



Observations of Child Care Provided by Family, Friends and Neighbors in Minnesota

A Report of the Minnesota Child Care Policy Research Partnership

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The Minnesota Child Care Policy Research Partnership

The Minnesota Child Care Policy Research Partnership (MCCPRP) is a collaboration among Minnesota state agencies, counties, child care resource and referral agencies and researchers. Coordinated by the Minnesota Department of Human Services, the partnership brings together researchers and policymakers from the Minnesota Department of Employment and Economic Development (formerly the Department of Economic Security), county child care units from Anoka, Becker, Brown and Hennepin Counties, the University of Minnesota, Child Trends, Wilder Research Center, the Minnesota Child Care Resource & Referral Network and several national researchers. The goal of this broadly based partnership is to foster sound research on child care issues of importance to policymakers at the state, local and national level.

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The research agenda of the Minnesota Child Care Policy Research Partnership is designed to answer critical questions about how affordability, quality and accessibility affect outcomes for families and children. A key objective is to enhance understanding of the impact on child care quality of various state policies, including the level of subsidies, tiered reimbursement and quality regulations or standards. The broad research questions include:

- What is the quality of care in Minnesota and what supports are needed to improve and maintain quality child care?
- How do parents and children describe their experiences with child care?
- How many providers meet criteria for high quality care? Where are they located?
- When parents receive child care assistance, what types of care do they use? What types of jobs do they have? How much do they earn? How long do they keep their jobs?
- How does child care assistance influence the availability and price of child care?
- How does the quality of child care vary for different groups, including families receiving subsidies and families from various cultural groups?

Currently the Minnesota Child Care Policy Research Partnership is conducting six interrelated studies, which will be available online at: http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_id_008779.hcsp.

This study focused on research questions related to the employment and earnings of parents receiving child care assistance.

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The Project Coordinator tirelessly called, organized visits and tracked study progress with participants. The Data Collection Team was committed to collecting reliable data that reflected the diverse situations they encountered.

Special thanks to the 41 caregivers who invited the research team into their homes and allowed their daily interactions and activities with children to be observed. Their open doors and willingness to participate were sincerely appreciated and have made this report possible.

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Executive Summary

Child care provided by family, friend and neighbor (FFN) caregivers (sometimes called informal care, kith and kin care or legally unlicensed care) is an integral component of the care and education system in Minnesota and the nation. Seventy percent of Minnesota's children ages 12 and under are cared for by an FFN caregiver on a regular basis according to data from the 2004 Minnesota statewide household child care survey (Chase, Arnold, Schauben, & Shardlow, 2005a). Nearly 50 percent of all children use FFN care either exclusively (24 percent) or as their primary child care arrangement (22 percent) (Chase, Arnold, Schauben, & Shardlow, 2005a).

Given the prevalence of FFN care in Minnesota, the importance of FFN care as a context for children's development, and the value of collecting on-site data about the environments and interactions children experience with FFN caregivers, the Minnesota Child Care Policy Research Partnership (MCCPRP) launched an exploratory observational study of FFN care with the following objectives:

- Complement findings from two recently-completed FFN surveys in Minnesota with in-person snapshots of caregiver-child interactions, the provision of learning opportunities, materials and activities, space and equipment and health and safety provisions in FFN settings. One previous survey included FFN caregivers registered with the Child Care Assistance Program (CCAP), Minnesota's child care subsidy program, and the other one surveyed FFN caregivers, irrespective of their participation in CCAP.
- Identify the strengths of FFN care and the areas of potential growth for better supporting children's development.
- Develop recommendations for FFN caregiver support initiatives that build on the strengths of FFN caregiving but also address any growth areas identified in the study.



Respondents from the two FFN surveys (Chase, Arnold, & Schauben, 2005; Chase Arnold, Schauben, & Shardlow, 2005b) were invited to participate in the observational study. Respondents who agreed to participate and who were eligible for the observational study (41 out of 613 caregivers) were visited in the home where they provide care. Trained data collectors spent two and a half hours observing different aspects of the care setting. The measurement tools were adapted from a national child care study that observed both licensed settings and settings legally exempt from regulation.

Because the sample is small and non-representative, it is helpful to know more about how the caregivers who chose to participate in the study compare to those who declined to participate. Data from the two FFN surveys provided additional information about the caregivers' demographic characteristics, features of the care they provide, and details about the children in their care. Respondents in the observational sample were more oriented to FFN caregiving as a profession than the average respondent in the survey samples (for example, they were more likely to be eager for support and interaction, provide care for more hours each week, and were less likely to have other paid jobs). Thus, the findings from this selected sample are more relevant for FFN caregivers who are more likely to seek out additional resources and training opportunities.

Summary of findings: FFN caregivers' interactions with children

Interactions were a clear strength of FFN care observed in this study.

- Caregivers consistently demonstrated interest in children, affection, responsiveness and helpfulness.
- Caregivers conversed with children and responded to their speech.
- Caregivers expressed warmth in their interactions, encouraged children, and acknowledged their efforts.
- Caregivers did not use harsh words or actions.
- Caregivers provided supervision appropriate for the ages and abilities of the children, and children had ample opportunities to play and explore their environments.

Three growth areas were identified in caregivers' interactions with children.

- Caregivers missed opportunities to talk with children about their emotions and help children understand and express their feelings, particularly when children were upset.
- Caregivers did not consistently foster cooperative play, sharing or turn-taking when two or more children were in the setting.
- Caregivers missed opportunities to support and extend children's learning by talking to children about their play, introducing new activities, helping children work on specific skills, or taking advantage of teachable moments arising in the context of everyday play.



From the perspective of children's development, each of these growth areas represents an opportunity to address an important component of school readiness.

- Accurate identification of emotions and the ability to manage frustration, anger and distress are critical skills for children to have as they enter school.
- The ability to work cooperatively and demonstrate prosocial behaviors ensures that children can form positive relationships with peers and teachers.
- The use of everyday opportunities to help children learn specific skills and concepts (for example, recognition of letters and words, sequence of events, time, shapes, numbers) can foster early math and reading skills that will benefit children as they enter school.

Summary of findings: Activities and materials available to children in FFN care

The FFN care settings observed in this study contained adequate age-specific toys for young children, materials to promote language and dramatic play, and opportunities to explore the natural and physical environment. Some books were accessible, and reading was encouraged in a majority of settings.

Overall, caregivers could expand the variety of activities and materials available to the children.

- Children had opportunities to engage in one or more of the following activities in about one-third of settings: making music, dancing and moving creatively, and learning about shapes and sound.
- Books were available in most homes, but 10 age-appropriate books or more were only available in about one-third of the settings.
- Basic art materials were available in fewer than half of the settings.
- Children were encouraged to use math (or pre-math concepts) in everyday contexts in about one-fifth of settings.

None of these activities needs to be formally structured but could be incorporated in the natural learning environment (including household chores and meals).

Television with appropriate content was used in nearly all of the observed FFN care settings. The issue of primary concern regarding television use in the settings was not the content, but the frequency of use. Caregivers did not consistently place limits on television use or turn off the television when children were not watching it.



Summary of findings: The physical environment and routines

A number of safety precautions and positive routines were observed in the FFN care settings.

- Smoke detectors were installed in a majority of homes.
- Equipment and materials were in good repair.
- The spaces for children were ample and comfortable.
- Meals provided opportunities for making conversation and learning self-help skills.

Two primary growth areas were identified.

- Caregivers should target safety issues such as children's access to hazardous items or spaces in the care settings. Children could reach items that they were not allowed to play with such as plants and breakable objects. Electrical outlets were not consistently covered, stairs were not secured with gates or barriers, and hazardous items were accessible to children in lower cupboards or on open shelves.
- Caregivers should focus on consistently washing their own hands and children's hands before and after preparing food and eating and after using the bathroom or changing diapers. Infrequent and incomplete handwashing are the primary ways germs are spread, so instituting proper handwashing routines will likely reduce illnesses for both the caregiver and children.

Recommendations

Recommendations in the FFN surveys in Minnesota and other studies emphasize the need for continued inclusion of FFN caregivers in statewide quality improvement initiatives, targeted outreach, and a neighborhood-based approach (Chase, Arnold, & Schauben, 2005; see also Brandon et al., 2002; O'Donnell & Morrisey, 2005). The findings from this exploratory observational study build on these efforts and can be used as the basis for the following recommendations.

1. Recognize, support and build on the strengths observed in FFN care in the development of new outreach initiatives.

Family and cultural connections are an integral part of caregivers' motivation to provide FFN care (Anderson, Ramsburg, & Rothbaum, 2003; Brandon et al., 2002; Chase, Arnold & Schauben; Porter, Rice & Mabon, 2003; Ramsburg & Anderson, 2005). The development of initiatives for FFN caregivers should frame the availability of resources and information as an opportunity to build on the already rich experiences and support they provide for the children in their care, not as a way to address deficits in the care they provide (Porter, Rice & Mabon, 2003).



2. Develop strategies to help caregivers:

a. Plan for, but not rigidly structure, their care environments.

Caregivers could benefit from guidance about the importance of creating a simple plan for their care of children. This recommendation does not imply that FFN caregivers should develop and implement a detailed daily schedule, lesson plan or curriculum. Rather, caregivers could think about the types of experiences they would like children to have while in their care and to set aside a few minutes each day to envision how they will make those experiences happen. This could help caregivers set priorities for their daily interactions, more proactively organize activities for children and better respond to individual children's needs.

b. Take advantage of natural learning opportunities to foster language, math and social skills

Materials and resources could be developed to help caregivers recognize the many opportunities they have in the context of routine activities to engage children. Cooking, doing laundry, shopping, gardening and other daily activities are perfect settings for discussing number, shape, size and sequence; comparing and contrasting items; introducing new vocabulary; identifying letters and words; and many other activities that are not only helpful for skill development but are also fun for children.

c. Obtain information about child development, basic materials and ideas for activities that are safe, stimulating and fun.

FFN caregivers are open to receiving information about children's development and how to help children learn and do well in school. Resources could be adapted and distributed that provide specific ideas for inexpensive activities caregivers can do with children or that answer caregivers' questions about young children. Many examples of these types of resources exist, including some that have been translated into multiple languages (for example, the Language and Math Tips for Parents available from Ready for K or the Questions about Kids available from the Center for Early Education and Development at the University of Minnesota). In addition, the distribution of books and art materials is a relatively inexpensive way to increase children's access to these important materials.

d. Recognize the importance of emotional understanding and social skills as dimensions of school readiness. Ensure that materials are developed that are culturally sensitive and respect the way emotions are expressed and responded to by different cultural groups.

FFN caregivers missed opportunities to help children identify and understand emotions and to actively guide children's behavior when they were upset or frustrated. Prosocial skills such as sharing, cooperating and turn-taking were not explicitly addressed by the caregivers. Yet, these skills are critical for children's success in school because they help children build positive social relationships and cope



with the demands of the school setting. When designing training and developing resources, efforts should be made to identify culturally-appropriate strategies for addressing emotions and social skills.

e. Recognize the importance of limiting television use.

Television viewing is a passive activity that precludes children's active exploration and play. Information should be provided to caregivers about appropriate alternatives and discussing television programs with children when they are watching. The American Academy of Pediatrics discourages the use of any television for children under age 2 and recommends a limit of no more than one to two hours per day of total entertainment media for children older than 2 (Committee on Public Education, American Academy of Pediatrics, 2001).

3. Target issues such as access to hazardous materials/areas and handwashing to improve the health and safety of FFN care environments.

More information and equipment is needed to ensure that health and safety practices are followed consistently. Young children had access to a number of hazardous areas (including stairs and outlets) and materials (including cleaning supplies) in the observed settings. Caregivers and children did not practice appropriate handwashing. Informational materials could be developed and safety devices such as outlet covers, door latches, safety gates, and fire extinguishers could be distributed to improve the safety of the settings. Materials should be developed to educate caregivers about the importance of handwashing and the steps to follow for complete handwashing. Small laminated posters or magnets could be distributed as reminders for caregivers and children.

4. Recognize the diversity of FFN caregiver's goals and motivations and the role FFN care plays in the lives of children.

Efforts to support FFN caregivers should be tailored so that they can be most effective. For example, Brandon and colleagues (2002) recommend that different strategies may be appropriate for grandparents, caregivers with limited English proficiency, caregivers with low education, and those caring for children with special needs. Based on the research of Todd and colleagues (2005) and Wilder Research (Chase, Arnold, & Schauben, 2005), approaches might also be tailored based on the degree to which caregivers are oriented to receiving support and resources. Finally, approaches might also be informed by the work of Porter and colleagues (2003) who posit that children's cumulative experiences across multiple care settings is important to consider when examining children's development in FFN settings. Resources could be developed to help caregivers assess the unique needs of the children in their care so that each child can be optimally supported. For example, a school-age child spending an hour after school with his grandmother two days each week has different needs than an infant or a preschool-aged child spending 40 hours per week in FFN care.



Conclusion

The approach taken in this study is that observation of strengths and growth areas in FFN care is not synonymous with ratings of quality. The results from this study provide an overview for policymakers and program developers of the general areas of FFN care that could be addressed in new initiatives. “One size does not fit all,” and approaches must be adapted for the unique cultural and caregiving circumstances of FFN caregivers.



Introduction

Background

Child care provided by family, friend and neighbor (FFN) caregivers (sometimes called informal care or kith and kin care, or legally unlicensed care) is an integral component of the care and education system in Minnesota and the nation. Seventy percent of Minnesota's children ages 12 and under are cared for by an FFN caregiver on a regular basis (Chase, Arnold, Schauben, & Shardlow, 2005a). Nearly 50 percent of children use FFN care either exclusively (24 percent) or as their primary child care arrangement (22 percent). Policy attention has increased in recent years as FFN caregivers have connected with child care subsidy systems. In particular, questions have been raised about the quality of care. Compared to more formal child care settings, little is known about the range of experiences and interactions children encounter across the diverse population of FFN caregivers.

Previous research, using samples of convenience and observational tools designed for formal child care settings, indicates that the global quality of care provided by FFN caregivers is low (Kontos, Howes, Shinn, & Galinsky, 1995; Maxwell, 2005; see synthesis of research by Brown-Lyons, Robertson, & Layzer, 2001). Informal settings are observed to offer fewer educational activities that promote literacy and learning, and children tend to watch more television than they do in center-based care (Brown-Lyons, Robertson, & Layzer, 2001). Health and safety concerns have also been reported in FFN care (Galinsky, Howes, Kontos, & Shinn, 1994). Yet parents often choose FFN caregivers because they know and trust the caregiver and want to provide a stable and familiar presence for their children. Ratios of caregivers to children tend to be very low, which can facilitate more sensitive and responsive caregiving (NICHD SECC, 1996). FFN caregivers are also available to care for children during nonstandard work hours when formal settings are closed. They often provide cultural and language continuity for children, particularly for children of immigrants.



As states and communities launch initiatives aimed at supporting FFN caregivers, further research is needed to better understand the care settings and the strengths and areas of concern. One approach to gathering information about FFN caregivers and their care is to ask questions about their characteristics, their daily activities with children, and their perceived needs and desired resources. Survey data can cover multiple topics and provide information about a large sample of caregivers that can be used to inform programs and policy. Minnesota recently completed two surveys of FFN caregivers, one focused on the statewide population of caregivers and one focused specifically on FFN caregivers registered with the Child Care Assistance Program (CCAP), Minnesota's child care subsidy program (Chase, Arnold, & Schauben, 2005; Chase, Arnold, Schauben, & Shardlow, 2005b).

A second approach is to augment survey data with on-site observations of caregivers and children. Observations add an opportunity for an in-depth assessment of the environments in which children are cared and the interactions that caregivers have with children. Observations allow for a deeper examination of constructs that are difficult to ask about in a survey context. Warmth and responsiveness to children's needs, for example, are important characteristics of caregivers, but they are difficult for caregivers to self-assess. Trained observers, in contrast, can rate these characteristics using standard criteria that are not biased by a provider's assumptions, expectations, or motivation to provide a socially desirable response.

Study objectives

Given the prevalence of FFN care in Minnesota, the importance of FFN care as a context for children's development, and the value of collecting on-site data about the environments and interactions children experience with FFN caregivers, the Minnesota Child Care Policy Research Partnership (MCCPRP) launched an exploratory observational study of FFN care with the following objectives:

- Complement findings from the two FFN surveys in Minnesota with in-depth observations of caregiver-child interactions, the provision of learning opportunities, materials and activities, space and equipment and health and safety provisions
- Identify the strengths of FFN care and the areas of potential growth for better supporting children's development
- Develop recommendations for FFN caregiver support initiatives that build on the strengths of FFN caregiving but also address any growth areas identified in the study.

The approach taken in this study is that observation of strengths and growth areas is not synonymous with ratings of quality. Currently, no consensus exists about whether and how to measure global quality in FFN care settings. The Sparking Connections National Consortium recommends that the conceptual work to define and measure quality in FFN care needs to be approached cautiously, recognizing the diversity of caregivers and families



who use FFN care (O'Donnell & Morrissey, 2005). The sample size of the current study prohibits an examination of subgroups and how patterns of strengths and growth areas differ by the unique circumstances of caregivers and children with different care profiles (for example, a grandmother caring for an infant two evenings each week compared to a neighbor caring for three non-related preschool-aged children 40 hours per week). This study provides an overview for policymakers and program developers of the general areas of FFN care that could be addressed in new initiatives. Approaches must be adapted for the unique cultural and caregiving circumstances of FFN caregivers and the children in their care.

Organization of the report

The report begins with a description of the specific research questions addressed in the study, the study design, and the measures used. The findings are then presented in three sections: an examination of the caregivers' interactions with children; a description of the materials and activities (including television watching) in the settings; and an analysis of the care environments that were observed. Throughout the presentation of the findings, areas of strength as well as potential growth are noted. All key findings are highlighted in bold. The report concludes with findings and recommendations for programs and policy. The resources, interactions and support opportunities that may be helpful for FFN caregivers are also described.

Research Questions

This study addressed the following research questions:

1. What areas of strength and what areas of potential growth are observed in FFN caregivers interactions with children?
2. What areas of strength and what areas of potential growth are observed in the materials and activities available in FFN care settings?
3. What areas of strength and what areas of potential growth are observed in the FFN care environment and routines?



Study Design, Measures and Procedures

Researchers conducted two telephone surveys that gathered information about FFN caregivers. The first survey used random digit dialing to identify 400 FFN caregivers (defined as an adult age 18 or older who provided FFN care for someone else's children age 12 or younger, at least once a week in each of the prior two weeks) from households across Minnesota. The response rate for the survey was 62.5 percent. A second survey of caregivers and parents used county records to identify a random sample of 213 caregivers registered to care for children receiving subsidies through the Minnesota Child Care Assistance Program (CCAP) and legally exempt from regulation. The response rate for the FFN caregiver portion of the survey was 76.6 percent. Final reports on each of these surveys – *Family, friend, and neighbor caregivers: Results of the 2004 Minnesota statewide household child care survey* (Chase, Arnold, Schauben, & Shardlow, 2005b) and *Families, friends, and neighbors caring for children through the Minnesota Child Care Assistance Program: A survey of caregivers and parents* (Chase, Arnold, & Schauben, 2005) – contain further details about the samples and findings.

FFN caregivers participating in either of the two phone surveys were invited to participate in the observational component of the study. The names and phone numbers of caregivers who indicated an interest in the study were transferred to Child Trends for follow-up recruitment phone calls. Of the 613 caregivers completing the phone surveys, only 24 percent agreed to participate. Of those 149 caregivers who agreed to be contacted, 114 were eligible for the study (76 percent). Despite making phone calls to interested survey respondents within a week after their phone survey, 14 percent already had a disconnected or out-of-service phone number. Additionally, 2 percent no longer provided regular care, and 8 percent did not speak English (a requirement of this study, though it will be important in future work to include non-English speaking participants).



Of the 114 caregivers eligible to participate in the study, 41 (36 percent) agreed. Of the remaining potential participants, 31 (27 percent) declined to participate. The remaining 42 (37 percent) never responded to follow-up phone calls. Despite the low response rate, one advantage to the phone survey data was the availability of information about those caregivers who declined to participate in the study. These data allowed us to thoroughly investigate the potential selection biases of the observational sample, that is, the characteristics of the sample that agreed to be observed that distinguished it from the larger survey sample. This comparison will be described below.

Nearly 70 percent of the sample was recruited from the CCAP survey of caregivers and parents. Yet, across the observational sample, only 41.5 percent of caregivers report that they receive payment from a county agency for any child in their care. Thus, while the sample over-represents caregivers registered with CCAP, fewer than half of the caregivers are actively receiving CCAP payments.

Survey measures

Through their participation in either the household child care survey (13 caregivers) or the CCAP survey of caregivers and parents (28 caregivers), data were available on a wide range of characteristics of the FFN caregivers and their care settings. These data for a larger, more representative sample are described comprehensively in the final reports for each of these surveys (Chase et al., 2005b; Chase, Arnold, & Schauben, 2005).

Observational visits and measures

Trained data collectors visited FFN caregivers in the home where they cared for children (usually their own home or the home of one of the children) and observed for 2.5 hours. Typically, such visits are scheduled on weekday mornings. However, once recruitment phone calls began, it became clear that a number of the care arrangements occurred during non-morning or weekend hours, or the provider indicated that she only cared for one child who would be napping for a large portion of the visit. Thus, when possible, visits were scheduled during the morning weekday hours (8:00 a.m. to 10:30 a.m.), but flexibility with the visit schedule was used so that all interested caregivers could participate in the study. Of the 41 visits, about one quarter (27 percent) occurred during non-morning or weekend hours.

Caregivers received a \$75 gift certificate for their participation. They also received a kit provided by the Minnesota Department of Human Services containing a fire extinguisher, first aid kit, a book on children's health, numerous pamphlets on topics related to child development and child care, a certificate to complete a course on CPR, crayons and a large pad of drawing paper.



During the visit, data collectors completed four measures¹: the Provider Rating, the Environment Checklist, a Modified Environment Snapshot, and the Caregiver Interaction Scale (CIS; Arnett, 1989). Although the data collection team was trained and reliable on the Family Day Care Rating Scale (FDCRS; Harms & Clifford, 1989), pilot observations revealed that the tool was capturing many of the concerns but few of the strengths in FFN care settings. The observational tools from the NSCCLIF assess many of the same constructs as the FDCRS, but the checklist format allowed for an examination of the consistency with which constructs were observed rather than the calculation of a rating based on quality benchmarks.

Two data collectors were trained on the measures over a one-month period. Both had a background in early childhood development and education and collected data in other observational studies. Training visits were conducted in the field in caregiving settings so that a full range of care settings could be observed.²

The Provider Rating. The Provider Rating was adapted by Abt Associates for use in the NSCCLIF from accreditation materials developed by the National Association for Family Child Care (NAFCC; items were developed from a previous version of the accreditation standards, not the 2003 revision, developed by the Family Child Care Accreditation Project). It contains 55 items rating aspects of caregiver-child interactions and the caregivers' support of the child's learning. The items are rated on a three-point scale:

1 = usually true/consistent evidence, 2 = partially or sometimes true/some evidence, and 3 = not true/little or no evidence. For some items, a "not applicable" rating was assigned (e.g. there was only one child in the setting, so an item about older children caring for younger children could not be scored). Prior to analysis, item frequencies were examined, and nine items that were scored infrequently were not included in the creation of subscales. Six subscales were created from the remaining 46 items using groupings of items assessing similar constructs: Caring and Responding, Positive Guidance, Avoidance of Harm, Fostering Social Skills, Supporting Learning and Activities. Two items assessing supervision in the setting were also summed and averaged.³

¹ All measures were used in the National Study of Child Care for Low-Income Families (NSCCLIF) conducted by Abt Associates for the U.S. Department of Health and Human Services (the final report containing the findings has not yet been released publicly).

² Inter-rater reliability was measured by calculating the proportion of items on which a pair of observers agreed exactly. Data collectors demonstrated inter-rater reliability of 85 percent or higher on the measures on two separate occasions before they began collecting data. Biweekly meetings between data collectors and the principal investigator were used to resolve coding questions that emerged in the field.

³ Chronbach's Alphas were calculated to examine the internal consistency of the subscales. The Alphas ranged from .72 to .85 indicating that the scales had acceptable internal consistency.



The Positive Attributes Scale. A second part of the Provider Rating involved ratings of the provider on nine attributes of interactions with children including the degree to which the provider appeared to be: relaxed and comfortable (versus tense), gentle (versus harsh or threatening), in control (versus out of control), physically competent (versus tired or weak), enjoying children (versus does not enjoy children), alert (versus inattentive), patient (versus hurried), flexible (versus rigid), and involved (versus uninvolved). Each attribute was rated on a 5-point scale with 1 equal to the positive dimension and 5 equal to the negative dimension. The ratings were summed and averaged to provide an overall score on Positive Attributes.

The Environment Checklist. The Environment Checklist was created by Abt Associates for use in the NSCCILF from accreditation materials used by the NAFCC as well as the *Stepping Stones to Using Caring for our Children: National Health and Safety Performance Standards Guidelines for Out-of-Home Child Care Programs* (items were developed from the 1997 edition of Stepping Stones, produced by the National Resource Center for Health and Safety in Child Care). The Environment Checklist contains 78 items rating six aspects of the care environment: Space, Materials, Indoor Health and Safety, Outdoor Health and Safety, Routines and Dangerous Situations. The items are rated on a three-point scale: 1 = usually true/consistent evidence, 2 = partially or sometimes true/some evidence, and 3 = not true/little or no evidence. For some items, a “not applicable” rating was assigned (e.g. there were no children in diapers in the settings, so an item about the frequency of diaper checks could not be scored). Because groupings of items into the six subscales (Space, Materials, Indoor Health and Safety, Outdoor Health and Safety, Routines and Dangerous Situations) revealed low internal consistency (that is, the items had low Chronbach’s Alphas), average subscale scores were not calculated. Instead, the items are described and analyzed individually.

The Modified Environment Snapshot. The Modified Environment Snapshot (originally developed by Abt Associates, but modified for use in this study) collected information at five points during the visit. Every half hour, the observer took two minutes to observe: the number and ages of children in the setting, the number and type (caregiver, assistant, parent, visitor) of adults in the setting, the emotional tone of the setting (whether children were crying or engaging in other negative behaviors as well as positive peer or caregiver-child interactions), and the activities of the children in the setting including routine care (eating, toileting/diapering, sleeping, transitioning from one activity to the next), fine motor play, gross motor play, dramatic play, books, television, games, nature/science activities, music, real life chores, and literacy or math activities. Information from the five Snapshots was summed and averaged to calculate the proportion of intervals during which each of the activity types was observed. For example, if fine motor play was observed during two of the five intervals, the score for fine motor play would be .40.

The Caregiver Interaction Scale (CIS). In addition to its use in the NSCCLIF, the CIS has been used in numerous studies and has demonstrated concurrent and predictive validity. The CIS consists of 26 items that measure the sensitivity, harshness, detachment and



permissiveness of caregivers. Observers rate a series of statements about the caregiver using a 4-point scale. A rating of 1 = not at all characteristic, 2 = is somewhat characteristic, 3 = quite a bit characteristic and 4 = very much characteristic of the caregiver.

Sample

The final observational sample included 41 caregivers. Table 1 displays selected characteristics of the sample. All but one provider is female (97.6 percent), and the average age is 53. The sample is racially diverse: 46 percent White, 32 percent Black, 5 percent Hispanic/Latino, 7 percent American Indian, and 5 percent identify themselves as African or Somali. Just over half (51 percent) of the sample is married, and 90 percent are parents. The parents in the sample do not tend to have young children. The average age of the oldest child in caregivers' families is 30. Three-quarters (78 percent) do not have paid employment in addition to caring for children. For their highest educational level attained, approximately 50 percent of the sample has a high school diploma (43 percent) or some high school (7 percent). Twenty-two percent have some college, 20 percent have a college degree, and just over 2 percent have attended post-graduate studies or professional school. Over two-thirds (68 percent) earn below \$40,000/year.

Table 1. Selected characteristics of the observational sample

	Total N = 41
Gender	
Male	2.4%
Female	97.6%
Age	
18–19	0%
20–29	4.9%
30–39	14.6%
40–49	26.8%
50–59	19.5%
60–64	19.5%
65–69	7.3%
70–74	2.4%
75–87	0%
Missing/refused	4.9%
<i>Mean age of FFN caregivers</i>	50.13

continued



Table 1. Selected characteristics of the observational sample

	Total N = 41
Race	
White or Caucasian	46.3%
Black or African American	31.7%
Hispanic or Latino	4.9%
American Indian	7.3%
Asian	0%
African/Somali	4.9%
Missing/refused	4.9%
Marital status	
Married	51.2%
Living together in a marriage-like arrangement, but not legally married	2.4%
Separated	4.9%
Divorced	14.6%
Widowed	12.2%
Never married	9.8%
Missing/refused	4.9%
Parent	
Yes	90.3%
No	7.3%
Missing	2.4%
Number of own children	
Zero	7.3%
One	9.7%
Two	29.2%
Three	17.1%
Four	7.3%
Five or more	27.0%
Missing	2.4%



Table 1. Selected characteristics of the observational sample

	Total N = 41
Age of oldest child	
No children	7.3%
1–2	0%
3–5	4.9%
6–9	2.4%
10–12	2.4%
13–17	4.9%
18 and older	75.6%
<i>Mean age of oldest child</i>	28.9
Paid job or jobs, in addition to taking care of children	
Yes	19.5%
No	78.1%
Missing	2.4%
Highest level of education completed	
Eighth grade or lower	0%
Some high school	7.3%
High school graduate or GED	43.9%
Some college (includes two-year degree/technical college)	22.0%
College graduate (B.A., B.S.)	19.5%
Post-graduate work or professional school	2.4%
Missing/refused	4.9%
Household income before taxes from all sources and all members	
Under \$10,000	12.2%
\$10,000 – \$19,999	19.5%
\$20,000 – \$29,999	14.6%
\$30,000 – \$39,999	12.2%
\$40,000 - \$49,999	9.8%
\$50,000 – \$99,999	19.5%
\$100,000 and above	2.4%
Missing/refused	9.8%
Survey from which the caregiver was recruited	
CCAP survey of caregivers and parents	68.3%
2004 Minnesota statewide household child care survey	31.7%

Source: 2004 Minnesota statewide household child care survey and the CCAP survey of caregivers and parents



Table 2 provides selected details about the caregiver and the care setting. Caregivers have been caring for children for an average of six years. In two-thirds of the cases, the caregiver cares for one or two children for more than 36 hours per week and 76 percent are paid something for that care. Approximately 42 percent receive CCAP payments for at least one child in their care. The majority of care (88 percent) occurs in the caregiver's own home. Over 60 percent of the caregivers are grandmothers to at least one of the children in their care. Twelve percent are aunts, and nearly 10 percent are friends of the family.

Table 2. Selected characteristics of the caregiving setting

	Total N = 41
Number of years caring for children	
Under one	19.5%
One–two	19.5%
Two–four	17.1%
Five–seven	14.6%
Eight–10	7.3%
11 or more	19.5%
Missing	2.4%
<i>Mean number of years caring for children</i>	6.1
Number of children that FFN caregivers usually care for on a regular basis	
One	31.7%
Two	34.1%
Three	12.2%
Four	9.8%
Five or more	9.8%
Missing	2.4%
<i>Mean number of children in FFN care on regular basis</i>	2.40
Number of children that FFN caregivers are paid to take care of	
Zero	19.5%
One	22.0%
Two	34.1%
Three	7.3%
Four	2.4%
Five or more	9.8%
Missing	4.9%
<i>Mean number of children FFN caregiver is paid to take care of</i>	1.9



Table 2. Selected characteristics of the caregiving setting

	Total N = 41
Receive CCAP payment for any child in care	
Yes	41.5%
No	53.6%
Missing	4.9%
Number of hours provide FFN care in a typical week	
Less than eight	0%
Eight–24	22.0%
25–35	14.6%
36 or more	61.0%
<i>Mean hours per typical week</i>	46.7
Usual place of care	
In FFN caregiver's own home	87.8%
In the child(ren)'s home	9.8%
Missing	2.4%
FFN caregiver's relationship to a randomly sampled child	
Grandmother/grandfather	63.4%
Friend of family	9.8%
Aunt/uncle	12.2%
Neighbor	0%
Other relative	4.9%
Nanny	2.4%
Cousin	2.4%
Missing	2.4%

Source: 2004 Minnesota statewide household child care survey and the CCAP survey of caregivers and parents

Comparison of the observational sample and the combined survey sample

Because the sample that agreed to participate in the observational study was small and potentially unrepresentative of the larger survey sample from which it was drawn, it was necessary to compare selected characteristics of the two samples (the observational sample and the combined household child care survey and CCAP survey sample). Caregivers in the observational study differed from those in the combined survey sample in the following



ways, many of which indicate that the observational sample is more oriented to FFN care as a profession than the combined survey sample:⁴

- Provide more hours of care per week (average of 47 hours compared to 24 hours for the combined survey sample).
- Are paid for more children, on average, in their care (paid for two children compared to one child for the combined survey sample).
- Are less likely to have a paid job in addition to their work providing FFN care (20 percent compared to 53 percent for the combined survey sample).⁵
- Are more likely to be “eager” for support and interaction in their role as FFN caregivers (70 percent compared to 51 percent in the combined survey sample) and less likely to be “open to some support and interaction” or “independent and uninterested in support and interaction” (24 percent and 6 percent respectively, compared to 31 percent and 18 percent respectively in the combined survey sample).
- Have been providing FFN care for fewer years (average of six years compared to 10 years for the combined survey sample).
- Are more likely to be African-American (32 percent compared to 11 percent for the combined survey sample) and less likely to be White (46 percent compared to 82 percent for the combined survey sample).

There were no statistically significant differences between the samples in the caregiver’s age, marital status, household size, household income, country of origin, home language, home ownership, or educational attainment; the number of children cared for each week; the amount of money earned each week from FFN care; and the caregiver’s self-reported attributes of quality.⁶ The fact that the sample is biased toward caregivers who are eager for support and interaction in their caregiving and may be more oriented to caregiving as a profession is important from a policy and program perspective since these are the caregivers most likely to seek out additional resources and training opportunities. The findings from this study are particularly relevant for this group.

⁴ All differences are statistically significant at the .05 -.01 level. Means were compared using one-way analysis of variance (ANOVA). Distributions were compared using chi-square.

⁵ Researchers created three categories – eager, open and uninterested – to describe FFN caregivers’ orientation to offers of support and interaction for quality improvement in their caregiving. The categories were created based on caregivers’ responses to a range of survey questions (Chase, Arnold, and Schauben, 2005).

⁶ Researchers created a quality index based on eight self-reported attributes of quality appropriate for FFN care settings: intentionality of caregiving; extent of caregiving training; the caregiver’s connection to other caregivers for support and information; strength of the partnership between the caregiver and the child’s parents; and the extent of natural teaching and other activities for literacy, cognitive development, social/emotional development and physical development (Chase, Arnold, and Schauben, 2005).



Results

Key findings from observations of the caregiver with children

The first set of findings focuses on observations of the FFN caregivers and their interactions with the children in their care. Key findings are presented for different dimensions captured in the Provider Rating and the CIS including sensitivity and responsiveness, use of positive guidance and discipline, and the caregiver's support of children's learning.

Key Finding: FFN caregivers frequently conversed with children and responded to their language, showed affection and offered children help.

The average score on the Caring and Responding subscale was 1.2⁷, indicating that caregivers were consistently demonstrating nurturance, affection and responsiveness to the children in their care (see Table 3 for distribution of scores on selected items). They conversed with children, responded to their language, and showed an interest in what children said.

Table 3. Sample distribution on selected items from the Caring and Responding subscale

Caring and Responding Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Has conversations with children	41	95%	5%	0%
Shows affection	41	88%	10%	2%
Shows interest in what children say and do and listens attentively	41	81%	19%	0%

⁷ Scores were on a three-point scale with 1 equal to consistent evidence, 2 equal to some evidence, and 3 equal to little or no evidence



Key finding: The sensitivity of caregiver-child interactions was in the middle range: sensitivity was usually, but not always, observed.

The average rating on the Sensitivity subscale of the CIS was 2.7. A “3” was scored on the CIS if a statement was “quite a bit” characteristic of the caregiver, meaning that the observer usually saw the characteristic (but there were a few instances where she did not). Thus, the caregivers in the sample usually displayed sensitive behavior, but it was not consistently observed. The characteristics on this subscale include speaking warmly to children, listening attentively, displaying enjoyment of the children, encouraging the children to try new experiences, being enthusiastic about the children’s activities and efforts, and kneeling/bending down to a child’s level to have face-to-face conversations.

Key Finding: Caregivers missed opportunities to help children with emotional expression and understanding and to actively guide their behavior during conflicts or when children were upset.

The average score on the Positive Guidance and Discipline subscale was 1.8, indicating that caregivers set some limits and helped in children’s understanding of emotion but their actions weren’t consistent (see Table 4 for distribution of scores on selected items). Caregivers missed opportunities to help children resolve conflicts and redirect children who were frustrated or upset.

Table 4. Sample distribution on selected items from the Positive Guidance and Discipline subscale

Positive Guidance and Discipline Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
States needed limits	40	35%	60%	5%
Helps children understand and express feelings	41	32%	49%	19%
Emphasizes what to do, instead of what not to do	41	29%	66%	5%

Key finding: Caregivers displayed some detachment and permissiveness in their behavior.

The average score on the Detachment subscale of the CIS was 2.1. A “2” was scored on the CIS if a statement was “somewhat” characteristic of the caregiver. Thus, while the caregivers were usually engaged with the children, there were some instances when they appeared distant or detached (not sitting with children, not speaking or interacting) or spent time in activities not involving interaction with the children.



The average score on the Permissiveness subscale of the CIS was 2.8. This indicates that the caregivers were often, but not consistently, permissive in their behavior. Caregivers were rated as more permissive if they did not exercise firmness to keep children's behavior in control or did not acknowledge children's misbehavior.

Key Finding: Caregivers exercised appropriate levels of supervision for the activities and abilities of children in their care.

Supervision was analyzed by combining two items from the Provider Rating that assessed whether the caregiver could see and/or hear children at all times during the observation and whether the caregiver tailored the level of supervision to the children's activities and abilities (for example, letting a school-age child move freely outside while monitoring a toddler very closely). The average score on the items was 1.3 indicating that the majority of caregivers were consistently providing appropriate supervision.

Key Finding: Caregivers avoided the use of physical punishment and harsh interactions with children.

The average score on the Avoidance of Harm subscale was 1.2 indicating that caregivers consistently refrained from using physical or harsh punishment or treating children negatively by criticizing or threatening (see Table 5 for distribution of scores on selected items).

Additionally, the average score on the Harsh subscale of the CIS was 1.4. A “1” was scored on the CIS if a statement was “not at all” characteristic of the caregiver. While being observed, caregivers rarely seemed critical, spoke with irritation or hostility, used threat as a means of controlling children, or used harsh methods of discipline.

Table 5. Sample distribution on selected items from the Avoidance of Harm subscale

Avoidance of Harm Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Provider does not use physical punishment	41	98%	2%	0%
Provider does not criticize, shame, tease, threaten or yell at children	41	80%	15%	5%

Key Finding: Caregivers missed opportunities to foster positive social skills, practice cooperation and encourage social interactions among children.

The average score on the Fostering Social Skills subscale⁸ was 1.8 indicating that caregivers encouraged some cooperation and other positive social skills, but they did not demonstrate these behaviors consistently (see Table 6 for distribution of scores on selected

⁸ A number of items on this subscale were scored only if there was more than one child in the setting.



items). A substantial portion of caregivers missed opportunities to help children work together, to help them learn about sharing and taking turns, and to encourage children to help each other.

Table 6. Sample distribution on selected items from the Fostering Social Skills subscale

Fostering Social Skills Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Provides opportunities for children to work together	20	40%	40%	20%
Encourages other children to help and take care of others	20	40%	30%	30%

Key Finding: Caregivers provided ample opportunities for children's exploration and play, but they did not consistently support and extend children's learning through active participation in their play and by asking open-ended questions.

The average score on the Supporting Learning subscale was 1.6 (see Table 7 for distribution of scores on selected items). The score indicates that caregivers provided opportunities for play and exploration, but they did not consistently promote children's learning of new skills and concepts by being actively involved in their play or taking advantage of natural learning opportunities that arose during play. The observers were not looking for highly structured interactions in which caregivers could "teach" children but were instead looking for more natural interactions that emerged in the context of everyday activities.

Table 7. Sample distribution on selected items from the Supporting Learning subscale

Supporting Learning Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Provides opportunities for children to make choices and explore interests for at least 60 minutes during each half day	41	85%	15%	0%
Helps children learn specific skills and concepts	40	40%	43%	17%
Takes advantage of "teachable moments" or natural learning experiences	41	27%	58%	15%



Key finding: Caregivers were rated very favorably on a scale of positive attributes including flexibility and gentleness.

At the end of the observation, the observers completed a global rating of the FFN caregiver on a number of dimensions. On the Positive Attributes rating (the average rating on nine positive attributes, scored on a 1 to 5 scale, with 1 as the most positive rating), the average for the sample was 1.7, indicating that providers were rated very favorably on these dimensions.

Key findings on activities, materials and television viewing in FFN care

The next set of findings uses information from the Provider Rating and the Modified Environment Snapshot to describe the activities that children in FFN care engaged in during the observation. Because previous research identified excessive television viewing as a concern in FFN care, items related to television are examined separately in this section.

Key Finding: Caregivers missed opportunities to engage children in a variety of activities including reading, music, math and art.

The Activities subscale of the Provider Rating examines a range of different activities including reading, music and movement, art, learning about shapes and sounds, using math and exploring the natural and physical environment. The activities did not have to be formal or rigidly structured. Rather, the items on the subscale explore the extent to which the caregiver incorporated the activities into everyday contexts (for example, counting a child's toes while putting on his socks, talking about a bird or a squirrel the child saw from the window or encouraging a child to look at a book while she is waiting for breakfast).

The average score for the Activities subscale was 2.1 indicating that caregivers did not consistently provide access to or encourage participation in a variety of activities (see Table 8 for distribution of scores on selected items). Yet, in over 80 percent of the settings, children had opportunities to explore the natural and physical environment, and in over half of the settings, children were given at least some encouragement to look at books on their own.

Key Finding: The care settings generally contained adequate age-specific toys and materials, but they did not consistently have enough age-appropriate books or art materials. Caregivers did not often take advantage of using household materials in children's play (for example, measuring spoons and plastic cups).

The Materials Checklist contains items rating the adequacy of toys and materials for children of specific ages (scored only if a child of the age range was cared for in the setting) (see Table 9 for distribution of scores on selected items). There were adequate age-appropriate toys and materials for children under age 5 (examined separately for infants,



Table 8. Sample distribution on selected items from the Activities subscale

Activities Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Children are given opportunities to explore the natural and physical environment	41	56%	27%	17%
Children are encouraged to look at or read books on their own	41	46%	5%	49%
Children have opportunities to learn about shapes and sounds	41	27%	29%	34%
Children have opportunities to make their own music	41	27%	32%	41%
Children are encouraged to use math in everyday contexts	41	20%	19%	61%

children ages 1 to 3 and children ages 3 to 5). In those settings with children older than 5, however, fewer than 10 percent of settings had adequate age-appropriate toys and materials.

The settings contained some books and materials to promote language and dramatic play. Adequate numbers (at least 10) of age-appropriate books for the children in care (for example, 10 board or vinyl books for infants and toddlers, 10 for preschoolers, etc.) and basic art materials were not consistently observed. Household items such as measuring cups and plastic bowls were not consistently used in children's play.

Table 9. Sample distribution on selected items from the Materials Checklist

Materials Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
There are some materials to promote language and dramatic play	41	73%	17%	10%
There are basic art materials	39	46%	26%	28%
Household items are used in learning and play	41	32%	na	68%
There are at least 10 age-appropriate books for each age group in care	41	32%	37%	31%



Key Finding: The content of the television programs and videos children viewed was appropriate, but the majority of caregivers did not limit children's television viewing and left the television on for long periods of time.

To get a better picture of the content and frequency of television viewing in FFN care, the items related to television from the Provider Rating, the Environment Checklist and the Modified Environment Snapshot were identified and analyzed separately. In 12 percent of the settings, television and videos were not used during the observation. Of those settings that did use television, nearly three-quarters (72 percent) were rated as having television programs or videos with content appropriate for young children (for example, not violent, stereotyped or sexually explicit). However, over half of the caregivers (54 percent) did not limit television or video use to one hour. Additionally, nearly half (46 percent) had the television on for the duration of the observation.

Findings from the Environment Snapshot confirm the ratings (see Table 10): the television was on for an average of 55 percent of the Snapshot intervals, and children were observed to be watching television for over a quarter (28 percent) of the intervals. Even though children are not always watching television when it is on, the sounds and pictures can be distracting to young children and can disrupt play and interactions with other children and adults. Thus, similar to what has been observed in other studies, the frequency of television use in FFN care is a concern.

Key Finding: Children were engaged with the caregiver in nearly two-thirds (3 out of 5) of the Snapshots. Of the five Snapshots, children were observed in fine motor play or gross motor play at least once. Other activities such as dramatic play, art and music were observed less frequently.

Every half hour of the observation, the observers took a Snapshot of the children, adults and activities in the setting. Five Snapshots were collected and averaged (see the Measures section for further details). Table 10 details the frequencies of different activities. An activity was classified as “frequently observed” if it was observed in over 21 percent of the intervals; an activity was classified as “sometimes observed” if it was observed between 6 and 20 percent of the intervals; and an activity was classified as “rarely observed” if it was observed, on average, in under 5 percent of the Snapshot intervals.

On average, in three of five Snapshots at least one child in the setting was observed to be interacting with the caregiver. Meals and snacks or transitions between activities were observed in between one and two of the Snapshots.

Fine motor play (manipulating small toys, building with legos) and gross motor play (active, physical play) were the most frequently observed activities. On average, they were observed in at least one of the five Snapshots. Other types of activities including dramatic play, arts and crafts, number or word activities, reading and music were observed infrequently.



Table 10. Frequency of Activities Observed in the Environment Snapshot⁹

Activity	Rarely Observed (under 5 percent of the Snapshot intervals)	Sometimes Observed (between 6 and 20 percent of the Snapshot intervals)	Frequently Observed (21 percent to 100 percent of the Snapshot intervals)
Children interacting with caregiver			63.5%
TV on			55.1 %
Watching TV			27.6%
Meals/snacks or transitions			26.7%
Fine motor play		20.3%	
Gross motor play		18.3%	
Caregiver involved in non-child activities		16.3%	
Children interacting with peers		15.4%	
Pretend/dramatic play		10.6%	
Arts/crafts		9.1%	
Numeracy or literacy activities		8.7%	
Reading		8.5%	
Music		6.9%	
Science/nature		6.9%	
Children sleeping	3.1%		
Real life chores	2.1%		
Group time or games	2.1%		
Children crying	2.1%		
Children withdrawn	2.1%		
Children fighting	2.1%		
Physical care/toileting	1.0%		

Key findings from observations of the care environment and routines

The final set of findings focuses on physical dimensions of the care setting, including the space, the physical care routines (eating, sleeping and bathroom practices) and the health and safety precautions taken by the caregiver both indoors and outdoors. The items examined in this section are from the Environment Checklist. Because subscale scores were

⁹ The activities listed in the table are not mutually exclusive, that is, more than one activity can be observed during each Snapshot.



not calculated, key findings were developed by analyzing the distribution of scoring on individual items on each dimension of the checklist.

Key Finding: The FFN care settings had ample, comfortable space. However, caregivers did not consistently remove “forbidden” items from children’s reach.

The Space Checklist examines aspects of the physical environment such as the adequacy of the space, the availability of areas for physical play, the presence of a cozy space for children to relax and factors such as lighting, noise and smell that relate to the comfort of the space (see Table 11 for scores on selected items). In general, the observed spaces were comfortable and allowed children to move around freely. Children could find spaces to relax and to play actively. One concern identified on the Space Checklist was that a majority of children could reach items or spaces in the setting that they were not allowed to reach (evidenced by a caregiver saying “no”) or that were unsafe to reach. This presented both a safety hazard for children (access to items that weren’t safe for them to use or touch such as plants or glass objects) and a supervision challenge for the caregivers who needed to closely monitor children’s access to the unsafe items.

Table 11. Sample distribution on selected items from the Space Checklist

Space Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
There is a comfortable and cozy space	41	100%	0%	0%
Space is adequate to carry out activities	41	95%	3%	2%
There is an area for active play	41	73%	22%	5%
Children can use what they can reach	41	29%	56%	15%

Key Finding: Caregivers have taken a number of safety precautions but need to address open stairways and uncovered electrical outlets in particular.

The Indoor Safety and Health Checklist assesses the condition of furnishings and equipment, the safety precautions taken in the space and the degree to which children can safely move through and exit the space (see Table 12 for scores on selected items). Overall, the furnishings and equipment in the space were in good repair. Exits were unobstructed and stairs with more than three steps had railings. Hot items and small objects were kept out of reach. However, two areas of concern were noted: stairways that were not secured with gates or barriers and electrical outlets that were not covered.



Table 12. Sample distribution on selected items from the Indoor Safety and Health Checklist

Indoor Safety and Health (Furnishings, Equipment, Exits/stairs) Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Equipment and materials are in good repair	41	88%	na	12%
Indoor stairs with more than 3 steps have railings	30	80%	3%	17%
Small objects are out of reach of children under age 3	31	68%	na	32%
Indoor stairs are secured with gates or barriers (if children under age 3 are present)	24	21%	na	79%
Electrical outlets are covered	41	12%	na	88%

Key Finding: Caregivers set up positive routines during meals and rests but need to enact more consistent handwashing for both children and adults.

The Routines Checklist examines the steps caregivers take to ensure that snacks, meals, rests, diapering and toileting are safe and healthy (see Table 13 for scores on selected items). Caregivers had set up a number of positive routines. Children sat down at meals and were

Table 13. Sample distribution on selected items from the Routines Checklist

Routines (Meals/snacks, Hand-washing, Toileting, Nap/Rest) Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Crib meets safety standards	21	100%	0%	0%
Provider keeps hand on children while changing diapers or clothes	19	100%	na	0%
Children helped to learn to feed themselves	39	92%	5%	3%
Children sit down to meals	39	82%	10%	8%
Meals and snacks are nutritious	39	57%	28%	15%
Diapers checked every 1.5 hours	27	56%	22%	22%
Food is prepared in a sanitary manner	38	50%	16%	34%
Container for soiled diapers is covered and out of reach	24	42%	na	58%
Provider washes hands consistently	40	18%	10%	72%
Children wash hands consistently	40	18%	12%	70%



given help to feed themselves. The food served was generally nutritious and sufficient in quantity. Diapering was done safely, though the containers for soiled diapers were not consistently covered and out of reach. The cribs used for young children were safe. The most prevalent problem observed in the settings was the lack of consistent handwashing by both adults and children. Fewer than one-fifth (18 percent) of the caregivers and children washed their hands before eating or preparing food and after diapering or toileting.

Key Finding: Outdoor play areas contained equipment that was in good repair, but many were not enclosed by fences or set up with adequate spacing or sufficient outdoor toys and materials.

Observations of items on the Outdoor Safety and Health Checklist were limited in this study. The majority of observations occurred during the winter months in Minnesota, so the observers did not always see outdoor play and were sometimes not able to observe the outdoor play area (regardless of whether the children played outside). As seen in Table 14, which contains scores on selected items, the sample available for each item varied according to whether the observer was able to examine the item sufficiently, or whether she had to code the item as "missing." Of those outdoor play areas that were observed, most had equipment that was in good repair (for example, no splinters or chipping paint). In over half of the settings, however, children had access to dangerous materials such as sharp garden tools, and the equipment was not spaced with enough distance between pieces to avoid safety hazards. Fewer than one-quarter of the settings had sufficient numbers of toys and materials, and the majority of the play areas were not enclosed by a fence or natural barrier.

Table 14. Sample distribution on selected items from the Outdoor Safety and Health Checklist

Outdoor Safety and Health Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
Equipment is in good repair	24	83%	13%	4%
Play space is free of dangerous materials	30	43%	30%	27%
Sufficient outdoor toys and materials	27	22%	56%	22%
Fence or natural barrier encloses the play space	31	19%	na	81%

Key Finding: Caregivers did not smoke and kept some dangerous items out of reach. However, dangerous items were accessible to children in lower cupboards or on open shelves.

The Dangerous Situations Checklist assesses the degree to which materials posing extreme hazards such as matches and poisons are kept out of children's reach as well as the precautions caregivers had taken to prevent dangerous situation from occurring (see



Table 15 for scores on selected items). Smoking was rarely observed, and some hazardous materials (matches, prescription drugs) were kept out of reach in a majority of settings. Smoke detectors were installed in nearly 60 percent of settings. However, in most settings children had access to dangerous items such as cleaning supplies in lower cupboards or on open shelves, and fire extinguishers were not consistently observed. Thus, some dangerous situations were adequately addressed, but others are of concern in these settings.

Table 15. Sample distribution on selected items from the Dangerous Situations Checklist

Dangerous Situations Items	N	Consistent Evidence (1)	Some Evidence (2)	Little or No Evidence (3)
No one smokes when children are present	41	93%	na	7%
Matches and lighters are out of reach	41	83%	na	17%
Smoke detectors are installed on each floor	41	58%	32%	10%
Lower kitchen cupboards are free of dangerous items	38	37%	24%	39%



Summary

The results of this exploratory observational study of FFN care in Minnesota complement and extend the picture of FFN care provided by findings from previous research and recent survey data in Minnesota. Areas of strength and areas for potential growth were identified across the three aspects of care that were studied: caregivers' interactions with children; the activities (including television watching) and materials available to children in FFN care; and the physical environment and routines.

Summary of FFN caregivers' interactions with children

The tone of interactions was a clear strength of FFN care observed in this study. In their interactions with children, caregivers consistently demonstrated interest in children, affection, responsiveness and helpfulness. Caregivers conversed with children and responded to their language. They expressed warmth in their interactions, encouraged children, and acknowledged their efforts. Harsh words or actions were not observed. Supervision was appropriate for the ages and abilities of the children, and children had ample opportunities to play and explore their environments.

Three growth areas were identified in caregivers' interactions. First, caregivers missed opportunities to talk with children about their emotions and help children understand and express their feelings, particularly when children were upset. Second, when two or more children were in the setting, caregivers did not consistently foster cooperative play, sharing or turn-taking. Third, caregivers missed opportunities to support and extend children's learning by talking to children about their play, introducing new activities, helping children work on specific skills, or taking advantage of teachable moments arising in the context of everyday play.



From the perspective of children's development, each of these growth areas represents an opportunity to address an important component of school readiness. Accurate identification of emotions and the ability to manage frustration, anger and distress are critical skills for children to have as they enter school. Similarly, the ability to work cooperatively and demonstrate prosocial behaviors ensures that children can form positive relationships with both peers and teachers. Finally, taking advantage of everyday opportunities to help children learn specific skills and concepts (for example, recognition of letters and words, sequence of events, time, shapes, numbers) can foster early math and reading skills that will benefit children as they enter school.

Summary of the activities and materials available to children in FFN care

The FFN care settings observed in this study contained adequate age-specific toys for young children, materials to promote language and dramatic play, and opportunities to explore the natural and physical environment. Some books were accessible, and reading was encouraged in a majority of settings.

Overall, caregivers could expand the variety of activities and materials available to the children. Children had opportunities to make music, dance and move creatively, learn about shapes and sound and had access to at least 10 age-appropriate books in only about one-third of settings. Basic art materials were available in fewer than half of the settings. Children were encouraged to use math (or pre-math concepts) in everyday contexts in about one-fifth of settings. None of these activities needs to be formally structured but could be incorporated in the natural learning environment (including household chores and meals).

Television with appropriate content was used in nearly all of the observed FFN care settings. The issue of primary concern regarding television use in the settings was not content, but the frequency of use. Caregivers did not consistently place limits on television use or turn off the television when children were not watching it.

Summary of the physical environment and routines

A number of safety precautions and positive routines were observed in the FFN care settings. Smoke detectors were installed in about 60 percent of homes, Equipment and materials were in good repair. The spaces for children were ample and comfortable and meals provided opportunities for conversation and learning self-help skills.

Two primary growth areas were identified. First, caregivers could target children's access to hazardous materials/spaces in the care settings. Children could reach items that they were not allowed to play with such as plants and breakable objects. Electrical outlets were not consistently covered, stairs were not secured with gates or barriers, and hazardous items were



accessible to children in lower cupboards or open shelves. Second, caregivers could focus on consistently washing their own hands and children's hands before and after preparing food and eating and after using the bathroom or changing diapers. Infrequent and incomplete handwashing are the primary ways germs are spread, so instituting proper handwashing routines will likely reduce illnesses for both the caregiver and children.



Recommendations

Using results from the statewide survey of FFN caregivers, researchers developed recommendations that emphasize the importance of (a) continuing state efforts to make quality improvement activities accessible to FFN caregivers, (b) continuing to target outreach to FFN caregivers (such as those registered with CCAP, those who care for children in immigrant communities or those who care for children with special needs), and (c) offering learning opportunities using a neighborhood-based approach (Chase, Arnold, & Schauben, 2005; see also Brandon et al., 2002; O'Donnell & Morrisey, 2005). Building on these key points, the findings from this exploratory observational study can be used as the basis for the following recommendations:

1. Recognize, support and build on the strengths observed in FFN care in the development of new outreach initiatives.

As discussions proceed about the most appropriate and effective ways to support FFN care, an important starting point is FFN care has many strengths that can support children's positive development. FFN care is responsive and sensitive. Caregivers listen, show interest and acknowledge children's efforts. Because the caregivers are often related to the children in their care (the majority of them as grandmothers), their relationships extend beyond the parameters of the care setting. Two-thirds of caregivers report that they saw a selected child in their care a few times a week or daily before they began formally caring for the child, and over 80 percent characterized their relationship with the child as "very close" (Chase, Arnold & Schauben, 2005). Cultural and family values, traditions and experiences are shared within and outside the care setting. These family and cultural connections are an integral part of the caregivers' motivation to provide FFN care. Indeed, "helping family" is a key reason caregivers are involved in FFN care (Anderson, Ramsburg, & Rothbaum, 2003;



Brandon et al., 2002; Chase, Arnold & Schauben; Porter, Rice & Mabon, 2003; Ramsburg & Anderson, 2005). The development of initiatives for FFN caregivers should frame the availability of resources and information as an opportunity to build on the already rich experiences and support they provide for the children in their care, not as a way to address deficits in the care they provide (Porter, Rice & Mabon, 2003).

2. Develop strategies to help caregivers:

a. Plan for, but not rigidly structure, their care environments

Caregivers could benefit from guidance about the importance of creating a simple plan for children. This recommendation does not imply that FFN caregivers should develop and implement a detailed daily schedule, lesson plan or curriculum. Rather, encouraging caregivers to think about the types of experiences they would like children to have while in their care and to set aside a few minutes each day to envision how they will make those experiences happen could help caregivers set basic priorities for their daily interactions, promote more proactive organization of activities for children and tailor their care to respond to individual children's needs. The goal is not to remove flexibility or add rigid structure to the environment, but to help caregivers be more intentional about the environment. For example, a caregiver who would like to support a four-year-old child's creative abilities might plan to add a new, inexpensive art material every week and set it out on the kitchen table while preparing lunch or dinner. Supporting language development for an infant or toddler might involve plans to add a song or book each day. Informational materials could emphasize the importance of different types of experiences for children's school readiness, a goal many caregivers inherently have for the children. Individual caregivers' goals and priorities will vary, but all settings can benefit from a small investment of caregivers' time and effort to plan the environment they create for (and with) the children in their care.

b. Take advantage of natural learning opportunities to foster language, math and social skills

Caregivers missed some opportunities to follow children's leads in everyday interactions and foster the development of language, math, social and other skills. Materials and resources could be developed to help caregivers recognize the many opportunities they have in the context of routine activities to engage children. Cooking, doing laundry, shopping, gardening and other daily activities are perfect settings for discussing number, shape, size and sequence; comparing and contrasting items; introducing new vocabulary; identifying letters and words; and many other activities that are not only helpful for skill development but are also fun for children.



- c. Obtain information about child development, basic materials and ideas for activities that are safe, stimulating and fun

FFN caregivers are open to receiving information about children's development and how to help children learn and do well in school. Resources could be developed and distributed that provide specific ideas for inexpensive activities caregivers can do with children or that answer caregivers' questions about young children. Some of these resources have been translated into multiple languages (the Language and Math Tips for Parents available from Ready for K or the Questions about Kids available from the Center for Early Education and Development at the University of Minnesota).

Age-appropriate books and art materials were not consistently available in the settings. Distributing these basic materials is a relatively inexpensive way to increase children's access to these important resources.

- d. Recognize the importance of emotional understanding and social skills as dimensions of school readiness. Ensure that materials are developed that are culturally sensitive and respectful of differences in the way emotions are expressed and responded to.

FFN caregivers missed opportunities to help children identify and understand emotions and to actively guide children's behavior when they were upset or frustrated. Prosocial skills such as sharing, cooperating and turn-taking were not explicitly addressed by the caregivers. Yet, these skills are critical for children's success in school because they help children build positive social relationships and cope with the demands of the school setting.

Emotions and social skills are challenging aspects of children's development. There are many cultural variations in the way emotions and social skills are viewed and transmitted to children. Efforts should be made to identify culturally-appropriate strategies for addressing this vital issue in training and resource materials.

- e. Recognize the importance of limiting television use

Although the content of television programs viewed by the children in this study was generally appropriate, few limits were placed on the amount of television that children watched. Caregivers also left the television on even when children weren't actively watching it. Television viewing is a passive activity that precludes children's active exploration and play. Information should be provided to caregivers about the need to limit children's television viewing, provide appropriate alternative activities, and discuss television programs with children as they are watching. The American Academy of Pediatrics discourages the use of any television for children under age 2 and recommends a limit of no more than one to two hours per day of total entertainment media for children older than 2 (Committee on Public Education, American Academy of Pediatrics, 2001).



3. Target issues such as access to hazardous materials/areas and handwashing to improve the health and safety of FFN care environments

Caregivers report that they understand and follow basic health and safety practices (Porter, Rice, & Mabon, 2003). Yet, the results of this study indicate that more information and equipment is needed to ensure that these practices are followed consistently. Young children had access to a number of hazardous areas (including stairs and outlets) and materials (including cleaning supplies) in many of the observed settings. Informational materials could be developed and safety devices such as outlet covers, door latches, safety gates and fire extinguishers could be distributed to improve the safety of the settings.

Caregivers and children often did not practice appropriate handwashing. Informational materials could be developed to educate caregivers about the importance of handwashing and the steps to follow for complete handwashing. Small laminated posters or magnets could be distributed as reminders for caregivers and children.

4. Recognize the diversity of FFN caregiver's goals and motivations and the role FFN care plays in the lives of children

A majority of FFN caregivers are grandmothers caring for their grandchildren as a way to help their family. They do not intend to continue caring for children after their grandchildren move to other settings. Yet FFN caregivers recognize their important role in children's lives and want to support children's school readiness, health and safety. Efforts to support caregivers should be tailored so that they can be most effective. For example, Brandon and colleagues (2002) recommend that different strategies may be appropriate for grandparents, caregivers with limited English proficiency, caregivers with low education, and caregivers caring for children with special needs. Based on the research of Todd and colleagues (2005) and Wilder Research (Chase, Arnold, & Schauben, 2005), approaches should be tailored based on the degree to which caregivers want support and resources. Finally, approaches might also be informed by the work of Porter and colleagues (2003) who posit that children's cumulative experiences across multiple care settings is important to consider when examining children's development in FFN settings. A school-age child spending an hour after school with his grandmother two days each week has different needs than an infant or a preschool-aged child spending 40 hours per week in FFN care. Resources could be developed to help caregivers assess the unique needs of the children in their care so that each child can be optimally supported.



References

- Anderson, S.G.; Ramsburg, D.M., & Rothbaum, B. (2003). *Illinois Study of License-Exempt Child Care: Interim report*. Executive Summary. Illinois Department of Human Services. http://www.dhs.state.il.us/newsPublications/plansReports/pdfs/dhs_planReports_esislecc.pdf
- Arnett, J. (1989). Caregivers in day-care centers: Does training matter? *Journal of Applied Developmental Psychology, 10*, 541-552.
- Brandon, R.N., Maher, E.J., Joesch, J.M., Doyle, S. (February, 2002). *Understanding family, friend, and neighbor care in Washington State: Developing appropriate training and support. Report to the Washington Department of Social and Health Services, Division of Child Care and Early Learning*. University of Washington: Human Services Policy Center, Evans School of Public Affairs.
- Brown-Lyons, M., Robertson, A., & Layzer, J. (May, 2001). *Kith and kin – Informal child care: Highlights from recent research*. New York, NY: National Center for Children in Poverty.
- Chase, R., Arnold J., Schauben, L., & Shardlow, B. (2005a). *Child care use in Minnesota: Report of the 2004 statewide household child care survey*. St. Paul, MN: Minnesota Department of Human Services.
- Chase, R., Arnold J., Schauben, L., & Shardlow, B. (2005b). *Family, friend, and neighbor caregivers: Results of the 2004 statewide household child care survey*. St. Paul, MN: Minnesota Department of Human Services.
- Chase, R., Arnold J. & Schauben, L. (2005). *Family, friend, and neighbors caring for children through the Minnesota Child Care Assistance Program: A survey of caregivers and parents*. St. Paul, MN: Minnesota Department of Human Services.



- Committee on Public Education, American Academy of Pediatrics. (2001). Policy statement: Children, adolescents, and television. *Pediatrics*, 107(2), 423-426.
- Family Child Care Accreditation Project. (2003). *Quality standards for NAFCC accreditation, 3rd Edition*. National Association for Family Child Care. <http://www.nafcc.org/books/qual03.pdf>
- Galinsky, E., Howes, C., Kontos, S., & Shinn, M. (1994). *The study of children in family child care and relative care: Highlights of findings*. New York, NY: Families and Work Institute.
- Harms, T. & Clifford, R. (1989). *Family Day Care Rating Scale*. New York, NY: Teachers College Press.
- Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1995). *Quality in family child care and relative care*. New York, NY: Teachers College Press.
- Maxwell, K. (April, 2005). *Legal, nonregulated care in North Carolina*. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Atlanta, GA.
- National Resource Center for Health and Safety in Child Care. (2003). *Stepping stones to using Caring for Our Children, 2nd Edition. National Health and Safety Performance Standards: Guidelines for Out of Home Child Care*. American Academy of Pediatrics, American Public Health Association, and Author. <http://nrc.uchsc.edu/STEPPING/SteppingStones.pdf>
- NICHD Early Child Care Research Network. (1996). Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly*, 11(3), 269–306
- Porter, T., Rice, R., & Mabon S. (December, 2003). *Doting on kids: Understanding quality in kith and kin child care*. New York, NY: Institute for a Child Care Continuum, Bank Street College of Education.
- Ramsburg, D.M., & Anderson, S. (April, 2005). *Illinois Study of License-Exempt Care: Informal child care from a parent and provider perspective*. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Atlanta, GA.
- O'Donnell, N.S. & Morissey, T.W. (on behalf of the Sparking Connections National Consortium). (January, 2005). *Family, friend, and neighbor care and early learning systems: Issues and recommendations*. New York, NY: Families and Work Institute.
- Susman-Stillman, A., Drake, P., & Greenspoon, B. (2004). *Family, friend and neighbor care: Promoting quality care and children's healthy development*. Scotts Valley, CA: ETR Associates.
- Todd, C., Robinson, V., & McGraw, L. (April, 2005). *Contextual influences on informal caregivers: Implications for training*. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Atlanta, GA.

This report and a briefing paper are available from the Minnesota Child Care Policy Research Partnership at
http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_id_008779.hcsp.



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Coordinated by the Minnesota Department of Human Services, the Partnership brings together researchers and policy-makers from around Minnesota along with several national researchers.
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