators of the positive outcomes and recommends (1) further investigation into the processes involved in establishing and maintaining these relationships, and (2) exploration of the mechanisms of service delivery are necessary to identify how and why programs can work with a diverse group of participants.

In a study reviewing six home visiting programs and why they may not work for some clients, Josten and associates (Josten, Mullett, Savik, Campbell, & Vincent, 1995; Josten, Savik, Anderson, Bendetta, Chabot, Gifford, et al., 2002) examined home visitor and client-home visitor relationship characteristics that led to approximately one-quarter of enrolled mothers to drop out of the program before completing their goals. Most of the participants who dropped out of the program told their home visitors that they no longer wished to continue the home visits and were leaving the program (n=35). The other 12 mothers who dropped out were dropped by the program administrators because they were never home when the nurses came out for appointments.

Josten and colleagues (2002) found that there were differences in the pattern and frequency of service delivery between the mothers who were able to complete the program by meeting their goals and the mothers who dropped out. This was associated both with nurse and mother characteristics. Nurses who had specific personality types and who reported being most satisfied with their jobs tended to put in more work hours and had participants who completed their program goals. Mothers who completed the program goals were more likely to be in more stable, well-off situations than the mothers who did not complete the program. Missed visits resulted in lack of participation in the program and ultimate failure in program outcome areas. The researchers concluded that the nurses' conscientiousness or neuroticism levels, as measured by the NEO personality inventory, influenced their work style with in turn affected the likelihood of being able to work with mothers to the completion of program goals. While not tested in this study, Josten et al., (2002) posit that the nurses' interaction styles may lead to specific types of relationships with the participants in a home visiting program, and this relationship and

interaction style may influence, either positively or negatively, the participants' progress in the program.

In summary, all of the studies reviewed to this point emphasize that both participants and home visitors bring unique work and interaction styles, strengths, and weakness to the relationship. Mother and home visitor demographic characteristics as well as qualities of the relationship have been shown to impact program outcomes. A variety of research publications identify home visitor characteristics to the same end. There are few studies that examine program delivery processes and characteristics of the interaction styles and relationships that can help explain why a program works and why it might not work, and they only begin to scratch the surface of these issues.

## Head Start Home Visiting Programs

In an effort to look at aspects of home visiting programs specifically related to child care, the literature yields only two articles describing and explaining home visiting programs associated with Early Head Start programs. These articles begin to fill the gap in both family child care home visitation research as well as relationship-based program process evaluation as a whole.

Early Head Start programs have recently been employing home visiting techniques to improve the quality of care children in the program receive when family child care is the care setting of choice. The following summaries of two relevant articles offer rich descriptions of the programs themselves and strive to analyze the processes involved within the program between the home visitors and the participants. It is this information about program process that is of interest and is summarized here.

In 2001, Roggman, Boyce, Cook, and Jump examined a program administered by Early Head Start (EHS) in Utah and Idaho designed to improve the caregiving skills and parent-child relationships/interactions with low-income mothers in a rural community. Home visitors reported having "outstanding" relationships with 30% of the participants, "better than most" relationships with 26%, typical with 23%, adequate with 13%, and tense/difficult relationships with 6%. Home visitors were asked to rate the quality of the home visits in the same manner. They reported that 23% of their home visits were "outstanding," 38% "better than most," 18% "typical," 7% "adequate," and 15% distracted/crisis oriented.

Roggman et al., (2001) reported that when families were perceived by their home visitor as functioning well at enrollment, they were also rated as showing improvement as the course of the program went on. When the home visitor perceives families positively, they also rate their interactions with the parents and the home visits themselves positively. Parents and home visitors had similar opinions about the quality of their relationships and home visits.

Roggman and associates (2001) suggest that it is important to gather information from both the home visitors and the participants in these types of programs. They noted that while there may be bias in the home visitors' ratings of the quality of their work (they rated the level of improvement in family functioning and parent-child interaction), the variation and moderateness of their ratings of their relationships with the participants and the home visits themselves suggests that bias was not a factor.

In conclusion, Roggman et al., (2001) emphasizes the uniqueness of each home visitor-participant relationship. Home visits vary in quality, content, process, and

perception within and across programs. Only home visitors can rate differences in their home visiting experiences, but it is important to gather information from the participants in order to further explain why some families succeed in a home visiting program and some do not. In this EHS program, parents who were seen as active participants during home visits, were perceived by the home visitor as functioning well and improving, were parents who received effective home visiting training and were rated as improved in caregiving quality at the end of the program.

Perhaps the most relevant home visiting evaluation research published to date, comes from Buell, Pfister, and Gamel-McCormick (2002) and is the beginning of the bridge between the family child care and home visiting literatures. It is the only article found in either genre that examines a home visiting program specifically designed for family child care providers. The main objective of this study was to examine the benefits family child care providers received by partnering with Early Head Start programs via training in the homes.

The study outlined here utilized Northern Delaware Early Head Start (NDEHS) caregivers and families as participants in the program being evaluated. NDEHS provides a trained home visitor to offer weekly technical assistance to each family child care provider accepting EHS children. These home visitors have background and education in child development, early childhood education, and early intervention. Home visitors, also called Early Care and Education Coordinators, are assigned to no more than 12 family child care homes. The family child care providers in the program develop their own improvement plans and are required to obtain CDA credentials within one year of receiving EHS children. The home visitors are available to facilitate the providers'

attainment of goals she has made for herself in the improvement plan. NDEHS offered financial support and assistance to the providers in the program to facilitate their achieving their goals, including obtaining the CDA. Providers used these funds to pay for materials and equipment to use with the children in their care as well as costs of participating in college/CDA classes and training workshops. A total of four family child care providers involved in the program for two years were evaluated individually and interviewed for this study. Buell et al., (2002) note that these women were also leaders in the field of family child care and in their communities.

The average score for these four providers on the Family Day Care Rating Scale (FCDRS, Harms & Clifford, 1989) was 5.9. The national average (and scale average) is 3.5. Each of these providers was over 40 years of age, and three were African American. They received more than 580 hours of training in child care, child development, and early childhood education from either in-home training offered by the program or via workshops and college courses paid for by the program. During the course of the program, all four providers earned their CDA credentials and one sought and obtained national accreditation. All providers involved in this study reported very high levels of job satisfaction and enjoyment. They also all reported that they had held other jobs and pursued other career paths prior to becoming child care providers.

Researchers interviewed the four participants for approximately 1.5 hours. Questions in the interview session addressed motivations for pursuing a career in child care, opinions about being a child care professional, what types of support the participants felt they received from the program, and what types of support were lacking from the program. All four of the providers reported feeling specific challenges

associated with caring for infants and toddlers. They all described caregiving as a profession that was more important than any other career available. They did report that they felt people outside the caregiving world did not value the job nor did they consider it to be a challenging or important career. These providers pointed to their CDA credentials to support their being professionals.

Buell et al., (2002) reported a variety of supports that were identified through themes in the interviews. Providers stated that their home visitors helped them to organize their programs, gave them activity and curriculum ideas for working with infants and toddlers, and helped them to identify and acquire necessary materials, equipment, and training. Providers also reported feeling emotional support through their relationships with their home visitors which resulted in increased feelings of self-esteem and self-efficacy. Providers valued above anything else their relationship with their home visitor and reported that that support was tantamount to their being successful in offering the highest quality of care possible. Providers also reported being supported by financial assistance, but these supports were not held as in a high a regard as the support received by having a home visitor.

Providers reported changing their attitudes and abilities in caregiving as a direct result of being involved in the NDEHS program. Three of the four providers indicated they felt they had improved their level of expertise in child care knowledge and their sense of professionalism. They extended this idea by reporting that these increases allowed them to feel better and more confident about their being child care providers and professionals in the child care field (Buell et al., 2002).

In summary, Buell et al., (2002) note that the purpose of the NDEHS program was to provide economic, training, and emotional support to family child care providers desiring to care for EHS children. The NDEHS program met the needs of the four providers interviewed in this study primarily by offering a technical support home visitor. Providers reported that the home visitor was the most important aspect of the program in improving their caregiving skills and sense of professionalism.

## Summary and Conclusions

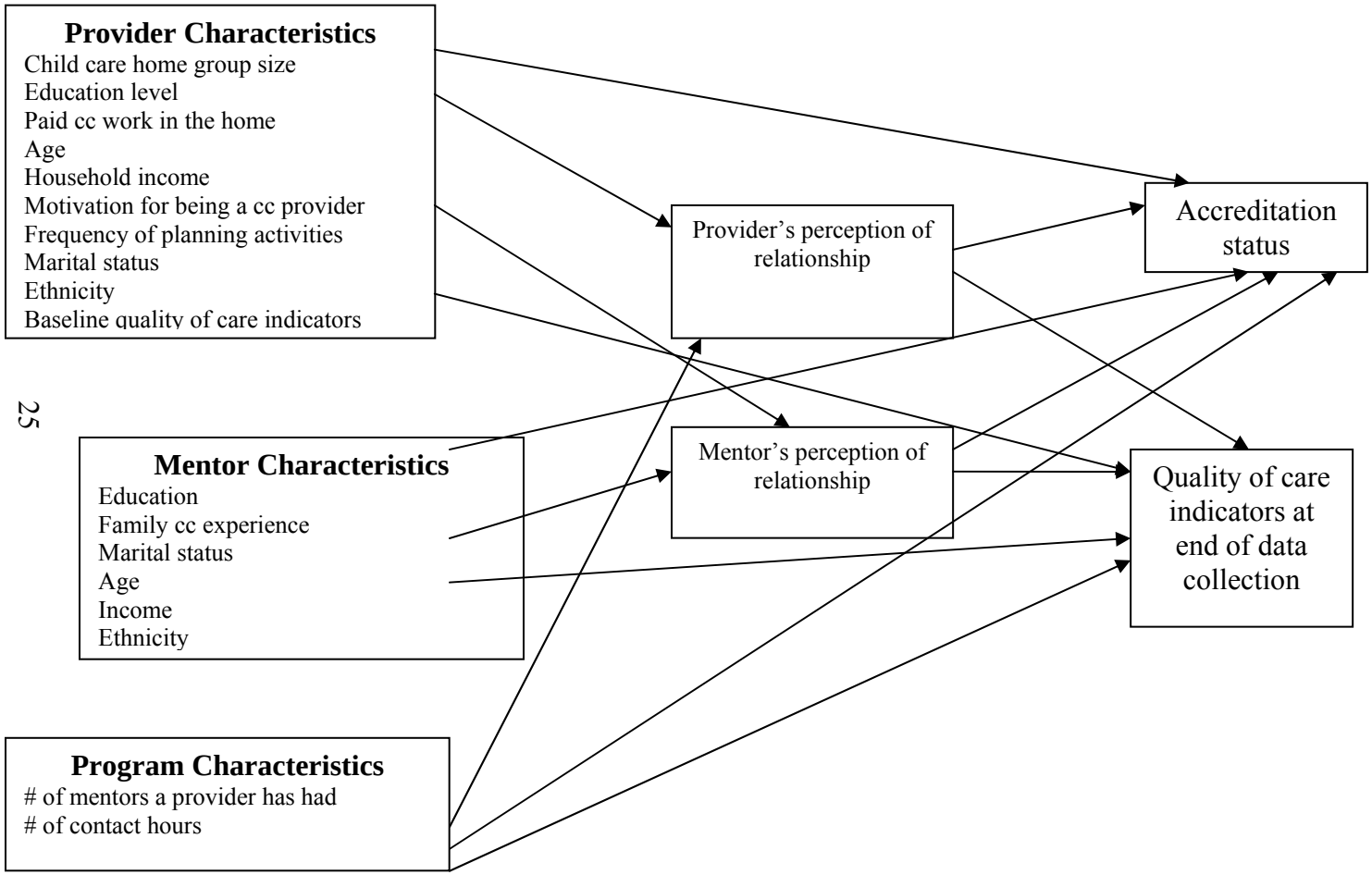
Research published about family child care quality and training indicates a need to provide training and quality enhancement assistance to family child care providers. The literature provides solid evidence that training increases quality (Galinsky et al., 1994), children in higher quality care have better outcomes (Howes, 1997a; Howes, 1997b; Howes, Hamilton, & Phillipsen, 1998; Howes, Hamilton, & Matheson, 1994), and one effective way to administer training to this underserved and often isolated group of caregivers is through home visiting (Buell et al., 2002; Gomby, 2000).

In reviewing the home visiting research, the utility of this method of training program delivery is clear. The home visiting research offers methods and models to test program effectiveness as well as processes through which home visiting programs work to be effective. Family child care providers themselves report the necessity and desire for continuing in-home training programs for these caregivers. The sparse amount of literature specific to family child care as well as the limited, but new, publications outlining program processes provides justification for more study of predictors and processes at play in program effectiveness.

The current research is designed to examine the features of the Family Child Care Partnerships (FCCP) mentoring program, the providers who are its participants and its home visitors (mentors), and the contributions of the provider-mentor relationship as they relate to indicators of provider success in increasing the quality of their child care practices. A visual summary of the key features from the above research literature associated with successful outcomes in family child care or home visiting training programs is found in Figure 1. Specifically, dependent variables include provider characteristics (e.g., child care group size, education, previous experience as a child care provider in the home, age, motivation for becoming a child care provider, martial status, and ethnicity); mentor characteristics (e.g., education, experience with family child care, age, household income, marital status, and ethnicity); and program characteristics (e.g., number of mentors assigned to a provider and contact hours). Independent variables to be analyzed include mentor-reported scores of providers on the FDCRS (Harms & Clifford, 1989) and three sub-scales of the Caregiver Interaction Scale (CIS, Arnett, 1989) – well-established, reliable assessments of child care quality. In addition, provider accreditation status as a result of participating in FCCP will be examined. The dependent and independent variables will also be examined in relation to potential mediators – provider perception of the quality of the mentoring relationship and mentor perception of the quality of the relationship – as measured by a modification of the Helping Relationships Inventory (Young & Poulin, 1998).

While home visiting program research has identified participant characteristics, home visitor characteristics, relationship quality variables, and program features as possible explanation points for successful program outcomes, none of the research

*Figure 1.* Illustration of Predictor, Potential Mediating, and Outcome Variables.



available takes a comprehensive view of all of these variables. The present study was designed to describe a targeted training program utilizing the home-visiting service delivery model and bridge the gap between descriptive studies of program evaluation and process-oriented examinations of program effectiveness.

# III. FAMILY CHILD CARE PARTNERSHIPS

## PROGRAM DESCRIPTION

### Project Overview

Increases in the minimum standards for licensing in Alabama, imposed in January 2001, required that family child care providers receive a minimum of 20 clock hours of training on an annual basis. A majority of providers have been willing to rise to the challenge of meeting the new standards, including the increased training requirements. However, even under the old training standards, many family child care providers had difficulty in finding after-hours (starting after 6:30 PM) training workshops they could get to that met their special needs and interests (i.e., working with multi-age groups and operating a home-based business). Additional barriers reported by family child care providers limiting their participation to accessible training include the perceived relevance of the training being offered to the specific needs and challenges of family child care and limited availability of transportation and time and financial resources needed to attend workshops.

The Family Child Care Partnerships (FCCP) project was designed to provide accessible training relevant to the needs of the family child care setting in a manner that addressed providers' perceived barriers. The primary purpose of FCCP is to assist

Alabama's licensed family child care providers to provide high quality child care services with a focus on moving them toward national accreditation standards. By fulfilling this purpose, it is the vision of FCCP that family child care providers will develop and apply their knowledge and utilize available supports to foster the healthy growth and development of the infants, toddlers, and preschoolers in their care. FCCP uses several approaches to promote high quality care and to provide caregivers with the tools and motivation needed to realize these goals.

28

The primary mechanism FCCP uses to teach and demonstrate principles of high quality child care is through individualized, in-home training provided by a knowledgeable mentor (home visitor) familiar with the special needs of family child care providers. Mentors address a variety of subjects during the home visits, including but not limited to the following: 1) health, safety, and universal precautions; 2) space and furnishings for care and learning; 3) child development; 4) facilitation of children's language, reasoning, literacy, and numeracy; 5) planning and conducting learning activities for mixed-aged groups; 6) positive discipline and guidance; 7) working relationships with families; 8) business practices for home-based child care; and 9) professional development (options for education, certification, accreditation, and membership in professional associations).

In addition to the mentoring component of the program, FCCP addresses some of the economic barriers to meeting high quality care standards. It provides its participants

with up to $500 to cover costs associated with having enough equipment that is in safe repair and developmentally appropriate for the children. FCCP also provides a full $495 scholarship to all providers enrolled in the program who reach a level of quality qualifying them to apply for accreditation by the National Association of Family Child Care (NAFCC).

A third way FCCP promotes quality child care practices among providers is by facilitating their professional development through promoting networking opportunities and their participation in training opportunities provided by other organizations and agencies. Mentor-facilitated group training meetings are designed to support additional educational needs, to encourage provider networking, and to foster provider professionalism. Mentors become familiar with other family child care-related agencies and organizations--including professional development networks and opportunities that serve to educate, recognize, scholarship, and/or reward providers with regard to implementing best practices and professionalism efforts--and facilitate providers' connections with them.

## FCCP Mentoring Processes

FCCP has been in operation in the field since April 2000, after 22 mentors were hired, trained, and began statewide recruiting of family child care providers into the program. Since then, influenced by budgetary restrictions and personnel changes, FCCP's mentoring staff has expanded to as many as 24 and ebbed to a low of 16 mentors, some of whom worked part-time. FCCP mentors are trained to conduct individualized, in-home training on a weekly basis, for a period of time varying according to the individual needs of the providers. The average length of a mentoring visit is between 2 and 3 hours, but

can range from 1 to 5 hours. Mentors average seeing 8 to 10 providers each week but can range from 3 to 15 providers on a caseload.

The assumptions underlying FCCP's use of a mentoring approach are the following:

- A mentoring approach maximizes the opportunity to identify specific needs for quality improvement for individual providers.
- It creates a sense of partnership that can facilitate new ways of perceiving and behaving in the child care setting and provide the impetus for change.
- Suggestions for quality improvements are more likely to be incorporated when a mentor with whom the provider has developed a rapport and established a trusting relationship context is available to coach her through the changes.
- Such suggestions for quality improvements are more likely to be relevant to a provider's individual child care setting when given by a mentor who visits regularly and understands the strengths and constraints of the provider's care giving.
- Assistance that is context-sensitive and addresses the specific, unique needs of family child care providers for information, support, and/or encouragement is more likely to be understood and applied than training addressing topics about which provider may not yet have a concern.

Mentors identify goals for improvement based quarterly assessments using the Family Day Care Rating Scale (FDCRS; Harms & Clifford, 1989) (see Appendix B), the Caregiver Interactions Scale (CIS; Arnett, 1989) (see Appendix C) and the NAFCC Quality Standards for Accreditation guidelines. Mentors utilize positive communication

and modeling techniques, as well as print and video materials (approved or developed by the FCCP Program/Mentor Coordinator), to offer instruction and improvement opportunities for providers.

Mentors are trained to use a combination of original and existing research-based curricular materials to work with providers on specific quality concern issues identified by the providers, mentors, and the Program/Mentor Coordinator. Mentoring staff attend, on average, quarterly training meetings, three times a year (usually two days in length) conducted primarily by the FCCP program coordinator and director. In addition, mentoring staff attend smaller, regional meetings as needed (usually 1/2 day in length, up to 3 times per year) conducted by the program coordinator. Training topics are identified from information gathered through normal supervisory channels, from needs expressed by mentors, from provider feedback, and from issues emerging from the within the family child care community as a whole.

Between pre-service training in March 2000 (and subsequently held for new mentors as they were hired) and December 2003, mentors received NAFCC observer training and were also educated on the following topics: instructional processes in mentoring and group instructional situations, procedures for quality control of provider group meetings and available training resources, the use of educational television programming in literacy activities, incorporating music and literacy activities in the child care home, provider-parent communication, the how's and why's of setting up provider associations, conflict management, goal setting, marketing and business practices, developmentally appropriate practice, language development, universal health and safety precautions, identifying and reporting child abuse and neglect, and a variety of quality

child care activities. These trainings are also an opportunity for mentors to share their successes with each other, to problem-solve their challenges, to learn about new, instructional resources and ways to use them effectively with their providers, and to improve their efficiency and effectiveness in the field.

Mentors encourage and facilitate provider participation in completing the professional development articles/activities presented in the "Everyday TLC" newsletter. Through the use of this resource, providers are able to earn 40 clock hours toward the CDA credential. Activities in the newsletter include suggestions for program design, child-directed, developmentally appropriate activities for all ages of children (birth through school-age), and professional development articles and activities. Mentors help providers to integrate the programmatic materials in the newsletter into their daily routines.

Mentors assist providers in developing appropriate activities that involve language, print materials, and basic math skills, with a focus on how to create reading and math centers/areas in their homes using both provider-made and commercial materials; appropriate use of reading, language, writing, and math materials; and the use of such materials with infants and toddlers as well as preschoolers.

Mentors work with providers to identify materials and equipment necessary to meet accreditation standards. Mentors then assist providers in requesting, through an application process, specific equipment from the FCCP program. Mentors also assist provider achieving NAFCC standards in obtaining and completing the application. FCCP makes available the $495 fee required for applying for accreditation.

Finally, mentors facilitate connections among providers and between providers and other family child care-related agencies and organizations, through formal and

informal professional development networks and opportunities that serve to educate, recognize, and reward providers with regard to implementing best practices and professionalism efforts. Mentors identify local resource agencies and foster relationships with those agencies in an effort to coordinate services and act as an informational liaison between the providers and the agencies. Mentors develop relationships and collaborations with organizations and agencies sharing similar goals for child care quality enhancement. Mentors inform providers of opportunities to involve themselves in professional organizations, continuing education programs, and FCCP group training meetings and encourage their doing so.

33

## Program Documentation

Data collection takes place during the first month of program enrollment to establish a baseline level of quality. Mentors are instructed to observe the provider during the first two visits for a minimum of 8 to 10 hours and complete global quality ratings (FDCRS and CIS – described below). Providers complete a demographic/child care business survey, a questionnaire about attitudes toward child rearing, and complete a perceived stress and social support interview within the first month of program participation. Quarterly assessments are completed by the mentors for each provider in their caseload including the FDCRS and CIS measures. Providers complete follow up surveys periodically throughout their participation in the program. All measures are described in detail in the following section.

After the initial month of visits designed primarily for in-take data collection and for the mentor and provider to begin a trusting relationship, mentors were instructed to schedule weekly visits with their providers. The duration of each visit (on average lasting

2 hours) as well as the topics addressed at those visits was determined by the mentor in partnership with each provider. When visits could not be kept, mentors were instructed to document the reason for not completing a visit.

Mentors documented aspects of each home visit on a "Daily Activities Report" (DAR). Each time a mentor conducted a home visit, she used the DAR to document the date of visit, arrival and departure time (which can be used to determine contact hours), number of children present, number of adults present, topics addressed during the visit, and method of service delivery. There are six categories of topics from which mentors could make a selection. These topics include Child Development, Health and Safety, Quality Care for Children, Child Care Professional and the Family, Language Development, and Positive Discipline and Guidance. Licensed family child care providers are required to receive 20 clock hours of training across these six domains each calendar year in order to maintain their license.

## Assessment of Benefits and Impact

Training through in-home visits is expected to result in measurable increases in the quality of provider care giving behaviors. Assessments for structural and process quality for each provider are carried out at provider intake and once per quarter thereafter (see Methods section for detailed information about measures). Changes on the quality measures are documented for each provider over the length of the mentoring partnership. Analyses of changes are documented by provider and reported by quality indicator category and by aggregate change per quarter. Across the course of the program's existence, we have seen more providers attempt achieving accreditation level status. When FCCP began in the spring of 2000, only 8 providers in the state were accredited.

Now (August 2005), 35 providers in the state have achieved accreditation and many more are in the accreditation process.

By offering and facilitating group training opportunities and encouraging the formation of local and state-wide provider associations, providers gain additional training hours on an ongoing basis. Providers also form informal support groups and/or formal provider associations and increase their levels of professionalism. In the fall of 2003, providers were asked to report their involvement in local provider association groups and whether or not they are continuing their education outside of participating in FCCP. Just over half (51.7%) of the respondents reported that they are members of their local association, and the majority of those involved in their associations reported attending meetings regularly. Many (18.8%) reported holding an office or being a committee member in the association. Of those reporting not being a member of an association, 22% reported there is no known association in the area. Very few providers (28 total) reported being involved in continuing education programs.

Information presented in Table 1 summarizes FCCP quality enhancement achievements in the context of 4 prior project years. It includes information about staffing, provider enrollment, number of hours of training offered, and provider achievements and how these aspects of the program have changed over the years.

Table 1 Mentoring Achievements

| | 2000-01 | 2001-02 | 2002-03 | 2003-04 |
|---|---|---|---|---|
| **Providers enrolled at the end of the year** | 155 | 198 | 161 | 207 |
| **Mentors employed** | 20 | 24 | 18 | 18 |
| **Mentored training hours awarded** | 5869 | 7541 | 7203 | 6375 |
| **Group training hours awarded** | 1440 | 4726 | 2482 | 1031 |
| **Accredited providers** | 1 | 0 | 18 | 25 |
| **Providers in the process of submitting NAFCC applications or awaiting NAFCC visit** | 0 | 5 | 34 | 36 |
| **Average provider FDCRS** score at end of project year** | 4.65 | 4.93 | 5.31 | 4.89 |

**** Family Day Care Rating Scale is a 32-item standardized child care quality assessment used by mentors to measure provider progress across a range of specific quality indicators. A score of 7 is the highest possible.**



## Participants

Since the inception of the FCCP program, approximately 330 providers have enrolled. Descriptive information is available for just 278 out of these 330, partly because participants in FCCP, while strongly encouraged to do so, are not required to complete in-take surveys and in part because some data were lost. Descriptive information about 15 of the 22 mentors employed by FCCP within the last year of data collection (those who gave permission for their information to be used for this study) is presented in Table 2 along with details and more information about characteristics of providers involved with the FCCP program. Additional information about provider employment history, services

and operations, job descriptions, involvement in local provider associations, and continuing education is listed in Table 3.

Table 2
Demographic Characteristics of Participants and Mentors

| Characteristic | Providers | Mentors |
|---|---|---|
| Ethnicity | N = 270 | N = 15 |
| White | 46 % | 20 % |
| Black | 53 % | 80 % |
| Age | N = 271 | N = 15 |
| Under 25 | 3 % | 0 % |
| 26-30 yrs | 11 % | 0 % |
| 31-40 yrs | 27 % | 20 % |
| 41-50 yrs | 37 % | 60 % |
| 51-60 yrs | 19 % | 20 % |
| over 60 | 4 % | 0 % |
| Education | N = 270 | N = 15 |
| Less than high school | 6 % | 0 % |
| High school graduate | 32 % | 7 % |
| GED | 9 % | 7 % |
| Some college, but no degree | 37 % | 20 % |
| Associate degree | 9 % | 13 % |
| Bachelor's degree | 7 % | 53 % |
| Master's degree | 1 % | 0 % |
| CDA (n=249) | 16 % | 13 % |
| Marital Status | N = 257 | N = 15 |
| Married | 80 % | 73 % |
| Single – not living with partner | 20 % | 27 % |
| Living Area | N = 260 | N = 15 |
| Rural area | 33 % | 20 % |
| Town | 21 % | 20 % |
| Suburb | 11 % | 13 % |
| City | 36 % | 47 % |
| Gross household income | N = 252 | N = 15 |
| Less than $5000 | 3 % | 0 % |
| $5,001-10,000 | 6 % | 0 % |
| $10,001-15,000 | 9 % | 0 % |
| $15,001-20,000 | 12 % | 0 % |
| $20,001-25,000 | 6 % | 0 % |
| $25,001- 30,000 | 12 % | 20 % |
| $30,001 and over | 53 % | 80% |

Table 3
Employment History and Operations

| | Enrollment |
|---|---|
| Employment History | |
| Number of years in paid child care | N = 274<br>X = 9.49<br>SD = 7.51<br>Min. = < 1 yr<br>Max. = 33 yr |
| Number of years as a paid family child care provider | N = 272<br>X = 7.63<br>SD = 6.72<br>Min. = < 1 yr<br>Max. = 33 yr |
| **Operations** | |
| Fee Structure | N=264 |
| Fees are set | 40 % |
| Fees change when more than one child per family is enrolled or based on age | 32 % |
| Fees are set or flexible depending on families enrolling children | 22 % |
| Other or more than 1 answer given | 7 % |
| Operating Hours | N=264 |
| Set and strict hours | 36 % |
| Set but flexible hours | 35 % |
| Changes based on needs of families | 29 % |
| No set hours | 1 % |
| Frequency of Planning Activities | N=262 |
| Several times per day | 18 % |
| At least once per day | 32 % |
| 3 to 4 times per week | 24 % |
| 1 or 2 times per week | 19 % |
| Less than 1 time per week | 7 % |

# IV. METHOD

## Procedures

Secondary data were available for this research protocol from providers enrolled in the FCCP program between April 2000 and December 2003. Each provider enrolled in the FCCP program (n = 331) was asked to complete a demographics and child care business survey upon enrollment. Quarterly quality assessments were completed by mentors for each provider (see section on measures for more information). Providers enrolled and/or actively participating in the FCCP program between March 2003, and March 2004 (n = 202), were asked to complete a Helping Relationships Inventory for the purpose of collecting information for this study. Mentors in the FCCP program employed between March 2003, and March 2004 (n = 22), were asked to complete a demographics and background survey as well as a Helping Relationships Inventory for each of the providers they were currently working with or had worked within six months of completing the questionnaire. Informed consent was obtained as directed by Auburn University's Institutional Review Board for all providers and mentors included in the study analyses.

Currently employed mentors were contacted in person and given instructions for completing the surveys, as part of their work normal responsibilities. They were also asked to give consent for their information to be used in the current research. Mentors previously employed by FCCP were contacted through a letter explaining the study and

inviting them to participate. Because the researcher is also the primary supervisor for currently employed mentors, procedures were put in place to protect the identity of all of the mentors and their respective decisions to participate or not participate in the study. Consent forms were gathered separately from the questionnaires, which were numbered with special codes. A graduate assistant collected the consent forms and assigned alternate identification codes to the mentors and providers whose data were included in the study. The assistant turned over to the researcher only those questionnaires provided by mentors who gave consent for their date to be used in this study. The researcher did not have access to the identification codes and is not able to determine the identities of study respondents.

## Study Participants

Participants in this study include 203 family child care providers who were enrolled in the FCCP program within one year of data collection (December 2003) and had a background and business practices survey on file as well as both baseline and one subsequent score on the quality of care outcome measures (see measures section for more information). Fifteen of the 22 mentors employed by FCCP within one year of data collection consented to allowing their information to be analyzed for the current study.

### *Provider Specific Information*

Upon enrollment in the FCCP program, providers reported information about their demographic characteristics, childcare services and operations, as well as their business and professional practices. Two-hundred-two FCCP providers (enrolled within one year of ending data collection for this study) were asked to complete a survey asking questions concerning their relationships with their mentors. One-hundred-twenty of those

invited to complete this survey responded, for a completion rate of 60%. Mentors reported information about their relationships with 108 of their providers. Relevant demographic information for providers enrolled in FCCP who were included in the study and for providers who completed information about their relationships with their mentors is presented in Tables 4 and 5. Note that not all demographic information is available for each participant. Providers included in the study had completed enrollment surveys about their backgrounds and business practices. However, not every participant answered every question on the survey.

Table 4 shows that for both the full participant group (those who have information on file about their demographics and outcomes) and the sub-sample of participants (those who have the Helping Relationships Inventory on file in addition to the other study variables), there are approximately equal numbers of white and black providers, the majority of providers for both groups are in their 40s, most have attended some college but have no degree, and the majority are married. Providers in both groups reported an average of seven years of experience in family child care and tend to plan activities at least once per day. Approximately two-thirds of the participants operate group childcare homes, which can serve 7-12 children with at least one assistant caregiver.

Table 4
Demographic Characteristics of Providers for Study

| Characteristic | Full Study Group | Sub-Sample |
|---|---|---|
| Ethnicity | N = 181 | N = 84 |
| White | 43% | 46% |
| Black | 56 % | 51% |
| Other | 1 % | 2% |
| Age | N = 181 | N = 83 |
| Under 25 | 2 % | 1% |
| 26-30 yrs | 8 % | 6% |
| 31-40 yrs | 24 % | 28% |
| 41-50 yrs | 41 % | 40% |
| 51-60 yrs | 20 % | 19% |
| over 60 | 5 % | 6% |
| Education | N = 180 | N = 85 |
| Less than high school | 4 % | 4% |
| High school graduate | 34 % | 27% |
| GED | 9 % | 7% |
| Some college, but no degree | 40 % | 47% |
| Associate degree | 7 % | 7% |
| Bachelor's degree | 6 % | 7% |
| Master's degree | 1 % | 1% |
| Marital Status | N =172 | N = 79 |
| Married | 81 % | 84% |
| Single – not living with partner | 19 % | 17% |

Table 5
Employment History and Operations for Providers in Study

| | Full Study Sample | Sub-Sample |
|---|---|---|
| Employment History | | |
| Number of years as a paid family child care provider | N = 182<br>X =7.83<br>SD = 6.67<br>Min. = < 1 yr<br>Max. = 33 yr | N = 82<br>X = 7.10<br>SD = 6.58<br>Min. = < 1 yr<br>Max. = 33 yr |
| Frequency of Planning Activities | N=175 | N = 82 |
| Several times per day | 19% | 24% |
| At least once per day | 31% | 29% |
| 3 to 4 times per week | 25% | 24% |
| 1 or 2 times per week | 17% | 15% |
| less than 1 time per week | 8% | 7% |
| Childcare Group Size | N = 187 | N = 86 |
| Single Family Home | 62% | 58.% |
| Group Home | 38% | 42% |

*Mentor Specific Information*

Upon completion of the mentor information survey, 8 of the 15 respondents identified themselves as having worked as a family child care provider or assistant. Twelve had worked in Head Start or child care center classrooms as teachers. Ten mentors reported having been child care center administrators prior to working with FCCP. Ten mentors reported having had prior work experience as consultants or technical assistance specialists working directly with family child care providers, and eight of those responding indicated they had more than 2 years of full-time experience in this capacity prior to working for FCCP. Four mentors reported having no experience in the workforce outside of the child care field prior to working with FCCP.

Mentors were asked to report how they saw their jobs as mentors for family child care providers as well as how they saw family child care providers themselves. Almost all mentors reported that being a mentor is their preferred occupation (n=13). One mentor reported seeing her job as temporary employment, and one mentor reported more than one answer. The majority of the mentors (n=11) reported that they believed family child care was something most providers choose to do for their careers, while four mentors reported that being a family child care provider is a good occupation to have when the providers' own children are young. Three mentors reported they were in the process of continuing their education by working on advanced degrees. All but one of the mentors responding reported belonging to at least one professional organization. All mentors received professional and continuing education through the FCCP program during their employment.

## Measures

### *Outcome Measures*

#### *Quality Care Assessments*

Mentors collected baseline quality care data during the first month of each providers' participation in the program and again approximately every three months thereafter. Mentors were asked to spend between 8 and 10 hours of observation with each provider before completing the Family Day Care Rating Scale (FDCRS) and Caregiver Interaction Scale (CIS) assessments. Specific information about each measure follows:

##### *Family Day Care Rating Scale*

The Family Day Care Rating Scale is a nationally standardized assessment tool designed to comprehensively measure key aspects of quality in family child care home settings (Harms & Clifford, 1989). The measure consists of 32 items, is broken into six sections, and is scored using a seven-point Likert-scale. The six scale categories are Space and Furnishings for Care and Learning, Basic Care, Language and Reasoning, Learning Activities, Social Development, and Adult Needs. An additional 7-item section is available to score settings in which special needs children are offered care. For each item, a description is offered to guide scoring at the 1, 3, 5, and 7 anchors of the scale. Items are scored as inadequate (1), minimal (3), good (5), or excellent (7). Scores of ranging from 5 to 7 indicate high quality care, 3 to 4.9 indicate average quality care, and 1 to 2.9 indicate inadequate quality care. (A complete listing of the items and instructions for scoring can be found in Appendix B.) Previous research has independently validated the FDCRS (Pepper & Stuart, 1985).

In the present study, the average of all items scored on the FDCRS is used to measure the overall quality of care being offered. Chronbach's alpha for the full FDCRS scale in this study was .98. Mentors were trained to use the FDCRS by completing a video training session, a review of the items with a trained and experienced user of the scale, and practice observations in the field. No observer reliability information is available; however, an examination of distributions of scores within each mentor's caseload indicated variance indicative of mentors using the measure discriminately.

*Caregiver Interaction Scale*

The Caregiver Interaction Scale is a widely used global measure of caregiver interaction styles published by Arnett (1989). It consists of 26 items and is scored on a four-point scale. Mentors are asked to rate each statement as it applies to the target provider with a score of 1 meaning the statement does not at all describe the provider, 2 describes the provider somewhat, 3 describes the provider quite a bit, and 4 describes the provider very much. A complete listing of the items and instructions for scoring can be found in Appendix C.

The CIS was designed for use in testing the effectiveness of a college-course training program for center-based care providers in Bermuda and piloted in a variety of settings prior to its publication. A factor analysis of the scale yielded a four-factor solution including subscales labeled "Positive Interaction," "Punitiveness," "Permissiveness," and "Detachment" (Arnett, 1989). This measure has been shown by its developer and in other studies to measure levels of communication, warmth, enthusiasm, harshness, discipline style, and involvement between adult caregivers and the children in their care (Arnett, 1989; Howes, 1997a; Howes et al., 1998; Howes, et al., 1994).

In the present study, Arnett's (2004) instructions were used to determine providers' interaction quality on the four pre-determined scales. Chronbach's alphas were examined for each of the four scales (positive relationships ∞ = .91; permissive ∞ = .39; punitive ∞ = .80; detached ∞ = .61 with item 13 deleted). Due to its low level of reliability, the permissive scale was not included in any analyses. Mentors were trained to use the CIS by reviewing the items with a trained and experienced user of the scale and practice observations in the field. No observer reliability information is available; however, an examination of distributions of scores in each mentor's caseload indicated variance indicative of mentors using the measure discriminately.

To facilitate appropriate use of this measure in the analyses for the study, the "punitive" and "detached" scales were reverse coded and renamed. "Punitive" was renamed "non-punitive," and "detached" was renamed "engaged." Doing so allows for interpreting all CIS sub-scales in a positive direction. High scores on any subscale indicate higher quality interactions than low scores.

*Accreditation Status*

Provider accreditation status is a categorical variable ranging from 1 to 4 that is assigned to a provider based on her progress through FCCP's monitoring process designed to support successful application to the National Association for Family Child Care (NAFCC) for accreditation. Providers apply for accreditation through the FCCP office. Once the application has been received, an observer from the program is assigned to visit with the provider and evaluate her accreditation readiness. Information from this visit about provider needs for improvement is relayed back to the office, the provider, and the mentor working with that provider. Once needs for improvement are addressed and

NAFCC documentation is complete, the FCCP office submits the provider's application to NAFCC headquarters with the $495 scholarship fee. NAFCC then schedules an official accreditation visit in the provider's home and, upon being assessed as meeting required criteria, the provider is awarded accreditation.

For the purposes of this study, a provider was assigned an accreditation status code of "1" when her FDCRS scores had not yet reached acceptable levels to begin the pre-accreditation evaluation process or, alternatively, when the provider had gone through the process and it was determined she was currently unable to meet accreditation standards. Provider status was coded as "2" when the provider had applied for accreditation and completed the pre-accreditation process but still needed to make significant improvements before the application would be forwarded to the accrediting agency. Provider status was coded as "3" when the provider had applied for accreditation, completed the pre-accreditation process, and her application was (or would soon be) evaluated by NAFCC. Provider status was coded as "4" if the provider had received notification of her accreditation.

*Provider-Reported Information*

Demographic characteristics and child care business practices were assessed by a 38-question survey which asked provider questions about their education, race, age, household income, child care-related training and work practices, whether or not they describe themselves as professionals, and how they run their child care business (see Appendix D for the complete survey). Providers completed this questionnaire during the first or second home visit and returned it to their mentor who then submitted it to the FCCP office. Details of provider characteristics were reported in the preceding chapter.

*Helping Relationships Inventory (HRI)*

In the fall of 2003, providers were asked to complete the HRI in order to measure providers' perceptions of their relationships with their mentors. The HRI is based on a clinical survey developed by Young and Poulin (1998) for social workers to measure the quality of the helping relationship social workers have with their clients (see Appendix E for complete survey). For FCCP's purposes, the language in the survey was modified so that it could be filled out from the providers' perspective, reflecting their understanding and involvement in that relationship. Providers were mailed this survey and asked to send their completed survey back to the office without having the mentors facilitate this process. This method of response was deemed necessary to avoid social desirability and preserve the mentor-provider relationship.

The survey contains 20 questions. Nine items address aspects of the provider-mentor relationship in the context of what actually happens during a home visit (eg. "How much input have you had in determining the goals you are working on?"). Providers use a 5-point Likert-scale to indicate how much each question reflects their situation (1=not at all; 5=a great deal). Eleven items address aspects of the emotional or interpersonal quality of the relationship (eg., "Does talking with your mentor give you hope?). Providers use a 5-point Likert-scale to indicate how they feel about their relationship with their mentor (1=not at all; 5=a great deal). Scores were summed across all 20 items, with higher scores representing higher quality relationships. Total scores on the HRI were used to determine quality of the mentor-provider relationship from the provider's perspective. Chronbach's alpha for the total HRI was .96.

*Mentor Reported Information*

Mentors completed a demographics and background survey asking for information such as education, race, age, household income, child care-related training and professional experience, etc. Details about mentor characteristics were reported in the preceding chapter, and Appendix F contains the entire survey.

Mentors completed the "Helping Relationships Inventory" (Young & Poulin, 1998) on each of their provider relationships (with modifications in wording to describe the mentor-provider relationship from the mentor's perspective). Like the HRI completed by the providers, mentors assessed their individual relationships by responding to 20 questions, nine concerning what actually happens during a home visit (eg. "How much input have you had in determining how the two of you will work together?") and 11 addressing the emotional or interpersonal quality of the relationship (eg., "Does talking with your provider give her hope?). The full inventory can be found in Appendix G.

As with the provider version of the HRI, mentors used a 5-point Likert-scale to indicate how much each question reflected their situation (1=not at all; 5=a great deal). Scoring for the mentor version of the HRI was the same as described previously for the provider version. Total scores on the mentor form of the HRI were used to determine quality of the mentor-provider relationship from the mentor's perspective. Chronbach's alpha for the total HRI was .93.

# IV. RESULTS

## Preliminary Analyses

Correlations among the available variables for study are presented in Table 6. Note that variables related to mentor characteristics are not included in these analyses due to the low sample size (n= 15). To determine which indicators of provider and program characteristics would be included in the model tests, correlations among these variables and the potential mediating and outcome variables were examined. Provider and program variables which were related to one or more of the hypothesized mediating or outcome variables were selected for subsequent analyses. Descriptive statistics for these variables are presented in Table 7.

Provider characteristics meeting these criteria included provider's level of education, years of paid child care experience, frequency of planning activities, and the four baseline indicators of provider quality. Two program characteristics, number of mentors a provider worked with and total number of contact hours, met these criteria. Correlations among FDCRS and the three CIS subscales at both baseline and final data collection periods indicated potential latent constructs to be present. (Latent variable analyses are presented in the "Structural Modeling" subsection of this chapter.)

No correlations existed between one of the hypothesized mediating variables, provider perception of the mentoring relationship, and any of the other predictor, mediating (mentor perception of the relationship), or outcome variables. Therefore,

Table 6

*Correlations Among Study Variables* *(N Min = 90; Max = 203)*

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| Provider Characteristics | | | | | | | | | |
| 1. Childcare Group Size | | | | | | | | | |
| 2. Education | .153* | | | | | | | | |
| | (179) | | | | | | | | |
| 3. Paid Childcare Work | -.025 | -.082 | | | | | | | |
| in the Home | (181) | (174) | | | | | | | |
| 4. Age | -.070 | -.056 | .435** | | | | | | |
| | (180) | (178) | (175) | | | | | | |
| 5. Marital Status | -.036 | .061 | .047 | .132 | | | | | |
| | (171) | (170) | (167) | (170) | | | | | |
| 6. Ethnicity | .084 | .048 | -.030 | -.059 | -.025 | | | | |
| | (180) | (178) | (175) | (179) | (172) | | | | |
| 7. Planned Activities | -.120 | -.146 | .167* | .036 | -.082 | .091 | | | |
| | (174) | (177) | (169) | (172) | (165) | (174) | | | |
| Quality Indicators at Baseline | | | | | | | | | |
| 8. FDCRS | .064 | .2177** | -.023 | -.035 | -.164* | -.022 | .025 | | |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | | |
| 9. CIS – Positive Relations | -.021 | .093 | .048 | -.098 | -.139 | .028 | .106 | .540** | |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | |
| 10. CIS- Non-Punitive Rel's | .020 | .053 | .014 | .012 | .088 | -.087 | .032 | .227** | .359** |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 11. CIS – Engaged Rel's | -.029 | .094 | .073 | .097 | -.024 | .060 | -.021 | .290** | .373** |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| Program Characteristics | | | | | | | | | |
| 12. Number of Mentors | -.112 | .084 | .015 | .168* | -.014 | .247** | .026 | .170* | .123 |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 13. Total Contact Hours | -.074 | .016 | -.002 | -.047 | .213** | .005 | -.138 | -.206** | -.108 |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| Mediating Variables | | | | | | | | | |
| 14. Provider Perception of | -.062 | .037 | -.070 | .096 | .018 | -.112 | -.098 | -.137 | -.165 |
| Quality of Relationship | (86) | (85) | (82) | (83) | (79) | (83) | (82) | (90) | (90) |
| 15. Mentor Perception of | -.020 | .045 | .009 | -.131 | -.190 | .078 | -.129 | .159 | .151 |
| Quality of Relationship | (102) | (99) | (99) | (100) | (96) | (101) | (98) | (108) | (108) |
| Outcome Variables | | | | | | | | | |
| 16. FDCRS | .146* | .181* | -.167* | -.126 | -.062 | -.077 | -.182* | .232** | .167* |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 17. CIS – Positive Relations | -.029 | .083 | -.104 | -.061 | -.133 | -.066 | -.112 | .122 | .324** |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 18. CIS – Non-Punitive Rel's | .049 | .093 | -.094 | -.086 | -.144 | .040 | .013 | .032 | .106 |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 19. CIS – Engaged Rel's | -.025 | .180* | .021 | -.039 | -.072 | .067 | .128 | .289** | .199** |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |
| 20. Accreditation | .106 | .268** | -.098 | .044 | -.087 | -.054 | -.138 | .378** | .210** |
| | (187) | (180) | (182) | (181) | (172) | (181) | (175) | (203) | (203) |

Table 6 (cont'd)

*Correlations Among Study Variables* *(N Min = 90; Max = 203)*

| Variables | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 |
|---|---|---|---|---|---|---|---|---|---|---|
| Quality Indicators at Baseline (cont'd) | | | | | | | | | | |
| 11. CIS – Engaged Rel's | .309** (203) | | | | | | | | | |
| Program Characteristics | | | | | | | | | | |
| 12. Number of Mentors | .054 (203) | .079 (203) | | | | | | | | |
| 13. Total Contact Hours | -.080 (203) | -.073 (203) | -.053 (203) | | | | | | | |
| Mediating Variables | | | | | | | | | | |
| 14. Provider Perception of Quality of Relationship | -.088 (90) | -.060 (90) | -.038 (90) | .087 (90) | | | | | | |
| 15. Mentor Perception of Quality of Relationship | .199* (108) | .158 (108) | .099 (108) | -.043 (108) | .036 (63) | | | | | |
| Outcome Variables | | | | | | | | | | |
| 16. FDCRS | .157* (203) | .047 (203) | .040 (203) | .022 (203) | -.064 (90) | .295** (108) | | | | |
| 17. CIS – Positive Relations | .205** (203) | .188 (203) | -.004 (203) | .019 (203) | -.082 (90) | .130 (108) | .590** (203) | | | |
| 18. CIS – Non-Punitive Rel's | .364** (203) | .037 (203) | .030 (203) | -.023 (203) | -.096 (90) | .217* (108) | .366** (203) | .535** (203) | | |
| 19. CIS – Engaged Rel's | .046 (203) | .402** (203) | -.174* (203) | -.168* (203) | -.033 (90) | .202* (108) | .000 (203) | .086 (203) | .137 (203) | |
| 20. Accreditation | .140* (203) | .133 (203) | .223** (203) | .035 (203) | .076 (90) | .315** (108) | .517** (203) | .285** (203) | .131 (203) | .036 (203) |



52

Table 7
*Descriptive Statistics for Study Variables*

| Variables | N | Min. | Max. | Mean | Std. Dev. |
|---|---|---|---|---|---|
| Provider Characteristics | | | | | |
| 1. Childcare Group Size | 187 | 1 | 2 | 1.38 | 0.49 |
| 2. Education | 180 | 1 | 7 | 3.31 | 1.32 |
| 3. Paid Child Care Work in the Home | 182 | < 1 | 33 | 7.83 | 6.67 |
| 4. Age | 181 | 1 | 7 | 4.83 | 1.07 |
| 5. Marital Status | 172 | 1 | 2 | 1.19 | .40 |
| 6. Ethnicity | 181 | 1 | 6 | 1.61 | .65 |
| 7. Planning Activities | 175 | 1 | 5 | 2.63 | 1.20 |
| Quality Indicators at Baseline | | | | | |
| 8. FDCRS | 203 | 1.31 | 7.00 | 4.14 | 1.20 |
| 9. CIS – Positive Relations | 203 | 12 | 40 | 32.58 | 5.34 |
| 10. CIS – Non-Punitive Rel's | 203 | 15 | 26 | 25.14 | 1.72 |
| 11. CIS – Engaged Rel's | 203 | 1 | 9 | 7.49 | 1.97 |
| Program Characteristics | | | | | |
| 12. Number of Mentors | 203 | 1 | 3 | 1.22 | .51 |
| 13. Total Contact Hours | 203 | 13 | 467.25 | 155.99 | 94.59 |
| Mediating Variables | | | | | |
| 14. Provider Perception of Quality of Relationship | 90 | 21 | 100 | 84.4 | 18.17 |
| 15. Mentor Perception of Quality of Relationship | 108 | 50 | 98 | 79.71 | 10.56 |
| Outcome Variables | | | | | |
| 16. FDCRS | 203 | 1.40 | 7.00 | 5.42 | 1.04 |
| 17. CIS – Positive Relations | 203 | 16 | 40 | 33.38 | 5.43 |
| 18. CIS – Non-Punitive Rel's | 203 | 10 | 26 | 24.88 | 2.41 |
| 19. CIS – Engaged Rel's | 203 | 1 | 9 | 6.97 | 2.36 |
| 20. Accreditation | 203 | 1 | 4 | 1.57 | 1.02 |

provider perception of the relationship was eliminated from all further analyses. Figure 2 presents all of the variables in the models to be tested in subsequent analyses.

## Structural Modeling

Structural equation modeling was used to test the hypothesized mediation model and examine potential latent constructs among the quality indicators at both baseline and final data collection periods. Analyses were computed with Mplus (Muthen & Muthen, 1998), using the maximum likelihood estimation method. Five indexes were used to assess the model fit to the data. The chi-square statistic examined the general fit of the model. The Comparative Fit Index (CFI) and Tucker-Lewis or Non-Normed Fit Index (TLI) compare the fit of the model being tested to a baseline model (one in which none of the observed variables are correlated with one another). The Root Mean Square Error of Approximation (RMSEA) examines the model with respect to the population allowing the model to be fitted independent of sample size. The Standardized Root Mean Square Residual (SRMR) examines fit in reference to standardized scores for observed variables. A non-significant chi-square, CFI and TLI of 0.90 or higher, a RMSEA close to zero, and an SRMR of less than .05 indicate a "good" model fit (Bollen, 1989; Keiley, Dankoski, Dolbin-MacNab, & Liu, 2005).

## Latent Variable Analyses

Latent variable analyses were performed to examine whether the four "quality" indicators yielded a single "quality" construct with regard to baseline quality. The model provided an excellent fit, $X^2(2) = 5.02$, ($p = .08$), CFI = .98, TLI = .93, RMSEA = .09, SRMR = .03, indicating that the four quality indicators underlie a single factor. Non-standardized parameter estimates and standard errors for this fitted latent variable model

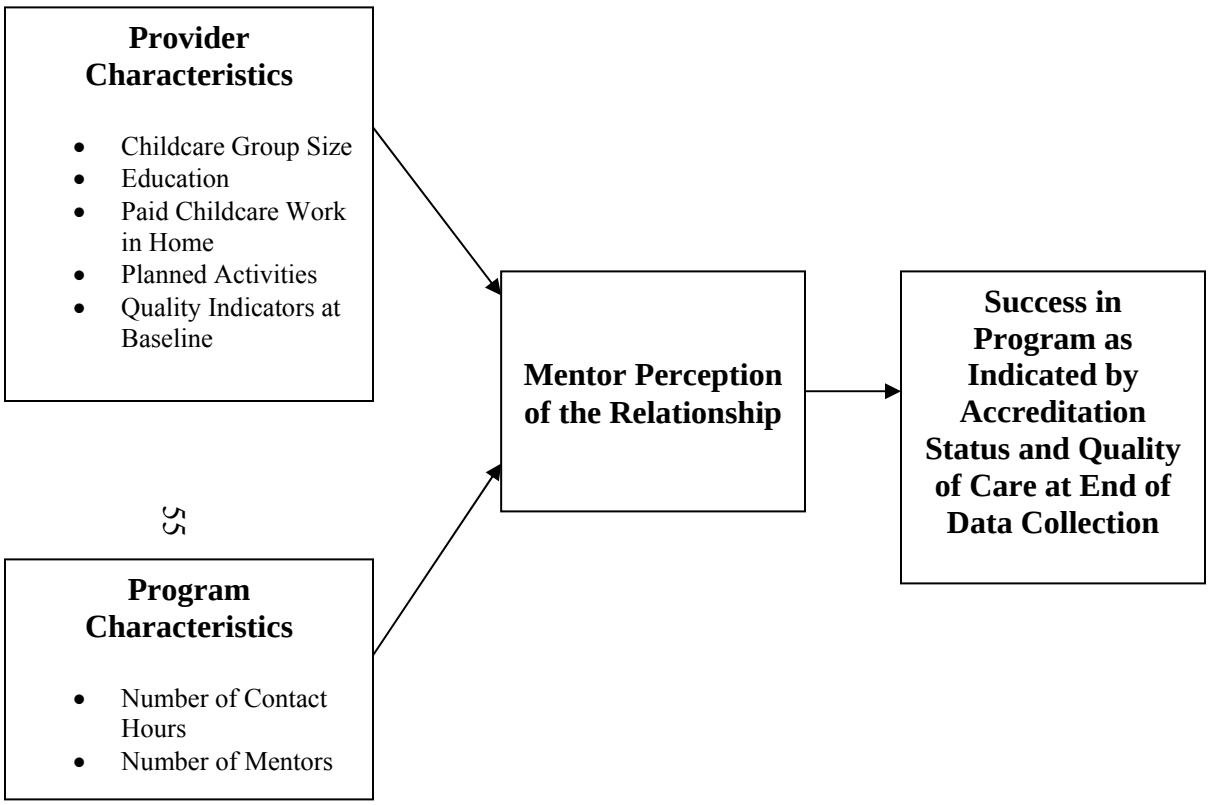



*Figure 2:* Hypothesized Model to be Tested Using Study Variables and Data

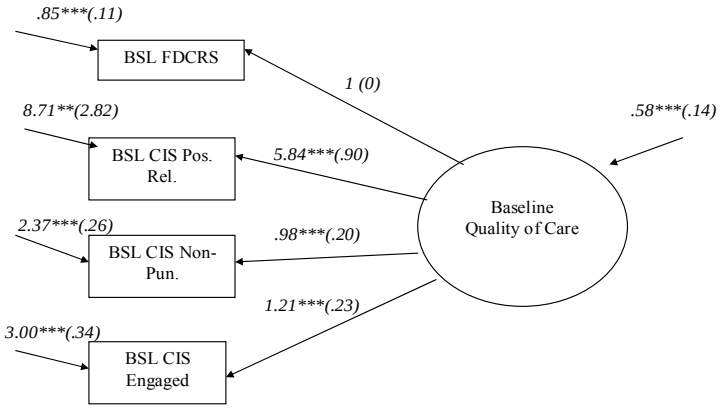
are presented in Figure 3 while standardized estimates are presented in Figure 3a. With regard to end-of-data collection quality measures, the model provided an excellent fit, $X^2(2) = 3.33$, ($p = .19$), CFI = .99, TLI = .97, RMSEA = .06, SRMR = .03, indicating that the four quality indicators again underlie a single factor. Non-standardized parameter estimates and standard errors for this fitted latent variable model are presented in Figure 4 while standardized estimates are presented in Figure 4a. These findings provide construct validity to the quality measures used in the present study.

## Structural Model Tests for Mediation

### *Accreditation Status*

The correlations among variables (Table 6) show that accreditation status at the end of the program is related to the provider's education, baseline quality indicators, number of mentors, and mentor's perception of the quality of the relationship. The mentor's perception of the quality of the relationship is related to a single aspect of the latent variable baseline quality.

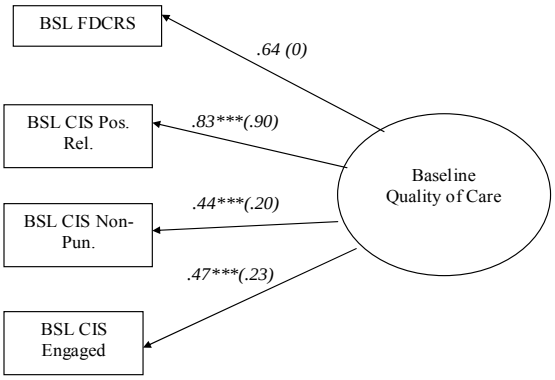
Following Baron and Kenny's (1986) instructions for testing mediation, three models were fitted to examine mentor perception of the relationship as a mediating factor in predicting provider accreditation status. Model 1 (Figures 5 and 5a) tested the hypothesis that provider and program characteristics independently influence the mentors' perception of the quality of the mentor-provider relationship. The model yielded a good fit to the data, $X^2(11) = 17.69$, ($p = .09$), CFI = 0.95, TLI = 0.91, RMSEA = 0.06, SRMR = 0.03; however, a small $R^2$ (.004) for the mediating variable indicates that no variance is being explained. In addition, the parameter estimates (path coefficients) are not significant. Continued testing for mediation is not warranted.




** $p < .01$

*** $p < .001$

Figure 3: Fitted Model with Parameter Estimates and Standard Errors
Depicting Latent Variable "Baseline Quality of Care"
$X^2(2) = 5.02$, ($p$=.08), CFI = .98; TLI = .93; RMSEA = .09; SRMR=.03



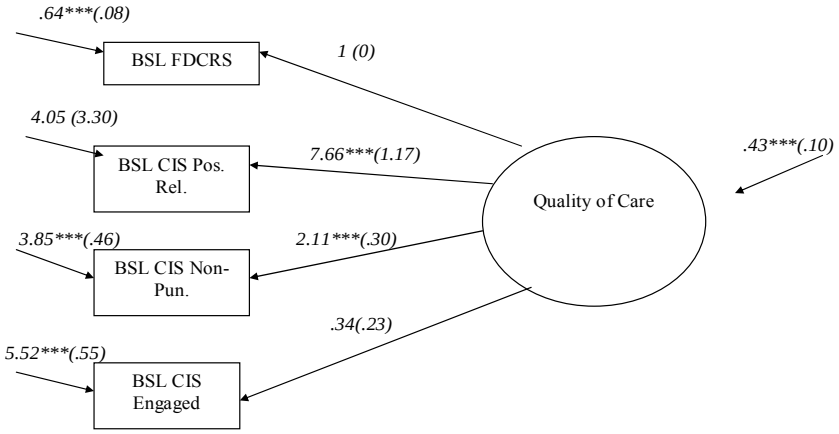

** $p < .01$

*** $p < .001$

Figure 3a: Fitted Model with Standardized Estimates and Errors

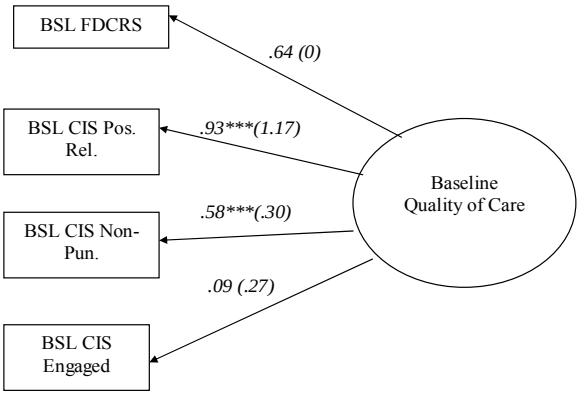
Depicting Latent Variable "Baseline Quality of Care"

$X^2(2) = 5.02$, ($p$=.08), CFI = .98; TLI = .93; RMSEA = .09; SRMR=.03




*** $p$ <.001

Figure 4: Fitted Model with Parameter Estimates and Standard Errors
Depicting Latent Variable "Quality of Care"
$X^2(2) = 3.33$, ($p$=.19), CFI = .99; TLI = .97; RMSEA = .06; SRMR=.03




*** $p$ <.001

Figure 4a: Fitted Model with Standardized Estimates and Errors
Depicting Latent Variable "Quality of Care" at the End of Data Collection
$X^2(2) = 3.33$, ($p$=.19), CFI = .99; TLI = .97; RMSEA = .06; SRMR=.03

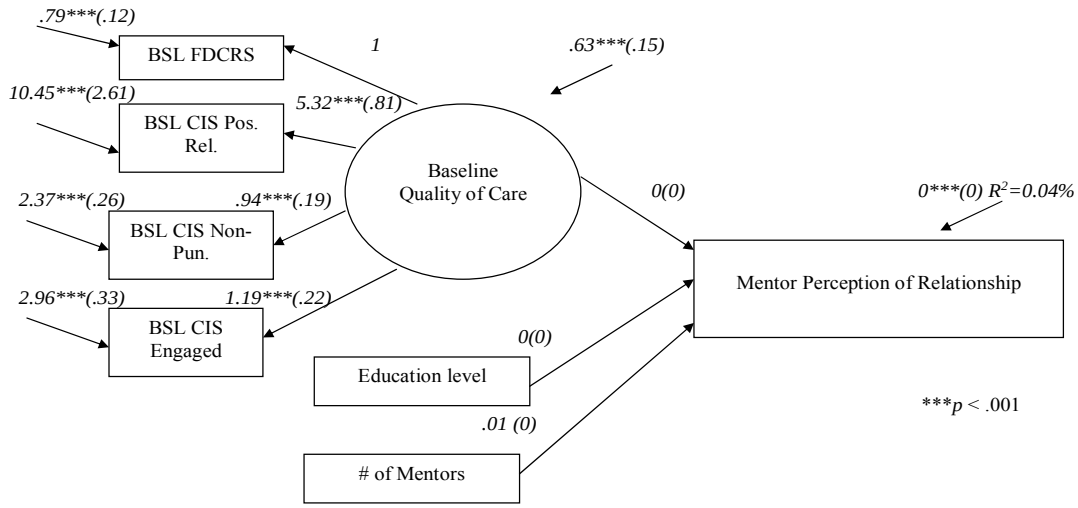



Figure 5: Model 1 – Fitted Model with Parameter Estimates and Standard Errors Depicting Provider and Program Influence on Mentor Perception of Relationship

$X^2(11) = 17.69$, ($p$=.08), CFI = .95; TLI = .91; RMSEA = .06; SRMR=.04

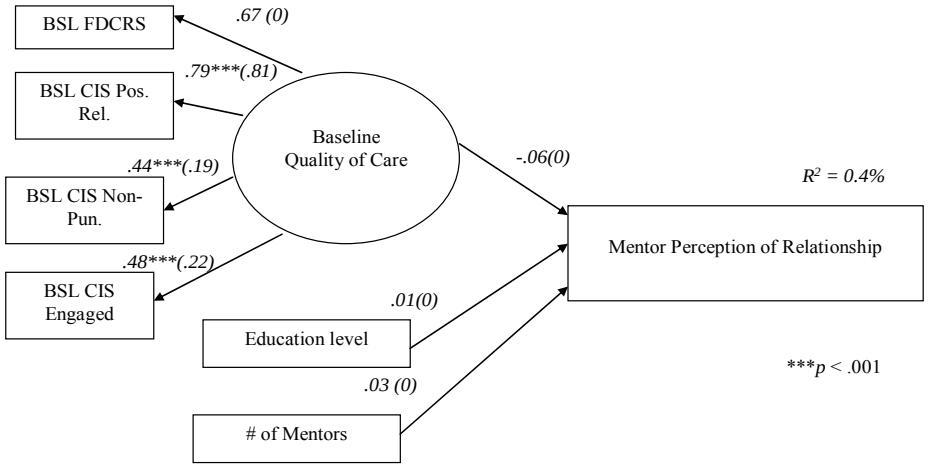



Figure 5a: Model 1 – Fitted Model with Standardized Estimates and Errors Depicting Provider and Program Influence on Mentor Perception of Relationship

$X^2(11) = 17.69$, ($p$=.08), CFI = .95; TLI = .91; RMSEA = .06; SRMR=.04

*Quality Care*

The correlations among variables (Table 6) show that quality of care at the end of the program is related to the childcare group size, provider's education, provider's experience (as indicated by number of years of paid childcare work in the home), frequency of planning activities, baseline quality indicators, number of mentors, total contact hours in the program, and mentor's perception of the quality of the relationship. The mentor's perception of the quality of the relationship is related to a single aspect of the latent variable baseline quality.

Again, following Baron and Kenny's (1986) instructions for testing mediation, models were fitted to examine mentor perception of the relationship as a mediating factor in predicting providers' quality of care. Model 2 (Figures 6 and 6a) tested the hypothesis that provider and program characteristics independently influence the mentors' perception of the quality of the mentor-provider relationship using the variables listed above that were related in a bivariate way to quality of care. The model yielded a good fit to the data, $X^2$ ( 23) = 25.60, ($p$ = .32), CFI = 0.98, TLI = 0.97, RMSEA = 0.02, SRMR = 0.03; however, a small $R^2$ (.09) for the mediating variable indicates that little variance is being explained. In addition, parameter estimates, with the exception of the path between "total contact hours" and "mentor perception of the relationship," were not significant. Because of the low $R^2$ (.09) and the knowledge that "total contact hours" is not correlated with the quality of care outcome variable, no further testing for mediation was warranted.

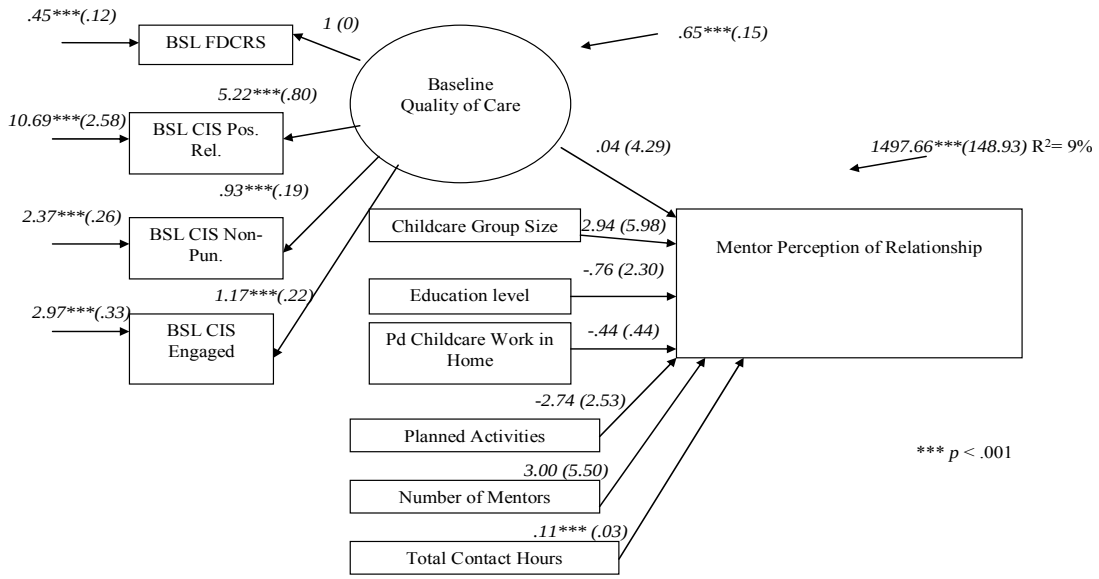



Figure 6: Model 2 – Fitted Model with Parameter Estimates and Standard Errors Depicting Provider and Program Influence on Mentor Perception of Relationship as These Variables Relate to Quality of Care at End of Data Collection

$X^2(23) = 25.60$, ($p$=.32), CFI = .98; TLI = .97; RMSEA = .02; SRMR=.03

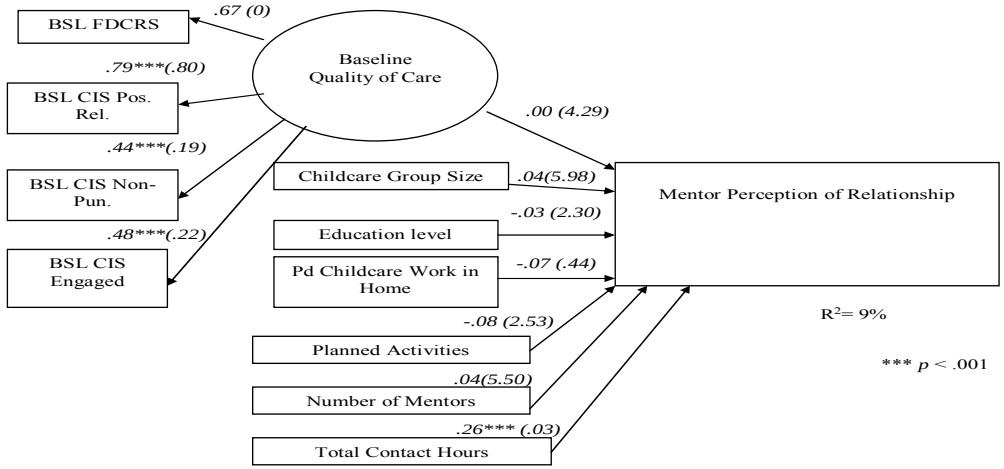



Figure 6a: Model 2 – Fitted Model with Standardized Estimates and Errors Depicting Provider and Program Influence on Mentor Perception of Relationship as These Variables Relate to Quality of Care at End of Data Collection

$X^2(23) = 25.60$, ($p$=.32), CFI = .98; TLI = .97; RMSEA = .02; SRMR=.03

## *Post Hoc Analyses*

### *Accreditation Status*

Because mediation of accreditation status in the tested model was not detected, the $R^2$ for the outcome variable and parameter estimates for the model were examined. The $R^2$ for accreditation ($R^2 = 0.005$) indicates that less than one percent of the variance in accreditation status can be predicted from the model. Parameter estimates for the model tested did not indicate any justification for eliminating variables and subsequently testing a model with fewer pathways. However, a direct effects model – one in which the mediating variable is eliminated – may yield a better fit to these data. Post Hoc Model 1 (Figures 7 and 7a) tested the hypothesis that provider and program characteristics influence the outcome variable "accreditation status" directly. Post Hoc Model 1, looking at "accreditation status" as the outcome variable, yielded a close to good fit to the data, $X^2(11) = 20.51$, ($p = .04$), CFI = .95, TLI = .90, RMSEA = .07, SRMR = .04. The $R^2$ (.20) for accreditation status is a reasonable amount of variance being explained in this model, all but one fit indices were within the normal parameters, and all parameter estimates were significant which indicates that this is a good model for predicting accreditation status. Provider baseline quality care indicators and education along with number of mentors significantly predict accreditation status.

### *Quality Care*

Because mediation of quality of care was not detected, the $R^2$ for the outcome variable and parameter estimates and path coefficients for Model 2 were examined. The $R^2$ for mentor perception of the relationship ($R^2 = 0.09$) in Model 2 indicates that less than ten percent of the variance in that variable can be predicted from the model.

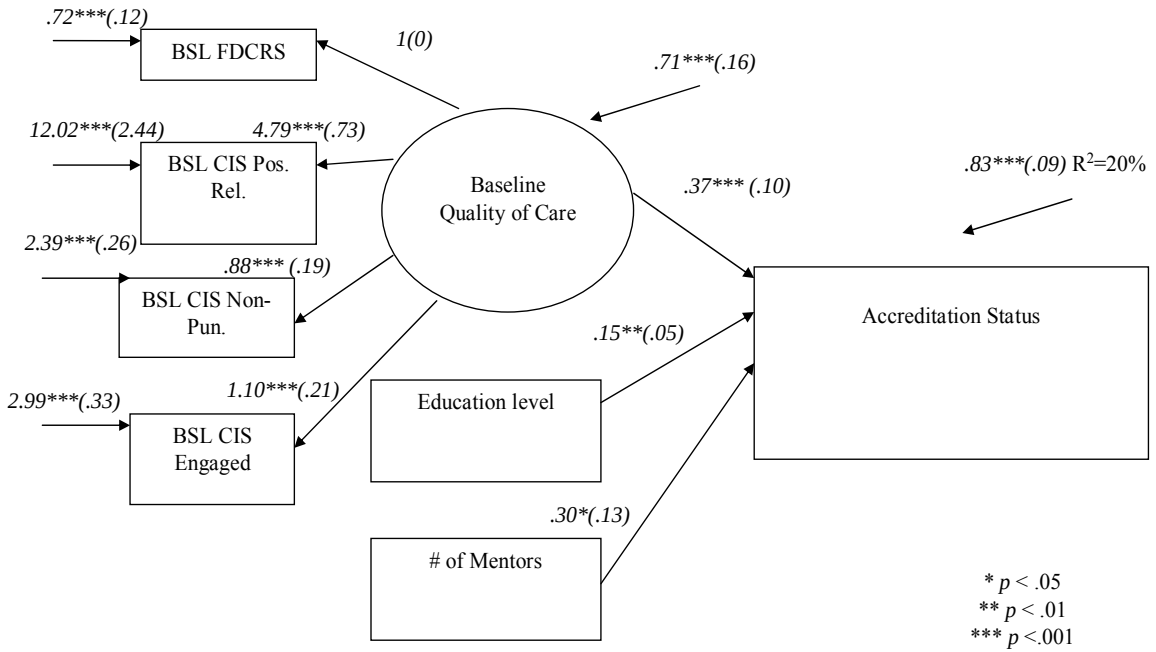



Figure 7: Post Hoc Model 1 – Fitted with Parameter Estimates and Standard Errors
Depicting Provider and Program Influence on Accreditation Status
X2(11) = 20.51, (*p*=.04), CFI = .95; TLI = .90; RMSEA = .07; SRMR=.04

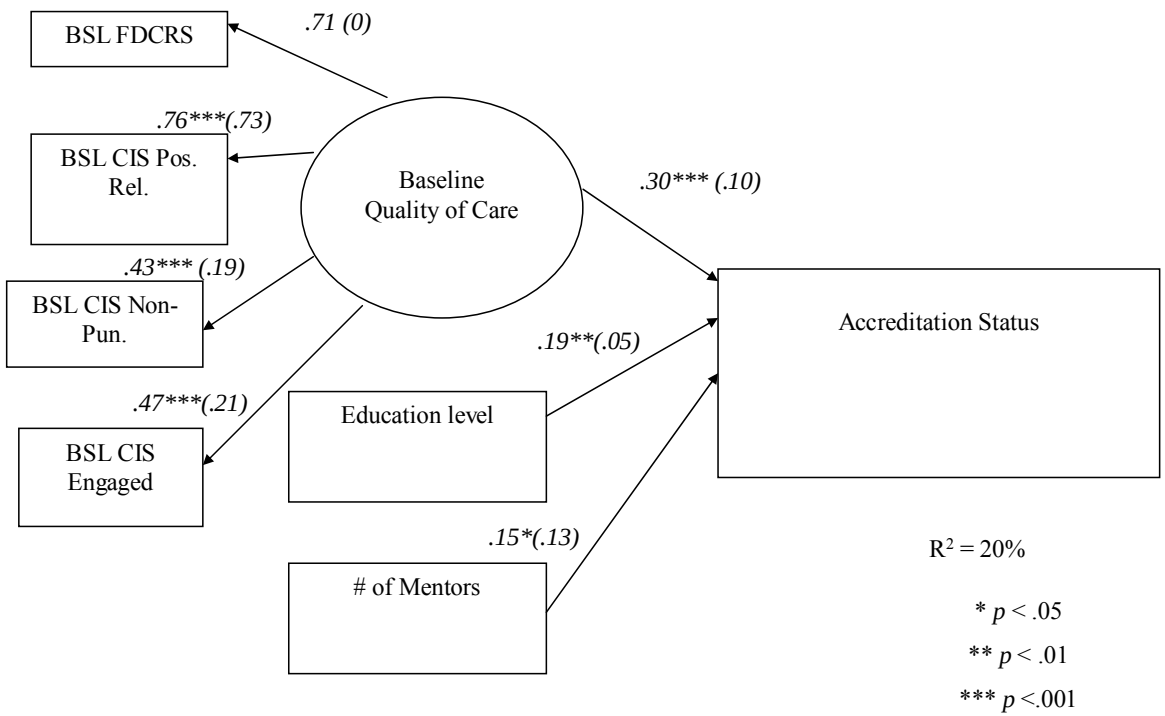



Figure 7a: Post Hoc Model 1 – Fitted with Standardized Estimates and Errors
Depicting Provider and Program Influence on Accreditation Status
X2(11) = 20.51, (*p*=.04), CFI = .95; TLI = .90; RMSEA = .07; SRMR=.04

Parameter estimates indicate that only "total contact hours" has an influence on mentor perception of the relationship (β = .26). However, contact hours and the proposed mediating variable are not related to quality of care at the end of data collection.

Again, a direct effects model looking at the predictive ability of the provider and program characteristics for quality care may yield a better fit to the data. Post Hoc Model 2 (Figures 8 and 8a) tested the hypothesis that provider and program characteristics influence the outcome variable "quality of care" directly. Post Hoc Model 2, looking at "quality of care" as the outcome variable, yielded a poor fit to the data, $X^2(55) = 176.19$, ($p = .00$), CFI = .72, TLI = .61, RMSEA = .10, SRMR = .07. The $R^2$ (.18) for quality of indicates that a reasonable amount of variance being explained in this model.

69

The $R^2$ for quality of care ($R^2 = .18$) in Post Hoc Model 3 indicates a reasonable amount of variance is being explained, and the only significant parameter estimate between hypothesized predictors and end-of-data collection quality of care is the baseline quality of care variable (β = .35, $p$=.001), a simpler model was tested. Post Hoc Model 3 (Figures 9 and 9a) tested the hypothesis that provider baseline quality of care may have direct effects on quality of care at end-of-data collection. Results from testing Post Hoc Model 3 yielded a poor fit to the data, $X^2(19) = 111.93$, ($p = .00$), CFI = .77, TLI = .66, RMSEA = .16, SRMR = .10, $R^2 = .13$ for quality of care.

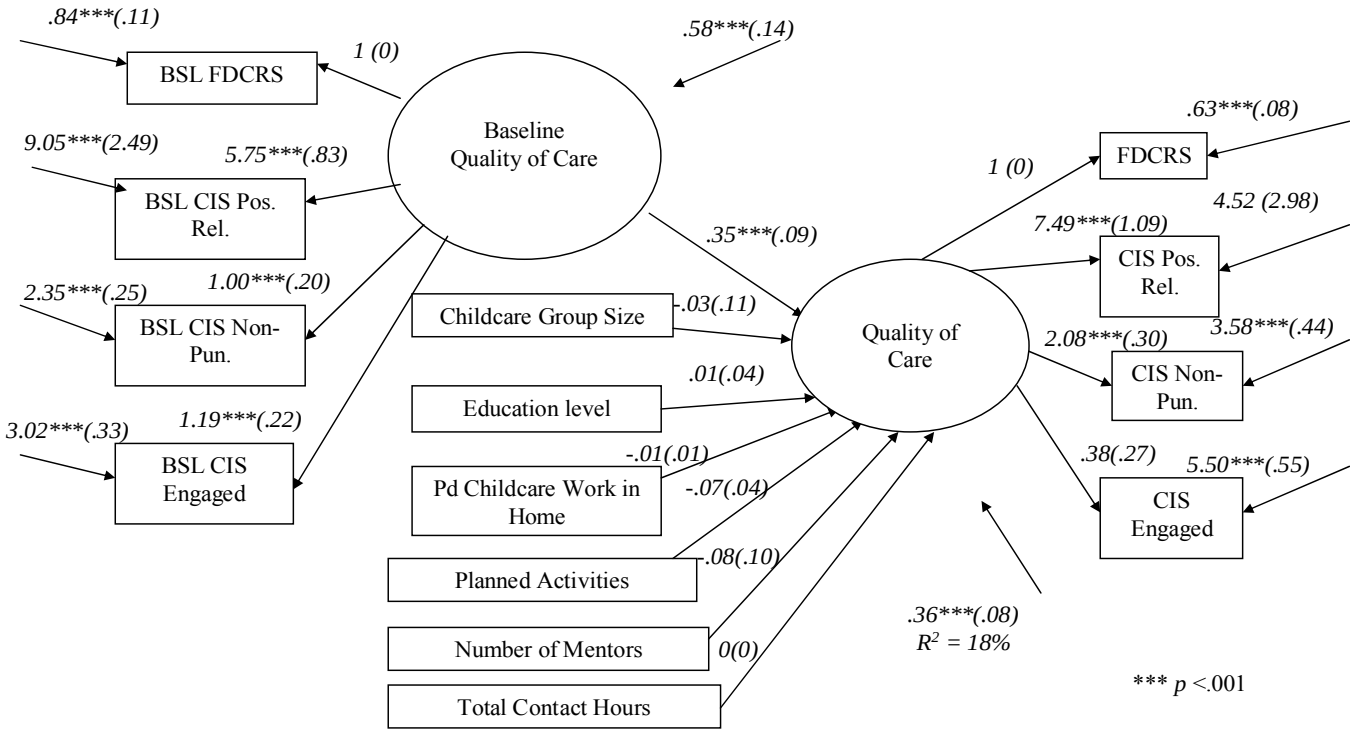



Figure 8: Post Hoc Model 2 – Fitted Model with Parameter Estimates and Standard Errors Depicting Provider and Program Influence on Quality of Care at End of Data Collection

$X^2(55) = 176.19$, ($p$=.00), CFI = .72; TLI = .61; RMSEA = .10; SRMR=.07

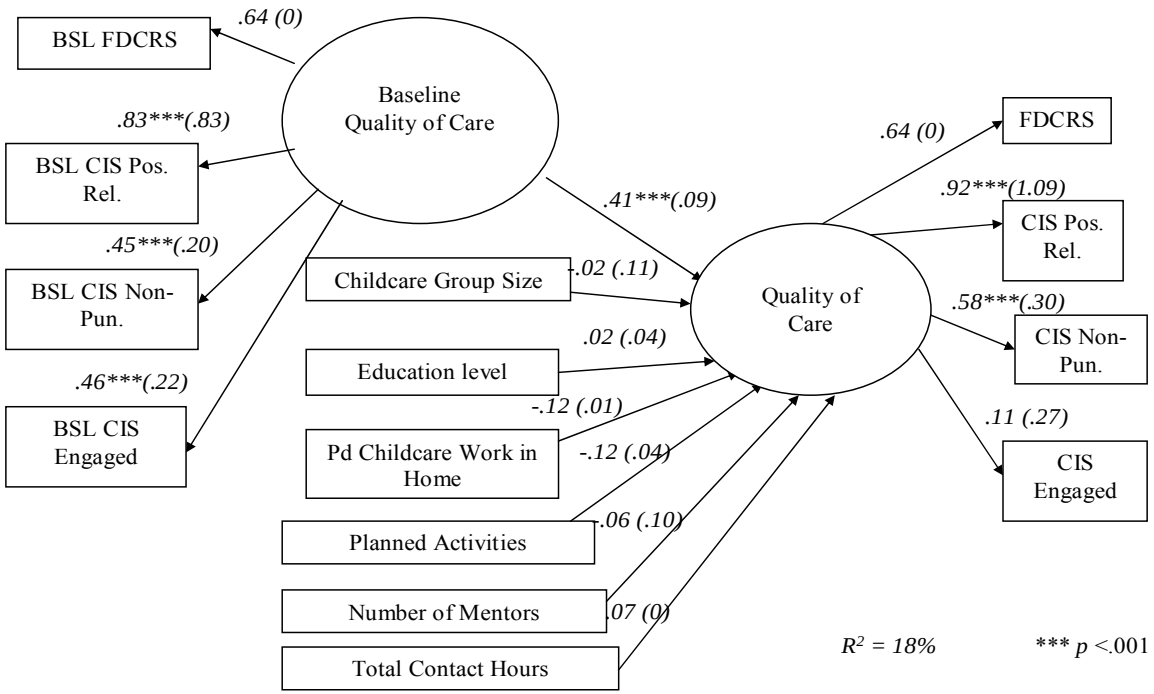
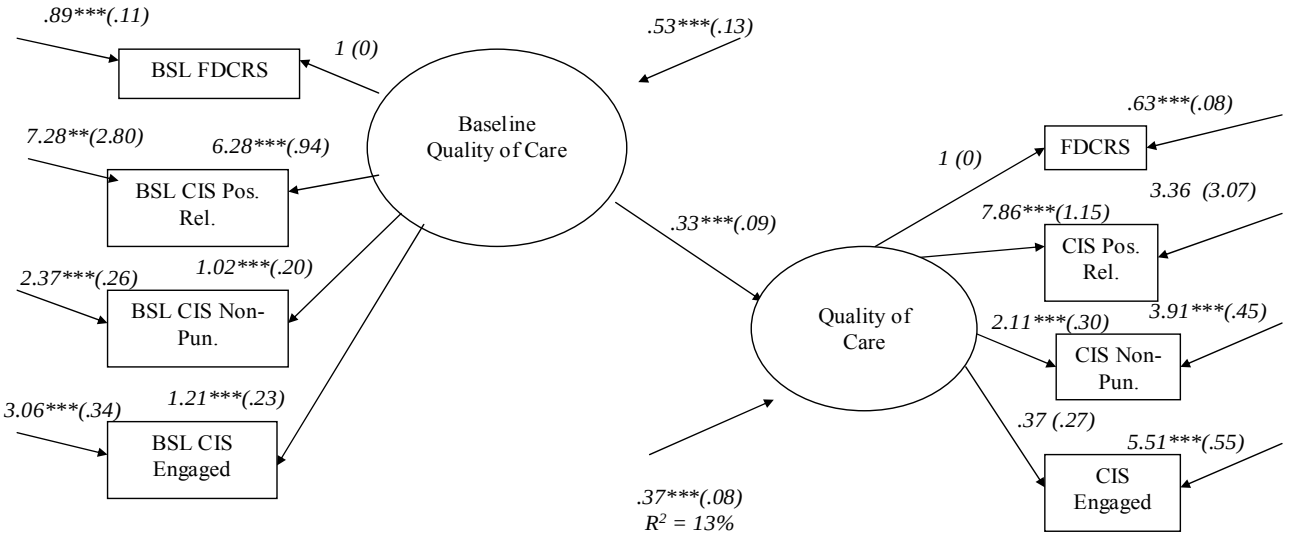



Figure 8a: Post Hoc Model 2 – Fitted Model with Standardized Estimates and Errors Depicting Provider and Program Influence on Quality of Care at End of Data Collection

$X^2(55) = 176.19$, ($p$=.00), CFI = .72; TLI = .61; RMSEA = .10; SRMR=.07

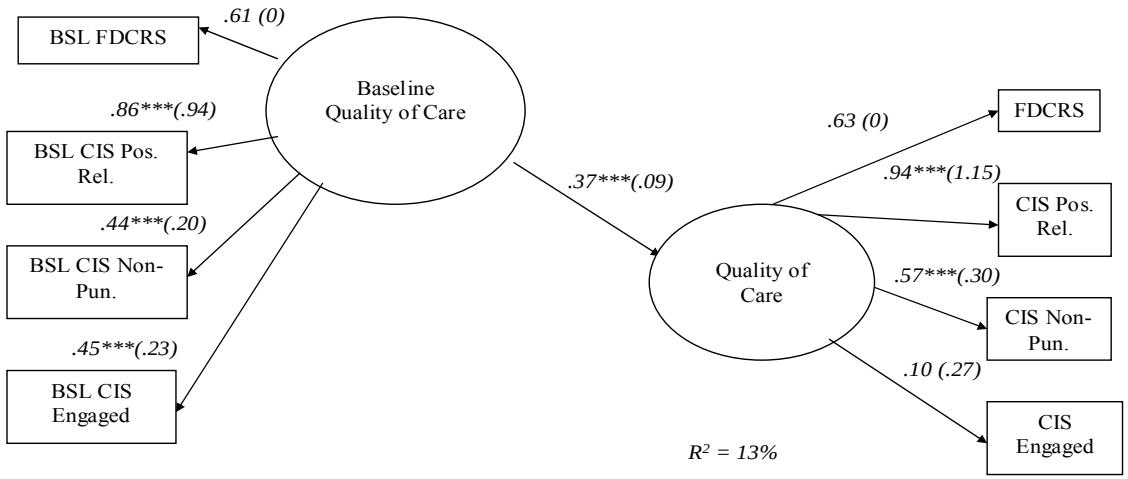



** $p < .01$

*** $p < .001$

Figure 9: Post Hoc Model 3 – Fitted Model with Parameter Estimates and Standard Errors Depicting Baseline Quality of Care as a Predictor of Quality of Care at End of Data Collection

$X^2(19) = 111.93$, ($p$=.00), CFI = .77; TLI = .66; RMSEA = .16; SRMR=.10




** $p < .01$

*** $p < .001$

Figure 9a: Post Hoc Model 3 – Fitted Model with Standardized Estimates and Errors Depicting Baseline Quality of Care as a Predictor of Quality of Care at End of Data Collection

$X^2(19) = 111.93$, ($p$=.00), CFI = .77; TLI = .66; RMSEA = .16; SRMR=.10

# VI. DISCUSSION

The goals of this study were to describe in detail a mentoring program for family child care providers in Alabama and examine a proposed model of the process through which the program works to help providers improve the quality of care they offer and achieve accreditation. The main findings indicate that a provider's level of quality upon enrollment in the program is a significant predictor of accreditation status, but this did not hold true for predicting quality of care (at the end of the data collection period). When providers come into the program and are rated as relatively higher in quality, their potential to achieve accreditation is higher than those who come into the program with lower quality scores. The process proposed as a mediating variable – mentor-provider relationship quality -- was not supported by these data.

## Implications for Previous Research

Previous research examining family child care provider characteristics associated with quality of care has examined the amount of training providers received, group size, ratio of children to adults, provider work commitment, motivations of being providers, education, frequency of planning activities, experience, and intentionality (Galinsky et al., 1994; Kontos, 1994). Results from the present study's correlational analyses support the majority of Galinsky's (Galinsky et al., 1994) descriptive findings. Provider education, aspects of intentionality (motivation, professionalism, and planning activities), and group size were significantly and positively correlated with quality of care in the

Galinsky (Galinsky et al., 1994) study. Group size, provider education, and frequency of planning activities were positively correlated with quality of care, and provider education was correlated with accreditation outcomes in the present study. However, unlike the Galinsky (Galinsky, et al., 1994) study, provider experience was significantly correlated with the outcome quality of care.

Previous research examining the effectiveness of workshop-style training programs on child care provider quality has been correlational in nature as well. In the Kontos (1994) study, no significant association between provider characteristics and quality of care measures were found, but caregiver experience approached significance and was included in their analyses for examining correlates of quality of care outcomes. The current study included provider experience as a predictor variable but did not find support for the hypothesis that provider experience predicts quality of care outcomes.

Research has suggested that providers who seek out and receive specialized training tend to have higher quality scores and report being more committed and intentional than less trained providers (Galinsky et al., 1994), and that participants in technical assistance and training programs experienced more change in the quality of care compared to groups of providers not involved in these programs but who were equal on all background characteristics (Kontos, 1994; Kontos et al., 1996; Wilkes et al., 1998). In the present study, participation in the FCCP training program, as measured by number of contact hours, was correlated with one aspect of quality of care (the "engaged" sub-scale of the Caregiver Interaction Scale), but was not a significant predictor of program success in the models tested. Regardless of providers' demographic background, frequency of planning activities, or level of participation in the program (as indicated by the number of

contact hours they had with their mentors), the level of quality upon enrollment in the program was the most important predictor of program success as indicated by accreditation status. None of the other variables in the study were predictive of end level quality of care when placed in a causal model. In light of these findings, correlations found in previous studies may not be meaningful in terms of being able to predict which training programs will be effective and which will not nor which providers will be successful in a particular training program.

The nurse home visiting studies reported mother characteristics and relationship quality variables as being significantly associated with positive program outcomes (Josten et al., 1995; 2002; Korfmacher et al., 1998; McNaughton, 2002). It was concluded that the quality of the contact was more important that the quantity of contact (Korfmacher et al., 1998), and that when home visitors worked toward maintaining a positive relationship, the quality of the relationship mediated the mothers' success in the program. While this "mediational" explanation was a stated conclusion by these researchers, no mediation model was tested to statistically prove this out. The same was true in the early head start home visiting programs. When relationships were positive, the home visitor tended to work more intensely with her clients yielding more successful participants (Roggman et al., 2001). These studies suggest that regardless of provider and home-visitor demographic characteristics, the quality of the relationship between the two is most important in determining who will be successful in a program and who will not.

The results from this study do not warrant a similar conclusion relative to family child care providers. While the quality of the mentor-provider relationship, as reported by the mentor, is positively correlated with both accreditation status and quality of care

outcomes as well as number of contact hours providers had in the program, causal analyses do not support the notion that relationship quality is important for the quality of care providers offer. It is possible that the importance of achieving success in the FCCP program is different from that of the nurse-home visitor programs (NHVPs). While participants in both programs volunteered to receive training, there may be more at stake if the participant is the mother of the child in care rather than a paid caregiver caring for someone else's children. Participants in the NHVPs may be in more dire straits and rely more heavily on their home visitors compared to participants in the FCCP program. NHVPs also had specific end dates of service; whereas, FCCP providers are technically allowed to remain in the program indefinitely. Perhaps if providers were given a time limit to achieve a particular level of quality or be released from the program, they would meet program goals more readily due to a sense of urgency to get the most one can out of a limited-term program. When a participant views their relationship with their home visitor as more or less important, it may affect how invested they become in a program or the relationship itself. Perhaps mothers who are in home visiting programs feel it more urgent and necessary to work to create and maintain a positive relationship with their home visitors because they see it is important to getting them most out of the program. Providers in FCCP might not see the importance or urgency in improving their quality levels; therefore, they may not be as invested or participatory in the relationship creation and maintenance with their mentor.

Previous research also has suggested that relationship quality in mentoring-type and home-visiting programs is influenced to some degree by what the participant initially comes to the program with (personal background, individual situation, motivation, and

personality) and how the participant perceives the mentor as being able to relate to her and her situation (Olds & Korfmacher, 1998). In the current study, the quality of the relationship as reported by the provider was not correlated with any provider-related, program-related, or outcome variables. A provider who is internally driven toward success may achieve high quality care and/or accreditation despite a less positive relationship with her mentor. Mentors may work with providers they do not have positive relationships with due to external program factors such as needing to keep their caseloads full. Providers may work with mentors they have positive relationships with but never make changes in quality that would lead them to high quality of care scores and/or accreditation. In short, a provider may like her mentor yet not make any changes, or a provider might not like her mentor and make all the changes necessary to become accredited. It may be the case that a mentor-provider relationship may be of relatively lower quality, but for some reason the provider is able to improve her situation resulting in higher quality of care being offered and in some cases accreditation being achieved. It may also be the case that a mentor-provider relationship may be of a higher quality, but for reasons unknown, the provider does not make quality improvements and never reaches accreditation.

Although the provider's perception of her relationship with the mentor was not associated with any other aspect of her participation or quality of caregiving, the mentor's perception of the relationship was. However, in the models tested, mentor reports of the quality of the relationship were not predictive of provider success in the program as indicated by quality of care. The literature on child care quality, training, and even the home visits for early head start, do not look at a causal relationship among the variables

available. No published research is available using a causal model to examine or predict how these factors work together to explain caregiving quality. The current study takes a first step in doing so and, as a result, calls into question the adequacy of prior research in explaining quality outcomes associated with training programs.

The nurse home visitor and early head start home visitor program literatures begin to suggest that the quality of the relationship is most important in predicting a participant's quality outcomes, although this research did not statistically examine the causal relationship among these variables. The current study tests the hypothesis that the home visitor's evaluation of the relationship drives the providers' success in the program. The results from the current study do not support this hypothesis even when the visitor's perception of the relationship is positively and significantly correlated with the participant's success in the program.

## Implications for the Model

The hypothesized model looking at provider, mentor, and program characteristics and their ability to predict accreditation and quality of care outcomes via the quality of the mentor-provider relationship was not fully testable due to insufficient amount of data to test in the model. In addition, the provider's report of the quality of the mentoring relationship was not correlated with any outcome variables or any predictor variables; therefore, it was not include in model tests. As shown in the results, only a direct effects model predicted provider accreditation status; whereas, quality of care at the end of the data collection period was not predicted in any model tested.

While the analyses tested causal models for examining the processes by which home visiting educational programs work for family child care providers, mediation was

not indicated. Simplified model tests, eliminating the mediating variable, suggested a better set of predictors among those examined for accreditation status. A direct-effects model using baseline quality indictors, provider level of education, and number of mentors predicted 20 percent of the variance in accreditation status. Providers with higher baseline quality, higher education levels, and who had more than one mentor to work with over the course of the study period are getting farther along on the path to accreditation than those participants with lower quality, education, and number of mentors.

Quality of care at the end of data collection could not be predicted by any of the provider or program variable sets examined. It is curious to note that while there is a significant path between the quality of care variables (at baseline and end of study period) showing that 13% of the variance in end quality of care is explained by baseline quality of care, the model does not fit the data well. The fact that none of the tested models examining causes of quality of care at the end of the study period indicates that there must be some external or unmeasured influence on whether or not a provider with improve during her participation in the FCCP program.

These findings suggest that models in this study are not good predictors of program successes with the exception of the direct effects model for accreditation status. The models may be strengthened with the addition of other variables not discussed in the literature and not measured in the current study may account for the variability in participant success in training programs such as Family Child Care Partnerships. Further discussion on this possibility can be found further along in this chapter. It can be

concluded that common correlates of provider success in programs are not necessarily the causes of that success.

### *Implications for the Family Child Care Partnerships Program*

The most important implications for the FCCP program relate to data collection and measurement issues and provider level of quality upon enrollment in the program. Based on this study, salient program features such as total contact hours are not indicating that they are meaningful in a provider's path toward accreditation and increasing quality of care. Additional in-take information may be warranted to discover predictors of participant success. Perhaps additional outcome measures would be helpful in determining how participating in FCCP actually does benefit proviers.

First, a closer look at the in-take information gathered for this program is necessary. Additional information about a provider's home environment (especially stability, person relationships and support, and traumatic events), previous training, motivation for being a family child care provider, motivation for being enrolling in FCCP, client turn over, and provider personality and/or work style may be relevant to determining why some providers are more successful than others in this program. Information should be gathered from all mentors in the program including personality traits and work style. Other program features such as intensity of training, category of training, participation in group workshops sponsored by FCCP, and utilization of other program benefits and opportunities such as equipment grants, specialized in-home training activities, and receipt of program support materials could be examined. Inclusion of different aspects of provider characteristics like prior training (not education but participation in specialized workshops and training sessions before enrolling in the FCCP

program), concurrent training (offered by other agencies or through study-at-home programs), personality traits, stress factors, social support and networks, and degree of motivation may yield more insight regarding for whom the program works best. Examination of different program variables such as participation in group trainings, content analyses of training that takes place during the visits rather than just looking at contact hours, and the work style of the mentor (i.e., goal-oriented versus reacting to situations as they arise during visits; planned versus not-planned) may provide more information about how and why some providers are more successful in the program than others.

Additional outcome variables might be considered for measurement. Provider stress, social support, personal feelings of satisfaction and confidence, knowledge of best practices at the end of the program as compared to knowledge at the beginning of the program, or whether or not providers have achieved in other areas of professional development (ie., gone back to college to obtain a Child Development Associate credential or higher degree; taking leadership roles in local or state-wide provider and/or child support/advocacy organizations) could all be considered measures of success that may have been influenced as a result of participating in the program or having a mentor working with them.

This additional in-take and outcome information may be the key to including variables for study that allow causal model path analyses to be significant. As mentioned previously, the current research supports previous research regarding correlational analyses, but those variables do not work in the causal models and cannot predict significant aspects of participant success in the program as measured.

Additional or different measures of the quality of the mentoring relationship might be gathered. For example, targeted questions could be asked of the provider during routine semi-annual quality control calls that could be content-analyzed for relationship quality indicators. Identifying the program features, type of mentor, provider, or relationship between the two that has the most impact on a provider's success in the program would be of utmost importance in streamlining the FCCP program and therefore making it more cost-effective, replicable, and worthy of continued funding.

A realistic and cost-effective approach to these suggestions for increased data collection may be to begin with developing brief questionnaires that the providers themselves would complete. A revision to the existing in-take survey of provider background and business practices could be made and used with all newly enrolling participants as well as modified and sent to all currently enrolled participants. A few key questions about motivation for being a child care provider and participating in FCCP and on-going training and education should be included. A set of personality questionnaires could be sent to randomly selected participants in the program. With FCCP serving an average of 200 providers each program year, a fair number of respondents could be asked to participate in answering such questionnaires.

A second approach to a cost-effective and efficient examination of information could be to identify additional outcome information that shows the impact of the program. Perhaps questionnaires could be used to ask providers about their confidence levels in caregiving now that they have a mentor to work with. A re-evaluation of data already collected could be suggested as well. While global quality of care outcomes were not predicted in the existing study, perhaps sub-sets of outcomes can be. If a provider is

able to improve her caregiving in one category (eg., health and safety) but not another (eg., social development), the overall quality score may mask an important improvement in the care being offered by that provider. An examination of small categories of caregiving quality could be useful in showing how the program helps providers make changes in the care they give.

As stated previously, another important implication for the program found in this study concerns the providers' quality level upon enrollment. It appears from the models tested that quality upon enrollment is the best predictor of whether or not a provider achieves accreditation. It would be important that this finding not drive a program like FCCP to target providers who are already using best practices and offering high quality care to enroll in the program. Doing so would diminish the ability of the program to meaningfully impact providers who really need assistance to improve their caregiving and environments. Offering services to only those providers who are most likely to succeed might serve to maintain the program's credibility and funding but would, in effect, cheat those who really need assistance out of an important educational service.

In the current study, it is difficult to say how FCCP works for providers at the lower ends of the FDCRS-assessed quality spectrum. We do not know whether providers at the lower ends made improvements. Future analyses could be designed to examine only the low-end providers to determine what strides they made in quality improvements and compare those to the levels of change high-end providers made. It may be that low end providers in this study made the same degree of improvement as high quality providers, but because they were equal in magnitude, the providers who were scored low at the beginning of the study period were also comparatively low at the end of the study

period. Re-evaluating the existing data in light of the current findings and looking at different outcomes that could define success in the program may help us see how our program impacts providers enrolling with lower quality.

## Limitations, Contributions, and Future Directions

In light of findings from this study that do not support much of the previous research, limitations of the study must be thoroughly considered. Originally, it was proposed that this study would examine the effectiveness of the mentoring program in light of provider, mentor, program, and relationship characteristics. The data available for study did not allow for any analyses of the mentor characteristics and how they may or may not impact provider success in the program. Because a meaningful analysis of mentor characteristics could not be done due to lower than expected participation rates of mentors, examination of a match or mismatch between mentor and provider backgrounds was not possible. The nurse home visiting literature suggests that participants were more receptive to home visitors who were similar in background, created more positive relationships with those home visitors, and were therefore more successful in the program (Korfmacher et al., 1998). An examination of the predictive ability of this idea in a causal model would let us know whether or not the correlations reported in the literature are meaningful in predicting participant success in home visiting programs.

Analyzing secondary data, while often convenient, has its limitations as well, especially in terms of how variables were operationalized. For example, providers in this study were asked a single question about their motivation for becoming a family child care provider as a proxy for measuring intentionality ("What would you say was the main reason that you chose to become a family child care provider? – response options were a)

"I wanted to stay at home with my own children/grandchildren;" b) "I wanted to work with children;" c) I wanted to help parents who needed child care;" or d) I wanted to work in my home." This question was created based on the current conventions in the literature, but upon review of that question for the current study, it was determined that it did not differentiate highly motivated versus not highly motivated reasons for getting into the family child care business.

In the present study, variables available for analyses may also be affected by response bias. Mentors are the sole reporters of provider quality of care both at enrollment and throughout the program. No independent observations are available to validate those scores, and no other indicators of program success are collected to corroborate mentor reports of provider quality other than accreditation status. While mentors do score providers in their caseloads differently from one another at any given time in the program, and it would serve no job performance related purpose to inflate or deflate a provider's quality score, there may be measurement error involved.

Mentors and providers were asked to report on the quality of their relationships for the specific purpose of collecting data for this study. Social desirability issues may play a role in the response rate and the content of those responses. Mentors who participated may have agreed to participate in the study as well as reported having more positive relationships with their providers because the program supervisors are also the researchers. Mentors who did not participate may have felt, despite a number of efforts to separate participation in the study from job performance evaluations, they needed to portray themselves and their relationships with their providers in a more positive light than in reality. There may be selection bias at play concerning providers who submitted

relationship quality information. Those who completed the Helping Relationships Inventory may have stronger feelings about their relationships with their mentors than providers who did not respond.

Mentors and providers reported on relationships that may not be current. While many of the participants in the study who were eligible to report on relationship quality were enrolled in the program at the time, several providers and mentors were asked to report on the quality of relationships they had that may have been one year old. The accuracy of remembering what a relationship was like that ended six months to a year ago may be significantly different from the accuracy of remembering aspects of a relationship that is on-going or more current.

The current study does make some meaningful contributions to the field and the FCCP program itself. The current study indicates that current conventions in taking correlates of quality care and assuming they are causes can no longer be done. Common correlates of quality are not necessarily causes of that quality. New variable sets and hypotheses must be made to shed light on why and how training programs equal participant improvements in care. A theoretical research based on common sense deductions and extrapolations of findings from center-based care program research can no longer be accepted. Grounded theory and research specific to in-home care settings are a must to developing new hypotheses and tests of causal pathways necessary to explain and support educational training programs.

A re-evaluation of the way FCCP administers and monitors its program may be warranted. It is possible that because there is no pre-determined amount of time a participant is allowed to stay in the program that the providers may not be making the

changes expected since there are virtually no consequences for not making improvements. Providers are allowed to remain in the program indefinitely. If providers knew that they would only have access to FCCP resources and assistance for a finite period of time, they might make greater strides in improving the care they offer if there is a sense of urgency involved. No consequences for mentors are available either. If a mentor never has a provider achieve accreditation or reach a high level of quality as reported on the FDCRS, there are no negative repercussions for that lack of success. FCCP program administrators may want to consider implementing time limits for provider achievements and provide rewards and "punishments" (in the guise of negative performance evaluations) for both providers and mentors in the program.

Future research in the field of home visiting programs and for FCCP itself needs to include different sets of predictor and outcome variables as well as continue examining process variables in order to determine why and for whom home-visit based training programs work. While previous research and the current study include predictor and outcome variables that make logical sense, these variables are only correlated with one another. When these commonly used variables are put in a causal model for testing, the results are limited in scope.

A study designed to examine a match/mismatch between provider and mentor characteristics, including background/demographics, work style, personality, and perception of the relationship may be a more plausible model to test the current hypotheses. If the quality of the relationship is in fact the cornerstone process through which participants are going to be successful or not successful in a program, it would be paramount for program developers and managers to know how and from whom those

relationships work best. There may also be additional outcome variables that are meaningful in terms of program success in a non-traditional sense. For example, perhaps the confidence level of a provider could be measured or a change in structure of her social support network.

Future studies examining the effectiveness of home visiting programs, specialized training for family child care providers, and/or the processes through which these programs and trainings help participants be successful could attempt to obtain control group information to make more comparisons about the program's effectiveness. In the current study, it could be said that participants in the FCCP program are more likely to achieve accreditation than those who are not because there have been no other providers in the state to achieve accreditation during the tenure of FCCP. However, we do not know why that might be the case. It could simply be that the cost of the accreditation fee ($495) or lack of knowledge that an accreditation for family child care providers exists could be the reasons behind the lack of non-FCCP provider accreditation. Without a control group, it is impossible to tell.

Employing a theoretical framework from which to select variables and collect new or different information may be useful as well. The nurse home visiting literature indicates that aspects of participant and home-visitor personality may be involved in the quality of the relationship and success in the program. This literature also discusses participant self-efficacy and social context as factors in program success. The family child care and training literature indicates that provider motivation and internal drive may be important factors involved in quality of care and success in training programs.

As previously stated, finding grounded theory from which to select variables and design models for testing is important. Previous research in the home-visiting literature and family child care literature suggests that motivation, intentionality, and feelings of self-worth and competence are key to program success. Social cognitive theory, more specifically the self-efficacy aspect of this theory, may help future research develop predictor and outcome measures and variables better. Coming from a social cognitive theoretical perspective, Bandura defined self-efficacy as "judgments of how well one can execute courses of action required to deal with prospective situations" (Bandura, 1982, p.122). Bandura's perspective emphasizes cognitions about reinforcements, rather than the reinforcements themselves, indicating that motivators for action are not just in the environment, but also in the thoughts about the environment. As a result, self-efficacy is not a fixed measure, but is constantly adapting to the acquisition of new information (Lipsmeyer, 2005).

## Summary and Conclusions

It is important for practitioners to understand the contributions the clients, staff, and program make to the success or failure of a training program. Previous research shows that when child care providers receive specific, relevant training, they offer higher quality care (Kontos, et al., 1996; Taylor, et al., 1999). Results from the current study indicate that it is the provider's initial level of quality that is most important in predicting whether or not a provider will achieve accreditation. In spite of its limitations, the study makes an important contribution in questioning the findings of previous research in explaining why some providers make quality improvements in the family child care setting and others do not.

While additional research is needed to explore other aspects of program processes that may explain additional variation in provider success in programs such as Family Child Care Partnerships, the current study continues to bridge the gap between descriptive information about programs and explanatory research concerning program processes. The current study could not shed light on many provider or program variables nor any relationship variables statistically significant to a provider's ability to obtain accreditation, but it is important to point out that when FCCP began in 2000, there were no nationally accredited providers in Alabama. At the end of the data collection period for this study, there were 28. At the conclusion of writing this report, there are 35 accredited providers in Alabama with 13 more having submitted their applications to the National Association for Family Child Care and waiting to hear that they have obtained accreditation.

Considering the importance of children being cared for in high quality environments, the FCCP program is a valuable instrument in creating a strong foundation from which children will embark on their journey in the world. FCCP's ability to assist Alabama's family child care providers in their quest for accreditation should not be dismissed or minimized. It remains to be seen exactly why and how the FCCP program facilitates accreditation and quality care improvements, but for now, it is the only program through which family child care providers in Alabama receive assistance specifically designed for them to improve on measurable aspects of quality of care and achieve national accreditation.

## VII. REFERENCES


Arnett, J. (1989). Caregivers in day-care centers: Does training matter*? Journal of Applied Developmental Psychology*, 10, 541-552.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191-215.

Bandura, A. (1982). Self-efficacy mechanisms in human agency. *American Psychologist, 37*, 122-147.

Bollen, K. A. (1989). *Structural Equations with Latent Variables.* New York, NY: John Wiley & Sons.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New Your, NY: Basic Books.

Buell, M. J., Pfister, I., Gamel-McCormick, M., (2002). Caring for the caregiver: Early Head Start/family child care partnership. *Infant Mental Health Journal, 23 (1-2),* 213-230.

Byrd, M. E. (1997). A typology of the potential outcomes of maternal-child home visits: A literature analysis. *Public Health Nursing, 14 (1),* 3-11.

Campbell, T. L. (1994). Impact of prenatal/early infancy on home visitation on family health. *Family Systems Medicine, 12 (1),* 81-85.

Cole, R., Kitzman, H., Olds, D., & Sidora, K. (1998). Family context as a moderator of program effects in prenatal and early childhood home visitation. *Journal of Community Psychology, 26 (1),* 37-48.

Galinsky, E., Howes, C., Kontos, S., & Shinn, M. (1994). *The Study of Children and Family Child Care and Relative Care.* Families and Work Institute. New York, NY.

Gomby, D. S. (2000). Promise and limitations of home visitation. *Journal of the American Medical Association, 284 (11),* 1430-1431.

Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home visiting: Recent program evaluations – analysis and recommendations. *The Future of Children, 9 (1),* 4-26.

Harms, T. & Clifford, R. M. (1989). *Family Day Care Rating Scale.* Teachers College Press. New York, NY.

Hiatt, S. W., Sampson, D., & Baird, D. (1997). Paraprofessional home visitation: Conceptual and pragmatic considerations. *Journal of Community Psychology, 25 (1)*, 77-93.

Howes, C. (1997a). Teacher sensitivity, children's attachment and play with peers. *Early Education and Development, 8,* 41-49.

Howes, C. (1997b). Children's experiences in center-based child care as a function of teacher background and adult-child ratio. *Merrill-Palmer Quarterly, 43,* 404-425.

Howes, C., Hamilton, C. E., & Phillipsen, L.C. (1998) Stability and continuity of child-caregiver and child-peer relationships. *Child Development, 69 (2),* 418-426.

Howes, C., Hamilton, C. E., & Matheson, C. C. (1994). Children's relationships with peers: Differential associations with aspects of the teacher-child relationship. *Child Development, 65 (1),* 253-163.

Josten, L. E., Mullett, S. E., Savik, K., Campbell, R., & Vincent, P. (1995). Client characteristics associated with not keeping appointments for public health nursing home visits. *Public Health Nursing, 12, 5,* 305-311.

Josten, L. E., Savik, K., Anderson, M. R., Bendetto, L. L., Chabot, C. R., Gifford, M. J., McEiver, J., Schorn, M. A., Frederickson, B. (2002). Dropping out of maternal and child home visits. *Public Health Nursing, 19, 1,* 3-10.

Keiley, M. K., Dankoski, M., Dolbin-MacNab, M., & Liu, T. (2005). Covariance structure analysis: From path analysis to structural equation modeling. In D.H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy (2nd edition)* (pp. 432-460). New York: Guilford Press.

Kitzman, H. J., Cole, R., Yoos, H. L., & Olds, D. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. *Journal of Community Psychology, 25 (1),* 90-109.

Kitzman, H., Yoos, H. L., Cole, R., Korfmacher, J., & Hanks, C. (1997). Prenatal and early childhood home-visitation program processes: A case illustration. *Journal of Community Psychology, 25 (1),* 27-45.

Kontos, S. (1994). The ecology of family day care. *Early Childhood Research Quarterly (9),* 87-110.

Kontos, S., Howes, C., & Galinsky, E. (1996). Does Training Make a Difference to Quality in Family Child Care? *Early Childhood Research Quarterly (11),* 427-445.

Kontos, S. & Wilcox-Herzog, A., (1997). Influences on children's competence in early childhood classrooms. *Early Childhood Research Quarterly, 12*, 247-262.

Korfmacher, J., Kitzman, H., & Olds, D. (1998). Intervention processes as predictors of outcomes in a preventive home-visitation program. *Journal of Community Psychology, 26 (1),* 49-64.

Lipsmeyer, K. (2005). *Adolescent co-parenting relationships and their effect on parental self-efficacy.* Unpublished master's thesis, Auburn University, Auburn, Alabama.

McNaughton, D. B., (2000). A synthesis of qualitative home visiting research. *Public Health Nursing, 17 (6),* 405-414.

Muthén, L. K., & Muthén, B. O. (1998). *MPlus User's Guide.* Los Angeles, CA: Muthén & Muthén.

O'Brien, R. A., & Baca, R. P. (1997). Application of solution-focused interventions to nurse home visitation for pregnant women and parents of young children. *Journal of Community Psychology, 25 (1),* 47-57.

Olds, D., Henderson, c., Kitzman, H., Eckenrode, J., Cole, R., & Tatelbaum, R. (1998). The promise of home visitation: Results of two randomized trials. *Journal of Community Psychology, 26 (1),* 5-21.

Olds, D., Kitzman, H., Cole, R., & Robinson, J. (1997). Theoretical foundations of a program of home visitation for pregnant women and parents of young children. *Journal of Community Psychology, 25 (1),* 9-25.

Olds, D. L., & Korfmacher, J. (1998). Maternal psychological characteristics as influences on home visitation contact. *Journal of Community Psychology, 26 (1),* 23-36.

Peisner-Feinberg, E. S., & Burchinal, M. R. (1997). Relations between preschool children's child-care experiences and concurrent development: The cost quality, and outcomes study. *Merrill-Palmer Quarterly, 43,* 451-477.

Roggman, L. A., Boyce, L. J., Cook, G. A., & Jump, V. K. (2001). Inside home visits: A collaborative look at process and quality. *Early Childhood Research Quarterly, 16 (1),* 53-71.

Taylor, A. R., Dunster, L., & Pollard, J. (1999). …And this helps me how?: Family child care providers discuss training. *Early Childhood Research Quarterly, 14 (3),* 285-312.

Wilkes, D. L., Lambert, R., & VandeWiele, L. (1998). Technical assistance as part of routine inspections of family child care homes. *Early Childhood Research Quarterly, 13 (2),* 355-373.

Young, T. M. & Poulin, J. E. (1998). The helping relationship inventory: A clinical appraisal. *Families in Society, 79 (2),* 123-133.

# APPENDICES

# APPENDIX A

## Home Visiting Programs, Procedures, Processes, and Outcomes

### *Meta-Analyses and Review Articles*

Recent literature reviews and meta-analyses in the nurse home visitor field have focused on creating a greater understanding of common factors involved in home visiting programs. The purpose of these reviews and analyses is to synthesize the current research in the home visiting area in an attempt to explain why and how home visiting programs work. These articles identify target participant populations, program goals/objectives, life stage in which the participants are enrolled and receive program services, outcomes/evaluations, and to the degree available, information about the specific processes involved in these relationship-based programs.

Many of the articles evaluated in these reviews and meta-analyses offer rich descriptions of what the program was designed to do, who the program was designed to serve, who the participants and the home visitors were, and what the outcomes were. It is much more difficult to determine program processes and mechanisms by which participants receive information that causes change in attitudes, beliefs, and behaviors. It is one thing to describe individual aspects of a program and evaluate it. It is quite another to explain why and how a program worked or did not work.

The majority of empirical home visiting research since the mid 1960s identify outcomes primarily for the mothers involved in the programs (Byrd, 1997). These

programs measured mothers' knowledge, beliefs, and attitudes about children and child rearing. It was not until the 1970s that the research turned to examine child-related outcomes. These outcomes were indirect in nature. When mothers participated successfully in the programs, their children were less likely to have negative health problems. It was not until the 1990s that the researchers began to examine the interactions between mothers and their newborns as salient outcomes variables (Byrd, 1997).

Byrd (1997) found in her review of three decades of research, that mothers' personal health (status of physical health, knowledge of health, and utilization of health care services), knowledge of prenatal care, and compliance with prenatal health care recommendations were universal variables measured in home visiting program evaluation. Child outcomes variables universally included (starting in the 1970s) basic health, including diet/nutrition, and basic development. As programs became more sophisticated and the empirical demands for research programs required, child outcomes such as number of reported abuse and neglect cases, number of emergency medical visits, and children's self-esteem/confidence were measured.

Byrd (1997) also found that home visiting programs throughout the years evaluated the basic environment in which participants lived. Various aspects of the environment were measured including utilization of health care services for well children, completion of immunizations for children, and mothers' return to work or school. Mothers' education and employment, health, and utilization of health care services continued to be evaluated. More recently, programs evaluated the individual home

environments using the widely known HOME inventory, and aspects of the mothers' support and social competence were measured.

Byrd (1997) summarized her review of home visiting programs by noting outcomes measured indicate mother-child home visiting programs affect various characteristics and qualities of the mothers, children, and the interactions between them, as well as the environment surrounding them. Missing from the outcomes measured in these programs were evaluations of how families may have been affected overall (outside of the specific mother-child relationship), differences in outcomes as a result of service delivery being offered by professionals versus paraprofessionals, and participant reported information about how they perceive the program to have affected them.

Home visiting research published since the Byrd (1997) article shows a recognition of these missing pieces in understanding more fully the impact these programs have on mothers, children, families, and communities. The home visiting programs outlined in the Gomby and associates' article (Gomby, Culross, & Behrman, 1999) have similar goals and utilize similar methods. They all target high risk families, operate in multiple locations, and use random assignment to treatment or control/comparison groups. As delineated in Gomby's review article (Gomby et al., 1999), the program goals, background of home visitors, and training requirements for the visitors were very similar. All programs were designed to assist parents with raising healthy children, decreasing abuse and neglect, and helping parents prepare their children for school. With the exception of the Nurse Home Visitor Program, all home visitors were paraprofessionals. The NHVP used professional nurses for the initial program and utilized paraprofessionals in later trials. All home visitors were required to attend

pre-service training and received on-going training and supervision throughout the program (Gomby et al., 1999).

The target population served by each program varied from only high-risk families to being open to all parents across the country. Service delivery varied from one program to another as well. While all programs require participants to open their homes to the home visitors, the frequency of those visits ranged from weekly to quarterly, and, in the Parents as Teachers program, visits were determined based on family needs. Home visitation start dates varied across programs. For example, most of the programs began upon the birth of the child and continued until the child turned five years old. The HIPPY program did not start until a child was three or four years old, and the NHVP and PAT programs begin with prenatal home visits and continue until the child is two or three years old respectfully (Gomby, et al., 1999).

Each of these programs has produced outcomes showing increases in parent (usually mothers) knowledge of child-rearing practices and child development principles as well as decreases in abusive or neglectful parenting practices. Because the trials are randomized, program researchers conclude that the positive outcomes resulting from participating in the nurse home visiting program are causal in nature. Parents and children in control and comparison groups did not show changes in rates of abuse and neglect, health care concerns, and children's development (Gomby et al., 1999).

Gomby and associates (1999) concluded that identification of families who would both most benefit from a home visiting program and would be most receptive to the resources and information offered in these types of programs would afford a researchers and program administrators with more success stories. Matching programs to fit the

needs of receptive and targeted families should yield positive outcomes for a greater percentage of its participants. In addition, the identification of the level and frequency of service delivery will assist in program implementation and on-going training and program development. Explicit information about these aspects of programs can also assist others in replicating these programs through other agencies.

Gomby (2000) noted that many of the published home visiting programs only involve 20 to 50 clock hours of home visitation across a number of years. And, often only half of the prescribed number of visits actually take place. Gomby (2000) reports that on average, families receive between 20 and 67 percent of the visits programs protocols recommend. It is suggested that more intense and frequent visits may yield more substantial results. This limited number of contact hours may be at the root of why home visitors report frustration in administering the protocols and the slow rate of improvement that is perceived as well as measured. If more intensity or frequency in service delivery is not allowed for in a program, Gomby (2000) recommends that program administrators expect more modest results.

McNaughton in 2000 published an article examining fourteen home visiting programs in an attempt to explain what the mechanisms are in the nurse-client relationship that effect change. McNaughton's goal was to look at a variety of home visiting programs in a meaningful way to explain what happens during the course of a home visiting program at that makes the participants change their attitudes, beliefs, and behaviors targeted by the program as a result of the interaction with the home visitor. The fourteen studies examined are qualitative in nature but analyzed in a quantitative way.

The results sections of the fourteen studies in this analysis were coded in a way that allowed each classification to be statistically tested. Relevant information about the nurse-participant relationship, nurse role during the visit, participant role during the home visit, and expected results from the interactions were explored. It is important to note that five of the fourteen articles reviewed stemmed from one study. These fourteen articles reviewed include information from 142 nurse home visitors and their interactions with participants across 59 home visits (McNaughton, 2000).

McNaughton (2000) identified four stages involved in the nurse-participant relationship. First, a pre-entry category was identified. Factors influencing the relationship included participant experience with other program staff or medical professionals in any setting, participant relationships with other relatives or friends and interpersonal style, participant perceived need to be involved in a program, the level of influence and support offered by the participant's family members, and reasons the participant is participating in the program.

The second stage was labeled "entry." During the second stage, the nurse must establish or create the relationship and gain entry into the participant's home. There is a physical and relationships aspect to this entry. It is one thing to be allowed into the participant's home, and another to be received into the participant's personal life. McNaughton (2000) noted that both physical entry into the home (making and keeping a first appointment) and the entry into a relationship with the participant can take quite a long time.

The third stage was labeled "working." During this stage, the nurse and the mother work together to identify needs (primarily health-related) and establish a plan for

addressing those needs. Nurses must continue to maintain the relationship during the working part of the process so that she can continue to gain entry into the home of the participant. The working part of the service delivery program can vary in length and intensity both based on the program's protocols and the specific needs and quality of the nurse-mother relationship.

The final stage of the relationship is "termination." Like the working stage, termination may be dictated by the program protocol itself or as a result of the quality of the nurse-mother relationship. Termination may happen at a prescribed time if the participant remains involved in the program until the end of the protocol. However, termination may happen prior to the completion of the program as a result of participants not being interested in what the program has to offer, not having a positive relationship with the nurse visitor, or external factors such as moving, change in schedules, or even community or household hazards that may make it unsafe for the home visitor to return (McNaughton, 2000).

McNaughton (2000) noted that nurse-mother relationships could be dichotomously categorized as either "collaborative" or "difficult." When the relationship was collaborative, nurses and mothers were able to work successfully toward mutual goals. The mothers were receptive to the program's methods and content, trusted the nurses, and showed general interest, openness, and improvement in caregiving skills throughout the course of the program. The length of collaborative relationships was significantly longer than those classified as difficult. Difficult relationships were classified as such when mothers would open their doors to the physical entry of the home visitors, but were not receptive to the goals of the program and refused to create a

relationship with the nurses. Mothers in difficult relationships were observed or reported to be closed to the ideas presented by the nurses, actively rejected them and their information in some cases, did not keep appointments, and did not utilize referrals to outside agencies. Mothers who were uninvolved and inattentive during the visits and showed no effort toward improvement in the program were also classified as difficult.

McNaughton's article (2000) examined both British and American home visiting programs. She found that the actual frequency or total amount of home visits was limited in many cases by the home visitor's workload and by the wishes of the mothers. Nurses had to balance the demands of the program and the demands of the workload and the demands of the mothers. The American programs were also constrained by funding issues. In addition to these demands, nurses reported they often had to weigh the demands of program protocols and service delivery against the demands of keeping the relationship maintained. Pushing too much or trying to force participants to maintain a particular level of involvement and progress often resulted in the termination of the relationship. Nurses reported that their main goal throughout the program was to maintain the relationship with the mothers on their caseloads. This sometimes conflicted with the demands of the programs, but it protected the relationship and ability to offer some level of service to the participants.

Nurses were found across programs to focus primarily on creating and maintaining a collaborative relationship. Nurses reported that the participants were more receptive to program information and change if the nurse was perceived to be sympathetic and understanding of the participants' individual needs in all areas of their lives. In order to create and maintain that type of relationship, the nurses often had to get

to know the participants on a personal level, interact with relatives that either lived in the participant's home or influences them greatly, and address aspects of the participants' lives and individual circumstances outside the range of the program. Relationship maintenance was the primary objective unless a specific or urgent health matter required the nurse to confront the participant in such a way that may jeopardize the relationship and continuation in the program (McNaughton, 2000).

Relationship creation and maintenance was one aspect of the role nurses had in home visiting programs. The other role nurses had was to deliver program content. Most often, this was health-related information designed to improve the quality of care and environment the infants and children in the home experienced. The participant's role was identified as making a choice of whether or not to be open to and make changes in her behaviors based on the information and instruction offered by the nurses. The participant holds all the controls in the relationship with her home visitor. The participant controls the entry, intensity, and frequency aspects of the home visits themselves as well as controlling the level of information reception and behavioral change that results (McNaughton, 2000).

In this meta-analysis, McNaughton (2000) looked at the outcomes included in the fourteen studies. She noted that the program goals and research outcomes were not reported by the nurses to be the goals nurses had for the participants. Program goals and research outcomes focused on changes in caregiving behaviors, attitudes, and beliefs that lead to the improved caregiving and environment experienced by the participants' children. Nurses reported that their goals for the mothers were to empower them, instill problem-solving skills, and enhance mothers' self-esteem. Researchers reported they

wanted to see improved or positive child outcomes such as birthweight, APGAR scores, general health, and decreased instances of abuse and/or neglect.

McNaughton (2000) concluded that the relationship between the nurse and the participant is the key to success in home visiting programs. She suggests that aspects of this relationship maintenance in combination with the nurses' goals for these mothers (self-esteem and self-efficacy) are mediators of the positive outcomes. Further investigation into the processes involved in establishing and maintaining these relationships along with continued exploration of the mechanisms of service delivery are necessary to identify how and why programs can work with a diverse group of participants. This information can also lead to program improvement and individualization so that programs can show stronger results in a more efficient manner of service delivery. McNaughton (2000) points readers to two models with which future home visiting research can be tested. First, Peplau's relationship model can be utilized to examine the process of forming and maintaining the nurse-mother relationship. Second, the "Interaction Model of Client Health Behavior" can be used to describe and examine the nurse-mother interactions that lead to positive outcomes as a result of the home visiting program. (See the Proposed Analyses section for explanations and applications of these theories.)

In summary, the review articles and meta-analyses point to specific and universal variables examined in home visiting programs. Mothers' are typically the main target of programs and evaluations of program effectiveness. Mothers' personal health, knowledge of caregiving and child development, as well as compliance with program goals and basic health practices are the most common outcomes measured. Children's basic health and

development are universal child outcomes measured in these programs. More recently, programs researchers have examined aspects of program success or failure. Specifically, programs are implementing evaluation procedures in order to predict participant success, environmental impact on program effectiveness, and relationships between service deliverers and the participants which may affect program effectiveness.

In the following reviews of home visiting programs, characteristics of the mothers, home visitors, environment, and relationships between these variables will be highlighted. The studies chosen for review most closely match the purpose, methodology, and evaluation found in the Family Child Care Partnerships program. A detailed contextual picture will be painted to provider general background information and a theoretical context from which to interpret the specific program reviews. While the individual studies reviewed here may have a variety of facets and interesting details to report both descriptively and methodologically, only a brief contextual outline and relevant pieces of information that related directly to goals, methods, and analyses involved in the FCCP program will be brought forth for the purpose of the current proposed study.

## Nurse Home Visitor Programs

### Background and Theoretical Underpinnings

In 1977, a comprehensive, theory-based nurse home visiting program was begun in Elmira, NY, with 400 pregnant women. This prevention program was designed to educate low-income, primarily young, first time mothers in order to decrease the likelihood of pregnancy problems and poor infant health and development, as well as assist participants in making choices to improve their own lives. Outcome measures for

the Elmira program were focused on children's health and development and mothers' life course trajectories and were used to determine the success or failure of the program itself. Subsequent programs modeled on the Elmira program also included measures of the program processes in order to explain how and why the program yields those outcomes in children and their mothers. The theoretical underpinnings and description and results of this study were published in two seminal articles led by Olds and Kitzman (Olds, Henderson, Kitzman, Eckenrode, Cole, & Tarelbaum, 1998; & Olds, Kitzman, Cole, & Robinson, 1997) and are summarized next.

The theoretical foundations for the Nurse Home Visitor Program were originally based on Bowlby's (1969) attachment theory and Bandura's (1977) self-efficacy theory. The Elmira study was designed, carried out, and analyzed with these theories guiding research decisions. The Elmira program was improved upon and replicated in two subsequent randomized trials – Memphis, TN, and Denver, CO. In each of the later two trials, the influence and application of both attachment and self-efficacy theories were expanded upon and Bronfenbrenner's (1992) person-process-context model of human development was incorporated into improvements in the program.

Attachment theory (Bowlby, 1969) was used to guide much of the content of the program. Nurses were trained in appropriate caregiving practices that would enable them to model such practices for their clients. Nurses were also trained in self-efficacy theory (Bandura, 1977) explicitly in order to implement the protocols and effect change in the mothers' behaviors. The program protocol had specific lesson built in that each nurse was to teach (through direct instruction or modeling) each mother concerning specific caregiving skills (e.g., quieting a crying baby or redirecting toddler behaviors). Nurses

were instructed and trained to deliver these lessons in a way that would promote the self-efficacy of the mothers. The idea was to create an atmosphere of trust and competence in caregiving that would allow the mothers to exhibit appropriate caregiving behaviors and feel competent, willing, and able to continue those behaviors when the nurse was not present in the home.

Self-efficacy theory alone was not sufficient to explain why some mothers and children had successful outcomes during and after the program was administered. The introduction of Bronfenbrenner's (1992) theory encouraged Olds and company (1997) to look at the ecological aspects of program participation and results. Participants' culture, school and work environment, community services, family and friends, and influences on parenting were the relevant aspects of context assessed and analyzed in the Memphis and Denver trials. The parents' (mothers') psychological resources were examined as aspects of the "person" part of the model. Those resources included adaptive behavior such as health-related behaviors, qualities of caregiving, and education, work, and pregnancy as well as influences of program process and the child involved. Program processes included the nurse-mother relationship, education received as a result of the home visits, goal-setting skills, problem solving practices, and changes in influences in parenting behaviors. The influences of the children's characteristics were also examined with reference to the person-process-context theory. Child characteristics included status of birth weight or gestational age at delivery, any health or behavior problems caused by child maltreatment, injuries, or developmental delay, and influences on child behavior by parenting practices.

A key element of the nurse home visiting program trials that were designed, implemented, and evaluated after the Elmira program was a focus on the program's processes and the processes external to the program that affected mothers' abilities to raise their children appropriately. Program process were operationalized as the ways the nurse home visitors worked with parents to enhance, improve, and change their parenting behaviors and competencies. Other processes that were included in assessments and analyses were the influences of psychological and family resources on the mothers and the interactions and influences of the child on the mothers. The effect of the program on mothers' context was hypothesized to be mediated by mothers' behaviors. The program was designed to change both the behaviors themselves and the contexts that affect those behaviors (Olds et al., 1997 & 1998).

The nurses in the NHVP sites were trained in a solution-focused approach while working with the participants (O'Brien & Baca, 1997). This approach is at the root of the process by which mothers changed their attitudes, beliefs, and behaviors with their children. Nurses used this idea to promote mothers' self-efficacy and self-sufficiency. This approach is hallmarked by understanding that the participating mothers have the most information about their own lives and situations. Nurses were trained to recognize participants' strengths and capitalize on them. Using the mothers' strengths as a springboard for instigating change was expected to allow for the most success in the program.

O'Brien & Baca (1997) further explain this working style in their article. Nurses utilized interview questions and objective evaluations upon participant enrollment (see further details below) and at the first home visits to establish the needs the participants

have as well as the resources (strengths) they have available. Nurses used a question and answer format to get the participant to offer her own solutions to problems. For example, the nurse may perceive a need for the mothers to allow their infants to have "tummy time." The nurse presents the information about the importance of offering this activity and asks the mother how she thinks she can include this activity for her baby during the day. When the mother is able to offer reasonable solutions to this "problem," she gains self-esteem and self-confidence which can be built upon for future solution-focused interactions concerning more difficult situations.

Nurses used these simple, early interactions to establish positive relationships and also to determine the mothers' ability and motivation to make changes. When nurses were able to recognize the mothers' motivation for change early in the program, they could gear their expectations to the ability and motivational level of the mothers. Appropriate goal setting and presentation of points for change were noted to be critical for the maintenance of a positive working relationship (O'Brien & Baca, 1997).

O'Brien & Baca (1997) do an excellent job of describing the specific interaction techniques nurses and other home visitors used in the NHVP sites. As previously mentioned, nurses used a question and answer technique to help participants understand the importance and nature of the problems as well as allow them to offer their own solutions. These questions can be classified into several categories. "Pre-session change questions" are questions the nurses asked participants in an effort to show the mothers that they had made some positive changes in their situations, even if the changes were very small. These questions allowed the nurses to find out how ready for change the mothers might be as well as identify goals they could set together at the beginning of the

program. “Miracle questions” were asked when during conversation or evaluations the mothers expressed concern about a specific problem. Nurses asked questions that would assist the mothers in developing their own action plan for changing their behaviors so that the problem will be solved. These questions allowed the nurses to show the mothers that they can make changes, they can make good decisions to make those changes, are in control of their own behaviors, and can envision a future with the problem solved. “Exception questions,” “scaling questions,” and “coping questions” were also utilized to assist mothers in feeling competent in their abilities to change or have success in addressing/conquering their problems.

Nurse also used several “language techniques” when working with the participants. Nurses tried to reflect back what the participants had said using the participants exact verbiage. When home visitors use the same words participants had used, they are able to reach the participant in a personal and meaningful way. This showed that the nurse was listening to and accepting the participant, which strengthened the relationship (O’Brien & Baca, 1997).

When it is time for the nurse to offer information and assistance with a specific intervention point, she tried to convey a message to the mother with whom she is working. Nurses offered the mothers “compliments” specific to the goal they were trying to attain. Nurses emphasized mothers’ competencies and reinforced their belief that the mothers could make necessary changes. The nurses, along with the mothers, identified an action plan with prioritized tasks designed to make progress toward achieving a specific goal. The nurses also provided an explanation for why the goal is important as well as how the tasks identified are designed to achieve the goal. The challenge for the nurses in

this process was to set goals that would be attainable by the mothers, present the goal in a way that will be received positively by the mothers, and identify and assign tasks that match the mothers' motivation and ability to change (O'Brien & Baca, 1997).

All of these techniques are evaluated at subsequent visits. Techniques were deemed appropriate and productive if the mother was able to complete the tasks assigned and achieves the goal that was set. When goal completion did not occur, nurses were required to evaluate their own communication and goal setting techniques and make adjustments. O'Brien & Baca (1997) stated the program administrators did not view lack of goal attainment as failure, but useful information that is now to be used to make adjustments in the program service delivery. The techniques identified and described in the O'Brien & Baca (1997) article are those used in all of the Nurse Home Visiting Programs described in the following section.

*The Original Elmira Nurse Home Visiting Program*

Participants in the Elmira program were recruited from private obstetrics offices and free clinics in a moderately sized county in Appalachian New York State. Pregnant women were invited to participate if they had had no previous live births, were less than 26 weeks pregnant at enrollment, and were any one of the following – young (under 19), single parent, or low SES. If women not meeting these requirements requested to be in the program, she was enrolled as long as she had not previously had a live birth. The final sample consisted of 400 enrollees. Eighty-five percent of those enrolled met at least one of the risk criterion (teenage, single, or low SES). No participants had previously had a live birth. Eighty-nine percent were white.

The sample was stratified and participants were randomly assigned to one of four treatment groups. Group one (n=94) received sensory and developmental screening for their children at 12 and 24 months of age. Group two (n=90) received sensory and developmental screenings for their children at 12 and 24 months of age and free transportation for prenatal and well-child care appointments through the child's 2nd birthday. Group three (n=100) received the same screenings and transportation as group two, and also received a nurse who came to their homes during their pregnancies. Group four (n=116) received the same treatments as group three, and they continued to receive nurse home visits through their children's second birthdays. For the purposes of analysis, groups one and two were combined and compared to the combination of groups three and four.

Nurse home visitors provided prenatal home visits for 206 participants and continued visits for another two years with 116 participants. Five registered nurses were hired though an independent agency to work exclusively with this program. Each nurse carried a caseload of 20 to 25 families and was supervised in the clinical (home visiting) setting regularly. The home visits included structured curriculum-type lessons that were prescribed for each session. However, nurses were given great latitude in implementing those lessons considering a primary emphasis of the program was to create a close relationship between the nurses and the mothers participating. Nurses were instructed to take individual needs and participant goals into consideration (Campbell, 1994; Kitzman, Cole, Yoos, & Olds, 1997).

The Elmira study involved a number of interviews, assessments, and follow-ups. Children and their mothers from the study were followed, interviewed and tested until the

children's 15th birthday. Interviews and assessments were completed upon enrollment (or the 30th week of pregnancy), and at the 24th, 36th, 46th, and 48th month, and 15th year of the children's lives. The study completion rate was 81% for the originally randomized participants overall; 90% of women carrying to full term and who did not give their children up for adoption completed the all assessments. The majority of the assessments were completed without the interviewer knowing which treatment group the mothers were originally assigned to.

In-home observations and interviews were conducted to assess mother-child interactions (looking at maternal warmth, control, and involvement) and home safety hazards including seat belt and car seat use and control of poisonous substances in the home. Results from the Elmira Nurse Home Visiting Program are outcome-oriented, focused on children's health and well-being. Women who were active participants in the program prenatally improved their own health and had healthier babies especially if the mothers were smokers. Program effects were greatest for unmarried, low-income mothers. These effects were most prevalent in the 4 to 15 years after the program ended. This result was correlated with mothers' sense of mastery and control in their caregiving and life circumstances. Mothers in the home visiting program were found to have higher senses of mastery and control over their lives compared to mothers not receiving home visits. This implies that the nurse visitation helps poor, young mothers feel more competent and confident in their caregiving skills.

## The Memphis Nurse Home Visiting Program

The Memphis Nurse Home Visiting Program utilized the Elmira program as a model. The description and results of this study were published by Olds, Henderson,

Kitzman, Eckenrode, Cole, & Tatelbaum (1998). It was designed to service a different demographic from the Elmira study, and modifications were made to address the specific needs of this new participant group. Participants in the Memphis program were recruited from the obstetrical clinic at the Regional Medical Center in Memphis and were subject to the same selection criteria as those in the Elmira study. The final sample consisted of 1139 enrollees. The majority of participants were African American (92%), single (97%), young (age 18 or under at enrollment; 65%), and low income (85% at or below federal poverty line).

Participants in the Memphis study were assigned to one of three treatment groups during three different time frames of the recruitment period (15 months). An additional treatment group was created during the later months of the enrollment period intended to decrease the mothers assigned to the home visiting groups. Mothers assigned to group one only received free transportation to and from prenatal appointments (n=166). Mothers assigned to group two (n=515) received free transportation for prenatal appointment and their children were developmentally assessed and referral services were provided when the child was 6, 12, and 24 months. Mothers assigned to group three (n=230) received all services offered to group two, and they participated in intensive home visits prenatally, were visited once in the hospital after delivery, and visited once at home after discharge. Mothers assigned to group four (n=228) received all the services described for group 3 as well as home visits for the two years after the child's birth (until child's second birthday) (Olds et al., 1998).

Like the Elmira program, mothers in the Memphis program were interviewed and assessed by research staff at enrollment and throughout the program. At enrollment,

mothers were asked demographic, mental health, personality, and child-rearing beliefs and practices questions. Mothers were interviewed at the 28th and 36th weeks before delivery and 6, 12, and 24 months after their children were born. Mothers were also assessed on their cognitive functioning and maternal control, self-efficacy, and childrearing confidence and competence. The results of these assessments functioned as an index for mother sense of mastery. When children were 6 months old, they and their mothers were interviewed and observed in a laboratory setting to determine rates of breast feeding, beliefs about child abuse and neglect and child rearing, and mothers' childrearing practices as they were involved in a developmentally challenging activity set up by the researchers. Mothers were observed and scored on their caregiving behaviors such as sensitivity, responsiveness, and quality of instruction. Children were observed and scored on their responsiveness and level/quality of communication toward their mothers. Mothers completed the interview assessments in the research offices again when their children were 12 and 24 months old. The mother-child interaction task and observation were repeated as well. During home visits at these time points, researchers completed the HOME inventory (Olds et al., 1998).

Results from the Memphis study were substantially different from the Elmira study. In the Memphis program, 96% of the participants in the home visitation conditions completed assessments through the child's second birthday. There were no program effects on new-born health. Mothers participating in home visiting were less likely to have beliefs about child-rearing and practices associated with child abuse and neglect, their homes were rated as more environmentally acceptable for children as measured by the HOME, and they had the least number of emergency medical incidents with their

children. Children's health and well-being was most positive for mothers participating in home visits. Children of mothers who had the fewest psychological resources were observed to be more responsive and higher quality communication toward their mothers, however, their mothers were not observed to be more sensitive or responsive during interactions at the laboratory observation (Olds, et al., 1998).

It is clear when comparing the two programs that more success, as measured by child outcomes, were found with the Elmira program. Why the Elmira program "worked" and the Memphis program did not have as dramatic of effects is not clear. For both programs, nurse home visitors were trained to model and educate mothers on appropriate caregiving behaviors and practices. For both programs, mothers in the most dire conditions (youngest, poorest, least efficacious at enrollment) changed their lifestyles and caregiving practices the most in a positive direction. Successful participants and their children were seen in both programs to improve their environments and life courses well after the program had ended. However, it is left to speculation as to how or why some participants have these positive results and others do not when the program is designed and delivered similarly to all participants.

*Comparing Elmira to Memphis*

An attempt to explain the differences between the Elmira and Memphis programs is outlined in the Kitzman, Cole, Yoos, & Olds (1997) article by taking a qualitative look at the Memphis program. To do so, full-time nurses were asked to choose two families and report in a systematic, structured way detailed information about service delivery. The nurses chose one family exhibiting typical progress in the program and normal family processes development. The other family to be chosen was to be one at high risk

for having positive outcomes even though they were receiving the home visits. Part-time nurses were asked to choose one family in the high risk category. A total of 27 families were chosen for this analysis.

In the Kitzman et al (1997) article, the main purpose of the analysis was to determine global challenges common to all participants in the program. In this process the characteristics of the nurses were identified. Seventeen nurses were hired by the Memphis-Shelby County Health Department. Ten of the nurses were white, seven African-American, ranged in age from 28 to 50 years, and 13 had children of their own. Their clients were all African-American and ranged in age from 13 to 26 years. The nurses tape-recorded their descriptions of each visit with the chosen sub-section of mothers and these comments were recorded after each visit from start to finish. The tape recordings were begun after the first visit during the pregnancy and ended when the mother completed the program. Mothers participated in the program from 7 to 29 months with an average participation of 17.3 months. Over 100 pages of transcription for each of the families were gathered.

The transcriptions were analyzed for content concerning nurse-mother interaction types. Specific themes were identified that characterized the interactions over time. These themes were then interpreted by looking at cultural and social theories in the literature, discussions with other experts in the field, and the nurse home visitors themselves. Characteristics of both the mothers, the nurses, and the relationship as well as the greater social context in which these interactions take place are identified as contributors to the successes and challenges reported in the nurse narratives. Kitzman et al (1997) identified nine main challenges reported throughout the narratives.

The primary, and chronologically first, challenge identified by the nurses in working with their clients concerned creating the relationship in the first place. Nurses were asked to visit low income, young, first time mothers in their homes over a period of two years. It was reported that nurses often had difficulty making and keeping appointments with their clients at the beginning of the home visiting process. Even though mothers had committed to the program, nurses reported problems in gaining the mothers' trust and working with mothers who took the program seriously enough to make keeping appointments a priority. When appointments were kept, nurses were hard pressed to complete the objectives for that visit because the client was in control of the timing of that visit. Because the visits are at the clients' homes, the clients are in control of nurses gaining access to them.

Nurses reported that mothers frequently cancelled or missed appointments for a variety of reasons. Sometimes mothers simply forgot or had other obligations that got in the way of the home visits. Sometimes mothers were described as not being organized and not used to keeping schedules or appointments in general. Making and keeping appointments was not part of the mothers' repertoire of social skills. Often nurse reported that mothers would change the location of the visits at the last minute as the mothers decided to stay with friends or other relatives on the day of the visit. On some occasions, nurses reported they felt the cancellations and missed appointments of some of their clients were intentional. Nurses viewed this behavior as a result of not being committed to the program.

Again, the main purpose of the home visiting program was to regularly visit mothers in their homes over a period of time. Part of making this happen involved

gaining the trust of the mothers. Nurses had to balance the demands of the program with the individual relationships and needs of the mothers. If nurses pushed program goals too hard, mothers might decide the program was too demanding and drop out. If nurses were not flexible to the mothers' scheduling issues, nurses might never be able to make an appointment that could be kept. If nurses broached a subject required by the program in an insensitive or offensive way, the mothers might be turned off to the program and the nurse and no longer be an active participant during the remainder of the program or drop out completely.

Kitzman et al (1997) reported that nurses attempted to identify why mothers cancelled or missed visits. Once the nurses were able to identify the nature of the challenges in this domain, they were able to develop an individualized plan to address the problem in a way that would be most beneficial to the nurse-client relationship. Nurses described a type of "risk/benefit ratio" decision making rule in how and when to address the situation. Nurses reported feeling they could not confront these issues because they were afraid of losing a client altogether. Nurses also reported they did look at the cause of the missed visits and would confront clients with the situation if the cause was thought as harmful to the client even if the risk of having the client drop out of the program was great. Analysis of the narratives indicated that nurses based their decisions about addressing the challenge of keeping appointments on the type of conflict and cause that was associated with the missed visits. No association with nurse characteristics was noted in the method, timing, or results of nurses addressing this specific challenge.

Nurse narrations identified the home environment as a significant challenge to being successful in the program. Frequent difficulty in finding a private or even quiet

location to discuss program objective was cited. Nurses were often unable to demonstrate a program objective due to the lack of resources within the home. For example, nurses might not be able to demonstrate reading to the child if no books were in the home. Nurses reported having to prioritize the health and safety concerns they had so not to overwhelm the mothers with environmental improvements that must be made. For example, nurses would address the need for the mother to make poison hazards (cleaning supplies, insect poisons, etc.) inaccessible, but would not address less dangerous hazards such as temperature of the hot water in the bathroom until the nurses felt the mothers would have more resources (physical and psychological) to deal with that issue.

The third challenge identified in the nurse narrations involved extended family members and multiple caregivers in the home. Nurses reported they often had difficulty in identifying and understanding the multiple caregivers in the homes. Fathers, grandmothers, and other extended family member and even friends were often involved in the children's care. Nurses expressed difficulty in determining which issues needed to be brought up with the mothers alone and which should involve the other caregivers. Nurses often were not aware that the mothers wanted or did not want a grandmother or father involved in the program objective for the day. When extended caregivers wanted to be a part of the program, nurses reported being unsure of how much of the program's resources should be invested in direct service delivery to non-mothers. Frequently these other family members had their own sets of problems and needs for intervention and assistance that was within the skill level of the nurses but outside the scope of the program. Time spent addressing these issues meant time not spent with the mothers and program goals. An opposite type of challenge by these same extended family caregivers

was noted when these people were not open to the objectives and suggestions offered by the nurses. In these cases, the other family members created a barrier between the nurse and the mother resulting in lack of service delivery.

As previously stated, the nurses were required to deliver the program goals and lessons while being sensitive to the individual needs of the mothers. The program was designed with over-arching goals and objectives but enough flexibility was built in to address client-specific needs not part of the program itself as well as client-specific needs in method and timing of service delivery. The nurses main objective in service delivery was to teach new mothers self-help skills in promoting the health and well-being of their newborns. Some of the client-specific needs that presented challenges to service delivery were limited literacy skills, acceptance of the program's teachings, and time investment. Nurses reported that mothers and their families were often unreceptive to the program objectives because they did not agree with these ways of caring for children and because they felt the goals would take too much time and effort to implement on their own. Mothers expressed that they would not or could not meet program goals because they were already spending all of their time simply trying to survive. Nurses did not report mothers to be uncaring or unconcerned about their children, rather mothers did not understand how to implement program goals in light of their other commitments and stresses. Nurses then had to provide service deliver in such as way as to show mothers that they could change their routines and activities to meet both the basic needs of the family and the program objectives.

Nurses reported another aspect of the balance of the relationship and service delivery protocols concerning the mental, economic, and psychological abilities of

mothers to implement program objectives. Nurses often had difficulty in determining what was too much and too little information and instruction and assignment to give the mothers. It was reported to be difficult to gage the amount of instruction relevant to program objectives during any given visit because nurses were evaluating the ability of the mothers to be able to understand and complete program objectives. Nurses battled the desire to "take over" and do too much for the client, thereby hampering the client's ability to learn self-help skills and be independent, and the desire to not present any material at all, thereby not giving the client the chance to receive or participate in a particular aspect of the program.

Nurses stated that they made their decisions on their levels of involvement based on perceived client needs, resources, abilities, and previous experience with the client in carrying out program tasks. Nurses reported two main reasons for doing tasks for the mothers that the program protocol assigned for the mothers to do. First, nurses noted they would do a task for the mothers in an effort to show the mother that the nurse cared for her and wanted to give the mother a sense that the nurse was invested in her success. Second, nurses noted they would do a task for the mothers when the nurse thought the mother would experience failure in attempting the task and that failure would risk the mother's participation in the remainder of the program.

The sixth main challenge to completing the program successfully is also related to the idea of balancing program demands and client needs. Nurses reported that there were times during the program that mothers were unable to meet program goals because of the mothers' developmental progress. On some occasions, mothers had returned to work or school making it difficult to schedule a time to visit when the mother was home and

difficult for the mother to have additional tasks other than work/school and raising a child. Nurses had to balance the needs of the family and mother against needs of the program and the child.

Nurses also reported it was difficult to help these mothers understand that the skills and goals involved in the program were designed to help the mother in the future. Often the needs of the mothers and their families were immediate and pragmatic. Nurses were faced with trying to teach long-lasting problem-solving skills while needing to make immediate changes for which the mothers were not yet skilled in handling. The home visit program is future-oriented while circumstances the mothers and families are in are more immediate. It was difficult to teach mothers how to prevent problems and gain the skills to work through things that might come up in the future when today the mother is needing electricity restored to her home or has run out of formula and has no money with which to get more.

While several of the nurses in the Memphis Trial were of similar ethnic background with their clients, the nurses reported a need to understand the cultural background and surround of the clients. Nurses, as previously reported, were older than their clients, were professionals, and may or may not have children of their own. The clients were all young and of low-income, African-American background. Nurses noted that they had to understand and learn about the mothers' culture and lifestyle in order to provide workable solutions to problems. Nurses frequently had to find ways to offer assistance and suggestions that did not conflict with the clients' cultural upbringing and would not change their lifestyles drastically while maintaining program goals and objectives. However, nurses reported that it was challenging at best to determine if a

caregiving practice stemmed from a culture belief or lifestyle that was in and of itself damaging to the mother and her child.

The final challenge identified by Kitzman, et al., (1997) focused on the mothers' psyche. Nurses stated that they often felt that mothers and their families needed a break from the regularity of the home visits and wanted time to assimilate the lessons learned from earlier participation in the program. Some nurses reported that mothers were overwhelmed with day-to-day activities of survival and often felt pressure when the goal-oriented program approach was presented by the nurses. When these conflicts arose, mothers often resisted change and the assistance offered by the nurses via the program. Nurses had to design service delivery methods that would convey the information in a way that individual mothers would best receive and use it. Nurses had to be creative in their methods and almost make the mothers believe they had come up with the technique or information or idea on their own rather than it having been something they were taught by the nurse as part of the program. Mothers had to be prepared to receive the information before they became receptive to it and actually put the lessons and techniques into practice.

These challenges identified by the nurses in their collective 2700 pages of narrative were pervasive and ever-present in the two-year protocol with the selected families. No distinction was made between challenges presented by families nurses thought would be high risk for completion and success and those nurses thought were "average" participants. The challenges were bigger than just the mothers or the mother-nurse relationship. They involved a broader social, cultural, family, and environmental context. The nurses met these challenges by being flexible and creative in service

delivery with their clients with an overarching goal of maintaining the relationship even at the cost of no longer offering all aspects of the program protocol. Nurses had to work hard at recruiting other family members into the program to support the mother in making behavioral and environmental changes. Nurses had to work even harder at retaining the mothers in the program for the entire protocol.

In conclusion, Kitzman et al. (1997) stated that it was of utmost importance to the success of the program that the nurses be sensitive to the individual culture, environment, and personal context and needs of each participant. Flexibility was key. In order for the program objectives to be delivered successfully and have mothers improve their caregiving abilities, nurses had to be sensitive, flexible, and creative in service delivery methods.

In order to examine more closely what processes may be taking place within the nurse-client relationship Kitzman, Yoos, Cole, Korfmacher, & Hanks (1997) followed a single nurse-client relationship qualitatively through the course of the program. In this case study, Kitzman and colleagues (1997b) took an in-depth look at the many facets and challenges involved in administering this type of program in a single nurse-client relationship. The nurse had to plan for both short- and long-term goals relevant to both the program and the client's needs. Each activity or lesson brought to the mother at her home was carefully designed and administered in an effort to promote problem-solving skills and more positive caregiving behaviors for the mother. The activities were designed to build upon one another and have an additive effect so that mothers would be able to cope successfully with stresses and offer adaptive and developmentally appropriate caregiving behaviors to her child after the protocol was complete.

In the case analysis, Kitzman et al (1997b) determined that the relationship had to be based on trust in order for the client to be open to the information and be engaged in the lessons in the context of the home visit. The nurse involved in this case study constantly reported that external factors (family and environmental context) and the mother's personal goals and agendas often interfered with the administration of the program protocols. The nurse reported she frequently had to assist the mother with balancing her own needs, her family's needs, and the needs of the program and her child. By helping the mother problem solve challenges posed by her family and environmental context, the nurse veered away from the program protocol. In the long run these deviations served to strengthen the relationship between the nurse and the mother as well as create more opportunities to administer the program on subsequent visits (Kitzman et al., 1997b).

Kitzman et al., (1997b) began the conversation of program processes. Olds and Korfmacher (1998) took the next step by applying a "person-focused" perspective with which to examine the questions "for whom did the intervention best work?," "under what conditions did the intervention work?," and "how did the intervention bring about change?" Olds and Korfmacher (1998) explored aspects of the participating mothers' internal characteristics as contributors to program success or failure. The authors acknowledge that most intervention programs focus their analyses and results on program outcomes rather than program processes.

While intervention program outcomes are often reported in reference to the entire group of subjects, person-focused analyses are done looking at individuals and individual relationships. Olds and Korfmacher (1998) looked at the conditions in which individuals

in the program had the best and worst outcomes. The theoretical background guiding their analyses included the idea of mastery and sense of control as well as availability and utility of psychological resources (e.g., intelligence, mental health stability, and positive coping abilities) in the participants. Using the mothers enrolled in the Elmira sample (see previous description of the Elmira Nurse Home Visitor Program), Olds and Korfmacher (1998) hypothesized that mothers would participate differently in the program based on their level of mastery and control and psychological resources. Mothers (as perceived by the nurses delivering the program to them) with fewest psychological resources and lowest sense of control were expected to have nurses interact with them more intensely, schedule more visits with them, and would be more actively involved in facilitating the mothers' success in the program. It was expected that nurses would see these mothers as needing the program the most. Mothers (as perceived by the nurses) with the most psychological resources and sense of control were expected to participate more actively in the program by keeping scheduled appointments and initiating contacts with the nurse as opposed to the nurses always contacting these mothers.

In the Elmira trial, 400 young, pregnant, low-income, white, first time mothers were enrolled in the program. Olds and Korfmacher (1998) utilized the sub-section of mothers assigned to the complete, 2-year nurse home visiting program to explore their hypotheses (n=99 in the final sample). Nurses visited their clients approximately bi-weekly, but this schedule could be modified to meet the individual needs of the mothers and their families. Completed visits ranged from 0- 67 for this sample. The average number of completed prenatal visits was nine; postnatal visits was 23. Nurses also contacted their clients by phone between visits. Phone consultation lasted an average of

5.2 minutes per call, and the average number of completed nurse-client calls was 14 (range, 0-58). Total contact time by phone and in person was used to calculate level of participation and involvement in the program by both the nurses and the mothers. Phone calls were subdivided into those made by nurses and those made by the mothers. Contact time was the dependent variable in these analyses. Maternal sense of control was used as the independent variable in these analyses. Mothers' sense of control and mastery was measured using a modification of the Rotter's Locus of Control scale. High scorers were labeled as feeling more in control than low scorers. The variables of social class and support from a male significant other were used as controls (Olds & Korfmacher, 1998).

Olds and Korfmacher (1998) found that mothers' sense of control predicted the number of home visits that were completed. Mothers with the lowest levels of control received the most visits by the nurses. Some mothers at the highest end of the control measure were found to receive more visits by the nurses than mothers at just lower levels. The high control mothers also spent more time in phone conversations initiated by the mothers with the nurses than their lower control counterparts. Time spent in phone conversations initiated by the nurses was not significantly different for high and low control groups. The control variable of SES was not related to the duration and frequency of visits or phone calls for either group of mothers. However, when a male support person was involved, it negatively impacted the frequency and duration of calls initiated by the nurses. Male support was not related to duration or frequency of calls initiated by the mothers.

Olds and Korfmacher (1998) also tested their hypotheses on participants in the Memphis Nurse Home Visitor Program (n = 207 who completed the 2-year home visiting

program). These analyses were aided by the narrative reporting and record-keeping systems employed by the nurses in the Memphis trial. Investigators were able to determine not only the frequency and duration of the phone contacts, but also the frequency and duration of the home visits themselves. Number of completed home visits and length of telephone contacts were used as two indicators of program involvement when comparing mothers from the Elmira and Memphis programs. Mothers in the Memphis program were seen by nurse home visitors slightly more than the mothers in the Elmira program. Mothers in the Memphis program received 4 times as much phone consultation when compared to the Elmira program.

Olds and Korfmacher (1998) found that as Memphis program participants' psychological resources improved or increased, home visitation participation decreased, but for mothers with the highest level of psychological resources throughout the program's duration, nurses completed the most visits. Memphis program mothers who were lowest in SES were visited by nurses more often than those in a high SES category. SES in the Memphis program did predict number of visits mothers would complete. Support from a male significant other did not predict participation in the program in any way. When mothers' work status was factored in, it predicted number of visits completed and was related to psychological resources. Mothers who worked the most months during the program's duration received the fewest home visits but had high levels of psychological resources. There were no relationships found among the predictor variables and nurse-mother phone contact after babies were born.

Olds and Korfmacher (1998) summarized that when mothers' level of control and psychological resources are identified by nurses, number of completed home visits can be

predicted. Nurses who perceived mothers to be low in control and low in psychological resources attempted to schedule more contacts with those clients and actually completed more of those contacts than with mothers having higher levels of control and psychological resources. Mothers with the highest level of control and psychological resources were more apt to make and keep visits with the nurses when they could be made, but making these appointments was often reported to be difficult due to mothers' outside-the-home commitments. These high control/high psychological resources mothers also initiated more contacts with their nurses than the low control/low psychological resources mothers.

In conclusion, Olds and Korfmacher (1998) made the following suggestions for program improvement and development. Flexibility in program delivery and scheduling is important to facilitate participation in the program. It is recommended that people administering the program, in this case nurses, be given a balanced caseload. Nurses need a client base with differing levels of need so that each participant can receive adequate levels of service. Those on the front line administering programs perceive their clients in different ways. These perceptions influence how program services and resources are parceled out. In the case of the Elmira and Memphis programs, when nurses perceived mothers to need the most assistance, they attempted to meet those needs by scheduling more service delivery points (in person and by phone).

To follow up, Korfmacher, Kitzman, & Olds (1998) published an article designed to explore, explain, and discuss how the variations (identified in previously reviewed articles above) in how nurses delivered program services may mediate program effects. Korfmacher et al. (1998) utilized the participants from the Memphis Nurse Home Visitor

Program (n=228). In this article, the authors describe in detail the program itself – participants and procedures – and evaluate the program in terms of the processes to identify differences in service delivery and how those differences are related to differential program outcomes. Associations between differential program outcomes and program participation and whether or not the nurses actually delivered the program as designed are analyses and discussed.

Korfmacher et al. (1998) operationalized program involvement as length of time participating, level of services addressing parenting specifically, and the emotional quality of the nurse-mother relationship. First, the investigators sought to determine whether or not the program was effective, then determined for whom it was most and least effective, and finally explored the program processes that lead to program success or lack thereof. Program success was measured with parenting assessments such as attitude toward parenting, home environments, and parenting behaviors as observed during mother-child interactions. Korfmacher and associates (1998) hypothesized that program processes or variability in service delivery could predict program effects. It was expected that the quality and the quantity of service delivery would explain the differences in program outcomes. Specifically, investigators expected that mothers who participated more often and actively and received targeted programmatic instruction (information on appropriate caregiving) would be assessed at the end of the program as offering a more warm, nurturing, safe environment and have overall better child health and development outcomes than mothers who participated the least (both qualitatively and quantitatively) or received information not directly related to caregiving.

Mother participation was measured by calculating the amount of time spent actively participating during home visits with respect to time on program-specific information (i.e., caregiving skills). Mothers' emotional participation in the program was measured by having the nurses complete a 12-question survey on involvement after each visit. These items included mothers' attentiveness, attitude (positive or negative) toward the nurse and the information presented, nurse perceptions of what the mothers actually understood about the information presented in each session, and the amount of problem-solving skills instruction and practice that took place during each session. The mothers were asked to assess the nurse-client relationship at the end of the program (2 years after the child's birth). Investigators utilized a 27-item "Helping Relationships Inventory." This measures was designed to determine the mothers' perception of the quality of their relationship with the nurses, how much they thought the nurses understood their individual circumstances, and how much acceptance and sensitivity the nurses offered. Outcome measures included assessments of mothers' caregiving/parenting beliefs (including empathy toward child) and behaviors, quality of mother-child interactions, demographics, psychological resources, and maternal empathy (Korfmacher, et al., 1998).

The average amount of nurse-mother contact was 32 hours from time of enrollment (prenatally) to the child's second birthday. Twenty-six of those contact hours were spent during home visits. Most mothers only received half of the prescribed number of visits as per the original home visiting protocol. Investigators found that during the visits that were kept, mothers were described as emotionally engaged and actively participating in the visits. Mothers with high levels of empathy toward their children and

nurses level of empathy with the mothers was significantly related to program outcomes. Psychological resources accounted for 28% of the variance in empathy scores at the end of the program. Psychological resources, mother engagement level, nurse empathy, and quality of service delivery (staying focused on targeted instruction on caregiving skills) contributed to variability in scores on the HOME inventory (17% of variance explained). Specifically, results suggest that mothers with the lowest levels of psychological resources and who received high levels of caregiving instruction during visits had higher scores on the HOME inventory at the end of the program. Korfmacher et al., (1998) concluded that the program's effects were meditated by the nurse-mother relationship and the mothers' psychological resources.

Investigators focused some discussion on the finding that most mothers did not received the number of visits deemed necessary for program delivery and success. This is an important aspect of programmatic evaluation in that it is critical for programs to determine as near as possible the required number of visits to ensure effectiveness. It appears that while nurses were flexible in their scheduling, it was not damaging to the objectives of the program. Investigators concluded that different participants with differing needs, individual abilities, and resources, may require different levels of intervention and services to achieve the same positive outcomes. Results also indicate that when the nurse-client relationship was strong and positive in nature, participants were more actively engaged in the program and had more successful outcomes regardless of contact. It appears that quality versus quantity of contact is most important in program success (Korfmacher, et al., 1998).

To this point, investigators involved with these studies have examined mother characteristics, nurse characteristics, environmental influences, and characteristics of the nurse-mother relationship in an effort to describe and explain program effectiveness and processes. The addition of the Memphis site to the Nurse Home Visiting Program has been beneficial in the effort to determine and explain how this program works and can produce successful outcomes for its participants. The Memphis site offered researchers a unique demographic of participants that could be compared to the participants in the Elmira trial. As the programs evolved, so to did the research questions. In 1997, the Nurse Home Visiting Program was expanded to a third site – Denver, Colorado. The addition of this third site resulted in additional opportunities to replicate studies assessing program effectiveness and process.

*The Addition of the Denver, CO site and Comparison to Elimra and Memphis*

Hiatt, Sampson, & Baird (1997) utilized information gathered in the Home Visitation 2000 program which was administered in Denver, Colorado. This nurse-home visitor program was modeled on the Elmira and Memphis home visit program trials. Home Visitation 2000 was developed in such a way as to be able to identify and evaluate specific program implementation and service delivery processes as they related to differing characteristics of the persons delivering the program. Home visitors in the Denver program were all paraprofessionals. The main point of replicating the Nurse Home Visitor program in Denver was to determine whether or not the program could be successful using paraprofessionals as home visitors. Hiatt et al. (1997) compared the service delivery processes and outcomes between mothers working with professional nurses and those receiving services through a paraprofessional. In addition to this goal,

Hiatt et al. (1997) expected that when those administering the home visit s (nurses and paraprofessionals) were also mothers, that shared experience of motherhood was facilitate a closer and more productive relationships with the new mothers participating in the program.

All nurses employed in Home Visitation 2000 had bachelor's degrees or higher. The paraprofessionals had high school degrees, but no professional training or education in the health professions, education, or social work fields. The paraprofessionals were all familiar with their communities and the community resources available to new mothers. All of the paraprofessionals were mothers. Over 70% of the nurses were also mothers themselves. Paraprofessionals were younger on average than the nurses.

Hiatt and colleagues (1997) found many challenges associated with implementing a program designed to be delivered by professional nurses being delivered by paraprofessionals. A description of hiring practices is outlined in this article. Parapro's who were hired as home visitors came from a variety of ethnic, SES, and experiential backgrounds. Program administrators specifically looked for and hired paraprofessionals with personalities and work-styles that would facilitate creation of a trusting relationship. Staff must be excellent communicators, be good role models for their clients, and have the ability to gain the trust of their clients. Formal interviewing protocols did not lend themselves to gathering this information. While the program described here sought to hire parapro's with these characteristics, it was not always successful in doing so.

Denver program administrators found that paraprofessionals needed assistance with being seen as credible by the community agencies they interfaced with as well as their nurse counterparts within the program. Parapro's in the program reported they felt

other agencies and the nurses did not believe they were competent or trained enough to do their jobs appropriately. This perception may have been something within the parapro's themselves (and not a real feeling nurses or other agencies had about them), but this feeling resulted in anxiety in the workplace. Program administrators reported they had to design support systems within the program to train and support the parapro's specifically to alleviate these feelings (Hiatt, et al., 1997).

Program administrators addressed credibility issues through a process of professionalization and training. Administrators had to find ways to allow parapro's development to take place without damaging their self-esteem and image as well as keep their momentum going. Training included assistance in developing appropriate social skills, monitoring feelings and self-evaluation in order to facilitate positive work-place interactions, and instruction on creating and maintaining boundaries so as to keep personal and professional relationships separate. Pre-service training took place in a classroom setting. Parapro's attended over 50 clock hours of training before beginning work with clients. Once this formalized pre-service training was complete, the parapro's delivered program services to two or three pilot families before administering the complete protocol to program families. Home visitors were supervised regularly and received on-going training throughout the program's length.

A key component of the training protocol involved assisting parapro's with their relationship skills. The relationship between the client and the service provider is paramount to the success of a program. Visiting clients in the comfort of their own homes goes far in the process of creating a comfortable environment for clients to receive information and evaluation. Hiatt et al (1997) articulated that the first visit was vital to

setting the relationship off on the right foot. Training parapro's in relationship building and maintenance is necessary to setting the foundation of the relationship at that first visit.

Significant levels of training on professionalism are required when employing paraprofessionals. Parapro's were hired in this study in part because their ability to relate to their clients resulting from the parapro's congruent backgrounds with the target client population. When people have shared experiences, they may tend to blur the boundaries between the client-mother relationship and be involved in more of a friendship. Friendships can result in developing a close, trusting relationship, but they can also prohibit offering criticisms and suggestions for correcting behaviors as is required by the program protocols. The empathy a parapro can feel with a client can be a strong asset in the relationship-building process, but also can be a deterent to offering the necessary criticisms involved in a training and behavior modification program.

In summary, results from this study showed that parapro's were equally competent, given appropriate training and supervision, as professional nurses in administering the program as delineated in the program protocol. However, additional and specialized training was required to achieve that result. Parapro's required assistance in relationship building and maintenance skills as well as developing boundaries with their clients. Parapro's were reported to have addressed the program content in unique ways compared to the nurses, but program outcomes were similar for mothers in both groups.

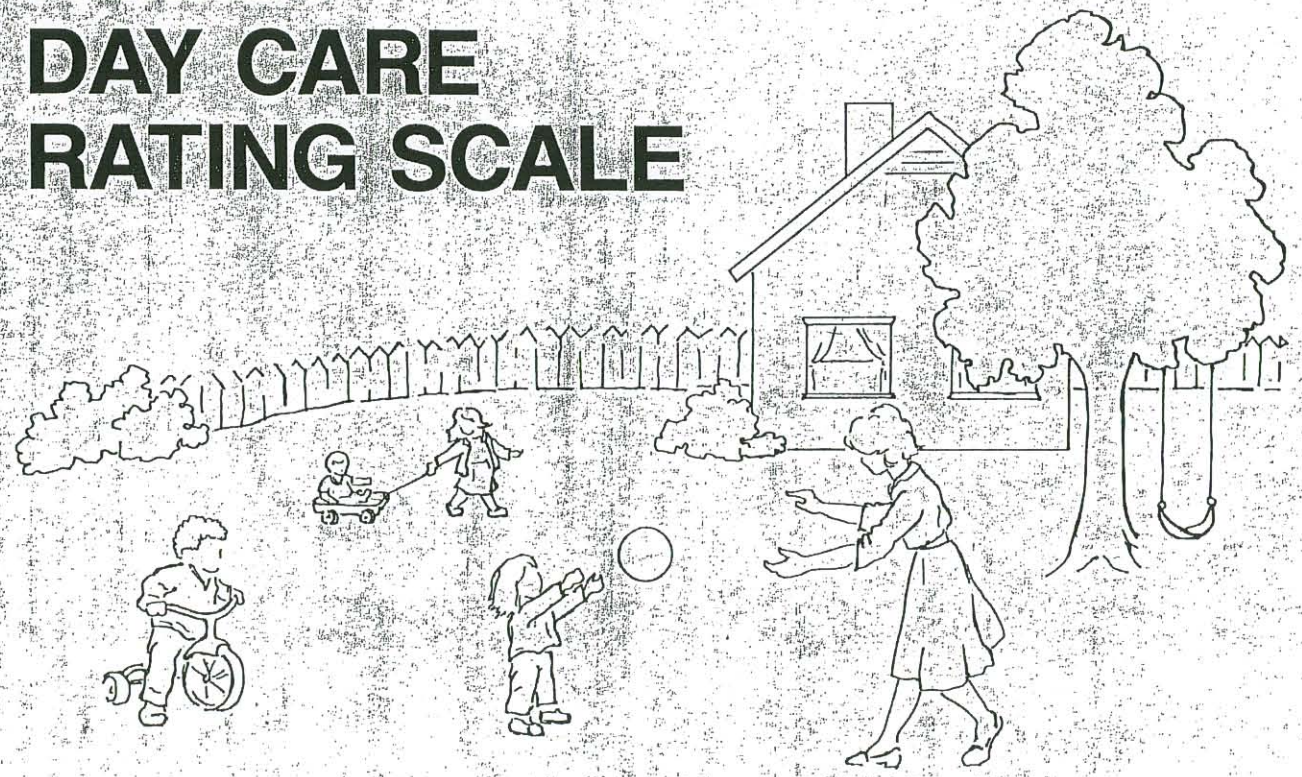
Comprehensively, the Nurse Home Visiting Program as administered in all three of its locations, has been a success. The research coming out of evaluating a variety of

aspects about this program has started a conversation about processes involved in implementing relationship-based interventions. The detailed descriptions of all aspects of the program and depth of information available to test a variety of hypotheses offers other researchers interested in program design, implementation, and evaluation a firm foundation on which to base subsequent research.

# APPENDIX B

## Family Day Care Rating Scale

# FAMILY DAY CARE RATING SCALE



THELMA HARMS RICHARD M. CLIFFORD

# FAMILY DAY CARE RATING SCALE

**THELMA HARMS**
Director, Early Childhood Curriculum Development

**RICHARD M. CLIFFORD**
Associate Director, Bush Institute for Child and Family Policy

Frank Porter Graham Child Development Center
University of North Carolina at Chapel Hill

TEACHERS COLLEGE PRESS
Teachers College, Columbia University
New York and London

Published by Teachers College Press, 1234 Amsterdam Avenue,
New York, NY 10027

Copyright © 1989 by Thelma Harms and Richard M. Clifford

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, or any information storage and retrieval system, without permission from the publisher.

Cover design by Marcia J. Decker



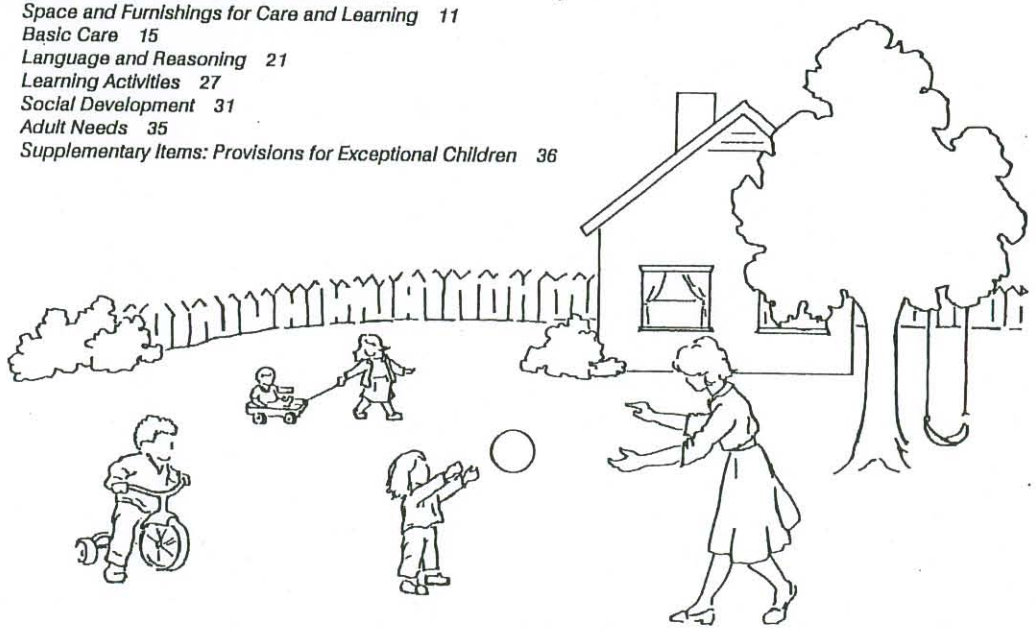
Printed in the United States of America

ISBN 0-8077-2955-8

00 99 98 9 8 7

## CONTENTS





# Preface

The Family Day Care Rating Scale (FDCRS) is an adaptation of our previous publication, the *Early Childhood Environment Rating Scale* (Teachers College Press, 1980). Although the format of both scales is the same, the content is different, just as family day care settings differ from center-based settings even though both serve the same general goals and the same population.

The FDCRS has had a long period of development, field-testing, revision, and considerable use in research and training prior to this publication. We started work on an adaptation of the ECERS for family day care homes in 1980. Additional work on the adaptation was completed during the summer of 1981, with the assistance of Efrat Padan-Belkin. The first version of a rating scale for day care homes appeared in 1981 under the title Day Care Home Environment Rating Scale (DCHERS). Dr. Padan-Belkin returned to Israel in August of 1981 and did not continue to work with us on the scale after that time.

Following some initial field testing, we met weekly during the 1981-82 school year to revise the scale with a knowledgeable and devoted group of day care specialists, including Debby Cryer, Beth Bourland, Diane Adams, and Deirdre Dowdakin. Repeated field-testing and revision continued during 1982 and resulted in a new version of the DCHERS that year. In 1983, further revisions were made with the help of Debby Cryer and Beth Bourland, and a reliability field test was undertaken with their asistance and that of Mary Rutala, Janet Anderson, Fran Perkowski, Bess Cheney, and Teresa Waggoner.

Although we were pleased with the overall reliability, individual item reliabilities for a few items were judged too low. We made slight revisions in those items with the lowest reliabilities before the 1984 revision was printed. This revision was named the Family Day Care Rating Scale and was substantially the same as the version presented here. The modest current revisions clarify wording based on our own experience as well as that of many colleagues who have used the FDCRS in both research and practice.

How can we properly thank all the people who helped us develop this scale? There have been countless family day care providers in our own and neighboring North Carolina counties who have opened their homes to us so that we could field test and revise the scale. We are most grateful to them and to our colleagues who worked with us on the many revisions.

Research and training use of the previous versions of the FDCRS have also contributed greatly to its development. We are particularly appreciative of the work of Carolee Howes and her colleagues at UCLA, as well as Alan Pence, Hillel Goelman, Susan Pepper, and Barbara Stuart in Canada. Continuing interest and invaluable feedback from M. A. Lucas and her staff at the Child Development Services Division of the U.S. Army Community and Family Support Center have resulted in significant improvements in the practical usefulness of the scale. Nancy Travis and Joe Perreault have provided encouragement through their Family Day Care Technical Assistance Conferences.

The special education items were developed with Don B. Bailey and field tested and revised with Debby Cryer. Sylvia Jones and the staff of the Family Day Care Project, an HCEEP program in Ann Arbor, Michigan, field tested the special education items.

The development of this scale has been a long and absorbing process. We are most grateful to all of the colleagues mentioned here and to the many others who have provided extensive feedback from their experiences in the field. We are especially thankful for the patience, assistance, and encouragement of our colleagues here at the Frank Porter Graham Center.

Thelma Harms
Richard M. Clifford
Frank Porter Graham Child Development Center
University of North Carolina at Chapel Hill

# Development of the FDCRS

## RATIONALE

When parents need child care outside their own homes, they are more likely to choose care in a caregiver's home than in a day care center, particularly for children under three. Family day care is the name given to child care that is provided in an individual's home for a small group of children, often including the provider's own children. Despite the fact that family day care is more prevalent than center-based care, state regulations for family day care homes are minimal, usually covering the number of children of various ages that are permitted and some basic health and safety protections. A statement by the caregiver attesting to good moral character and sound health is also commonly required. Regulatory standards vary widely from state to state. Some states require only registration with spot monitoring while others require licensing with regularly scheduled monitoring visits. Requirements and resources for training also vary across the country.

Originally, child care was seen as a substitute for parental care and therefore primarily a service for parents. As child development knowledge grew, the quality of the child's experience in child care became a concern because of the possible detrimental effects of custodial, unstimulating care on the child's development. More recently, questions about possible negative effects on the child's social, emotional, and cognitive development have been raised, especially in the case of infants. There is also concern that parents who put babies into child care may feel cut off from their child and therefore may not properly bond to their child or develop a sense of parental competence.

High-quality day care in both family and center settings is now seen to be important for both the child and the parents. The goal for the child in quality child care is to foster total development rather than to provide only custodial care. The goal for parents is to provide continued opportunities for involvement and communication. The family day care provider is expected to be a more professional, aware person who can provide a safe, supportive, and stimulating environment for a group of children with varying needs, and can also communicate well with parents. Since family day care is a small business providing an important service, adjustments will have to be made in a home when it becomes a family child care home, just as adjustments have to be made to accommodate any other business or profession run in a home.

The Family Day Care Rating Scale (FDCRS) defines quality of family day care comprehensively. The 32 items of the scale cover six categories: Space and Furnishings for Care and Learning, Basic Care, Language and Reasoning, Learning Activities, Social Development, and Adult Needs. Each item is described in four levels of quality: inadequate (does not even meet custodial care needs), minimal (meets custodial needs and, to some degree, basic developmental needs), good (meets developmental needs), excellent (high-quality personalized care). The inadequate and minimal ratings focus on provision of basic materials and on health and safety precautions. The good and excellent ratings require positive interaction, planning, and personalized care as well as good materials. The descriptors cover the needs of a range of ages from infancy through kindergarten.

The FDCRS tries to remain realistic for family day care home settings by not requiring that things be done as they are in day care centers. Yet a family day care home should not be thought of as simply the private home of a family; it must provide the necessary additional organization, space, materials, activities, and interaction to give developmentally appropriate experiences to the children who are enrolled there for day care.

Viewing family day care providers as child care professionals is consistent with the Child Development Associate Family Day Care credential, made nationally available for family day care providers in 1985. Candidates must prepare for and show proficiency on six competency goals. Comparing the FDCRS items with the six CDA competency goals shows that the scale provides items to assess each competency. The chart below displays the FDCRS items for each CDA goal.

| *CDA Competencies* | *FDCRS Items* |
|---|---|
| 1. Establish and maintain a good environment | |
| Safe | 13, 26 |
| Healthy | 8, 9, 10, 11, 12 |
| Learning | 1, 2, 3, 4, 5 |
| 2. Advance children's competence | |
| Physical | 5 |
| Cognitive | 17, 18, 24, 25, 26 |
| Communication | 14a & b, 15a & b, 16 |
| Creative | 19, 20, 21, 22, 23, 25 |
| 3. Support social/emotional development | 6a & b, 7, 27, 28, 29 |
| 4. Establish positive relations with families | 7, 30 |
| 5. Ensure a well-run program | 25, 26, 32 |
| 6. Maintain commitment to professionalism | 31, 32 |

The FDCRS was designed to be comprehensive yet easy to use so that it would be helpful in self-evaluation by care providers, for supervision and monitoring by agency staff, and also in research and program evaluation. It is currently being used in both training and research in a wide variety of programs.

## RELIABILITY AND VALIDITY

Two concepts in test development are of concern for the development of measurement scales like the FDCRS. The first is reliability. For FDCRS, reliability means the ability to obtain consistent ratings. The value of the FDCRS is largely determined by its ability to be used consistently to measure environmental quality. The second concept of concern is validity--that is, the degree to which

FDCRS really measures environmental quality in family day care. Efforts to measure reliability and document validity are discussed briefly below.

**Reliability.** Two different approaches to measuring reliability have been used. The first is interrater reliability, the degree to which two different raters' independent ratings of a given family day care home agree. In the first attempt to determine interrater reliability, six people were trained to use the scale. Pairs of raters observed in 19 family day care homes in central North Carolina. The pairs were then rotated so that a true test of freedom from observer bias could be made. An interrater reliability coefficient of .864 was obtained in the study. However, since 8 items had individual item level reliabilities of less than .5, we decided that revisions should be made in those items before additional studies were undertaken.

Substantial revisions were made to the eight items. Minor changes in wording were also made to a number of other items. The revised scale was used by the Family Day Care Training Project in Ann Arbor, Michigan, under the direction of Sylvia Jones. Dr. Jones and her colleagues obtained a median interrater reliability of .83 in the project (Jones & Meisels, 1987). In working with this project, which mainstreamed handicapped children, it became clear that the item on provisions for exceptional children should be dropped and supplemental items focusing in more detail on the needs of exceptional children developed. Those items for exceptional children are now included as an addition to the main portion of the FDCRS. Reliability studies on the special items have not been conducted.

In two separate studies using the FDCRS, Howes and Stewart (1987) and Howes (1987) measured interrater reliability using the revised version. Study I involved two raters observing in 55 family dare care homes in Los Angeles. Study II involved two different observers and 101 family day care homes also in Los Angeles. The individual item median interrater agreements were all greater than or equal to .90 for both studies.

A second measure of reliability is internal consistency. This measure observes the degree to which similar items are scored similarly across various raters. Howes and Stewart (1987) calculated internal consistency of the FDCRS subscales with data from Study I. Cronbach's Alpha was the statistical test of internal consistency. Subscale alphas are shown below.

| | |
|---|---|
| Space and Furnishings for Care and Learning | .86 |
| Basic Care | .90 |
| Language and Reading | .90 |
| Learning activities | .93 |
| Social Development | .83 |
| Adult Needs | .70 |

On the basis of these studies, we concluded that, given proper observer training, the FDCRS is capable of being a reliable measure of family day care home environments. Howes (1987) emphasizes the importance of subscale scores. She found them to be appropriate to use and valuable in identifying aspects of the environment related to other measures used in her studies.

**Validity.** As with reliability, there are a number of different approaches to determining validity. One difficulty in establishing validity for an instrument new to its field, such as the FDCRS, is the lack of existing instruments with which to compare results. Measures of what is commonly known as concurrent validity were not possible for the FDCRS.

Content or face validity is another important dimension of overall validity. As discussed above, the FDCRS is an adaptation of the *Early Childhood Environment Rating Scale*. The items in the FDCRS closely parallel those of the ECERS, but have been adapted to reflect the realities of care in a home setting. Content validity of the ECERS was established during its development by a panel of experts, who reviewed an early version of the ECERS and rated each item on importance to child care and relevance to the scale.

The center-based version has also been used extensively in studies of child care in which a relationship has been demonstrated between environment as defined by ECERS and hypothesized outcomes, including language and social development of children in child care centers. The established validity of the ECERS provides face evidence that the FDCRS is also a valid measure of environmental quality.

The expectation that FDCRS should be a valid measure has been reinforced by the limited number of studies in which it has been used to measure environmental quality in family day care homes in the United States and Canada. The study of family day care homes in Los Angeles described briefly above provided a partial validation: The FDCRS was found to correlate positively with both observed behaviors and regulatable aspects of family day care environment (Howes & Stewart 1987).

Pepper and Stuart (1985) found that scores on the early versions of the FDCRS were highly correlated ($r = .80$) with home visitors' ratings of family day care settings. Furthermore, they found that the scale scores were related to caregivers' education. Jones and Meisels (1987) found that improvements in family day care home environments as a result of training could be documented using the FDCRS. All known work to date indicates that the FDCRS is a valid measure of the quality of environments in family day care home settings.

Thus in addition to having an established interrater reliability when observers are properly trained, the FDCRS also has a demonstrated ability to distinguish among family day care homes of varying quality of environments as assessed by outside observers. Scores on the FDCRS are related to various measures of quality, including caregivers' education and child outcomes. All of these findings support claims for validity of the FDCRS. However final determination depends on a wide range of studies documenting the ability of the scale to distinguish varying levels of environmental quality and the relation of this variation to child outcomes.

## References


Howes, C. (1987). Inter-observer reliability for the Harms and Clifford Family Day Care Rating Scale. Personal Communication.

Howes, C., & Stewart, P. (1987). Child's play with adults, toys, and peers: An examination of family and child care influences. *Developmental Psychology, 23,* 423–430.

Jones, S. N., & Meisels, S. J. (1987). Training family day care providers to work with special needs children. *Topics in Early Childhood Special Education, 7* (1), 1–12.

Pepper, S., & Stuart, B. (1985). *Informal family day care: A study of caregivers.* Ontario Mental Health Foundation.

## Instructions for Using the FDCRS

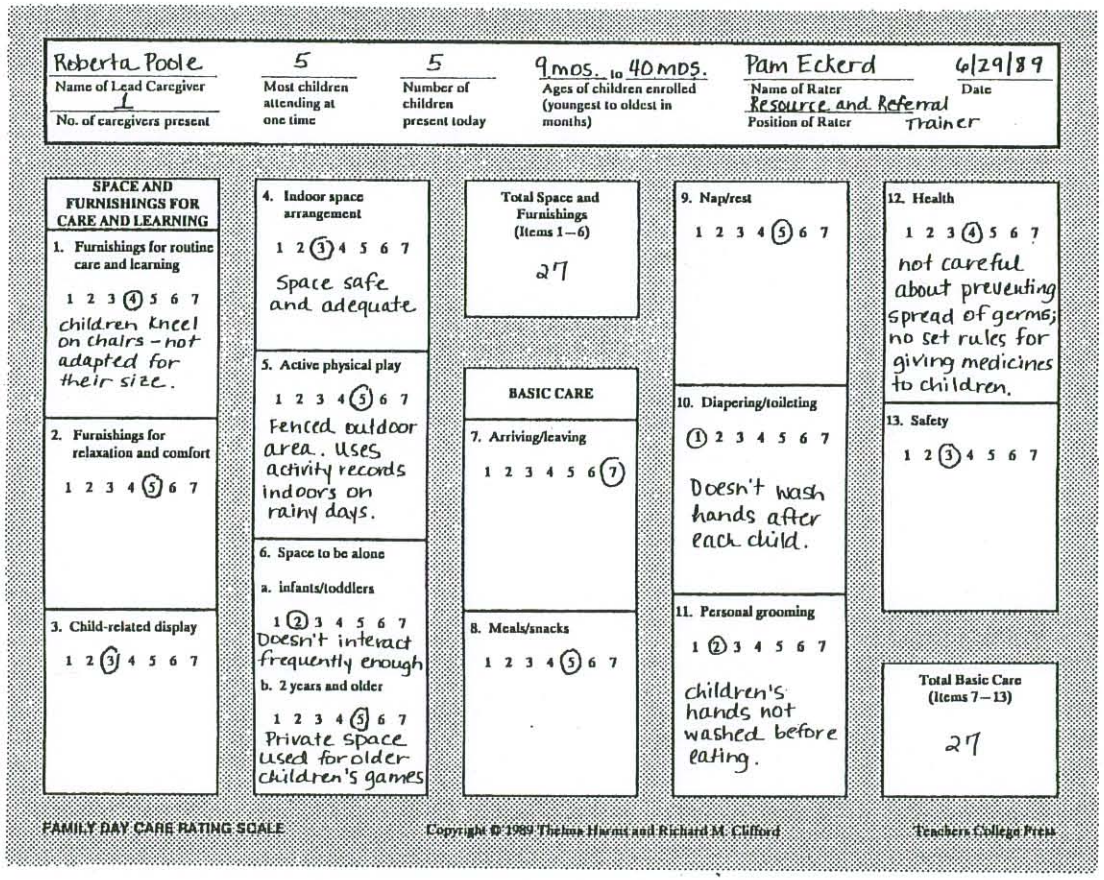
The *Family Day Care Rating Scale* (FDCRS) has been designed to give an overall picture of the quality of care provided for children in a family child care home. The scale can be used by a care provider as self-assessment, or by a supervisor, trainer, or researcher after an appropriate observation period.

1. Read the entire scale carefully before attempting to rate a child care home. In order to be accurate, all ratings have to be based as exactly as possible on the descriptions provided in the scale items. If the facility enrolls a special needs child, the Supplementary Items for Exceptional Children should be used in addition to the scale.
2. If two or more observers are being trained to use the scale, differences in interpretations should be resolved in order to reach a common understanding of the items before the scale is used in the field. Trial observations in a home, followed by discussions of the ratings given by each observer, produce the best results.
3. A block of 2 hours or more should be set aside for observation if an outside observer (anyone other than the care provider) is doing the rating. Observations are best accomplished when children are awake and active.
4. The rating scale should be kept open and at hand during the entire observation so that the observer can read the items as decisions about ratings are made.
5. All ratings should be circled and comments written on the score sheet while observing (see the sample completed score sheet on pages 6–8). Ratings should not be entrusted to memory for later recording. A clean copy of the rating score sheet should be used for each observation.
6. Ratings are to be assigned in the following way:
   - Ratings are based on the current situation that is observed or reported, not on future plans.
   - A rating of 1 is given if any part of that description applies.
   - A rating of 3 or 5 is given only if all parts of the description are met. All positive descriptions in 3 must be met before any higher rating is given for an item.
   - A mid-point rating of 2 is given if nothing in 1 is present and half or more of 3 is observed.
   - A mid-point rating of 4 or 6 is given when all of the lower and half or more of the next higher description applies. Partial credit within descriptors may be given for mid-point ratings.
   - A rating of 7 is given only when all of the description in 5 plus all of the description in 7 applies.
   - Three items (items 6, 14, and 15) have alternate versions for children younger than or older than two years of age. Rate one or both versions depending on ages of children served.
   - Items marked with a ♦ are omitted for a child care home where all children are 12 months old or younger. If even one child is older than 12 months, the items should be rated.
   - Rate items 33–40 only when a special needs child is served by the child care home.
7. If you are an outside observer, take a few minutes to get settled. Put the caregiver at ease with a smile. Remember that you are a guest in her/his home. Follow the movement of the caregiver and children so that you can hear and see what is happening, but do not interrupt with questions or comments. Make appropriate arrangements if a follow-up visit is needed. Remember to thank the careprovider for allowing you to visit.
8. For an outside observer, here are some hints about the order in which to do the items:
   - Begin with those items most easily observed (furnishings for routine care and learning, furnishings for relaxation and comfort, child-related display, and indoor space arrangement: Items 1–4).
   - Some activities happen only at specific times of the day. Be aware of those items and rate them as they occur (arriving/leaving, meals/ snacks, nap/rest, diapering/toileting, personal grooming: Items 7–11).
9. Avoid asking questions or talking to the care provider while she/he is busy. Be a considerate observer. Arrange for a few minutes to ask questions at the caregiver's convenience.
   - Items such as active physical play, space to be alone, language and reasoning, learning activities (Items 5, 6, 14–24, 26–29) may require information in addition to what you observed.
   - You will also need to ask about the remaining items that usually require information from the caregiver (health, safety, schedule of daily activities, adult needs: Items 12, 13, 25, 30–32).
10. It takes skill to phrase questions so that they do not give the answers away.
    - Practice some open-ended questions. For example: "Can you tell me what happens when children come and when they leave?" "What would you do if a child got sick while he was at your child care home?"
    - Ask factual questions directly and nonjudgmentally. For example: "Do you have a substitute or back-up caregiver available?" "Have you taken a first-aid course? When?" "What is 'off limits' for the child care children?"
11. *Using the Score Sheet:* The score sheet provides a convenient way of recording individual item scores, which can be added to form subscale scores and total score.
    - It is advisable to use pencil on the score sheet during the observation. The final score sheet entries should be written clearly and be dark enough to

photocopy, should that be necessary. The scores you finally decide on should be circled clearly.

- The score sheet can be marked to indicate which item(s) you need to ask questions about in order to get additional information. Underline the highest score that can be assigned to the item based on your observation. Then put a question mark near the item(s) that require questions, and indicate the nature of the question by writing key words near the question mark. By preparing your score sheet in this way, questions can be asked systematically in a short period of time. Remember to ask only those questions needed to decide on a score higher than the score you have assigned based on your observations alone.
- The score sheet can also be used to briefly indicate the reasons for each of your scores. Key words describing what was observed serve to remind you about the reasons for your decisions. These key words can later be used to make plans for improvement or to compare your scores with the caregiver's scores.

*Please note:* The working copy of the score sheet included in the centerfold of this book should be removed for ease in scoring. Additional copies of the score sheet are available, in packages of 30, from Teachers College Press, P.O. Box 2032, Colchester, VT 05449; toll-free phone: (800) 445-6638 [in Vermont, call collect: (802) 878-0315].



| Roberta Poole | 5 | 5 | 9mos. to 40mos. | Pam Eckerd | 6/29/89 |
|---|---|---|---|---|---|
| Name of Lead Caregiver | Most children attending at one time | Number of children present today | Ages of children enrolled (youngest to oldest in months) | Name of Rater | Date |
| 1 | | | | Resource and Referral Trainer | |
| No. of caregivers present | | | | Position of Rater | |

**SPACE AND FURNISHINGS FOR CARE AND LEARNING**

1. Furnishings for routine care and learning
   1 2 3 (4) 5 6 7
   children kneel on chairs – not adapted for their size.
2. Furnishings for relaxation and comfort
   1 2 3 4 (5) 6 7
3. Child-related display
   1 2 (3) 4 5 6 7
4. Indoor space arrangement
   1 2 (3) 4 5 6 7
   Space safe and adequate
5. Active physical play
   1 2 3 4 (5) 6 7
   Fenced outdoor area. Uses activity records indoors on rainy days.
6. Space to be alone
   a. infants/toddlers
   1 (2) 3 4 5 6 7
   Doesn't interact frequently enough
   b. 2 years and older
   1 2 3 4 (5) 6 7
   Private space used for older children's games

Total Space and Furnishings (Items 1–6)
27

**BASIC CARE**

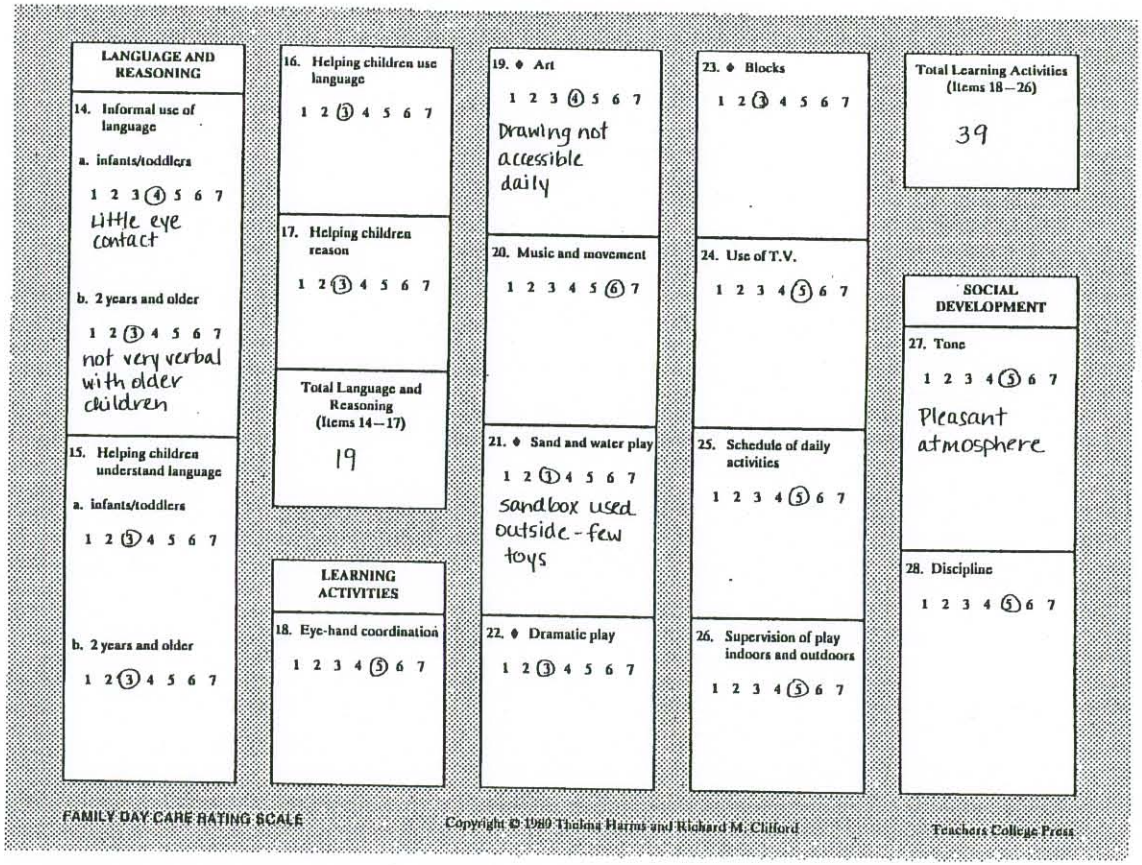
7. Arriving/leaving
   1 2 3 4 5 6 (7)
8. Meals/snacks
   1 2 3 4 (5) 6 7
9. Nap/rest
   1 2 3 4 (5) 6 7
10. Diapering/toileting
    (1) 2 3 4 5 6 7
    Doesn't wash hands after each child.
11. Personal grooming
    1 (2) 3 4 5 6 7
    children's hands not washed before eating.
12. Health
    1 2 3 (4) 5 6 7
    not careful about preventing spread of germs; no set rules for giving medicines to children.
13. Safety
    1 2 (3) 4 5 6 7

Total Basic Care (Items 7–13)
27

FAMILY DAY CARE RATING SCALE

Copyright © 1989 Thelma Harms and Richard M. Clifford

Teachers College Press



**LANGUAGE AND REASONING**

14. Informal use of language

a. infants/toddlers

1 2 3 (4) 5 6 7

Little eye contact

b. 2 years and older

1 2 (3) 4 5 6 7

not very verbal with older children

15. Helping children understand language

a. infants/toddlers

1 2 (3) 4 5 6 7

b. 2 years and older

1 2 (3) 4 5 6 7

16. Helping children use language

1 2 (3) 4 5 6 7

17. Helping children reason

1 2 (3) 4 5 6 7

Total Language and Reasoning (Items 14–17)

19

**LEARNING ACTIVITIES**

18. Eye-hand coordination

1 2 3 4 (5) 6 7

19. ♦ Art

1 2 3 (4) 5 6 7

Drawing not accessible daily

20. Music and movement

1 2 3 4 5 (6) 7

21. ♦ Sand and water play

1 2 (3) 4 5 6 7

sandbox used outside - few toys

22. ♦ Dramatic play

1 2 (3) 4 5 6 7

23. ♦ Blocks

1 2 (3) 4 5 6 7

24. Use of T.V.

1 2 3 4 (5) 6 7

25. Schedule of daily activities

1 2 3 4 (5) 6 7

26. Supervision of play indoors and outdoors

1 2 3 4 (5) 6 7

Total Learning Activities (Items 18–26)

39

**SOCIAL DEVELOPMENT**

27. Tone

1 2 3 4 (5) 6 7

Pleasant atmosphere

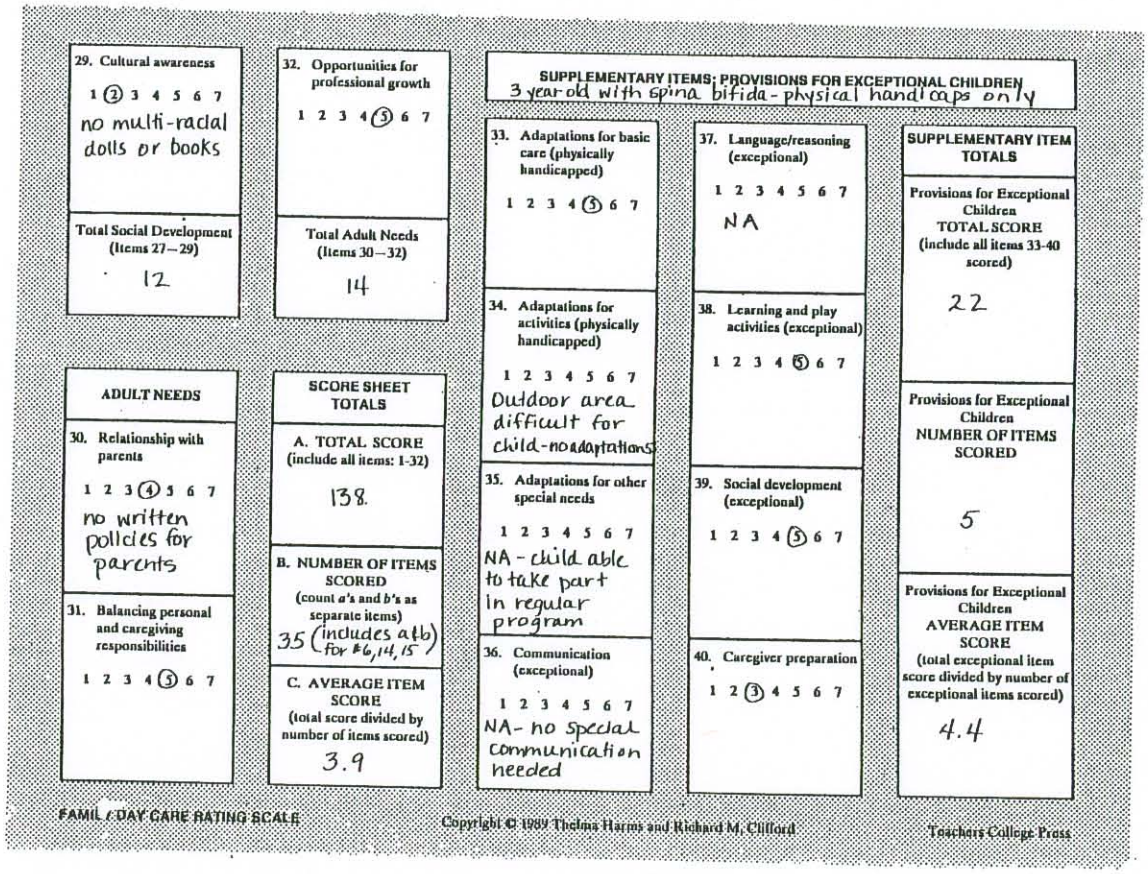
28. Discipline

1 2 3 4 (5) 6 7

FAMILY DAY CARE RATING SCALE

Copyright © 1989 Thelma Harms and Richard M. Clifford

Teachers College Press



29. Cultural awareness
1 (2) 3 4 5 6 7
no multi-racial dolls or books

Total Social Development (Items 27–29)
12

32. Opportunities for professional growth
1 2 3 4 (5) 6 7

Total Adult Needs (Items 30–32)
14

SUPPLEMENTARY ITEMS: PROVISIONS FOR EXCEPTIONAL CHILDREN
3 year old with spina bifida - physical handicaps only

33. Adaptations for basic care (physically handicapped)
1 2 3 4 (5) 6 7

34. Adaptations for activities (physically handicapped)
1 2 3 4 5 6 7
Outdoor area difficult for child - no adaptations

35. Adaptations for other special needs
1 2 3 4 5 6 7
NA - child able to take part in regular program

36. Communication (exceptional)
1 2 3 4 5 6 7
NA - no special communication needed

37. Language/reasoning (exceptional)
1 2 3 4 5 6 7
NA

38. Learning and play activities (exceptional)
1 2 3 4 (5) 6 7

39. Social development (exceptional)
1 2 3 4 (5) 6 7

40. Caregiver preparation
1 2 (3) 4 5 6 7

SUPPLEMENTARY ITEM TOTALS

Provisions for Exceptional Children TOTAL SCORE (include all items 33-40 scored)
22

Provisions for Exceptional Children NUMBER OF ITEMS SCORED
5

Provisions for Exceptional Children AVERAGE ITEM SCORE (total exceptional item score divided by number of exceptional items scored)
4.4

ADULT NEEDS

30. Relationship with parents
1 2 3 (4) 5 6 7
no written policies for parents

31. Balancing personal and caregiving responsibilities
1 2 3 4 (5) 6 7

SCORE SHEET TOTALS

A. TOTAL SCORE (include all items: 1-32)
138

B. NUMBER OF ITEMS SCORED (count a's and b's as separate items)
35 (includes a&b for #6, 14, 15)

C. AVERAGE ITEM SCORE (total score divided by number of items scored)
3.9

FAMIL / DAY CARE RATING SCALE

Copyright © 1989 Thelma Harms and Richard M. Clifford

Teachers College Press

154

## The Family Day Care Rating Scale

## Notes for Clarification

1. *For a score of 5 on any item, everything needed for a 3 must be present as well as everything in the description under 5, even though it is not repeated for each item. The phrase "Everything in 3 plus" is understood to precede each description under 5. Similarly, for a score of 7 on any item, everything needed for a 5 must be present as well as everything in the description under 7. The phrase "Everything in 5 plus" is understood to precede each description under 7 (Excellent).

   **Since children are different sizes at different ages, the intent here is that furniture should be the right size for the children in care. Furniture that is smaller than adult-size may not be the right size to be considered child sized for a 2- or 3-year-old but may be child-sized for a 6- or 7-year-old. For example, when child sits in chair, child's feet rest on floor; table height comfortable (knees fit under table, elbows above table).

2. *Softness in the environment is important for providing comfort, relaxation, and reassurance. For cleanliness of soft toys and other soft things, see Health (Item 12).

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| **SPACE AND FURNISHINGS FOR CARE AND LEARNING** | | | | | | | |
| 1. Furnishings for routine care and learning | › Not enough furniture for eating, sleeping, and storing children's things.<br>› No furnishing provided for play activities.<br>› Furniture broken or not safe. | | › Enough pieces of furniture to meet basic needs of all children.<br>› Some furnishings used for play activities (Ex. kitchen table used for art, couch used for reading).<br>› Furnishings are safe and in good repair.<br>› Place to store children's own things. | | *Everything in 3 plus** › Furniture used for child care routines and play activities made suitable to children's size (Ex. high chairs or adult chairs with cushions used while eating or doing art work).<br>› Furnishings well cared for (Ex. sheets changed weekly or more, tables washed after eating or art activity). | | *Everything in 5 plus** › Some child-sized** furniture (Ex. small table and chairs).<br>› Furniture does not crowd space used for child care.<br>› Child-sized play furnishings (Ex. play kitchen, easel). |
| 2. Furnishings for relaxation and comfort | › No soft* furniture, cushions, or rugs available for children to use, except for cribs or cots. | | › Children allowed to use at least one piece of soft furniture in area used for child care (Ex. a soft chair or couch).<br>› Some carpeted area for children's use. | | › Children allowed to use 2 or more soft pieces of furniture in area used for child care.<br>› Many soft stuffed toys for daily use.<br>› Adult provides body contact for infants and toddlers (Ex. holds and rocks children). | | › Soft, child-sized furnishings provided especially for children (Ex. floor cushions, beanbag chairs, child-sized rocker, padded high chair). |
| 3. Child-related display | › No child-related pictures, mobiles or children's artwork put up for children to look at. | | › Some children's artwork displayed.<br>› Some store-bought or adult-made pictures put up especially for children to look at (Ex. nursery rhymes, ABC's, numbers, holidays). | | › Much children's work displayed: at least two items per child enrolled.<br>› Some children's work down low on child's eye level. | | › Many items of interest to children on child's eye level or where children are held up to see (Ex. in feeding area, near cribs, crawling and play areas).<br>› Display changed at least monthly to match children's activities and interest. |

## Notes for Clarification

4. *When infants and toddlers are confined in swings, cribs, playpens, infant seats, or hig chairs, and thus prevented from moving around freely, they cannot learn through exploration. They may also be cut off from interaction with others. Generally, a very young child should not be confined at all if unhappy. Even if a child is playing happil confinement should not exceed a period of half an hour at a time. Most of the day should be spent unconfined.

5. *Materials:
   *For infants* — outdoor pad or blanket, crib gym, walkers, push/pull toys.
   *For toddlers & preschoolers* — wagon, tricycle, scooter, doll carriage, balls, climbing objects, slide, cushions or rugs for tumbling, large cardboard boxes.
   **Children should be dressed properly and allowed to play outdoors except on the few days of very bad weather, such as rain or snow.

| Item | Inadequate<br>1 | 2 | Minimal<br>3 | 4 | Good<br>5 | 6 | Excellent<br>7 |
|---|---|---|---|---|---|---|---|
| 4. Indoor space arrangement | › Inadequate space set aside for use by children.<br>› Crawling/walking infants and toddlers kept in cribs or playpens for long periods.*<br>› Area used lacks good ventilation, heat, or light. | | › Adequate space set aside for use by children: crawling space for infants, play space for toddlers and preschoolers.<br>› Space cleared of breakable objects and other "no-no's" so children can play with few restrictions.<br>› Area used for child care has good light, ventilation, and temperature. | | › Space is well arranged (Ex. not crowded with furniture, traffic patterns do not interfere with activities, materials with similar use placed together).<br>› Two or more play areas clearly defined (Ex. doll play, blocks, art, or book areas).<br>› Adequate storage and space to play in each activity area (Ex. box or shelves for storing blocks near rug or open space on floor for block play).<br>› Space set up so children of different ages can use it at the same time. | › Additional materials organized and available to add to or change play areas.<br>› Arrangements made to promote independent use by children (Ex. labeled storage boxes or shelves). |
| 5. Active physical play* | › No safe outdoor or indoor space used for active physical play (Ex. no space for tricycle riding, ball playing, climbing; or infants not taken outdoors).<br>› No crawling space used indoors for infants and toddlers.<br>› No materials, or materials unsafe, in poor repair. | | › Safe outdoor physical play for all ages provided at least 3 times a week year-round except in bad weather** (Ex. safety assured by close supervision; area fenced if needed).<br>› Clean, safe indoor space provided for infants and toddlers to crawl and walk around much of the day.<br>› Some materials, all in good repair. | | › Outdoor space used by children for 1-3 hours daily year-round, except in bad weather.<br>› Physical activity provided indoors for all ages in bad weather.<br>› Materials stimulate variety of large muscle skills (Ex. crawling, walking, balancing, climbing, swinging, playing ball). | › Many materials for each age group.<br>› Materials provided for toddlers' and preschoolers' imaginative play (Ex. movable boards and crates for creative building).<br>› New challenge added each week through planned activity (Ex. obstacle course, crawling tunnel, games with beanbags, tumbling on mat, ball games). |

## Notes for Clarification

6a. *Space to be alone is not to be confused with time out. The intent of Item 6 is to provide relief from the constant social pressure of groups of children. For infants and toddlers, being kept in a crib or playpen without interaction for periods of half an hour or more while awake is an inappropriate use of alone space, even if toys are provided. (For use of time out, see Discipline, Item 28.)

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 6a. Space to be alone* (infants/toddlers) | › Children left alone without interaction for half an hour or longer while awake (Ex. kept in crib or playpen, isolated in room alone).<br>OR<br>› No chance to play alone protected from others. | | › Caregiver provides space to be alone, protected from others, for infants/toddlers (Ex. puts baby in playpen or crib while playing with popular toy for a short period of time).<br>› Removes child from alone space within half an hour, or sooner if child seems unhappy or bored.<br>› Interacts with child at least every 10 minutes. | | › Careprovider interacts frequently (more than once every 10 minutes) with infants/toddlers who are placed in space to be alone (Ex. smiles at or talks to infant in high chair playing with toys; brings new toys to two toddlers playing together in protected area). | | › Planned activities provided for play-alone spaces.<br>› Play-alone activities used by careprovider to give individual time and attention (Ex. play special game, talk about mobile). |
| 6b. Space to be alone (2 years and older) | › No possibility for children to play alone, protected from being bothered by others. | | › Children are allowed to find space to be alone (Ex. in play equipment, behind furniture). | | › Space is set aside and made safe for one or two children to play, protected from others (Ex. no-interruption rule, space out of sight of other children). | | › Caregiver uses play-alone space to avoid problems or to help concentration on an activity.<br>› Play-alone activities provided on a regular basis. |
| **BASIC CARE** | | | | | | | |
| 7. Arriving/leaving | › Greeting of children neglected.<br>› Children's leaving not prepared for (Ex. children's possessions not ready for parent). | | › Some children greeted, but not each one individually.<br>› Children greeted only when convenient for caregiver.<br>› Some talking with parents. | | › Individual greeting and goodbye for all children.<br>› Parents greeted as well as children.<br>› Caregiver uses arriving/leaving time to share information with parents. | | › Warm, organized greeting and departure for all children regardless of when they arrive or leave (Ex. conversation on arrival; art work, clothes ready for leaving).<br>› Caregiver helps children adjust to arriving/leaving (Ex. directs to favorite toy, talks about plans for tomorrow). |

## Notes for Clarification

8. *If food is sent by the parents, the caregiver cannot be held responsible for the nutritional quality of that food. However, the caregiver is still responsible for all other aspects of meal/snack time, including any additional food she/he provides. If nutritional value of the food provided by parents is a problem, this should be noted on the score sheet.

10. *Adequate sanitary procedures are essential to avoid the spread of germs when diapering babies and helping to toilet children. The purpose of the sanitary procedures is to prevent the germs in the urine or stool from remaining on the caregiver's or child's hands, on the diapering surface, or on any other surface the children might touch.

    Four measures are essential to cut down on the spread of gastrointestinal illness: thorough handwashing after each diaper change with warm water and soap or a waterless wash, using a different sink than the one used in food preparation; disinfecting the diapering surface after each diaper change; hygienic disposal of diapers in a covered can, preferably with a step pedal so the caregiver's hands do not get recontaminated; physical separation of diapering area from food preparation area.

    Potty chairs should be avoided since they are very hard to sanitize and must be thoroughly disinfected after each use.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 8. Meals/snacks* | › Meal/snack schedule not dependable and consistent.<br>› Cooking and eating area not kept clean.<br>› Infants have bottle propped, not held for feeding.<br>› Infants/toddlers put to bed with bottles.<br>› Nutritional quality of food is questionable. | | › Well-balanced meals/snacks served on regular schedule.<br>› Cooking and eating area clean.<br>› Sanitary preparation of food.<br>› Infants held while bottle fed.<br>› Toddlers seated or head propped when holding own bottle.<br>› Infants/toddlers not put to bed with bottles. | | › Careful organization of meal time (Ex. meal and table prepared ahead).<br>› Feeding of different ages handled to avoid waiting (Ex. babies are bottle-fed before older ones eat, activity provided for children who are fed later).<br>› Caregiver talks with children and provides pleasant social time. | | › Self-help skills encouraged (Ex. infant/toddler encouraged to finger-feed self; fork and spoon introduced when ready; children set table, help prepare food, pour and serve when able).<br>› Caregiver sits with children, eating with them when possible.<br>› Parents made aware of menus. |
| 9. Nap/rest | › Nap/rest time or place not right for children (Ex. too early or late, too short/too long, irregular schedule, crowded area, noisy, no fresh air, not clean).<br>› Little or no supervision provided. | | › Nap/rest is scheduled daily.<br>› Each child has own crib, cot, or bed with clean sheets, blankets, etc.<br>› Same bedding not used by different children unless washed.<br>› Caregiver remains in house and is alert to handle problems. | | › Nap/rest is scheduled appropriately for different age groups (Ex. babies, toddlers, and preschoolers have different schedules).<br>› Space used is good for resting (Ex. home is quiet, children placed at least 2 feet apart). | | › Children helped to relax (Ex. cuddly toy, soft music, back rubbed).<br>› Individual needs of children are met (Ex. quiet activities for early risers and non-nappers; schedules are changed to suit as children grow). |
| 10. Diapering/toileting | › Problems with meeting toileting needs (Ex. diapers not changed often enough, infants unsafe on diapering table, children left on toilet seat too long).<br>› Basic sanitary conditions not met* (Ex. diapers not disposed of properly, toilet area not clean, inconsistent handwashing).<br>› Caregiver punishes or gets angry when toileting accidents occur. | | › Diapering/toileting area meets basic sanitary conditions (Ex. diapering area thoroughly cleaned or protective pad changed after each use).<br>› Caregiver washes hands with soap after each diapering or when helping children with toileting.<br>› Diapers checked and changed often.<br>› Children's hands washed after using toilet.<br>› Caregiver handles toileting accidents calmly. | | › Diapering done near source of hot water.<br>› Equipment promotes self-help (Ex. steps near sink, child-sized toilet seat if needed).<br>› Caregiver works with parents to toilet train toddlers.<br>› Pleasant tone between adult and child during diapering/toileting. | | › Diapering/toileting used as time to talk with and relate warmly to children.<br>› Diapering/toileting used to promote self-help in cleanliness and dressing skills (Ex. hand washing, using toilet paper, buttoning and snapping.) |

## Notes for Clarification

12. *Keeping caregiving areas clean includes washing all toys at least weekly and air drying if possible. Floor areas should be vacuumed or damp mopped with a disinfectant frequently to kill the germs that can live for days and even weeks on floors, rugs, and furniture. Feeding chairs should be cleaned daily with a cloth dampened with a sanitizing solution.

# FAMILY DAY CARE RATING SCALE

# Score Sheet

THELMA HARMS RICHARD M. CLIFFORD

TEACHERS COLLEGE PRESS

Name of Lead Caregiver

No. of caregivers present

Most children attending at one time

Number of children present today

Ages of children enrolled (youngest to oldest in months) ____ to ____

Name of Rater

Position of Rater

Date

**SPACE AND FURNISHINGS FOR CARE AND LEARNING**

1. Furnishings for routine care and learning

1 2 3 4 5 6 7

2. Furnishings for relaxation and comfort

1 2 3 4 5 6 7

3. Child-related display

1 2 3 4 5 6 7

4. Indoor space arrangement

1 2 3 4 5 6 7

5. Active physical play

1 2 3 4 5 6 7

6. Space to be alone

a. infants/toddlers

1 2 3 4 5 6 7

b. 2 years and older

1 2 3 4 5 6 7

Total Space and Furnishings (Items 1–6)

**BASIC CARE**

7. Arriving/leaving

1 2 3 4 5 6 7

8. Meals/snacks

1 2 3 4 5 6 7

9. Nap/rest

1 2 3 4 5 6 7

10. Diapering/toileting

1 2 3 4 5 6 7

11. Personal grooming

1 2 3 4 5 6 7

12. Health

1 2 3 4 5 6 7

13. Safety

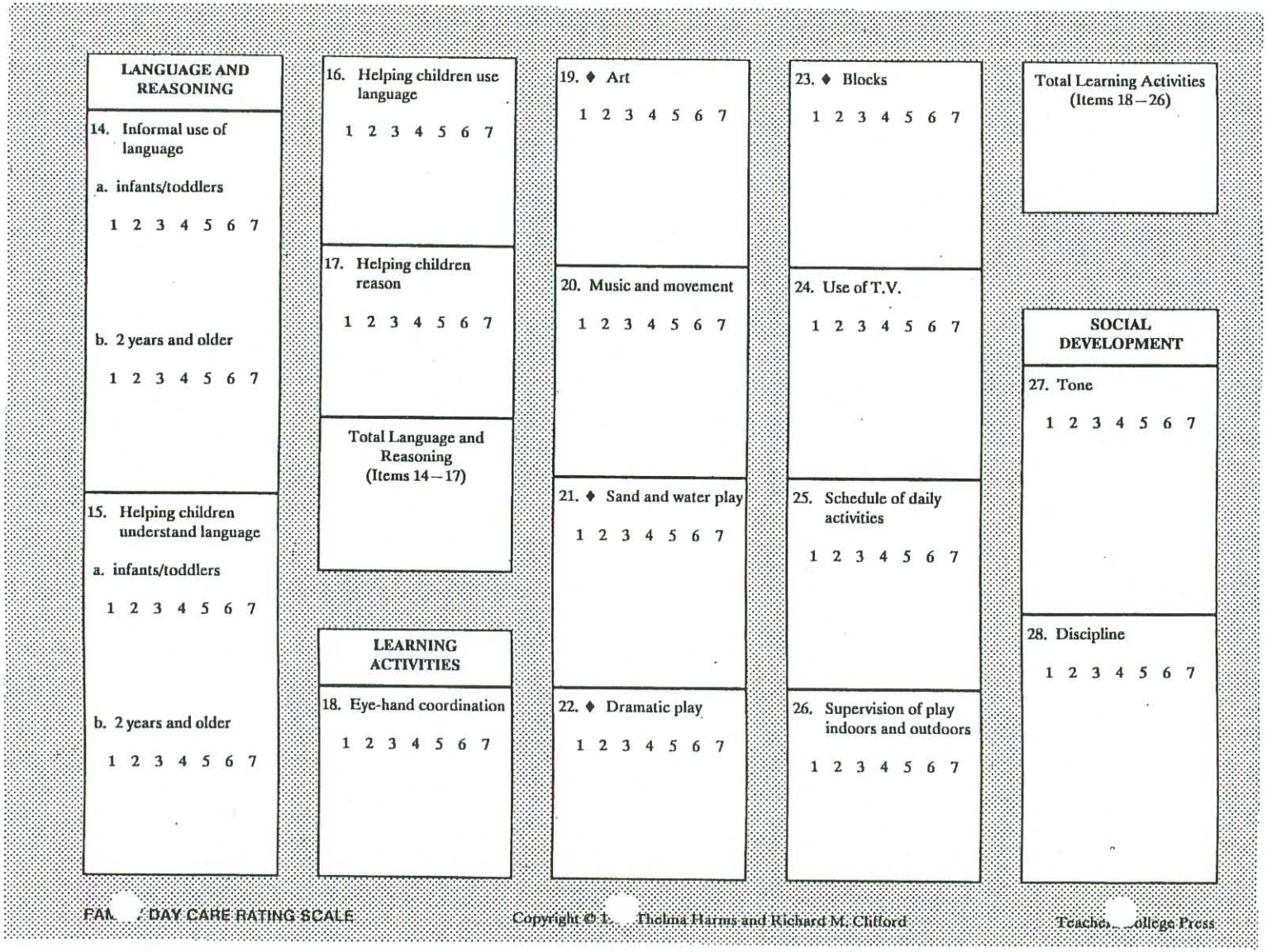
1 2 3 4 5 6 7

Total Basic Care (Items 7–13)

FAMILY [illegible] / CARE RATING SCALE

Copyright © 1989 T[illegible]na Harms and Richard M. Clifford

Teachers Co[illegible]e Press



**LANGUAGE AND REASONING**

14. Informal use of language

a. infants/toddlers

1 2 3 4 5 6 7

b. 2 years and older

1 2 3 4 5 6 7

15. Helping children understand language

a. infants/toddlers

1 2 3 4 5 6 7

b. 2 years and older

1 2 3 4 5 6 7

16. Helping children use language

1 2 3 4 5 6 7

17. Helping children reason

1 2 3 4 5 6 7

Total Language and Reasoning (Items 14–17)

**LEARNING ACTIVITIES**

18. Eye-hand coordination

1 2 3 4 5 6 7

19. ♦ Art

1 2 3 4 5 6 7

20. Music and movement

1 2 3 4 5 6 7

21. ♦ Sand and water play

1 2 3 4 5 6 7

22. ♦ Dramatic play

1 2 3 4 5 6 7

23. ♦ Blocks

1 2 3 4 5 6 7

24. Use of T.V.

1 2 3 4 5 6 7

25. Schedule of daily activities

1 2 3 4 5 6 7

26. Supervision of play indoors and outdoors

1 2 3 4 5 6 7

Total Learning Activities (Items 18–26)

**SOCIAL DEVELOPMENT**

27. Tone

1 2 3 4 5 6 7

28. Discipline

1 2 3 4 5 6 7

FAM[illegible] DAY CARE RATING SCALE

Copyright © 1[illegible] Thelma Harms and Richard M. Clifford

Teache[illegible] College Press

29. Cultural awareness

1 2 3 4 5 6 7

Total Social Development (Items 27–29)

32. Opportunities for professional growth

1 2 3 4 5 6 7

Total Adult Needs (Items 30–32)

**ADULT NEEDS**

30. Relationship with parents

1 2 3 4 5 6 7

31. Balancing personal and caregiving responsibilities

1 2 3 4 5 6 7

**SCORE SHEET TOTALS**

A. TOTAL SCORE (include all items: 1-32)

B. NUMBER OF ITEMS SCORED (count *a*'s and *b*'s as separate items)

C. AVERAGE ITEM SCORE (total score divided by number of items scored)

**SUPPLEMENTARY ITEMS: PROVISIONS FOR EXCEPTIONAL CHILDREN**

33. Adaptations for basic care (physically handicapped)

1 2 3 4 5 6 7

34. Adaptations for activities (physically handicapped)

1 2 3 4 5 6 7

35. Adaptations for other special needs

1 2 3 4 5 6 7

36. Communication (exceptional)

1 2 3 4 5 6 7

37. Language/reasoning (exceptional)

1 2 3 4 5 6 7

38. Learning and play activities (exceptional)

1 2 3 4 5 6 7

39. Social development (exceptional)

1 2 3 4 5 6 7

40. Caregiver preparation

1 2 3 4 5 6 7

**SUPPLEMENTARY ITEM TOTALS**

Provisions for Exceptional Children TOTAL SCORE (include all items 33-40 scored)

Provisions for Exceptional Children NUMBER OF ITEMS SCORED

Provisions for Exceptional Children AVERAGE ITEM SCORE (total exceptional item score divided by number of exceptional items scored)

FAMI[illegible]AY CARE RATING SCALE

Copyright © 198[illegible]elma Harms and Richard M. Clifford

Teachers [illegible]ege Press

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 11. Personal grooming | › Little attention paid to personal grooming (Ex. no hand or face washing, hair combing).<br>› No easy place for children to wash.<br>› Same towel or washcloth used by different children. | | › Easy place for children to wash hands (Ex. steps near sink).<br>› Each child has own towel/washcloth (paper or cloth).<br>› Children wash before and after meals.<br>› Extra clothes available to change children. | | › Self-help encouraged in personal grooming (Ex. easy-to-use aprons for art activities, mirror at child's eye level, towels within preschooler's reach).<br>› Bibs available for infants/toddlers at mealtimes.<br>› Care given to children's appearance (Ex. cleaned up after messy play, hair combed after nap). | | › Individual toothbrush used for each child at least once during the day.<br>› Personal care activities planned to teach children self-help skills (Ex. song about how to wash, practice in brushing hair). |
| 12. Health | › Caregiving areas and equipment not kept clean, (Ex. toys never washed, signs of animal contamination in house or yard).<br>› Caregiver does not have immunization, emergency care, and other health records for children.<br>› Caregiver has not had health exam within one year. | | › Caregiving areas clean.*<br>› Caregiver has emergency care and health information for each child with written permission from parent for medical care, information about child's doctor and dentist, and parent's work phone.<br>› Caregiver reports suspected child abuse.<br>› Caregiver has yearly health exam. | | › Careprovider cuts down spread of germs (Ex. runny noses kept wiped with clean tissue for each child, parents told about illnesses of others in day care home).<br>› Special health problems such as allergies, hearing loss, or hyperactivity are recorded and information is used in planning.<br>› Caregiver shows awareness of children's health status (Ex. checks irritable child for fever).<br>› Parents made aware of rules for attendance during illness.<br>› Medication given only from original container with written permission from parents. | | › Careprovider has arranged for medical consultant, such as a local doctor or nurse practitioner, to handle child care questions.<br>› Quiet area for sick child available.<br>› Health information provided for parents (Ex. pamphlets on nutrition, childhood illnesses, local health care services).<br>› Good health habits encouraged (Ex. nutrition activities, storybooks about health used with children).<br>› Caregiver is good model of health practices (Ex. eats healthful food, doesn't smoke in front of children). |

## Notes for Clarification

13. The following list of obvious hazards is not meant to be complete. Be sure to note all safety problems on the score sheet.

*Some indoor safety problems*

- no safety caps on electical sockets
- loose electrical cords
- heavy toys or other things child can pull down
- cleaning materials, medicines, and other dangerous substances not locked away
- trash accessible
- pot handles on stove accessible
- stove controls accessible
- toy box with heavy lid
- crib or playpen slats far enough apart to catch baby's head
- crib mattress doesn't fit crib snugly
- water temperature too hot
- mats or rugs that slide
- pieces of toys that can be swallowed accessible
- unprotected hot stove or fireplace in use
- open stairwells accessible

*Some outdoor safety problems*

- tools accessible
- garden sprays accessible
- tool shed or garage unlocked
- poisonous plants around
- unsafe play equipment
- unsafe walkways or stairs
- easy access to road

14a. & 14b. If caregiver has both age groups present, rate both *a* and *b*. If one age group is present, rate only the appropriate item.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 13. Safety | › No phone in home or no transportation available for emergency use.<br>› Obvious safety problems* indoors (Ex. loose electrical cords, no covers on outlets, medicines not locked up, cleaning supplies within children's reach, no gates on staircases).<br>› Hazards present in outdoor area (Ex. equipment unsafe, sharp or dangerous objects present). | | › Phone in home and transportation available for emergency use (Ex. own car, rescue squad)<br>› First aid supplies well stocked, ready to use.<br>› Emergency numbers posted near phone.<br>› Home has passed official fire safety inspection.<br>› Hot water managed safely.<br>› No obvious safety problems indoors or outdoors (Ex. medicines in locked cabinet, cleaning supplies out of reach, toys and objects small enough to be swallowed kept away from infants/toddlers, yard fenced).<br>› Alternate caregiver available for emergencies. | | › Emergency exit plans posted and practiced at least monthly with children.<br>› Caregiver uses car safety restraints for all (Ex. infant/toddler seats, separate seat belt for each older child and adult).<br>› Alternate caregiver familiar with caregiving activities, specific children in home, and emergency plans.<br>› Caregiver has had first aid training within last 2 years. | › First aid training includes CPR for children.<br>› Safety information shared with parents (Ex. pamphlets on car restraints, home safety tips, and safety plans at day care homes).<br>› Safety taught to children (Ex. rules for riding in car and crossing streets). |
| **LANGUAGE AND REASONING** | | | | | | | |
| 14a. Informal use of language (infants/toddlers) | › Little or no talking to infants and toddlers. | | › Talking used mainly to control child's behavior (Ex. "come here," "take this," "no, no!").<br>› Some social talking to children. | | › Careprovider responds to sounds infants make, takes part in verbal play (Ex. sings to child, imitates child's sounds).<br>› Maintains eye contact while talking to child. | | › Caregiver talks to infants and toddlers during routines about child's activities.<br>› Repeats what toddlers say, adding words and ideas when appropriate.<br>› Encourages toddlers to use words. |

## Notes for Clarification

14a. & 14b. If caregiver has both age groups present, rate both *a* and *b*. If one age group is present, rate only the appropriate item.

15a. & 15b. If caregiver has both age groups present, rate both *a* and *b*. If only one age group is present, rate only the appropriate item.
*Note:* Use of TV for language activities is rated separately under Item 24.

15a. *Materials for infants and toddlers: cloth or hardpage books, pictures of familiar objects, or common household objects that children can play with.

15b. *Materials for two-year-olds and older: children's books, magazines, or records; commercial or homemade picture games like lotto, talking about pictures.
**Accessible means that children can reach and use materials by themselves for at least one hour daily.
***Observer must see at least one example.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 14b. Informal use of language (2 years and older) | › Talking used mainly to control children's behavior and manage routines. | | › Careprovider does some social talking with children.<br>› Children are asked primarily "yes/no" or short-answer questions. | | › Much social talking between caregiver and children.<br>› Language used to share information with children.<br>› Children's talk encouraged (Ex. caregiver listens, asks questions to get children to talk more).<br>› Caregiver adds to ideas presented by children.<br>› Caregiver helps children enjoy language (Ex. sings with children, rhymes words). | | › Careprovider makes sure to have an informal conversation with each child every day.<br>› Preschoolers are asked "why, how, what if" questions needing longer and more complex answers.<br>› Children encouraged to use talking to solve problems. |
| 15a. Helping children understand language* (infants/toddlers) | › Fewer than 4 children's books and no picture games available in home.<br>› Caregiver does not name objects or pictures for infants/toddlers. | | › At least 8 books suitable for infants/toddlers (Ex. cloth or hardpage books, books with clear, colorful pictures).<br>› Materials used by caregiver with children at least 3 times a week.<br>› Caregiver names some objects or pictures for children. | | › At least 12 books for infants/toddlers.<br>› Careprovider names many objects, talks about pictures, says nursery rhymes, sings songs. | | › Caregiver plans and carries out at least one language activity for each infant/toddler daily.<br>› Works on improving understanding of language all day (Ex. gives clear directions to toddlers, describes infant's actions). |
| 15b. Helping children understand language* (2 years and older) | › Fewer than 6 children's books and no picture games available in home. | | › At least 10 children's books available; some picture games and records present.<br>› Materials used by caregiver with children at least 3 times a week (Ex. caregiver names pictures in books, reads story, plays a record and sings along). | | › At least 20 children's books and several picture games accessible** to children daily for independent use.<br>› Materials for all age groups.<br>› At least one planned activity daily*** (Ex. reading, story telling, talking about picture books, saying nursery rhymes). | | › Caregiver checks out materials from library once a month, or adds to materials in other ways.<br>› Works on improving understanding of language all day (Ex. gives clear directions, uses words exactly, points out items of interest indoors and outdoors, such as reading food labels and road signs). |

## Notes for Clarification

16. *Materials: puppets, books, props for dramatic play, toy telephones, records, dolls, mirrors, pictures.
    Activities: repeating nursery rhymes, singing and babbling to babies, naming familiar objects, talking about drawings or pictures in books, dictating stories, show and tell.

17. *Materials: either commercial or homemade toys to learn colors, sizes, shapes, numbers and letters; puzzles.
    Activities: nature, science, cooking.
    **Observer must see at least one example.

| Item | Inadequate<br>1 | 2 | Minimal<br>3 | 4 | Good<br>5 | 6 | Excellent<br>7 |
|---|---|---|---|---|---|---|---|
| 16. Helping children use language* | › No materials or activities for helping children practice talking. | | › Few materials for helping children practice talking (Ex. puppets, toy telephones).<br>› Careprovider uses one activity a day to encourage children to talk (Ex. finger plays, show and tell, singing, repeating nursery rhymes, babbling back to baby). | | › Many materials for helping children practice talking accessible for independent use daily.<br>› Caregiver uses 2 activities a day to encourage children to talk. | | › Daily plans provide a wide variety of activities to encourage talking in each age group, including infants, toddlers, preschoolers, and schoolagers (Ex. encourages infants/toddlers to name objects and pictures, preschoolers to talk about experiences, dictate stories). |
| 17. Helping children reason* (using concepts) | › No materials or activities for helping children reason.<br>OR<br>› Inappropriate teaching of school skills to children who are too young or not interested. | | › Some materials present and used.<br>› Daily experiences used to help children learn concepts of size, shape, color, number, and relationship.** | | › Variety of games and materials accessible and in good repair.<br>› While children are using materials, caregiver helps children think by talking about shape, size, etc. (Ex. asks questions to help preschoolers reason—"How many?" "What's different?").<br>› At least one nature/science/cooking activity each week (Ex. talks about leaves in fall, has children help make a snack). | | › Careprovider makes sure to work with every child on an appropriate concept-development game at least once a week (Ex. shape sorting boxes for infants, measuring cups and puzzles for toddlers, numbers for preschoolers).<br>› Encourages children to reason throughout the day by pointing out the sequence and results of daily events (Ex. "First let's change your diaper, then you can play," "What might happen if you play ball in the house?"). |

## Notes for Clarification

18. *Materials:
*Infants and toddlers*–grasping toys, household items such as clothespins, nested measuring cups.
*Two and older*–blocks, puzzles, crayons, pencils, children's scissors, small building toys, peg-board and pegs.

19. ♦ Omit this item if *all* children in care are 12 months of age or younger.
*Materials: crayons, paints, modeling dough, cutting and pasting supplies, wood and other scraps for gluing and carpentry.
**Drawing is an opportunity for children to create designs of their own. Therefore, coloring books are not considered drawing.

20. *Materials: record/tape player, variety of records or tapes, music boxes, musical toys and instruments, story records, dance props.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| **LEARNING ACTIVITIES** | | | | | | | |
| 18. Eye-hand coordination* | › No appropriate eye-hand materials are available for daily use by children. | | › Some eye-hand materials accessible** to children for independent use daily.<br>› At least 5 materials for each age group in care available (infants, toddlers, preschoolers, school-agers). | | › Variety of eye-hand materials, in good repair, accessible daily.<br>› At least 8 materials for each age group available (Ex. *infants:* rattles, objects of different sizes to pick up; *toddlers:* peg-boards, small building toys; *preschoolers:* crayons, scissors, puzzles).<br>› Space provided to play with materials. | | › Materials rotated to maintain interest.<br>› Materials organized to encourage self-help (Ex. picture labels for open storage shelves or boxes).<br>› Caregiver helps children develop skills (Ex. with scissors, puzzles, peg-board). |
| 19. ♦ Art* | › No art materials available for use by children. | | › Some materials, including drawing,** used at least twice a week. | | › Crayons and paper, or other drawing materials accessible daily for free expression (Ex. toddlers offered materials, preschoolers get own materials).<br>› Art materials needing supervision planned at least 3 times a week (Ex. cutting and pasting, painting, modeling dough).<br>› Creativity encouraged, very few projects have children copy an example. | | › At least 2 different activities offered preschoolers daily (Ex. drawing, cutting and pasting, painting).<br>› Activities include at least one 3-dimensional material per week (Ex. modeling dough, clay, carpentry, or wood gluing). |
| 20. Music and movement* | › No materials for music or movement available for children.<br>OR<br>› Loud background music interferes with ongoing activities. | | › Some musical experience available to children once a week (Ex. radio on for dancing, careprovider sings with children, record/tape player with at least 5 selections available). | | › Musical experiences regularly available to children at least 3 times a week.<br>› Careprovider sings with children informally daily.<br>› Musical experiences provided for all age groups (Ex. music boxes and musical toys for infants/toddlers, record player and records for preschoolers). | | › Space and time planned for music and movement daily.<br>› Variety of dance props and musical instruments accessible for independent use by children. |

## Notes for Clarification

21. ♦ Omit this item if *all* children in care are 12 months of age or younger.
*Materials: sand or similar material (corn meal, dry coffee grounds), kitchen utensils, shovel and bucket, small cars and trucks.

22. ♦ Omit this item if *all* children in care are 12 months of age or younger. Dramatic play means "making believe," such as when a child pretends to be a firefighter, or that dolls can talk and eat.
*Materials: dress-up clothes, playhouse, child-sized furnishings, dishes, pots and pans, dolls, doll house, garage; accesories that can be used to enhance play such as doll beds and doll clothes or a backpack and camping gear.

23. ♦ Omit this item if *all* children in care are 12 months of age or younger.
*Materials: different sized blocks, accessories such as small people, toy trucks, and toy animals to use with blocks.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 21. ♦ Sand and water play* | › Sand and water play not available to children indoors or outdoors. | | › Some sand or water play provided outdoors or indoors at least once every 2 weeks year-round. | | › Sand or water play at least once a week.<br>› Variety of toys for sand and water play (Ex. cups, funnels, trucks, pots, pans, spoons). | | › Sand and water play at least 3 times a week. |
| 22. ♦ Dramatic play* | › No materials available for dramatic play. | | › Some dramatic play materials available (Ex. dress-up clothes, dolls).<br>› Few accessories (Ex. beds or dishes for dolls). | | › Variety of dramatic play materials, with accessories available daily.<br>› Materials accessible to children for both indoor and outdoor use.<br>› Props for more than just housekeeping, including transportation, work roles, or adventure. | | › Dramatic play materials well organized for independent use (Ex. play dishes in separate box or on shelf instead of piled in a toy chest; play clothes hung on pegs).<br>› Some child-sized play furniture (Ex. small stove, baby stroller). |
| 23. ♦ Blocks* | › No materials available for block building. | | › Some blocks and accessories available. | | › Variety of blocks and accessories gathered together and available for daily use.<br>› Space used for block play out of traffic. | | › Blocks and accessories well organized for independent use (Ex. blocks and accessories in separate labeled boxes or on labeled, open shelves). |
| 24. Use of T.V. | › T.V. is always on, causing background noise and distraction, whether or not anyone is watching.<br>› T.V. on for caregiver's entertainment (Ex. "soaps" or other adult programs). | | › T.V. is used as a "baby-sitter" to amuse and keep children busy in place of play activities.<br>› T.V. is used no more than 2 hours daily.<br>› Programs not limited to those that are educational and good for children. | | › Careprovider limits use of T.V. to programs and video games regarded as good for children (Ex. "Mr. Rogers' Neighborhood," "Electric Company," and "Sesame Street," educational video games, but not most cartoons).<br>› Activities provided as an alternative while T.V. is on. | | › Caregiver uses T.V. as an educational experience.<br>› Joins children in viewing, asks questions, adds information.<br>› Some play activities planned to follow up on T.V. programs (Ex. points out objects with letters introduced on shows, conducts art activity seen on program).<br>OR<br>› Caregiver chooses not to use T.V. at all. |

## Notes for Clarification

27. *Tone refers to the general quality of interaction between caregiver and children and among children themselves. This item assesses the warmth and pleasantness of the adult-child and child-child interactions.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 25. Schedule of daily activities | › Lack of planning and organization results in children's routine needs not being met (Ex. crying children, rushed meal times, delays in diapering).<br>› No time between routines for talking with children or scheduled play activities (Ex. caregiver does not read books, play with children or provide art activities). | | › Schedule permits careprovider to successfully handle basic routines for each age group.<br>› Caregiver provides play activities as part of the daily schedule along with routines. | | › Variety of play activities provided for children's choice both morning and afternoon.<br>› At least two special activities scheduled daily, one indoors and one outdoors weather permitting (Ex. story, art, music, water play, walks).<br>› Schedule provides a balance of indoor and outdoor activities.<br>› Schedule provides a balance of active and quiet play. | | › Caregiver uses routines as learning experiences (Ex. teaches self-help skills, talks to children).<br>› Provides smooth transitions (Ex. sets out play materials for preschoolers before putting babies down for nap). |
| 26. Supervision of play indoors and outdoors | › No supervision provided except if problems occur.<br>› Careprovider is mainly concerned with her own work or interests (Ex. talking on the telephone, watching T.V., doing housework).<br>› Caregiver does not go outdoors with children. | | › Supervision provided near children.<br>› Attention mainly to safety, cleanliness, proper use of materials.<br>› Caregiver's work or interests do not take away from caregiving (Ex. work done while children are asleep, or children have fun helping to set the table or hang up the wash). | | › Careprovider interacts frequently with children, discusses ideas, and helps with materials.<br>› Helps children solve conflicts when necessary.<br>› Supervision suited to individual needs (Ex. close supervision of toddlers, more independence for 3- and 4-year-olds). | | › Caregiver looks for chances to extend learning (Ex. dramatic play idea recalled at later time by reading story).<br>› Careful setting up of activities avoids conflicts (Ex. duplicate toys for toddlers, enough blocks for several children at once). |
| **SOCIAL DEVELOPMENT** | | | | | | | |
| 27. Tone* | › Caregiver and children seem tense, voices sound angry, children cry often.<br>› Physical contact used mainly for control (Ex. hurrying children along, punishing). | | › Physical contact mainly for routine care of children, little display of affection.<br>› Caregiver does not often smile at, talk to, or listen to children.<br>› May have favorite child who gets most of the attention. | | › Caregiver uses physical contact to show affection to all children (Ex. gentle holding, hugging, pat on the head).<br>› Careprovider and children seem relaxed, voices cheerful, a lot of smiling. | | › Careprovider and children show respect for and kindness to one another.<br>› Caregiver praises children for being kind and helpful to others. |

## Notes for Clarification

28. *Descriptions apply to methods used with all children present, including caregiver's own child(ren).

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 28. Discipline* | › EITHER discipline is so strict that children are punished often, OR so lax that there is no order or control.<br>› Severe discipline such as spanking, constant shouting, or withholding food used as means of control. | | › Caregiver never uses physical punishment.<br>› Caregiver maintains enough control to keep children from hurting themselves and others. | | › Alternatives to physical punishment used effectively (Ex. time out, removing child from activity).<br>› Praise and attention are given for good behavior.<br>› Age and ability of children considered when rules are made and enforced.<br>› Reasons for rules are explained to children.<br>› Caregiver follows through with both rewards and punishment. | | › Careprovider thinks ahead and tries to avoid problems.<br>› Caregiver handles minor problems before they become serious (Ex. helps children share toys before they quarrel, makes taking turns easier by using sign-up sheets or a timer, redirects children to other activities).<br>› Careprovider helps children find positive solutions to problems through discussion. |
| 29. Cultural awareness | › All toys and displayed pictures are of one race only.<br>› No ethnic and racial variety in dolls, book illustrations, or pictorial materials.<br>› Boys and girls limited to traditional roles (Ex. girls directed towards housekeeping roles). | | › Dolls from at least 2 racial groups, and at least 2 books or pictures showing different races.<br>› Boys and girls not limited to traditional roles in choice of play activities. | | › Many examples of racial variety in dolls, pictures, and books.<br>› Holidays and cultural customs of all children in group included.<br>› Boys and girls encouraged to choose activities without being limited to traditional roles (Ex. girls encouraged to do carpentry).<br>› People of all ages represented in pictures and books. | | › Planned use of multicultural, multiracial and non-sexist materials (Ex. reads books introducing non-traditional roles for men, women, and minorities; boy and girl dolls). |

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| **ADULT NEEDS** | | | | | | | |
| 30. Relationship with parents | › No set policies given to parents (Ex. no information about policy of payment during child's absence, health requirements, hours of operation, or parental responsibilities).<br>› Caregiver has inadequate information about child's home and family (Ex. unclear about who may or may not pick up child). | | › Child care policies and rules told to parents.<br>› Parents welcomed as visitors before enrollment as well as while child is attending. | | › Written policies given to parents before child starts child care.<br>› Caregiver tells parents about the activities of their children at least once a week.<br>› Caregiver works cooperatively with parents (Ex. plans toilet training jointly, discusses methods of discipline). | | › Careprovider gives daily informal report about each child's activities.<br>› Parents encouraged to share skills and interests with the child care home (Ex. bring in materials, tell children about experiences, help with field trips.) |
| 31. Balancing personal and caregiving responsibilities | › Caregiver makes little or no change in her own schedule in order to care for children (Ex. house-keeping duties and errands outside the home come before children's needs).<br>OR<br>› Child care responsibilities interfere with family responsibilities. | | › Some changes in own schedule made on day to day basis to meet care-giving needs, but own responsibilities often interfere with caregiving.<br>› Children often left with substitute caregivers (Ex. family members, friends, or others).<br>› Needs of own children and family for space and attention difficult to meet. | | › Careprovider plans so that family responsibilities and child care program seldom interfere with one another (Ex. space is specified for child care children and family members, special time for own child given after child care hours).<br>› Primary focus during operating hours is on child care responsibilities.<br>› Substitute available as backup help. | | › Uses household jobs, when possible, in child care program as learning activities (Ex. lets children help bake bread, sort and fold clothes).<br>› Coordinates good care-giving activities with family responsibilities. (Ex. stops at playground on way back from an errand children enjoy doing). |
| 32. Opportunities for professional growth | › Caregiver does not take part in any professional development activities (Ex. no current books or magazines on child rearing available in home, attends no workshops or courses, not a member of any early childhood or day care association). | | › Limited involvement in professional growth activities (Ex. either attends one professional workshop per year or regularly reads books or articles on child rearing such as *Parent's Magazine, Young Children, Child Care Information Exchange,* professional newsletters). | | › Caregiver regularly takes part in professional development activities (Ex. attends 2 workshops, takes one course, or has 2 on-site training visits each year).<br>› Caregiver regularly reads child care books or magazines on child rearing. | | › Careprovider is an active member of an early childhood or child care professional group.<br>› Participates in professional development programs or activities at least 4 times a year. |

## Supplementary Items: Provisions for Exceptional Children

Items 33-40 are to be rated in addition to the preceding 32 items only when a child with special needs is included in the child care home. The terms *exceptional, special needs,* and *handicapped* are used interchangeably.

Since some handicapping conditions are not readily observable, it is necessary to know the nature of the child's handicap in order to correctly assign scores. While these items have been extensively field-tested and used in assessing programs that integrated children with special needs, they have not undergone the formal reliability testing given to the main body of the scale.

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 33. Adaptations for basic care (physically handicapped) | › Adaptive equipment needed for basic care routines is lacking (eating, sleeping, toileting, grooming), or not clean and in good repair.<br>› Child's special basic care needs not met consistently.<br>› Caregiver does not perform special basic care procedures competently (Ex. child positioned inappropriately for feeding). | | › Special adaptive equipment for basic care routines is clean and in good repair.<br>› Caregiver consistently and competently follows special basic care routines (Ex. catheterization, turning bedridden child). | | › Careprovider does not allow child's need for adaptive equipment and special procedures to isolate him from the group during routines (Ex. child eats at table with or very near other children).<br>› Careprovider is gentle and respectful in the performance of the special basic care and health routines (Ex. respects child's need for privacy, handles special equipment with care). | | › Caregiver plans and provides learning activities to develop higher levels of child's self-help skills (Ex. gradually introduces more advanced forms of solid food to child with chewing problems, encourages child to do as much as he can by himself).<br>› Caregiver responds sensitively to child's special basic care needs (Ex. anticipates when nonambulatory child feels tired of sitting and changes his position). |
| 34. Adaptations for activities (physically handicapped) | › Barriers limit child's use of space and materials and caregiver doesn't compensate. (Ex. toys out of reach, steps prevent easy movement).<br>› Needed adaptive equipment not present or used, thus preventing child from joining learning and social activities. | | › Barriers may be present but caregiver helps child gain access to activities when needed (Ex. moves non-walker to area where other children are playing).<br>› Some adaptive equipment present, clean, safe, and in good repair.<br>› Adequate space for adaptive equipment. | | › Needed adaptive equipment available for self-help, learning, and play activities, both indoors and out.<br>› Environment permits child free use of space and materials (Ex. toys put within child's reach, barriers to movement indoors managed effectively). | | › Caregiver encourages independent use of adaptive equipment.<br>› Careprovider plans activities for child to learn to use adaptive equipment, where needed.<br>› Caregiver helps other children accept adaptive equipment (Ex. by telling what it is for, answering questions, quieting fears, letting children try out equipment and help handicapped child). |

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 35. Adaptations for other special needs | › No adjustments made in space, furnishings, and/or schedule to meet special emotional, behavioral, or mental needs of child. | | › Some adjustments in space, furnishings, and/or schedule made to prevent the problems that could be caused by the special emotional, behavioral, or mental needs of child (Ex. removes breakable object, watches child carefully, simplifies cluttered area). | | › Many adjustments of space, furnishings, and/or schedule made to meet the needs of child (Ex. quiet work and play areas with appropriate toys for child who is easily distracted, time provided for one-to-one work on special needs skill development). | | › Caregiver encourages child to use space, furnishings, and time constructively and independently.<br>› Caregiver changes space, schedule, and/or furnishings as child's needs change. |
| 36. Communication (exceptional) | › Caregiver communicates less with special-needs child than with other children.<br>› Caregiver does not adjust speech to child's level of understanding; speaks in same fashion to all children.<br>› Caregiver does not provide communication options required by child's handicap (Ex. does not face hard-of-hearing child, does not provide alternatives to speech such as manual signing or communication boards where needed). | | › Careprovider communicates equally with special-needs child and other children.<br>› Caregiver attempts to adjust speech to child's level of understanding, but may use sentences that are too long or talk baby talk to child who can understand more.<br>› Communication options exist, where needed, but are not routinely used throughout the day (Ex. communication board used only during language lessons, hearing aid only used occasionally). | | › Caregiver communicates frequently with the special-needs child.<br>› Caregiver actively encourages child to communicate with caregiver.<br>› Caregiver encourages children to communicate with each other.<br>› Caregiver appropriately adjusts speech to child's level of understanding.<br>› When needed, use of communication options encouraged all day. | | › Careprovider praises or reinforces child's attempts to communicate.<br>› Caregiver extends language interaction with special-needs children.<br>› Caregiver plans activities to teach more advanced use of communication options as needed (Ex. teaches other children to sign, adds new communication board symbols or signs). |
| 37. Language/reasoning (exceptional) | › No attempt to adapt language/reasoning materials or provide special materials to meet the needs of exceptional child (Ex. no large-print books, textured books, or high-contrast pictures). | | › Caregiver adapts regular materials for use by exceptional child. | | › Language and reasoning goals for special-needs child are specified and worked on.<br>› When needed, caregiver provides specialized language/reasoning materials for exceptional child. | | › Caregiver uses routines and activities throughout the day to reach specified language/reasoning goals for the child.<br>› Specialized materials used as part of planned activities to reach specified language/reasoning goals. |

| Item | Inadequate<br>1 | 2 | Minimal<br>3 | 4 | Good<br>5 | 6 | Excellent<br>7 |
|---|---|---|---|---|---|---|---|
| 38. Learning and play activities (exceptional) | › Special-needs child excluded from play and learning activities available to other children (Ex. child in wheelchair not allowed to participate in messy activities, hearing-impaired child excluded from music, mentally handicapped child not given appropriate activities). | | › Special-needs child present during activities but not actively involved (Ex. child in wheelchair present as observer near dramatic play but not helped to participate).<br>› Some substitute activities available for exceptional child (Ex. child allowed to use free-play toys while others are involved in learning activities). | | › Developmentally appropriate activities provided for exceptional child.<br>› Activities adapted to help special-needs child participate (Ex. reduces size of group for aggressive child, uses table for activity usually done on floor).<br>› Careprovider participates in activities with the exceptional child to provide model.<br>› Caregiver provides additional directions and makes limits explicit as required to motivate and make special-needs child successful.<br>› Careprovider praises and reinforces child for play and learning using newly developed skills. | › Caregiver helps child develop skills needed to participate in a variety of regularly available learning activities.<br>› Specialized learning activities provided to help child reach specific developmental goals (Ex. activities used to teach self-help skills like buttoning, feeding self). |
| 39. Social development (exceptional) | › Few opportunities provided for social interaction involving all children, including handicapped and nonhandicapped children. | | › Schedule provides ample opportunities for social interaction involving all children, handicapped and nonhandicapped.<br>› Caregiver shows acceptance of handicapped child (Ex. hugs child to show affection, makes eye contact when child speaks). | | › Caregiver praises and reinforces child for learning social skills related to special needs.<br>› Caregiver encourages and reinforces social interaction involving all children, including handicapped and nonhandicapped children, throughout the day.<br>› Caregiver models appropriate social behavior and encourages children to imitate.<br>› Handicapped child accepted as part of group by other children. | › Careprovider identifies new social skills needed by the handicapped child and others, and provides learning activities to teach those skills (Ex. teaches handicapped child to respond when approached by others, encourages handicapped child to invite others to join him in play).<br>› Some books, pictures, dolls showing handicapped persons available, if appropriate. |

| Item | Inadequate 1 | 2 | Minimal 3 | 4 | Good 5 | 6 | Excellent 7 |
|---|---|---|---|---|---|---|---|
| 40. Caregiver preparation | › Caregiver does not seek additional information and skills required for care of handicapped child.<br>› No specialists are involved in assessing the handicapped child's special needs or in planning an appropriate program of child care.<br>› Caregiver and parents do not share information about child's special needs. | | › Caregiver requests basic information from assessments by specialists.<br>› Caregiver and parents share information about child's special needs (Ex. parents give caregiver information from professional assessments). | | › Caregiver uses information from assessments and advice of specialists to plan an appropriate program for child throughout the day.<br>› Caregiver works closely with parents to incorporate their goals and interests in daily activities. | | › Caregiver participates in specialized training on working with handicapped children (Ex. takes one workshop a year on needs of special children, works closely with a professional consultant, joins special education training or support group).<br>› Caregiver is sensitive to the special needs of parents of handicapped children (Ex. shares information with parents about parent groups, works appropriately with parents who have difficulty in recognizing child's special needs). |

The increasing concern over the effect of day care on children's lives has focused attention on the quality of that care. Since most out-of-home care is provided in family day care homes, the need has grown for an accessible, reliable, and thorough means of assessing the quality and suitability of such settings. The **FAMILY DAY CARE RATING SCALE**, an expanded adaptation of the popular *Early Childhood Environment Rating Scale* (Teachers College Press, 1980), provides an easy-to-use resource for evaluating family day care settings.

Developed through lengthy field testing, research, and revision, FDCRS consists of 32 items, organized under six major headings: Space and Furnishings for Care and Learning, Basic Care, Language and Reasoning, Learning Activities, Social Development, and Adult Needs. Eight additional items are included for rating a day care home's provisions for special-needs children.

FDCRS will serve a number of important functions: as a self-assessment tool for family day care providers, as a quality measure for state and private monitoring agencies, and as a valuable guide for concerned parents. The established reliability and validity of the scale make it particularly useful for early childhood research and training programs. Each book contains one scoring sheet. Packages of 30 scoring sheets can be ordered separately.

## About the Authors

**THELMA HARMS** is director of early childhood curriculum development for the Frank Porter Graham Child Development Center and clinical associate professor in the School of Education at the University of North Carolina at Chapel Hill. She was formerly at the Harold E. Jones Child Study Center at the University of California at Berkeley. Dr. Harms has had extensive experience working with preschool children; consulting with day care, Head Start, and public school programs; and educating teachers and parents. Her publications include a series of curriculum materials for training family day care providers.

**RICHARD M. CLIFFORD** is associate director of the Bush Institute for Child and Family Policy, Frank Porter Graham Child Development Center at the University of North Carolina at Chapel Hill. He is a former elementary school principal. Dr. Clifford has authored or edited numerous articles, books, and reports regarding the education and care of young children. He has consulted with many state and local departments of education and human resources in program planning and evaluation.

TEACHERS COLLEGE PRESS

Teachers College
Columbia University
1234 Amsterdam Avenue
New York, NY 10027

ISBN 0-8077-2955-8

90000>

9 780807 729557

# APPENDIX C

## Caregiver Interaction Scale

**Caregiver Interaction Scale**

**Mentor ID** _____ **Provider ID** _____ **Date of Completion**_____

| Item # | Description | Rating<br>1 = not at all<br>2 = somewhat<br>3 = quite a bit<br>4 = very much | Notes |
|---|---|---|---|
| 1. | Speaks warmly to children | 1 2 3 4 | |
| 2. | Seems critical of the children | 1 2 3 4 | |
| 3. | Listens attentively when children speak to her | 1 2 3 4 | |
| 4. | Places high value on obedience | 1 2 3 4 | |
| 5. | Seems distant or detached from the children | 1 2 3 4 | |
| 6. | Seems to enjoy the children | 1 2 3 4 | |
| 7. | When the children misbehave, explains the reason for the rule they are breaking | 1 2 3 4 | |
| 8. | Encourages the children to try new experiences | 1 2 3 4 | |
| 9. | Does not try to exercise much control over the children | 1 2 3 4 | |
| 10. | Sepaks with irritation or hostility to the children | 1 2 3 4 | |
| 11. | Seems enthusiastic about the children's activities and efforts | 1 2 3 4 | |
| 12. | Threatens children in trying to control them | 1 2 3 4 | |
| 13. | Spends considerable time in activities not involving interactions with the children | 1 2 3 4 | |
| 14. | Pays positive attention to the children as individuals | 1 2 3 4 | |
| 15. | Does not reprimand children when they misbehave | 1 2 3 4 | |
| 16. | Talks to children on a level they can understand | 1 2 3 4 | |
| 17. | Punishes the children without explanation | 1 2 3 4 | |
| 18. | Exercises firmness when necessary | 1 2 3 4 | |
| 19. | Encourages children to exhibit prosocial behavior, e.g. sharing | 1 2 3 4 | |
| 20. | Finds fault easily with children | 1 2 3 4 | |
| 21. | Does not seem interested in children's activities | 1 2 3 4 | |
| 22. | Seems to prohibit many of the things that children want to do | 1 2 3 4 | |
| 23. | Does not supervise the children very closely | 1 2 3 4 | |
| 24. | Expects the children to exercise self-control; e.g. to be undisruptive for group, teacher-led activities, to be able to stand in line calmly | 1 2 3 4 | |
| 25. | When talking to children kneels, bends, or sits at their level to establish better eye contact | 1 2 3 4 | |
| 26. | Seems unnecessarily harsh when scolding or prohibiting children | 1 2 3 4 | |

**Rate the provider on how well each statement describes her. The statement describes the provider "not at all", etc.**

# APPENDIX D

Provider Survey 1

Family Child Care Partnerships
Provider Survey - ID# _____
Part 1: Questions 1 to 38

Your Child Care Services and Operations

For each question, give the answer or mark the circle that best applies to your situation.

Q1. What type of child care service do you operate? (Mark all that apply.)
- O Family day care home
- O Group day care home
- O Head Start day care home
- O Other (please describe): _____

Q2. How do you describe your job/position? _____

Q3. How many years have you been involved in paid child care work (of any type)? _____

Q4. How many years have you worked for pay by caring for children in your home? _____

Q5. Which of the following statements best describes the operating hours of your child care home?
- O I have set operating hours, and I tend to be strict about keeping them.
- O I have set operating hours, and I tend to be flexible about keeping them.
- O I set my operating hours according to the needs of the specific families enrolled.
- O I do not have set operating hours.

Q6. In general, when does the first child arrive at your home in the morning?
- O Before 7:00 a.m.
- O Sometime between 7:00 and 8:00 a.m.
- O Sometime between 8:00 and 9:00 a.m.
- O After 9:00 a.m.

Q7. In general, when does the last child leave your care in the evening?
- O Before 4:00 p.m.
- O Sometime between 4:00 and 5:00 p.m.
- O Sometime between 5:00 and 6:00 p.m.
- O After 6:00 p.m.

Q8. How many full-time caregivers work for you? _____

Q9. How many part-time caregivers work for you? _____

Q10. How do you generally structure your fees? (Mark all that apply.)
- O I have a set daily fee per child.
- O I have a set weekly fee per child.
- O I have a set monthly fee per child.
- O I change my fees somewhat for families who enroll more than one child.
- O The fees I charge are different based on the age of the child.
- O Other (please describe): _____

Q11. What is your best estimate of the total amount of fees you collected last month? $_____/mo.

Q12. What is your best estimate of the total amount you spent to run your child care business last month? $_____/mo.

Q13. How many children are you licensed to serve? _____

Q14. For each of the following age groups, how many were enrolled last month?

| Age | Number Enrolled | Spaces Available But Not Used |
|---|---|---|
| 0-11 months | _____ | _____ |
| 12-23 months | _____ | _____ |
| 24-35 months | _____ | _____ |
| 3 year olds | _____ | _____ |
| 4-5 year olds | _____ | _____ |
| 6 years and older | _____ | _____ |

Q15. Was last month's enrollment typical for you?
- O Yes
- O No, it was higher than usual.
- O No, it was lower than usual.

Q16. Do you have need for a waiting list?
- O Yes →→ IF YES, for what ages do you have a waiting list? (Mark all the apply.)
- O No
  - O 0-11 months
  - O 12-23 months
  - O 24-35 months
  - O 3 years old
  - O 4-5 years old
  - O 6 years and older

Your Caregiving and Business Practices

Q17. How often do you plan specific lessons or special activities for children in your care?
- O Several times per day
- O At least once per day
- O Three to four times per week
- O Once or twice per week
- O Less than once per week

Q18. What resources do you use to plan lessons or special activities for your children? (Mark all that apply.)
- O Materials that I purchase from professional child care sources.
- O Materials that I receive at no cost from professional child care sources.
- O Information that I read in child care-related publications or magazines.
- O Information that I read in popular publications or magazines.
- O Ideas that I get from parents or other child care providers.
- O Ideas that I get from watching child care/educational programming.
- O Ideas that I get from provider training workshops
- O Ideas that I get from child development or child care courses I take/have taken.
- O Other (please describe):_____

_____

Q19. Please mark the circle that best represents how you most often communicate with your families about the common child care situations described below.

| How do you let parents know about... | Written Handout | Phone Call | Face-to-face Conversation | Other (Please describe) |
|---|---|---|---|---|
| a)...closing for vacations or holidays? | O | O | O | |
| b)...fee changes? | O | O | O | |
| c)...payment overdue? | O | O | O | |
| d)...child injuries requiring emergency medical care? | O | O | O | |
| e)...child injuries not requiring medical care? | O | O | O | |
| f)...need to use a substitute caregiver? | O | O | O | |
| g)...their children's behavior/misbehavior? | O | O | O | |
| h)...children's daily activities? | O | O | O | |

Q20. Child care providers have different ways of running their businesses. Please mark the circle that best represents your current approach to a variety of possible child care business practices.

| What is your approach to... | Currently Doing It | Planning To Do It | Don't Want To Do It | Want To Know More |
|---|---|---|---|---|
| a)...having parents' daytime phone # for each child | O | O | O | O |
| b)...getting parent's authorization to transport child | O | O | O | O |
| c)...having policies for fire or weather emergencies | O | O | O | O |
| d)...keeping doctor's phone # for each child | O | O | O | O |
| e)...having emergency authorization forms | O | O | O | O |
| f)...getting parent's authorization for alternative pick-up arrangements | O | O | O | O |
| g)...having a written parent-provider contract | O | O | O | O |
| h)...keeping immunization records | O | O | O | O |
| i)...depreciating your child care costs on taxes | O | O | O | O |
| j)...reporting your child care income on taxes | O | O | O | O |
| k)..reporting your child care expenses on taxes | O | O | O | O |
| l)...providing parents info they need to claim the child care tax credit | O | O | O | O |
| m)...protecting yourself with liability insurance | O | O | O | O |
| n)...signing up for health insurance | O | O | O | O |
| o)...setting up life or disability insurance | O | O | O | O |
| p)...saving part of your income for retirement | O | O | O | O |
| q)...arranging for paid vacation or holiday leave | O | O | O | O |
| r)...having homeowners/renter's insurance | O | O | O | O |

Your Special Situation and Background

Q21. Which of these age categories do you fit in?
- O Under 21 years old
- O 21-25 years old
- O 26-30 years old
- O 31-40 years old
- O 41-50 years old
- O 51-60 years old
- O Above 60 years old

Q22. What is your sex?
- O Female
- O Male

Q23. Are you currently:
- O Married
- O Single-not living with a partner
- O Living with a partner

Q24. If someone asked you what ethnic or racial group you identify with or belong to, what would you say?
- O White or Caucasian
- O Black or African-American
- O Hispanic or Latino
- O Asian or Pacific Islander
- O American Indian or Native American
- O Other (please specify): _____

Q25. Would you say you live in:
- O A rural area
- O A town
- O A suburb
- O A city

Q26. In terms of your own education, how much schooling have you had so far?
- O Less than high school
- O High school graduate
- O GED (General Education Diploma)
- O Some college, but no degree
- O Associate degree
- O Bachelor's degree
- O Master's degree
- O Doctorate

Q27. Do you have your CDA (Child Care Development Associate) credential?
- O Yes
- O No

Q28. What would you say is your total *household* income each year?
- O Less than $5000
- O Between $5001 and $10,000
- O Between $10,001 and $15,000
- O Between $15,001 and $20,000
- O Between $20,001 and $25,000
- O Between $25,001 and $30,000
- O Over $30,000

Q29. What would you say is your total *child care* income each year?
- O Less than $5000
- O Between $5001 and $10,000
- O Between $10,001 and $15,000
- O Between $15,001 and $20,000
- O Between $20,001 and $25,000
- O Between $25,001 and $30,000
- O Over $30,000

Q30. How many adults (not counting yourself) live in your home? _____

Q31. How many children are there in your family? _____

Q32. How many of your children live at home with you? _____

Q33. How many of your children go to full-day school during the day? _____

Q34. How many of your children stay at home with you (do not go to full-day school) during the day? _____

Q35. Before you became a paid family child care provider, what other kinds of paid work did you do? *(Begin with your most recent employment experiences of 1 year or more.)*

If you haven't done any paid work other than family child care, please check this circle: O

| Job/Position description | For how many years? | Approximate annual salary? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Q36. What would you say was the main reason that you chose to become a family child care provider? *(If you don't see an answer that explains your reasoning very well, write it in the space provided.)*

O I wanted to stay at home with my own children/grandchildren.
O I wanted to work with children.
O I wanted to help parents who needed child care.
O I wanted to work in my home.

Q37. Which of the following statements most closely describes the way you see your job as a family child care provider?

O It is a good job for me while my children are young.
O It is my chosen occupation.
O It is temporary employment.
O It is a stepping stone to other work I would like to do.

Q38. Since you became a family child care provider, what kind of training would you say you have had in each of the following areas? *(If you have not had any training in an area, please write N/A next to that area.)*

| | Total hours taken | Year of most recent training | Who provided or sponsored this training? |
|---|---|---|---|
| a) Business practices: accounting & budgeting | | | |
| b) Business practices: paperwork & taxes | | | |
| c) Business practices: payment & policies | | | |
| d) Child behavior management | | | |
| e) Child development | | | |
| f) Child immunization | | | |
| g) Child nutrition | | | |
| h) Communicating with families | | | |
| i) Curriculum planning | | | |
| j) Developmentally appropriate practices | | | |
| k) Finding/buying needed supplies & resources | | | |
| l) Home health and safety practices | | | |
| m) Insurance coverage options | | | |
| n) Other: _____ | | | |
| o) Other: _____ | | | |

THANK YOU very much for answering our questions. The information you provide will help us understand much more about both the unique situations of family child care providers and the characteristics common to their work experiences. We will do our very best to use this information to make this training and other aspects of the family child care profession in Alabama better.

Sometimes questions and answers on surveys do not completely capture your unique experiences. If there is anything else you can add to what you have already shared that would help us understand more about how to make the program more effective for providers like yourself, please write them on this page. Thank you!

# APPENDIX E

Helping Relationship Inventory -- Provider

## Helping Relationship Inventory

The following questions are about what you and your mentor do in your home visits together. It is possible that some of the questions might be about things not addressed by you and your mentor. Nevertheless, answer each question to the best of your ability by circling the response that best describes your situation. Please answer ALL of the questions using the scale below.

| Not At All | A Little | Some | A Lot | A Great Deal |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| How much input have you had in determining how the two of you will work together? | 1 | 2 | 3 | 4 | 5 |
| How much have you and your mentor discussed specific problems with which you want help? | 1 | 2 | 3 | 4 | 5 |
| How much input have you had in determining the specific problems you are addressing in your work together? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your mentor discussed the specific goal(s) you hope to accomplish in your work together? | 1 | 2 | 3 | 4 | 5 |
| How much input have you had in determining the goals you are working on? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your mentor discussed the specific actions you will take to achieve goals you are working on? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your mentor discussed the specific actions your mentor will take to address your goals? | 1 | 2 | 3 | 4 | 5 |
| How much have you and your mentor discussed how your progress is going to be assessed? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your mentor discussed your progress? | 1 | 2 | 3 | 4 | 5 |

**The next set of questions are about your relationship with your mentor.** There are no right or wrong answers. Circle the response that best describes your feelings. Please answer ALL of the questions.

| Not At All | A Little | Some | A Lot | A Great Deal |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| Do you feel your mentor pays attention to you? | 1 | 2 | 3 | 4 | 5 |
| Is your mentor's understanding of your challenges similar to your own? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor help you to believe more in yourself? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor help you get more organized about meeting your challenges? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor have a calming, soothing effect on you? | 1 | 2 | 3 | 4 | 5 |
| Does your mentor help you think more clearly about your challenges? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor give you hope? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor help you think of yourself as a professional? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your mentor help you feel more confident in your ability to work with the children in your care? | 1 | 2 | 3 | 4 | 5 |
| In general, do you feel you and your mentor see things in similar ways? | 1 | 2 | 3 | 4 | 5 |
| Do you feel that you and your mentor are alike in some ways? | 1 | 2 | 3 | 4 | 5 |

(Adapted from Young & Poulin, 1998.)

THANK YOU very much for answering our questions. The information you provide will help us understand much more about both the unique situations of family child care providers, the characteristics common to their work experiences, and the impact the Family Child Care Partnerships program has on its participants. We will do our very best to use this information to make our program and other aspects of the family child care profession in Alabama better.

Sometimes questions and answers on surveys do not completely capture your unique experiences. If there is anything else you can add to what you have already shared that would help us understand more about how to make the program more effective for providers like yourself, please write them on this or a separate page. Thank you!

If you have any questions about these surveys, please contact the FCCP office at 1-877-892-3227.

Please return these surveys (total of 4 pages) in the pre-addressed envelope provided.

# APPENDIX F

## Mentor Information Survey

ID#_____

**Family Child Care Partnerships**
**Mentor Information Survey**
**FY04**

For each question, give the answer or mark the circle that best applies to you:

Q1. In which of the following formal child care settings have you worked either for pay or as an unpaid worker ? (Mark all that apply.)

- ○ Family day care home provider #of years paid _____ #of years unpaid _____
- ○ Group day care home provider #of years paid _____ #of years unpaid _____
- ○ Group day care home assistant #of years paid _____ #of years unpaid _____
- ○ Head Start day care home #of years paid _____ #of years unpaid _____
- ○ Head Start teacher #of years paid _____ #of years unpaid _____
- ○ Head Start administrator #of years paid _____ #of years unpaid _____
- ○ Private center classroom teacher #of years paid _____ #of years unpaid _____
- ○ Private center administrator #of years paid _____ #of years unpaid _____
- ○ Other (please describe): _____

Q2. Before you were employed with FCCP, how much paid work experience did you have as a consultant or technical assistance specialist working with family child care providers?

- ○ None
- ○ Less than 1 year of full-time work experience
- ○ The equivalent of 1 year of full –time experience
- ○ The equivalent of 2 years of full-time experience
- ○ More than the equivalent of 2 years of full-time experience: [please give total number of years of experience _____]

Q3. Which of the sources of child care training below have awarded you training hours between January, 2000 and December 2003? (mark all that apply)

- ○ Childcare Management Agency/Resource Center # clock hours _____
- ○ Local community college #course/credit hours _____
- ○ 4-year College or University #course/credit hours _____
- ○ Alabama Cooperative Extension # clock hours _____
- ○ Alabama Public Television (APTV) # clock hours _____
- ○ Everyday TLC newsletter # clock hours _____
- ○ Provider Association Meetings # clock hours _____
- ○ Other (please describe): _____
  _____

Q4. What is your level of involvement in your local provider association? (mark all that apply)

- ○ There is no association in my area
- ○ I am not a member of my local association
- ○ I am a member of my local association
- ○ I attend association meetings regularly
- ○ I am an officer or committee member in my association
- ○ I am a consultant and support member for my association
- ○ I keep in contact with the association but do not actively participate unless specifically asked to do so

Q5. How many years did you work in a job unrelated to child care or teaching? _____

Q6. Are your children now or have they ever been cared for in a family child care home?

Yes No N/A (no children)

ID#_____

Q7. Are your children now or have they ever been cared for in Head Start or center-based care?
Yes No N/A (no children)

Q8. Are your grandchildren now or have they ever been cared for in a family child care home?
Yes No N/A (no grand children)

Q9. Are your grandchildren now or have they ever been cared for in Head Start or center-based care?
Yes No N/A (no grandchildren)

Q10. Which of these age categories do you fit in?
- O Under 21 years old
- O 21-25 years old
- O 26-30 years old
- O 31-40 years old
- O 41-50 years old
- O 51-60 years old
- O Above 60 years old

Q11. What is your sex?
- O Female
- O Male

Q12. Are you currently:
- O Married
- O Single – not living with a partner
- O Living with a partner

Q13. If someone asked you what ethnic or racial group you Identify with or belong to, what would you say?
- O White or Caucasian
- O Black or African-American
- O Hispanic or Latino
- O Asian or Pacific Islander
- O American Indian or Native American
- O Other (please specify): _____

Q14. Would you say you live in:
- O A rural area
- O A town
- O A suburb
- O A city

Q15. In terms of your own education, what is the highest level of schooling you have completed so far?
- O GED (General Education Diploma)
- O High school
- O Some college, but no degree
- O Associate degree
- O Bachelor's degree
- O Master's degree
- O Doctorate degree

Q16. Do you have a CDA (Child Development credential)? _____ No _____Yes (year CDA was awarded) _____

Q17. If you are currently attending classes, please indicate which program(s) in which you are involved. (Mark all that apply)
- O Not currently attending classes
- O CDA classes
- O The TEACH program
- O Working on Associate degree
- O Working on Bachelor's degree
- O working on graduate degree
- O Other _____

ID#_____

Q18. What is your total household income each year?

- O Less than $10,000
- O Between $10,001 and $20,000
- O Between $20,001 and $30,000
- O Between $30,001 and $40,000
- O Between $40,001 and $50,000
- O Between $50,001 and $60,000
- O Over $60,000

Q19. How many adults (not counting yourself) live in your home? _____

Q20. What is the age and sex of each of the children living in your home?

| | | |
|---|---|---|
| Child 1 | Age_____ | Sex M F |
| Child 2 | Age_____ | Sex M F |
| Child 3 | Age_____ | Sex M F |
| Child 4 | Age_____ | Sex M F |
| Child 5 | Age_____ | Sex M F |
| Child 6 | Age_____ | Sex M F |
| Child 7 | Age_____ | Sex M F |
| Child 8 | Age_____ | Sex M F |

Q21. Which of the following statements most closely describe the way you see your job as a mentor for family child care providers?

- O It is my preferred occupation.
- O It is temporary employment.
- O It is a stepping stone to other work I would like to do.

Q22. Which of the following statements most closely describes the way you see family child care providers?

- O It is a good occupation to have when their own children are young.
- O It is something most providers choose to do for their careers.
- O It is temporary employment.
- O It is a stepping stone to other work they would like to do.

Q23. List all professional organizations to which you currently belong and the number of years you have been a member or affiliate:

1. _____ Years _____
2. _____ Years _____
3. _____ Years _____
4. _____ Years _____
5. _____ Years _____
6. _____ Years _____
7. _____ Years _____

Q24. Which of these child care topics do you consider to be the area of your greatest expertise? (Select one.)

- o universal health and safety precautions and practices
- o developmentally appropriate practice
- o positive discipline and guidance methods
- o language development
- o quality child care practices
- o professional development

ID#_____

Q25. Which of these child care topics do you consider to be the area in which you have relatively less expertise? (Select one.)

- o universal health and safety precautions and practices
- o developmentally appropriate practice
- o positive discipline and guidance methods
- o language development
- o quality child care practices
- o professional development

Q26. The following statements are about child care topics. Please rate yourself on your abilities to work with providers in each of the child care topic areas below. Circle the response that best describes your situation.

| Needs improvement | Meet minimum qualifications | Is good | Is excellent |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**My ability to work with family child care providers in the area of....**

| | | | | |
|---|---|---|---|---|
| universal health and safety precautions and practices_____. | 1 | 2 | 3 | 4 |
| velopmentally appropriate practice_____. | 1 | 2 | 3 | 4 |
| positive discipline and guidance methods _____. | 1 | 2 | 3 | 4 |
| language development _____. | 1 | 2 | 3 | 4 |
| quality child care practices _____. | 1 | 2 | 3 | 4 |
| professional development _____. | 1 | 2 | 3 | 4 |

| Needed improvement | Met minimum qualifications | Was good | Was excellent |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**Prior to my employment with FCCP, my ability to work with family child care providers in the area of....**

| | | | | |
|---|---|---|---|---|
| universal health and safety precautions and practices_____. | 1 | 2 | 3 | 4 |
| developmentally appropriate practice_____. | 1 | 2 | 3 | 4 |
| positive discipline and guidance methods _____. | 1 | 2 | 3 | 4 |
| language development _____. | 1 | 2 | 3 | 4 |
| lity child care practices _____. | 1 | 2 | 3 | 4 |
| professional development _____. | 1 | 2 | 3 | 4 |

# APPENDIX G

Helping Relationship Inventory -- Mentor

## Helping Relationship Inventory - M

The following questions are about what you and your provider do in your home visits together. It is possible that some of the questions might be about things not addressed by you and your provider. Nevertheless, answer each question to the best of your ability by circling the response that best describes your situation. Please answer ALL of the questions using the scale below.

| Not At All | A Little | Some | A Lot | A Great Deal |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| How much input have you had in determining how the two of you will work together? | 1 | 2 | 3 | 4 | 5 |
| How much have you and your provider discussed specific problems with which she wants help? | 1 | 2 | 3 | 4 | 5 |
| How much input has your provider had in determining the specific problems you are addressing in your work together? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your provider discussed the specific goal(s) you hope she will accomplish in your work together? | 1 | 2 | 3 | 4 | 5 |
| How much input have you had in determining the goals she is working on? | 1 | 2 | 3 | 4 | 5 |
| How much input has your provider had in determining the goals she is working on? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your provider discussed the specific actions she will take to achieve goals you are working on? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your provider discussed the specific actions you will take to address your goals? | 1 | 2 | 3 | 4 | 5 |
| How much have you and your provider discussed how her progress is going to be assessed? | 1 | 2 | 3 | 4 | 5 |
| To what extent have you and your provider discussed her progress? | 1 | 2 | 3 | 4 | 5 |

**The next set of questions are about your relationship with your provider.** There are no right or wrong answers. Circle the response that best describes your feelings. Please answer ALL of the questions.

| Not At All | A Little | Some | A Lot | A Great Deal |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| Do you feel your provider pays attention to you? | 1 | 2 | 3 | 4 | 5 |
| Is your provider's understanding of her challenges similar to your own? | 1 | 2 | 3 | 4 | 5 |
| Did talking with your provider help her to believe more in herself? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your provider help her get more organized about meeting her challenges? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your provider have a calming, soothing effect on her? | 1 | 2 | 3 | 4 | 5 |
| Do you help your provider think more clearly about her challenges? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your provider give her hope? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your provider help her think of herself as a professional? | 1 | 2 | 3 | 4 | 5 |
| Does talking with your provider help her feel more confident in her ability to work with the children in her care? | 1 | 2 | 3 | 4 | 5 |
| In general, do you feel you and your provider see things in similar ways? | 1 | 2 | 3 | 4 | 5 |
| Do you feel that you and your provider are alike in some ways? | 1 | 2 | 3 | 4 | 5 |

(Adapted from Young & Poulin, 1998.)

THANK YOU very much for answering our questions. The information you provide will help us understand much more about both the unique situations of mentors working with family child care providers, the characteristics common to their work experiences, and the impact the Family Child Care Partnerships program has on its participants. We will do our very best to use this information to make our program and other aspects of the family child care profession in Alabama better.

Sometimes questions and answers on surveys do not completely capture your unique experiences. If there is anything else you can add to what you have already shared that would help us understand more about how to make the program more effective for providers like those in your caseload or for mentors, please write them on this or a separate page. Thank you!

If you have any questions about these surveys, please contact the FCCP office at 1-877-892-3227.