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

Dr. Richard N. Brandon, Director
Dr. Erin J. Maher, Lead Researcher
Dr. Jutta M. Joesch, Battelle, Lead Economist
Sharon Doyle, MA, Senior Researcher

Human Services Policy Center,
Evans School of Public Affairs
University of Washington

February, 2002

Understanding Family, Friend, and Neighbor (FFN) Care in Washington State: Developing Appropriate Training and Support
Highlights

We surveyed parents, caregivers, professionals, and policy makers to understand: how many children are in FFN care, for how many hours, and for what reasons; the characteristics, training, and motivations of FFN caregivers; and the views of policy makers and professionals regarding FFN care. For the purposes of this study, we defined FFN care as any regular, non-parental care other than a licensed center, program, or family child care (FCC) home. Since we were concerned with the whole spectrum of care received by children, we investigated all FFN care, not just care used while parents were working. *We found that*:

- FFN care involves a large number of children (480,000) in Washington and is the most common form of non-parental care for infants (age 0-1), toddlers (age 1-2), and school-age children (age 6-12).
- A large number of Washington children spend sufficient hours in FFN care that the quality of that care can affect their development: 145,000 children are in FFN care more than 10 hours per week and 87,000 children are in FFN care more than 20 hours per week.
- The state is already supporting FFN care financially: Among families receiving subsidies for a primary care arrangement, one-third of them use it for FFN care.
- Caregiving is a serious activity for the family, friends, and neighbors who do it. FFN caregivers provide care for an average of 18 hours a week, and 40% are paid for the care they provide.
- Compared to the adult population in Washington, FFN caregivers have less education and a majority have none of the specific training in child care, child development, or parenting skills that are known to affect children's cognitive, social, and emotional outcomes.
- A majority of FFN caregivers report problems in providing care, and two-thirds say they would like some type of training or support.
- FFN caregivers represent a wide range of backgrounds, have a variety of problems and needs for support, and should be offered a flexible menu of training and support options. They prefer that information and supports be built around specific problems and provided within a context of peer support, rather than in formal classes.
- FFN care is a large-scale concern, but no models of large-scale support programs are available in other states. We therefore recommend a multi-county pilot program that offers a range of training and support options and experiments with different ways to reach and engage those FFN caregivers who regularly provide care for a substantial number of hours and are not currently eligible to participate in programs oriented to licensed providers.

Detailed Findings:

FFN care is very common among children age 0-12. Approximately 480,000 Washington children are cared for by family, friends, or neighbors on a regular basis. For about 203,000 of these children, FFN care is the primary and regular source of non-parental care. Forty-eight percent of preschool children and 42% of school-aged children regularly spend some time in FFN care. Approximately two-thirds (65%) of all non-parental care hours for infants, 45% for toddlers, and 61% for school-age children are provided by FFN.

Children 0-5 years old average 5-7 hours per week in FFN care; 1 in 3 average more than 10 hours a week; and 1 in 4 average more than 20 hours a week. Many experts consider 10 hours a week sufficient for the quality of care to affect children's development.

About half of all hours spent in FFN care are during evenings and weekends. This is more than the evening and weekend hours spent in center care or FCC.

The average child:adult ratio for FFN care is 1.3 children per adult, which is lower than the 3:1 ratio for licensed family child care and the 5:1 ratio for child care centers.

Most parents (78%) do not pay for FFN care. For those who do pay, the average hourly payment is close to that of center care and family child care (FCC), ranging from about $2.60 to $5.00 per hour depending on the age of the child.

More than one-third of families receiving financial assistance use FFN care as their primary care arrangement. Regardless of primary care arrangement, families with children in FFN care are half as likely to receive assistance or subsidies as those with children in formal care – 4% vs. 8 to 9%.

Groups vary in the rate at which they use FFN or other types of care. The percentage of children in FFN care is similar for families above and below 2.5 times the federal poverty line. Low-to-moderate income families are slightly more likely than higher-income families to use FFN care for children age 6-12, and much less likely to use center care for younger children. Single heads of households are more likely to use all types of child care, including FFN arrangements. Employed mothers use more of all of types of child care than non-employed mothers. Mothers with higher education levels are least likely to select FFN care as the primary care arrangement.

Parents' reasons for selecting FFN care as the primary form of care vary by the child's age. A multivariate analysis, controlling for income and other demographic factors, revealed that:

- *For children age 0-5*: Families concerned with flexible and convenient hours or cost are more likely to select FFN care; those concerned with staff training or close location are less likely to choose FFN care. Parents are more likely to select FFN care when center costs are higher and when center care is less available.
- *For children age 6-12*: Families assigning greatest importance to a low child:adult ratio or to knowing and trusting the caregiver are more likely to use FFN care. Parents most concerned with cost tend to choose parental care rather than FFN care. Those seeking stimulating and enriching activities tend to select center care or FCC arrangements. When FCC costs are higher, parents are more likely to choose FFN care.

About 295,000 family, friends, and neighbors provide non-licensed care. FFN caregivers average 18 hours a week of care; one in four (91,000) provides care for more than 30 hours per week, the equivalent of a full-time job.

The majority of FFN caregivers have no specific training in child care, child development, or parenting. Most do not have college degrees. Approximately one-fifth have taken a course in early childhood education, child development, or psychology or received parenting training, watched training videos, or participated in workshops.

Two-thirds of FFN caregivers desire some type of support, and a majority report at least one caregiving problem. Therefore, we recommend offering a variety of voluntary support and training opportunities, tailored to different types of FFN caregivers in different communities. Offerings could include a newsletter, booklets and tip sheets, caregiver meetings, prepared kits for activities and home safety, vans and other mobile resources, and consultation concerning the challenges of caring for individual children. Existing materials and methods could be adapted for this purpose.

Almost one in five FFN caregivers care for a child with special physical, emotional, behavioral, or developmental needs. These caregivers expressed the greatest desire for support.

A one-year pilot project could be developed at a cost of $77,000-$125,000. This pilot would target FFN caregivers who regularly provide care for a substantial number of hours a week and are not eligible for programs oriented to licensed providers. If tested in 10 counties, annual costs are estimated to be between $330,000 and $450,000. The ultimate costs will depend both upon how many counties and caregivers participate and upon the degree to which existing entities can cover some functions under current funding. The state should invest approximately $150,000 a year to evaluate how effectively different efforts engage FFN caregivers, how caregivers respond to various types of training and support, and how participation affects the care provided to children. Total cost for the initial year of a ten county pilot would be between $560,000 - $725,000, which includes development, annual implementation cost, and evaluation.

This study was initiated at the behest of the Systems Subcommittee of the Washington State Child Care Coordinating Committee. Systems Subcommittee members served as an advisory group for the study, and provided valuable guidance. The Social and Economic Research Center at Washington State University conducted the surveys of parents and caregivers. Dr. Gwen Morgan of Wheelock College consulted on the training recommendations.

Acknowledgements

Many individuals and organizations provided support and assistance for this project.

The project was initiated and funded by the Washington Department of Social and Health Services/Division of Child Care and Early Learning. Rachael Langen and Pat Dickason supported and guided the project.

The need was originally articulated by the Systems Subcommittee of the state's Child Care Coordinating Committee. This subcommittee is chaired by Mari Offenbecher and Wilanne Ollila-Perry.

The parent and caregiver surveys were collected under sub-contract to the Social and Economic Sciences Research Center at Washington State University. Dr. John Tarnai and Marion Landry led the survey team.

We express our gratitude to Dr. Gwen Morgan of Wheelock College Institute for Leadership and Career Initiatives, Boston, for her invaluable contribution as a project consultant to the training recommendations section of this report.

We would also like to thank the following people who took the time to review and critique this report. They offered invaluable support, insight and information. We have incorporated their recommendations throughout.

Tory Clarke Henderson, Program Manager, Developmental Disabilities Council, Olympia, Washington
Garrison Kurtz, Director of Programs, Washington Early Learning Foundation, Seattle, Washington
Toni Porter, Institute for a Child Care Continuum, Bank Street College of Education, New York, New York
Karen Tvedt, Policy Division Director, and staff, Child Care Bureau, Administration for Children and Families, Department of Health and Human Services, Washington, DC
Dr. Marcy Whitebook, Senior Researcher, Institute of Industrial Relations, University of California, Berkeley, California

HSPC Staff who worked on the project included:
Dr. Richard N. Brandon, Director
Dr. Erin J. Maher, Lead Researcher
Dr. Jutta M. Joesch, Battelle, Lead Economist
Sharon Doyle, MA, Senior Researcher
Graduate Research Assistants: Shelley DeWys, Jolena Kraszka, Angela Chen, Alesha Durfee, Adam Glynn, and Krisztina Nagy
Louise Carter, editing
Sarah Bruch, production

For additional information about this report, please contact HSPC through our Web site www.hspc.org or at (206) 685-3135.

Understanding Family, Friend and Neighbor Care in Washington: Developing Appropriate Training and Support

Report to the Washington Department of Social and Health Services, Division of Child Care and Early Learning

Human Services Policy Center,
Evans School of Public Affairs, University of Washington
February, 2002

Table of Contents

Understanding Family, Friend and Neighbor Care in Washington: Developing Appropriate Training and Support

Report to the Washington Department of Social and Health Services, Division of Child Care and Early Learning

Human Services Policy Center,
Evans School of Public Affairs, University of Washington
February, 2002

List of Charts and Tables

Appendix A: Additional Data Charts

Appendix B: Multivariate Analysis

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

Human Services Policy Center,
Evans School of Public Affairs, University of Washington
February, 2002

A. EXECUTIVE SUMMARY

A.1. Introduction

Purpose

This report was conducted at the behest of the Washington State Department of Social and Health Services (DSHS), Division of Child Care and Early Learning, as part of their effort to improve the quality of care offered to children in Washington. The Systems Subcommittee of the State's Child Care Coordinating Committee initiated the commissioning of our study. This subcommittee, augmented by DSHS staff, served as an advisory group and offered us considerable guidance and review. Many types of caregivers, meeting different needs and demands of parents, participate in early care and education (ECE). We must consider the circumstances and demands of both caregivers and parents if we expect to adequately address the needs of all children. We incorporated the views of ECE experts and the values and preferences of parents and FFN caregivers into our assessment of the potential importance of training and support for family, friend, and neighbor (FFN) caregivers.

Definitions: Types of Care

For the purposes of this study, we defined FFN care as any regular, non-parental care other than a licensed center, program, or family child care (FCC) home. FFN care thus includes relatives, friends, neighbors, and other adults. Other types of non-FFN care are grouped into (a*) center care*, including licensed centers, Head Start, or the Washington Early Childhood Education and Assistance Program (ECEAP) program, nursery schools or pre-schools, and (b) *family child care* homes or mini-centers. *Primary care* refers to the non-parental care arrangement (of at least 5 hours per week) that is used more than any other arrangement.

A.2. Study Questions/Data Sources

This study answers several major questions:

1. *Demand for Care*: How many children are in FFN care, and for how many hours a week? Which families choose FFN care and for what reasons?

2. *Supply of Care*: Who are the FFN caregivers, how many children are they caring for and for how many hours; do they care for children with special needs; what are their qualifications and what problems do they experience in providing care? How many caregivers are likely to utilize various opportunities for support and training, and in what locations?
3. *Policy Implications:* Is FFN care a large enough issue to warrant state attention and involvement; if so, what types of training and support should be offered, to how many people, through what mechanisms, and at what cost?

For this study, we gathered several different types of new data specific to Washington State:

- A general population survey of almost 1,200 households with children age 0-12.
- A general population survey of almost 300 individuals who care for other people's children on a regular basis, but do not work in child care centers.
- Interviews with early care and education policy makers and professionals.
- A focus group with FFN caregivers.
- A forum at which participants included child care experts, caregivers, agency staff, advocates, parents and others engaged in developing ECE policy in Washington.

A.3. Major Findings

The major findings of the study are summarized below. This study recognizes that both pre-school-age children (0-5) and school-age children (6-12) often need non-parental care, but that needs, reasons, and preferences regarding care for these age groups often differ. We therefore present most of the findings separately for these two major age groups.

Demand for Care

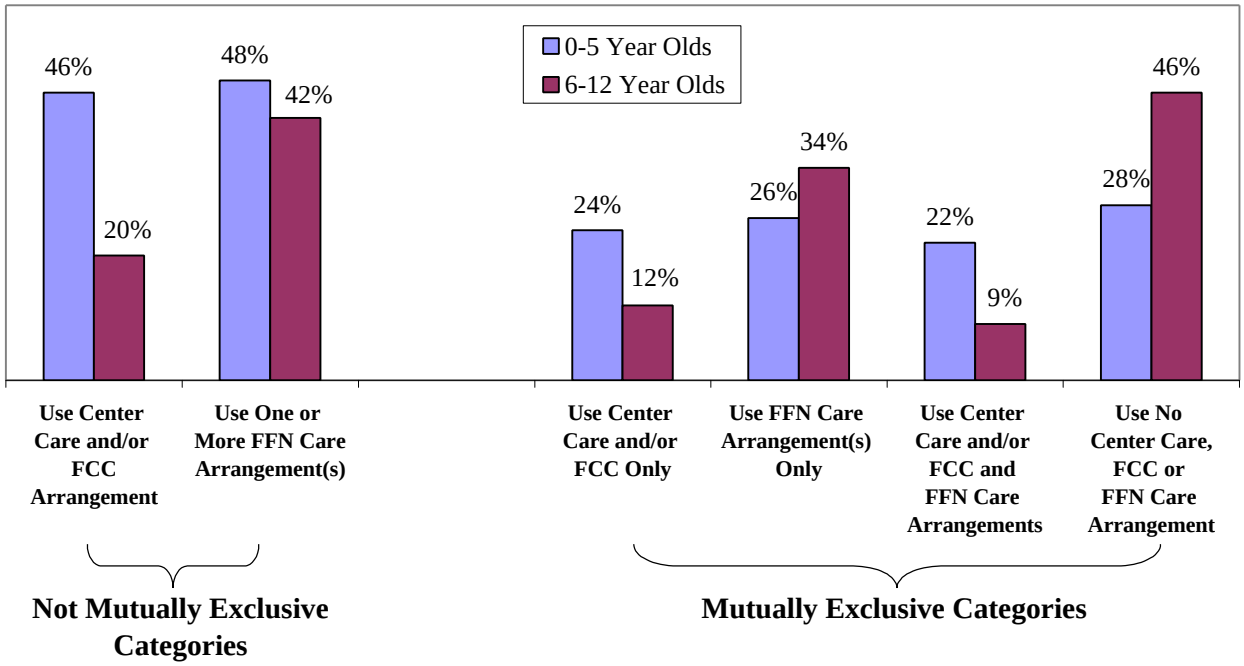
Question 1. Demand for Care*. How many children are in FFN care, and for how many hours a week? Which families choose FFN care and for what reasons?*

FFN Care Prevalence

FFN care is very common for all children from birth to age 12, and accounts for the greatest amount of non-parental care for infants (age 0-1), toddlers (age 1-2) and school-age children (age 6-12). Approximately 480,000 Washington children are in FFN care on a regular basis each week. Approximately 203,000 have FFN care as their primary non-parental care arrangement.

- *Almost half (48%) of young children (age 0-5) regularly spend some time in a FFN care arrangement,* slightly more than the forty-six percent who use a formal care arrangement. Forty-two percent of school-aged children (age 6-12) use an FFN care arrangement, twice the percentage using formal care arrangements [Chart 1b].

Chart 1b: Percent of Children in Each Combination of Center Care, FCC, and FFN Care



- *One in five children have FFN care as a primary non-parental care arrangement*, accounting for the greatest number of hours per week of non-parental care. FFN care is more likely to be primary for the youngest children: FFN care is primary for about twenty-seven percent of children 0-2 year-olds, compared to only fourteen percent for 3-5 year olds [Chart 4].
- *Families often use a combination of Center/Family Child Care (C/FCC) and FFN care.* For children 0-5 years old, one in five (22%) combine formal and FFN care, close to the percentage in C/FCC-only arrangements (24%) or FFN- only care (28%). For children 6-12, 1 in 11 (9%) combine C/FCC and FFN care, and one-third (34%) are in FFN- only care (in addition to school). [Chart 1b].
- *FFN care is the predominant form of non-parental care for infants (age 0-1).* Forty-two percent spend some hours in FFN care, compared to eight percent who spend some time in center care, and five percent in FCC [Chart 1a]. When we consider aggregate hours in non-parental care for the entire population of children, we find that forty-four percent of all the non-parental care hours provided in Washington State are in FFN care, compared to thirty-five percent in centers and twenty-one percent in FCC [Chart 3].
- *FFN care is also the most common type of care for toddlers (age 1-2).* A higher percentage use some amount of FFN care (58%) than center care (21%) or FCC (18%) [Chart 1a]. Forty-five percent of total toddler hours in non-parental care is in FFN care, compared to twenty-seven percent of hours in center care and twenty-eight percent in FCC [Chart 3].
- *Among children age 9-12, forty-one percent are in some FFN care,* compared to seven percent using center care and four percent using FCC [Chart 1a]. Eighty percent of non-

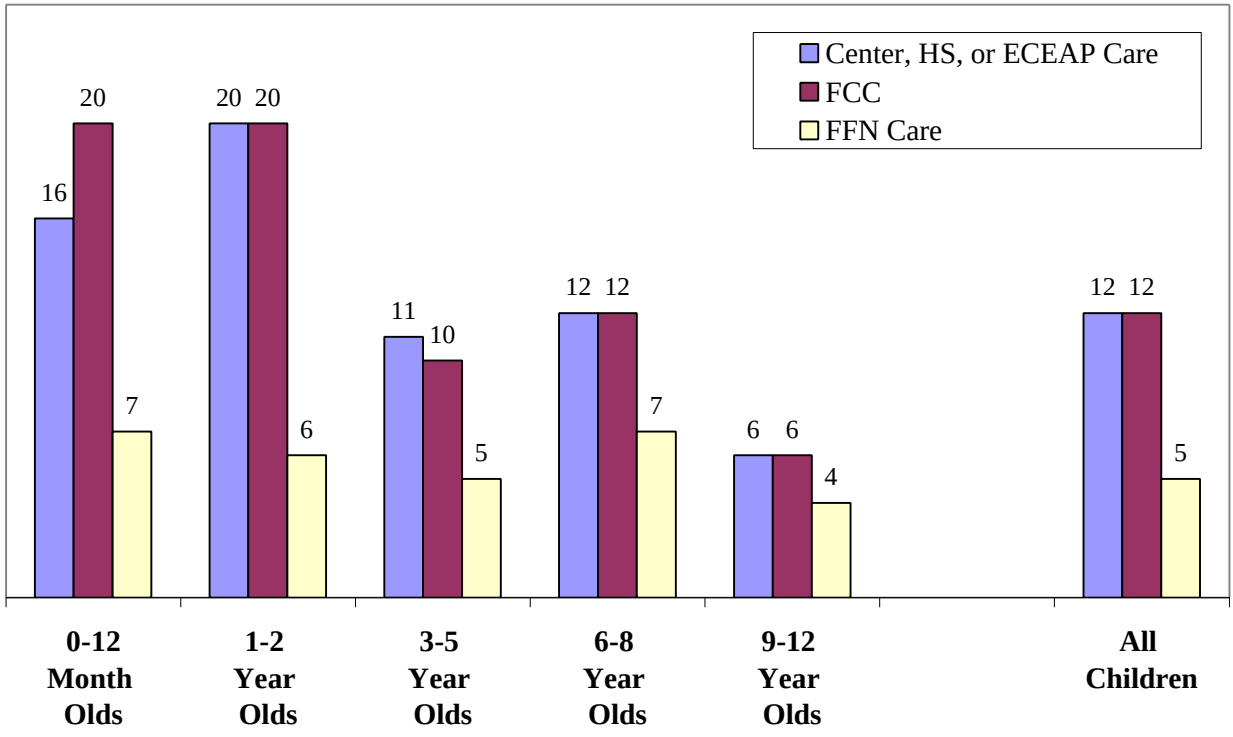
parental care hours for children 9-12 years old are in FFN care, compared to fourteen percent in center care and seven percent in FCC [Chart 3].

FFN Care Hours

On average, children spend a substantial number of hours per week in FFN care, but fewer hours than those in center care or FCC. About one third of children in FFN care spend more than 10 hours per week there, so the nature of that care is likely to affect their development. Therefore, we should be interested in supporting and improving the quality of that care.

- *Pre-school-age children (0-5 years old) in FFN care average approximately 6 hours a week in that care* [Chart 2]. One-third of these children spend more than 10 hours per week and one-fourth more than 20 hours per week in FFN care.
- *School-age children (6-12 years old) also average 6 hours a week in FFN care* -- about half the average time spent in care for the smaller number of children in C/FCC care. (These are in addition to the hours they spend in school.)

Chart 2: Median Hours per Week in Center Care, FCC, and FFN Care for Children in Each Type of Care by Detailed Age Groups



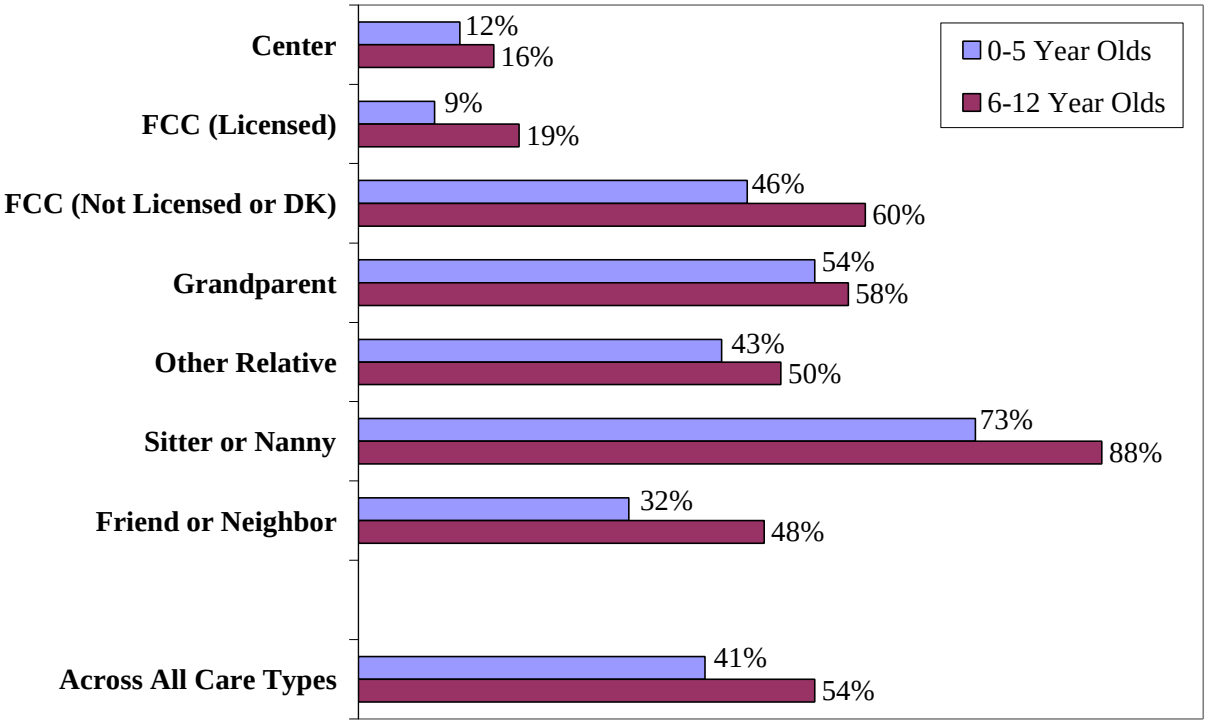
Evening and Weekend Care

FFN care is more heavily concentrated in evening and weekend hours than are other types of care. About half the children in FFN care receive some of this care during evenings or weekends. This rate of nonstandard hours among children in FFN care is dramatically higher

than for children in center care or licensed FCC. Children in FFN also spend a greater share of their care hours in evening/weekend care. For younger children, the use of evening or weekend FFN care is significantly greater among mothers who work evenings or weekends than among those who do not.

- *Approximately half of children in non-parental care situations (41% age 0-5, 54% age 6-12) spend some evening or weekend time in care* [Chart 5a]. The median number of evening/weekend hours used by those children is 5 to 6 hours per week [Chart 5b].

Chart 5a: Percent of Children in Each Type of Care with Some Evening or Weekend Care Each Week



- *Children in FFN care and unlicensed FCC are much more likely to spend time in evening/weekend care* (about half of them do) than are children in center care or licensed FCC (about 1 in 8 for each) [Chart 5a].
- *The median evening/weekend care hours for children using any evening/weekend care is 5-6 hours per week.* Children cared for by other relatives average 6 to 8 hours a week in evening/weekend care, which is slightly more than the 5 hours for those cared for by grandparents [Chart 5b].
- *Children of the one in five mothers employed on evenings or weekends are more likely to spend some time in evening or weekend non-parental care.* The difference is most pronounced for FCC and younger children in FFN care. Mothers working evenings or weekends are twice as likely to use evening or weekend FCC for their children than are mothers not working evenings or weekends. Mothers employed on evenings or weekends are significantly more likely to use evening/weekend FFN care for children 0-5 years olds (71% vs. 45%), but not for school-aged children [Chart 5e].

Child:Adult Ratios

FFN care has fewer children in the care of each adult than other types of care, which is favorable to many parents. The average child:adult ratio for FFN care is 1.3:1, lower than the 3:1 ratio for FCC and the 5:1 ratio for center care.[1]

- For FFN care, ratios do not vary by age of child.
- For center care, school-age children have a somewhat higher ratio of 5.5 children per adult, compared to 4.9 children per adult for children 0-5 years old.
- For FCC, the ratios reported by parents are actually somewhat lower for school-age children, 2.6:1 compared to 3.1:1 for children 0-5 year olds.

Payments for Care and Financial Assistance and Subsidies

Most parents (78%) report paying nothing for FFN care. For those who do pay, the average out-of-pocket hourly expense is close to that of center care and FCC. Across all kinds of care, only six percent of Washington families report receiving some form of financial assistance, including subsidies. For the limited number of families receiving government assistance, FFN care is the primary arrangement for about one in four children.

- While hourly FFN care costs are similar to center care and FCC costs, children spend fewer hours in FFN care, and their average weekly payments are therefore lower. FFN care payments average about $3.60 per hour or $47 per week for infants (0-1 years old), $4.50 per hour or $59 per week for children 1-2 year olds, $2.70 per hour or $32 per week for 3-5 year olds, and $5.00 per hour or $50 per week for 6-8 year olds [Chart 11a].
- *Many families are not receiving the government subsidies for which they are potentially eligible.* Among potentially eligible families, families with incomes below the federal poverty level are more likely to receive government subsidies for child care (33%) than potentially eligible families with higher incomes. Families are most likely to use subsidies for center care and for younger children [Chart 11d].
- *Children in FFN care are less likely to receive government assistance than children in center care or FCC.* Four percent of children in FFN care are receiving financial assistance, compared to eight to nine percent of children in center care or FCC [Chart 11c].
- *The state is already subsidizing FFN care.* Among families receiving subsidies for their primary care arrangements, about one-third (35%) have FFN care as primary.

Characteristics of Parents Using FFN Care

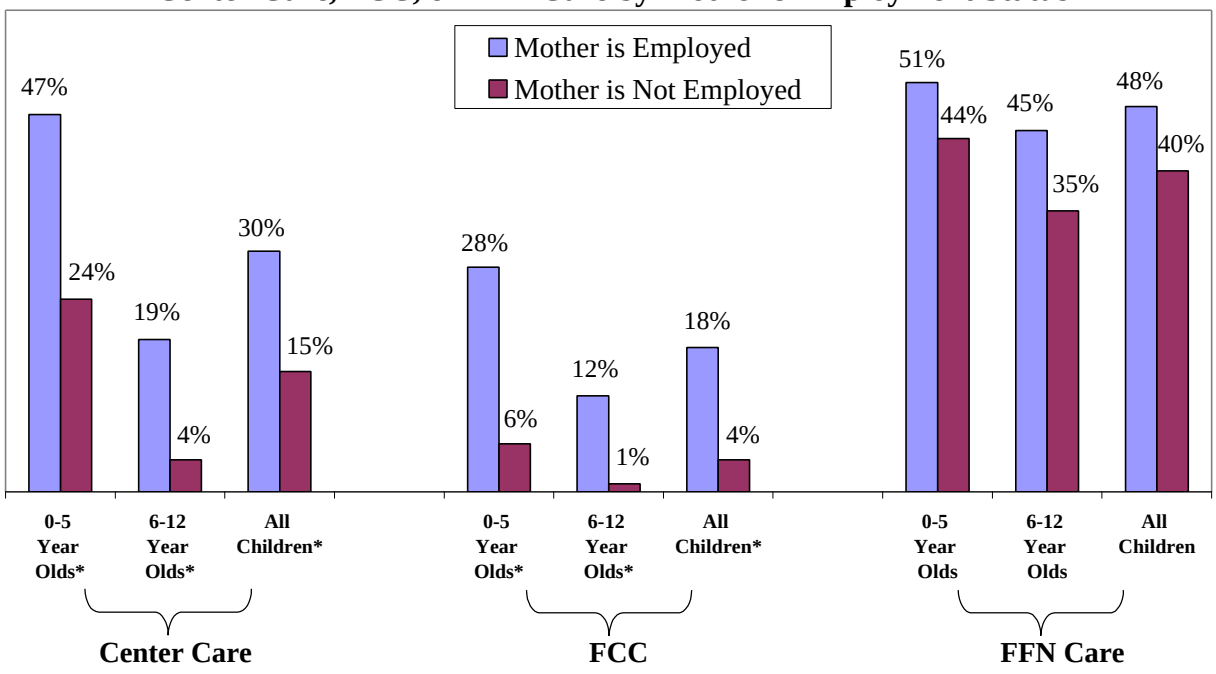
Groups differ in the rates at which they use FFN care or other types of care. Employed mothers and single heads of households are more likely to use all forms of care. Mothers with higher education levels are less likely to select FFN care and more likely to select center care or

[1] A major national study found that parents tend to report fewer children per staff member than directors do, indicating that parents tend to underestimate the child:adult ratio in centers; they are mostly accurate about ratios for other types of care (Willer 1990). This should be taken into account when considering the child:adult ratio we report for center care; the actual disparity may be even greater than reported here.

FCC as the primary care arrangement. Although their patterns of utilization resemble those of higher-income families, low- to moderate-income families are slightly more likely to use FFN care for school-age children and slightly more likely to use center care for young children.

- *Employed and non-employed mothers use FFN care at similar rates* – 48% of children with employed mothers are in FFN care, compared to 40% with non-employed mothers. However, the differences in rates of care by mother's employment status are more pronounced for FCC and center care, with employed mothers more likely to use both of these forms of care [Chart 7b].

Chart 7b: Percent of All Children in at Least Some Amount of Center Care, FCC, or FFN Care by Mother's Employment Status



*Differences are significant at $p < .05$

- *Employed mothers use twice as many hours per week of FFN care and center care for children age 0-5 than non-employed mothers [Chart 7c].*
- *For school-age children, non-employed mothers are more likely to use grandparents as the primary type of care than are employed mothers; employed mothers are much more likely to select center care or FCC as primary* [Chart 7f]. For children age 0-5, there were no significant differences in the type of primary care chosen by mother's employment status [Chart 7e].
- *Single parents are more likely than married or cohabiting parents to use all types of non-parental care,* including FFN care, but their choices among the different types of non-parental care are similar to those of married/cohabiting parents [Chart 7a].
- *There is no significant difference in the rates at which low- to moderate-income families and more affluent families use either FFN care or FCC.* More affluent parents are almost

twice as likely to use center care for young children, with 48% of these children in center care, compared to 28% of children from low-to-moderate income families [Chart 7d].

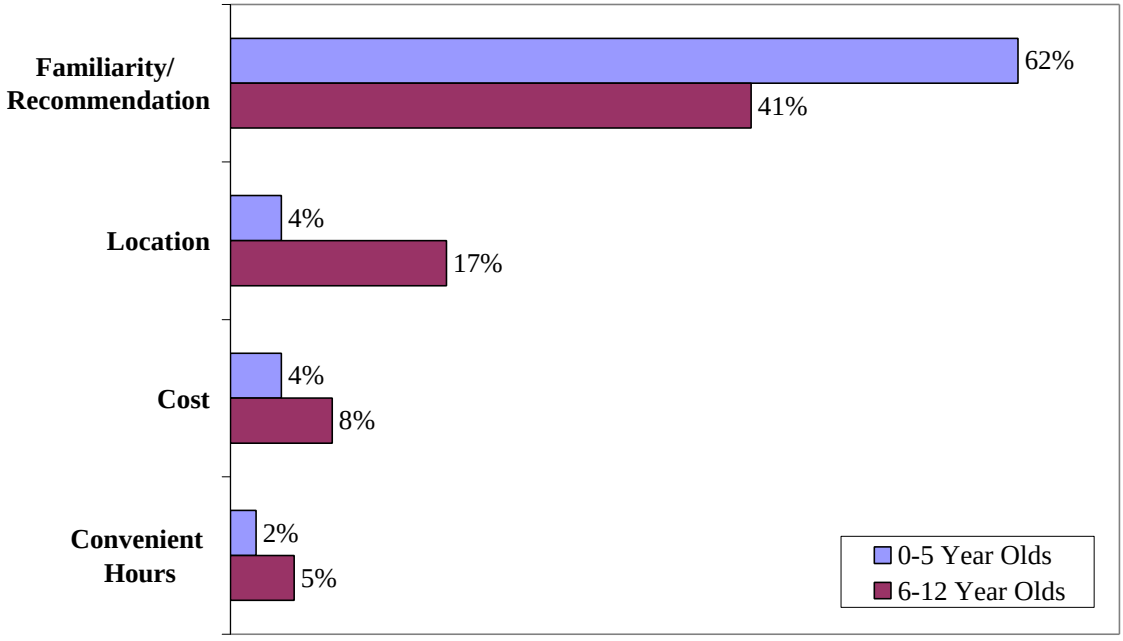
Each of these family characteristics has a small effect on the rate of using FFN care, but they are not the major determinants of that selection – the situation is more complex. We therefore conducted two other analyses to help understand which parents select FFN care and why they do so. First, we asked parents directly why they chose their child's primary care arrangement. Second, we conducted a multivariate analysis to distinguish among the many different family characteristics and parental preferences as predictors of which type of primary care parents use.

Factors Involved in Parent Choice about Types of Care

Parents who use FFN care as the primary form of non-parental care state a variety of reasons for those choices, with familiarity of the caregiver the predominant one. Note that 'primary' refers to the type of care used for the greatest number of hours a week that is at least five hours.

- *For young children (0-5), a majority (62%) of parents report familiarity with the caregiver as the main reason for selecting FFN care,* while four percent each cite location and cost. For school-age children, forty-one percent report familiarity as the main reason; seventeen percent cite location; and eight percent cite cost [Chart 9a].

Chart 9a: Percent of Parents Reporting Each as a Main Reason for Choosing FFN Care as the Primary Care Arrangement



- *Parents choosing center care or FCC for children 0-5 years old also cite familiarity with the caregiver (21%) as the top reason, but familiarity does not have the overwhelming prominence as it does for FFN care.* Parents are also quite likely (17%) to cite

programmatic aspects of the care (such as liking the curriculum, activities, or teaching staff) as selection criteria. For school-aged children, location is a major consideration in selecting center care or FCC. Issues of religion, culture, and values are important for a small minority (4-11 percent) and are more important for choosing FCC or center care for school-aged children than for younger children [Chart 9b].

We next analyzed the many different possible explanations for why parents choose FFN care. The first distinction we must make is *FFN care compared to what* — to center care/FCC or to parental care? We therefore employed statistical techniques to consider both of these choices. The second distinction is among three sets of factors that could affect parents choices: 1) *parental characteristics that might affect child care choice* (e.g., age, income, family structure, race-ethnic group), 2) *parents' stated values or preferences* (e.g., location, familiarity, training and qualifications of caregivers, quality of program, religious or cultural consistency), and 3) *the price and availability of licensed care alternatives* (the average price of center care and FCC in the county, the number of center or FCC slots per zip code). Since many of these possible predictors are highly inter-correlated (for example, income, race-ethnic group, and family structure), we used multivariate statistics, which allowed us to consider the impact of each factor when all others were held constant.

We found that the following factors significantly affected the likelihood of using FFN care, when all the potential factors listed above were taken into account (a fuller discussion of the factors affecting center and FCC care is included in the body of the report):

Family Characteristics:

- *For children age 0-5*: Single parents, families with younger children, or those with more children are most likely to use FFN care as the primary care arrangement. Native Americans use FFN as primary care more than whites do, while Blacks and Hispanics use it less than whites. More affluent families are less likely to use FFN care as the primary type of care than lower income families.
- *For children age 6-12*: Married couples and those who have an adult relative or non-relative living in the family or nearby are more likely to use FFN care as the primary care arrangement. Families are less likely to use FFN care for older children, while those with special needs children are more likely to use FFN care. African American mothers are less likely than white mothers to use FFN care as the primary care arrangement, while Asian American mothers are more likely than white mothers to use FFN care as the primary care arrangement. Mothers with higher levels of education are less likely to select FFN care for their children.

Values and Preferences:

- *For children age 0-5*: Families most concerned with staff training/credentials are less likely than other families to choose FFN care, as are those who place a priority on close location of caregiver. Those most concerned with flexible and convenient hours or cost are more likely to select FFN care.
- *For children age 6-12*: Families assigning great importance to a low child:adult ratio and to knowing and trusting the caregiver are more likely to use FFN care. Parents very concerned with cost are more likely to choose parental care rather than FFN care. Parents

very concerned with having stimulating and enriching activities for children are more likely to use C/FCC than FFN care.

Price and availability:

- *For children age 0-5:* Parents are more likely to use FFN care when fewer licensed center slots per population are available in the area of residence. When the average price of center care in their county is higher, they are also more likely to utilize FFN care. Thus, lower availability and affordability of center care is associated with more FFN care. The availability of a relative in the area tends to increase the use of FFN care, when other factors are taken into account.
- *For children age 6-12:* The availability of licensed slots in the zip code of residence does not seem to have a consistent relationship with the use of FFN care for school-age children. The availability of a relative in the area tends to increase the use of FFN care.

Factors Involved in Parent Choice about Types of Care: Summary

Our findings show that parents choose FFN care for a variety of reasons. Those influenced by price or availability of licensed care may reduce their use of FFN care as the provision and financing of licensed care evolves. Those influenced by familiarity with the caregiver, a low child:adult ratio, or caring for very young children within the family are likely to continue using FFN care. FFN care is therefore likely to remain an important component of the diverse set of care arrangements utilized by Washington families for the foreseeable future, but may decrease somewhat if the availability and affordability of licensed care options increase. Plans to support FFN caregivers should take into account the different reasons parents use that type of care and the expectations of what that care will do for their children. We address ways of doing that below.

Supply of Care

Question 2. Supply of Care. *Who are the FFN caregivers, how many children are they caring for, and for how many hours; do they care for children with special needs; what are their qualifications and what problems do they experience in providing care. How many caregivers are likely to utilize various opportunities for support and training and in what locations?*

Characteristics of FFN Caregivers

FFN caregivers are mostly relatives, with a significant minority of friends and neighbors. They have a wide range of age, education and income levels. The race-ethnic distribution of FFN caregivers approximates that of the adult population in Washington. Few FFN caregivers have received the type of specific training in early childhood care and development that has been shown to improve children's social, emotional, and cognitive development.

- *Relationship and marital status*. FFN caregivers are predominantly grandparents (36%) and other relatives (22%). Almost one third (32%) are friends or neighbors who are not related to the child [Chart 12]. A majority (57%) are married, twenty-five percent are single, and ten percent divorced or separated [Chart 14].
- *Age*. FFN caregivers cover a wide range of ages, with approximately one fifth in each of the following age categories: 16-25, 26-35, 36-45 and 46-55. Another fifth are over age

55, and only one in twelve is over age 66 [Chart 13].

- *Income*. There is a wide range of family incomes among FFN caregivers; overall, they are somewhat less affluent than the general Washington population. The median household income of FFN caregivers is about $30,000 a year, compared to about $45,000 overall [Chart 15].
- *Education*. Only about one in seven FFN caregivers has a four-year college degree, and only thirteen percent have less than a high school degree. Most have a high school degree (32%) or some college, including an Associate of Arts (AA) degree (40%) [Chart 17]. This is similar to the educational background of licensed FCC providers found in studies in other states (Kontos, Howes, & Shinn, 1992; Minnesota Department of Children Families and Learning, 2001b).
- *Specific training*. The majority (61%) of FFN caregivers have no specific training in child care, child development, or parenting. Each of the following types of training has been experienced by approximately one fifth of FFN caregivers: parenting training, a course in ECE, a course in child development, a course in child psychology, training videos, and participation in workshops. One in 17 have participated in training through the State Training and Registry System (STARS). Those who have been trained have each taken several types of training [Chart 25]. Friends and neighbors are significantly more likely than relatives to have received specific training [Chart 27]. Major studies have demonstrated a strong link between these types of caregiver training and the cognitive, social, and emotional development of young children (see NICHD Research Network, 2001; Shonkoff and Phillips, 2001).

Chart 25: Percent of All FFN Caregivers with Each Type of Training in Child Care and Related Topics

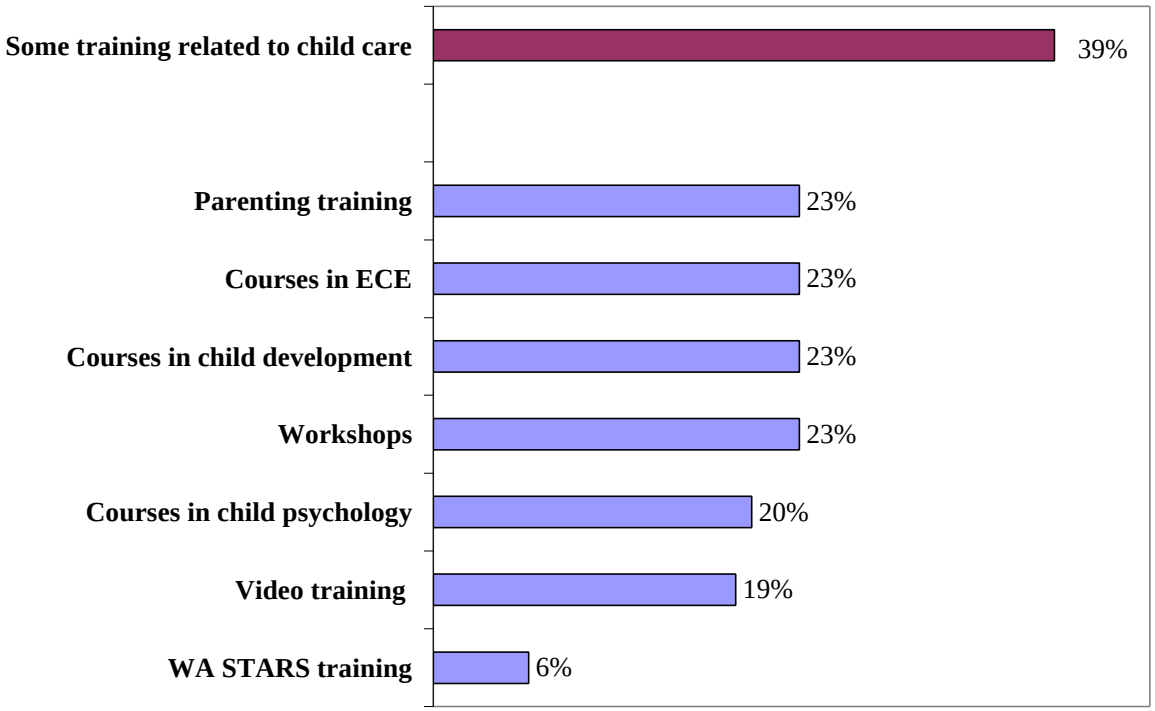
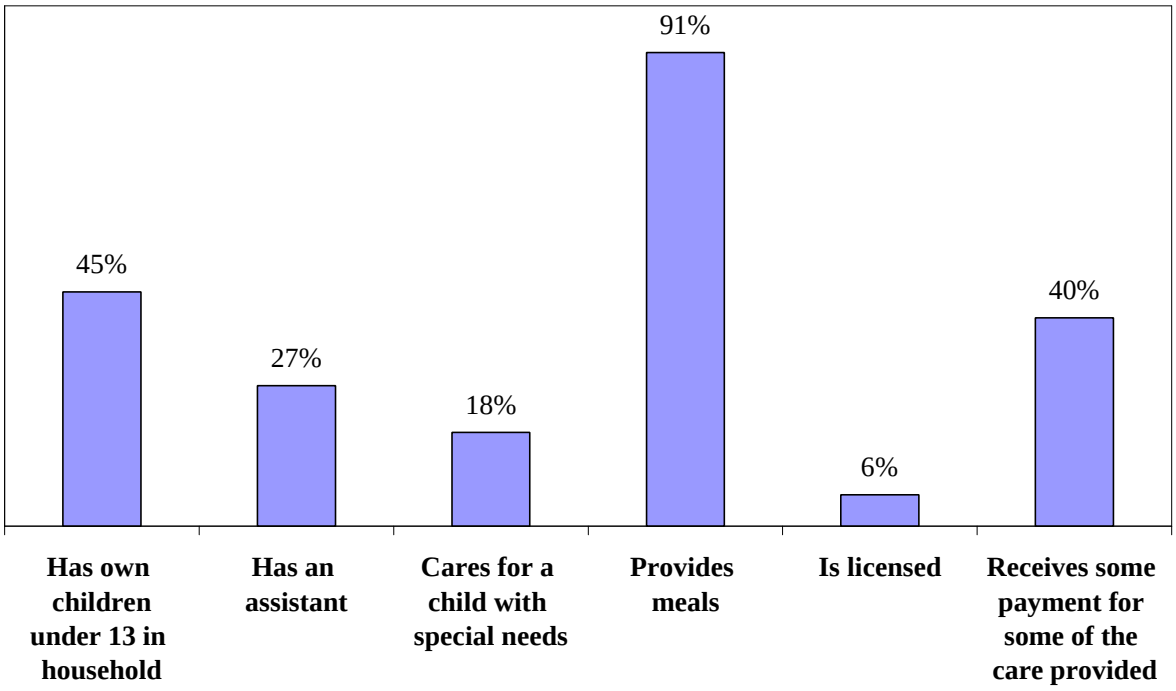


Chart 21: Percent of FFN Caregivers with Each Feature of Caregiving



- *Special Needs*. Almost one in five (18%) FFN caregiver reports caring for a child with special physical, emotional, behavioral, or developmental needs [Chart 21].
- *Motivation.* More than half (57%) report providing care to help out a relative or friend; a quarter (24%) report providing care because they enjoy being with children. Only four percent say they "need the income," though 40% are paid [Charts 18 and 21].

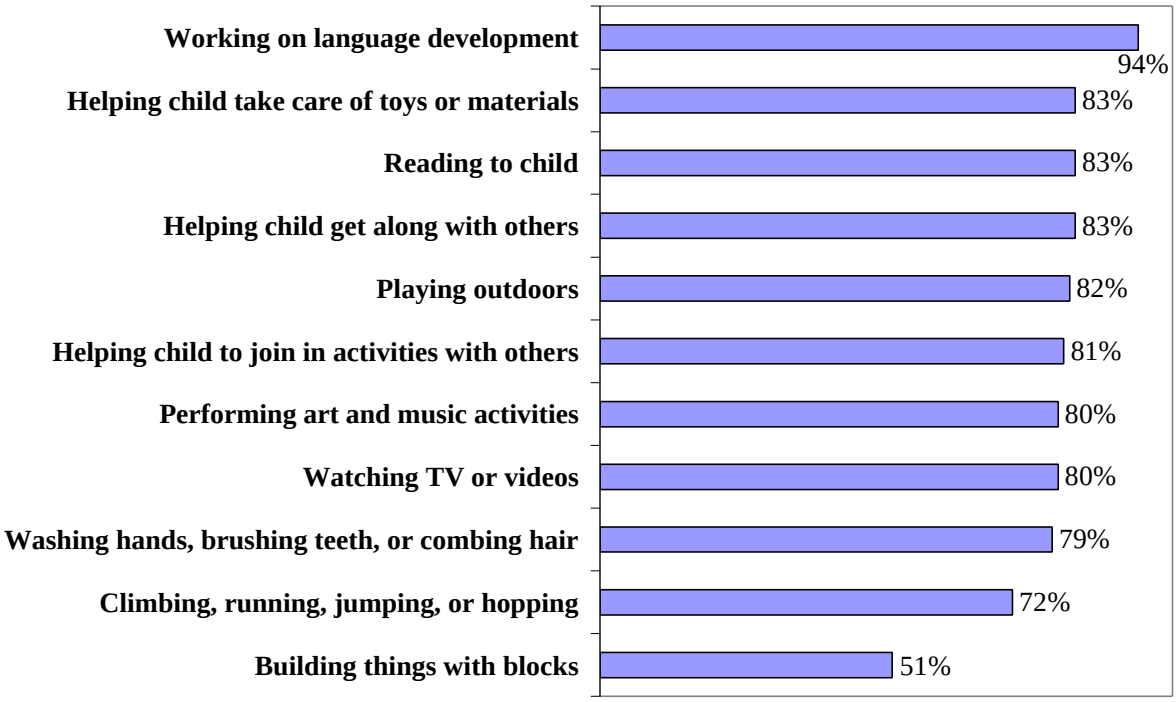
The Nature of FFN Care

We asked caregivers a range of questions designed to elicit some important information about the nature of the care they provide. While we did not have sufficient resources in this project to directly observe the nature of FFN care provided, these caregiver responses shed useful light on the nature of care.

- *Hours*. FFN caregivers provide care for an average of about 18 hours per week. For many, it is thus a part-time occupation, not a casual or occasional one. One in four FFN caregivers provides care for more than 30 hours a week, the equivalent of a full-time job [Chart 20].
- *Number of children in care*. Forty-two percent of FFN caregivers care for one child, one-third (31%) care for two children, and one-sixth (18%) for three children not including their own children. Only one in eleven (9%) cares for 4 or more children [Chart 19].
- *Activities*. Most FFN caregivers report engaging in a wide range of developmentally stimulating activities with the children in their care, ranging from language development, to art and music activities, to helping children get along with others. However, we were

not able to determine how much time was spent in stimulating activities such as reading, language development, climbing/jumping, art or music, as opposed to such passive activities as watching TV. One activity that seems to have lower than desirable rates of participation (only half) among caregivers of young children (age 0-5) is building with blocks [Chart 22]. Similarly, fewer than half of the caregivers participate in constructing or building things with objects with the older children in their care [Chart 23].

Chart 22: Percent of FFN Caregivers Who Report Participating in the Following Activities with Child (Age 0-5)



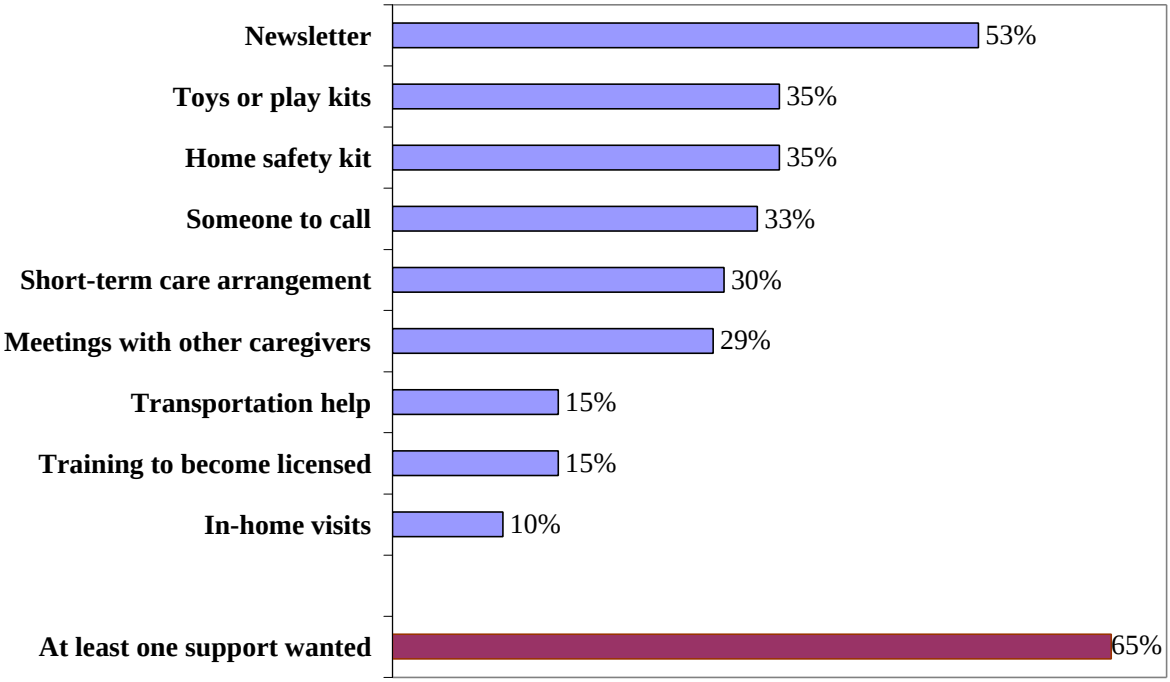
- *Discipline methods*. The most common forms of discipline by FFN caregivers are: talking about behavior with the child (35%), and putting the child in time out (31%). Only two percent or fewer report yelling or scolding or withholding activities, and none report spanking or slapping. However, only one percent report using distraction techniques, which is a recommended approach [Chart 24].

Potential Demand for Training and Support

Desired support. Two-thirds of FFN caregivers – an estimated 192,000 individuals – want some type of support, and more than half want a newsletter and tip sheets.

- One-third of FFN caregivers desired each of the following: play or safety kits, the ability to meet with other caregivers, and resources they can contact for help with difficult problems [Chart 29].
- Those FFN caregivers desiring support want an average of 4 types of support.

Chart 29: Percent of FFN Caregivers Who Report Wanting Each of the Following Child Care Supports



- Thirty percent of FFN caregivers indicated they would be likely to attend meetings held in their community [Chart 30]. The most popular potential locations for training or support offerings were a neighborhood school (32%), library (22%), or church or place of worship (20%). Fewer would be comfortable in a community center (15%) or community college (10%)[Chart 30].
- The one in five FFN caregivers caring for a child with special needs are significantly more likely than other caregivers to want multiple kinds of support: meetings with other caregivers, short- term care arrangements, in-home visits, and transportation help [Chart 31].

Problems experienced. A majority of FFN caregivers – an estimated 171,000 individuals – experience at least one caregiving problem. Those reporting problems average two problems each. There are not one or two particular problems experienced by most caregivers; rather there is a broad range of problems reported by caregivers. The major problems reported by FFN caregivers are: not enough time to self (25%), long or irregular work hours (23%), not enough interaction with parents (16%), insufficient pay (15%) and dealing with children who are withdrawn (12%) or crying/misbehaving (14%).

Policy Implications

Question 3. Policy implications. *Is FFN care a large enough issue to warrant state attention and involvement; if so, what types of training and support should be offered, to how many people, through what mechanisms, and at what cost?*

Reasons for Policy Engagement

The wide range of data compiled and analyzed for this study come together in a way that suggests compelling reasons for state policy engagement in supporting FFN caregivers.

- FFN care affects almost half of children age 0-12 in Washington– approximately 480,000 children –and is the predominant type of non-parental care for infants, toddlers, and middle school children. It is the primary form of care for about 203,000 children. Approximately 295,000 family, friends, and neighbors in Washington are caring for someone else's child on a regular basis.
- Many Washington children are in FFN care a sufficient number of hours for the quality of care to affect their development. One-third of young children are in FFN care more than 10 hours per week, and one-fourth are in FFN care more than 20 hours per week. One-quarter of FFN caregivers – about 74,000 individuals – provide care on almost a full-time basis.
- Parents and policy makers both place a high value on the skills and knowledge of caregivers, their disciplinary styles, and their ability to provide stimulating and enriching activities for children.
- Among children receiving a subsidy for their primary care arrangement, about one third have FFN care as primary, indicating that FFN care represents a substantial component of the early care system currently supported by state and federal funding.
- A majority of FFN providers lack the special training in child development or parenting techniques that could enhance the development of children in their care. This lack is reflected in low reported rates of participation in some important developmental activities and desirable disciplinary techniques.
- A substantial majority of FFN caregivers report problems with their caregiving experience, and two-thirds want some type of training and support. Most FFN caregivers prefer information built around the specific problems they face and provided within a context of peer support, rather than in formal classes.
- The fact that almost one in five FFN caregivers is caring for a child with special physical or emotional needs adds saliency to their need for support and suggests that special training or support options that address these special challenges should be developed and offered.
- Only a small percentage of FFN providers want training for licensing, suggesting that support systems should be voluntary and separate from the state's regulatory structure.

Since training of caregivers in child development and in specific techniques of quality care has been demonstrated to improve a wide range of child outcomes, increasing the training of FFN caregivers in these ways should result in children in their care for substantial numbers of hours having better physical, social, emotional and cognitive outcomes.

Designing and implementing a training and support system for as many as 200,000 to 300,000 FFN caregivers a year would be a complex and expensive enterprise. It is difficult to predict how many people would actually participate, whether they would participate on an ongoing basis, how they would respond to various offerings, and what impact those offerings would have on the quality of care experienced by children. It would therefore make most sense

for the state to use the information in this report to design a pilot effort and evaluate responses and impacts before committing to a large-scale system.

DSHS could initiate a pilot project offering the types of voluntary support and training opportunities that FFN caregivers desire and that experts think would enhance the quality of care. We have outlined the content for such a program, with a variety of offerings tailored to different groups of caregivers. Pilots should be developed on a county or regional basis, allowing variance in the exact offerings and the methods by which they are organized and marketed to FFN caregivers. It is important to recognize that only a portion of FFN caregivers regularly provide care enough hours a week to make improving their capacity a high priority activity. It therefore makes sense for an initial pilot to be targeted to FFN caregivers who engage in this activity on a regular basis and provide care a substantial number of hours a week. It seems that these are the individuals most likely to participate in any event. Some FFN caregivers may meet the requirements for licensure and should seek appropriate training and support offered to licensed providers.

Key Elements of a Training and Support System for FFN Caregivers

The key elements of a training and support system are outlined below. If the state decides to develop such a system, it should work with caregivers and experts to provide more detail concerning the scope and content of a training and support system. In addition, it should conduct an operational test to determine which approaches most effectively deliver such support, obtain feedback from caregivers, and observe the results. While we have developed a core set of offerings based on past research and feedback from caregivers and experts in our project, offerings should be varied according to local needs and conditions. Since so little is known about how to effectively market such offerings to this type of population, different approaches should be developed and evaluated. An initial pilot in 10 counties employing a variety of methods might cost between $560,000 and $725,000 to develop, operate, and evaluate in the first year. This cost could be reduced by limiting the types of activities and support offered or by conducting the pilot test in fewer counties. If this option is chosen, the pilot should still include a mixture of rural, urban, and suburban locations in different regions so that differences in operational needs and caregiver responses can be assessed. Based on our survey responses and consultation with leading national experts in training and supporting caregivers, we believe the support system should include:

- *For all FFN caregivers:* Newsletter, booklets, and tip sheets on discipline methods and activities that enhance development; hotline consultation on discipline and other problems; mini-grants for materials and short term assistance; a mobile lending system (including vans) for toys and equipment and materials to be given to parents (the system could also be staffed with someone who can offer advice); activity boxes; occasional substitute caregivers for respite or to enable caregivers to attend training/support sessions. Existing training and support opportunities should be available to FFN caregivers as well as licensed caregivers.
- *Grandparents:* Activity boxes, home safety kits, and opportunities to meet with other caregivers.

- *For those with limited English proficiency (LEP) or those caring for children whose parents are LEP:* Translation of all materials into appropriate languages.
- *For FFN caregivers with low education:* Literacy support.
- *For FFN providers caring for children with special needs:* Workshops on challenges, with information on techniques and resources; home visits to work on problems, if desired.

For some low-income individuals, providing care on a regular basis imposes a financial burden. This can be addressed by ensuring that parents and caregivers are aware that many state subsidies can be used to pay for relative care, not just for licensed provider care. The fact that only a small percentage of low-and moderate-income families receive any assistance suggests that, under existing income-related programs, considerable potential exists to expand assistance through more effective outreach.

Cost of a One-Year Pilot Project

The pilot we have suggested would require about $77,000 to $125,000 to develop material that could be used in several counties. To test various approaches in 10 counties would cost about $330,000 to $450,000 per year. An evaluation of the approaches would cost about $150,000 additionally each year.

A.4. Conclusion

Washington State has made the first critical step in recognizing the importance of family, friends, and neighbors as part of the early care and education system and commissioning this study to examine the scope of FFN caretakers' potential training and support needs. This report has found that FFN care is a large sector, involving almost half a million Washington children. We conclude that this investigation should be continued, with further analysis and testing of different training and support initiatives. Such testing could vary both the content and the delivery mechanisms, and should measure caregiver response, parent satisfaction, and developmental outcomes for the children in care.

B. BACKGROUND AND PURPOSE

B.1. Background

Today, many children spend considerable time in the care of relatives, friends, neighbors, and other caregivers operating outside the formal system of licensed/certified child care. This type of care is often referred to as family, friends, and neighbors (FFN) care, as these are the people providing much of this care. Some policy makers, child advocates, and child development specialists express concern that the care provided in these arrangements may not be optimal for a child's development. However, because this care is outside the formal system of licensing and regulation, we actually know very little about the quality of FFN care or characteristics of the people providing FFN care. Within Washington State's early care and education system (ECE), many types of caregivers, meeting different needs and demands of parents, participate in early care and education. We must consider all these factors if we expect to adequately address the needs of all children. In addition, we must examine FFN care for all children, not only those for whom such care is used exclusively when the mother is at work, school, or training. We must balance the views of ECE experts – many of whom stress the importance of providing training and support to FFN caregivers – with the values and preferences of parents and FFN caregivers.

In March 2000, the Washington State Department of Social and Health Services (DSHS) issued a request for proposals to conduct research focusing on FFN care and caregivers in Washington State. DSHS was particularly interested in obtaining information about the types of child care that families use, the characteristics of families using FFN care, in particular, and information on the characteristics of FFN care and its providers in Washington State. DSHS will use this information in considering the development of a training-and-support program for FFN providers in Washington State. For the purposes of this study, we define FFN care as any regular, non-parental care other than a licensed center, program or family child care (FCC) home. FFN thus includes relatives, friends and neighbors, and other adults.

The contract for the proposed project was awarded to the Human Services Policy Center (HSPC) at the University of Washington. This report describes:

- The research questions to be addressed by the study;
- The methodology used to address the research questions;
- Study results; and
- Study conclusions.

B.2 Purpose

The purpose of this study is to answer research questions in three broad areas:

1) *What is the demand for FFN care?* What proportion of Washington children under the age of 13 spend time in FFN care arrangements? How many hours a week do children spend in this care? How does this compare to other types of care? Which families choose FFN care and for what reasons? How might choices about the type and amount of care change in response to state policies?

2) *What is the supply of FFN care?* Who are the FFN caregivers? How many children are they caring for and for how many hours? How many care for children with special needs? What kind of training and educational background do FFN caregivers have? How many FFN caregivers experience problems in providing care, and what type of problems do they experience? How many caregivers are likely to use various opportunities for support and training and in what locations?

3) *What are the policy implications of what we know about the demand and supply of FFN care?* Is FFN care used enough to warrant state attention and involvement? If so, what types of training and support should be offered, to how many people, through what mechanisms, and at what cost?

C. METHODS AND SAMPLES

To answer the research questions specified above, project staff collected new data from several sources including:

- A general population survey of approximately 1,200 households in Washington with children under thirteen.
- A general population survey of approximately 300 FFN caregivers age 16 or older who care for other people's children on a regular basis but do not work in a licensed child care center.
- Interviews with policy makers and professional advocates.
- A focus group with FFN caregivers.
- A forum with outside experts for caregivers, agency staff, advocates, parents, and others engaged in ECE policy in Washington State.

C.1. The Surveys

Our data on the use and delivery of family, friend, and neighbor care in Washington State came from both parent and caregiver surveys, representing demand and supply sources, respectively.

The surveys were conducted in collaboration with the Social and Economic Sciences Research Center at Washington State University (WSU). Project staff at HSPC developed the survey questionnaires. WSU pre-tested the questionnaires twice on a total of 14 participants – 12 parents with children younger than age 13 and two caregivers. We used the pre-test results to modify and improve the questionnaires.

We fielded the final versions of both surveys between March and May of 2001, calling a total of 26,080 phone numbers. Of these, 1,185 eligible parent households participated in the parent survey, and 278 eligible caregiver households participated.

The parent survey (the demand data source) provided information on who uses FFN care, how much care is used, and for what reasons. Specifically, topics covered in the parent survey included:[2]

- A household roster of all children;
- Respondent's employment history and household income;
- All types of child care used, how much of each was used, child-to-adult ratios in care situations, transportation used for child care, and costs of care;
- Perceived costs of all types of child care and reasons for choosing one as the primary type of care;
- Parent's values regarding child care; and

[2] We developed survey questions building on experience with analyzing results from the National Child Care Survey, National Household Education Survey, and National Survey of American Families. About one third of non-employed mothers utilize non-parental child care arrangements.

- Household and respondent demographics, including family structure and the presence of adults other than parents.

We asked to interview the mother of the children in the household or the primary female guardian and only interviewed male guardians if the mother/female guardian was not available. Mothers tend to be more knowledgeable about the child care arrangements of the children in the household (Roschelle, 1997). In addition, child care decisions are typically handled by mothers and are more affected by the mother's employment decisions and earnings than the father's (Crawford & Pollack, 1990). Since we could only collect detailed employment questions on the survey respondent, we wanted this to be the mother whenever possible. Eighty-five percent of the survey respondents were the female guardians of the children in the household.

To minimize respondent burden and keep the interview at a reasonable length, we collected data only on the child care arrangements for the youngest child in the household. This approach is common among national child care surveys, in part because such surveys request so much detail about child care arrangements. We generalized this "youngest-child" information to other children of the same age in Washington.[3] On average, a parent interview lasted 24 minutes.

The caregiver survey collected information on the following topics:

- Number of children (not their own) in the respondent's care;
- Demographic characteristics of each of these children;
- Number of care hours during a normal week;
- Type and amount of payment the caregiver receives;
- Activities offered to children;
- Caregiver's education and training in child care;
- Problems encountered by caregivers;
- Types of support desired and preferred venues for support; and
- Household and caregiver demographic characteristics.

As with the parent survey, we were sensitive to respondent burden when designing the caregiver survey. In the interest of minimizing this burden, we asked caregivers detailed questions about payment and activities for only one child. If the caregiver cared for more than one child, we selected the target child randomly. However, we requested demographic information for all children in care. The caretaker interviews averaged 19 minutes.

Descriptive analysis of the parent and caregiver surveys and multivariate analysis of the parent survey allowed us to address the research questions outlined above. Together, these two sources of survey data offered a more complete picture of FFN care than has previously been available in Washington or any other state. These unique data facilitate the critical task of developing training and support for FFN caregivers in Washington.

[3] In later work, we plan to explicitly test the assumption that youngest children of a specified age are not significantly different than non-youngest children of the same age in other households in their overall child care patterns.

Oversampling Technique

The populations from which we drew our survey participants included both a simple random sample of telephone households and a separate oversample of areas with a high concentration of low- income households. We used this second sample to ensure an adequate number of low-income respondents necessary for our multivariate analyses.

Description of the Samples

Parent Survey

The sample for the parent survey consisted of 1,185 interviews with parents of children under the age of thirteen. Of these, 597 cases came from the regular random digit dial sample of WA State and 588 cases were from the random digit dial low-income oversample. Both samples, however, contain cases from all household income groups. Basic demographics of the parent sample were as follows:

- Parental ages ranged from 17-77.
- Thirty-one percent of the parents were non-white, with 16 percent Latino or Hispanic (the largest minority category).
- Thirty-three percent of the youngest children (the only children about whose care arrangements we inquired) were non-white.
- Nineteen percent of the households were at or below the federal poverty line and another 39 percent were between poverty and 2.5 times the federal poverty line.
- Sixty-one percent of the parents have a youngest child that is between the ages of 0 and 5 years old, and 39 percent have a youngest child age 6-12 years old.

Caregiver Survey

The sample for the caregiver survey consisted of interviews with 278 non-center caregivers. Of these, 132 came from the RDD low-income oversample. Basic demographics on this sample are as follows:

- Caregiver ages ranged from 16-83.
- Thirty-seven percent of the caregivers were non-white, with 15 percent Native Americans and 10 percent Latino or Hispanic.
- Twenty-seven percent of the caregivers' reported household incomes below the federal poverty line.

Weighting the Sample

As described above, our samples were not representative of parents or caregivers in Washington State. Rather, they reflected our oversampling in low-income areas. To produce estimates that represented the general population and not the oversample, we weighted the survey data so it corresponded to the population from which we were sampling. In addition, we weighted each case with an age adjustment so that the distribution of the "youngest children" reflect the actual

age distribution of children in Washington. Therefore, the proportions presented here differ from the weighted population estimates described in the results section (which should be representative of Washington State).

The variation in our sample's basic family characteristics allowed us to generate statistics about the diversity of parents, families, and caregivers. However, we did not have adequate resources to oversample or obtain data from immigrant groups or other small-population groups whose members were also less likely to have telephones. The results, weighted to correct for our over-sampling, were representative of most of Washington's population, including low-income groups, but did not reflect the particular needs, behaviors, and preferences of all subgroups.

Unless otherwise stated, we ran the statistical analyses reported here with the survey-population weights. The resulting estimates reflect the general population in Washington.

C.2. Focus Groups

We hoped that caregiver focus groups would balance the survey data with richer, more in-depth, qualitative information about FFN caregivers' experiences and desires. Previous research alerted us to the difficulty of reaching FFN caregivers (Morgan, 2001), and our experience confirmed this. We sent flyers for distribution to many places, including the Child Care Coordinating Committee (CCCC) and Family Support Centers statewide. Recruiting heavily in Wenatchee and Tacoma, we placed ads in the Tacoma Tribune and Wenatchee Herald and personally contacted several individuals and organizations in these areas. We eventually drew enough participants to hold one focus group in Tacoma, on June 7, 2001.

Of the thirteen people agreeing to participate, only seven actually attended the focus group. Six of the participants were female and one male. Five were grandmothers caring for their grandchildren during the day while the parent(s) worked. One was a great uncle caring for a great niece with serious medical problems, and one was a single parent caring for a friend's child.

We asked the participants a variety of questions about:

- Their relationships to the child(ren) and how long they planned to care for them;
- Their opinions about the qualities of a good caregiver;
- Their feelings about the most difficult aspects of caring for the child(ren);
- Their payment situations: whether or not they were being paid; if they were being paid adequately; if they received payment other than money; if they could talk with the parents about money;
- Their communication with the child's parents, including if they talked with the parents about the child and, if so, what things they talked about; and
- What kinds of help or support they would find most valuable.

C.3. Interviews with Policy Makers and Experts

In order to investigate the views of policy makers and experts on the relationship between social policy and FFN care, we identified nine key people in Washington involved in influencing or making policy related to children and child care at the state level. We conducted in-depth phone interviews with six of these people using an open-ended question format. The other three people were unavailable or did not respond. The interviews ranged from 15 to 20 minutes.

Four of the interviewees held elected offices and the other two were advocates in the child care community who worked hard to influence social policy. We asked the interviewees their opinions on the following topics:

- What constitutes a quality child care setting, and does this definition differ depending on the age of the child?
- What qualities should a child caregiver have?
- To what extent do FFN caregivers have these qualities?
- Should state support be available to FFN caregivers? If so, what types of support should be available and what should the state's role be in providing this support?
- What efforts, if any, should be made to license these caregivers?

C.4. HSPC and Child Care Resource and Referral Network Forum

As a part of our effort to learn as much as we could about FFN care, we convened a forum on the topic in April 2001. The Washington State Child Care Resource & Referral Network co-sponsored the forum. The purpose of this forum was to facilitate discussions and gather information that could contribute to our research as well as to policy decisions.

We invited several out-of-state presenters who are recognized experts in this area of research. These included Toni Porter of the Child Care Continuum, Bank Street College of Education, NY who has researched and written widely in this field; Donna Gay of the Child Care Coordinating Council of San Mateo, CA; and Rebecca Shine and Marnie Vlahos of the Enterprise Institute, Portland, OR who have developed programs for FFN caregivers in their communities. Local presenters included Rachael Langen of the Office of Child Care Policy, Lorrie Grevstad of Healthy Child Care Washington, Mary Seaton of Puget Sound ESD Head Start, and Kathy Hopkins of the Washington State Family Child Care Association.

About 45 delegates from key agencies and organizations in Washington participated in the discussions. Organizations represented include the City of Seattle Project Lift Off, Child Care Action Council, Head Start State Collaboration Office, City of Seattle Division of Family and Youth Services, School's Out Washington, Children's Initiative of the King County United Way, Governor's Executive Policy Office, and Department of Social and Health Services Child Care Division.

C.5. Definitions

Throughout this report, we use the following definitions:

- The term FFN care refers to care by relatives, friends, neighbors, or other types of paid or unpaid caregivers who are not licensed child care centers or family child care.
- Center care includes pre-school, nursery school, Head Start, or Early Childhood Education and Assistance Program (ECEAP) for younger children.
- The primary care arrangement is defined as the non-parental care arrangement that is used for more hours than any other type of non-parental care (the child must be in this type of care for a minimum of five hours a week).
- A child with a special need is a child with a physical, emotional, developmental, or behavioral condition that affects how the child is cared for, as reported by the parent.
- Family child care (FCC) is defined as an arrangement where care is provided by a non-relative in the caregiver's home. In some cases, this care is licensed and in others it is not, or the license status is unknown. We asked about FCC separately from and in addition to care by a friend or neighbor. Where appropriate, we present these results separately for licensed FCC and unlicensed or unknown FCC. For simplicity, we often collapse FCC into a category by itself that includes licensed, unlicensed, and unknown types.
- We often group Center Care and FCC into a single category when making comparisons to FFN care.
- We do not include before- and after-school programs and lessons, clubs, and sports in our definition of center care. We report these categories separately.
- Household Income Group is defined as a household's income, based on family size, relative to the federal poverty level.

D. RESEARCH FINDINGS: PARENT SURVEY

The descriptive analysis of the parent survey and the resulting weighted estimates address our first set of research questions: How many children use FFN care, for how much time, and for what reasons? All the results we present are weighted population estimates. By adjusting for the over-sample in low-income areas, the weighted estimates reflect what one would expect if sampling randomly in Washington State. The weighted estimates also contain an age adjustment so that the overall distribution of the ages of the youngest children (about whose child care arrangements we asked) equals the age distribution of all children in the state. And, except where otherwise stated, we present most analyses, when appropriate, separately for two age groups of children: children 0-5 and children 6-12 years old.[4]

D.1. Use and Types of FFN Care

Parents have many options for child care and use many combinations of child care arrangements for their families. In order to understand the use of FFN care, we need to place this care in the context of all types of available care. This section describes the overall patterns of FFN care use, regardless of why that care is used, and compares this care with other types of child care.

We use three different approaches to address purportedly simple questions about the number of children in each type of care and the relative amounts of time spent in each type of care. Because each approach offers a unique perspective on parents' choices and the implications for public policies and programs, we present the findings from all three in the sections below. The three approaches for understanding the prevalence and magnitude of FFN care are as follows:

- *Prevalence of care*: How many Washington children are in some amount of care in a typical week?
- *Quantity of care*: What is the total number of weekly hours of each type of care used by the entire population of Washington's children?
- *Primary care*: In what types of care do parents choose to place their children for the greatest number of hours per week?

We focus on the number of children in FFN care and the amount of time children spend in such care, regardless of mother's employment status. We know that many non-working mothers rely on child care, and that many working mothers use child care at times other than when they are working. The quality of that care matters, regardless of why it is used. In subsequent analyses, we break down the use and amount of care by mother's employment status. To do so here, however, might divert attention from the substantial number of children using FFN care each week for reasons other than mother's employment.

D.2. Prevalence of Care: How Many Children are in FFN Care?

First, we present information on the percentage of children in each type of care for at least some time each week. To review, center care refers to children in child care centers. For younger

[4] A small percentage of five year olds are in school. Including them with the other 0-5 year olds does not significantly alter the results. Thus, they remain in the results presented for 0-5 year olds.

children (0-5 years old), it also includes pre-schools, nursery schools, HS, and ECEAP.[5] FCC refers to all types of family child care arrangements regardless of whether the parent knows the caregiver's license status. FFN care refers to care by relatives, friends, neighbors, and nannies or sitters. When compared to other types of care, the amount of FFN care is striking. Chart 1a presents results. Our major findings are:

- For each detailed age group (except 3-5 year olds, who use more center care), FFN care is the most commonly used type of care.
- For most age groups, twice as many children are in FFN care than in all other types of care combined.

Additional analyses indicate that:

- For both age groups (0-5 and 6-12 year olds), grandparent care is the most commonly used form of FFN care, with thirty-one percent of 0-5 year olds and twenty percent of 6-12 year olds cared for at least some time each week by a grandparent
- Center care is the most used type of care for 0-5 year olds as a group; grandparent care is a close second to center care.
- A large percentage of school-age children are in before- and after-school programs (24%) and lessons, clubs, and sports (60%).
- For school-age children, grandparent care is the most common care arrangement, not including before- and after school- programs and lessons, clubs, and sports. [See Appendix A for additional charts.]

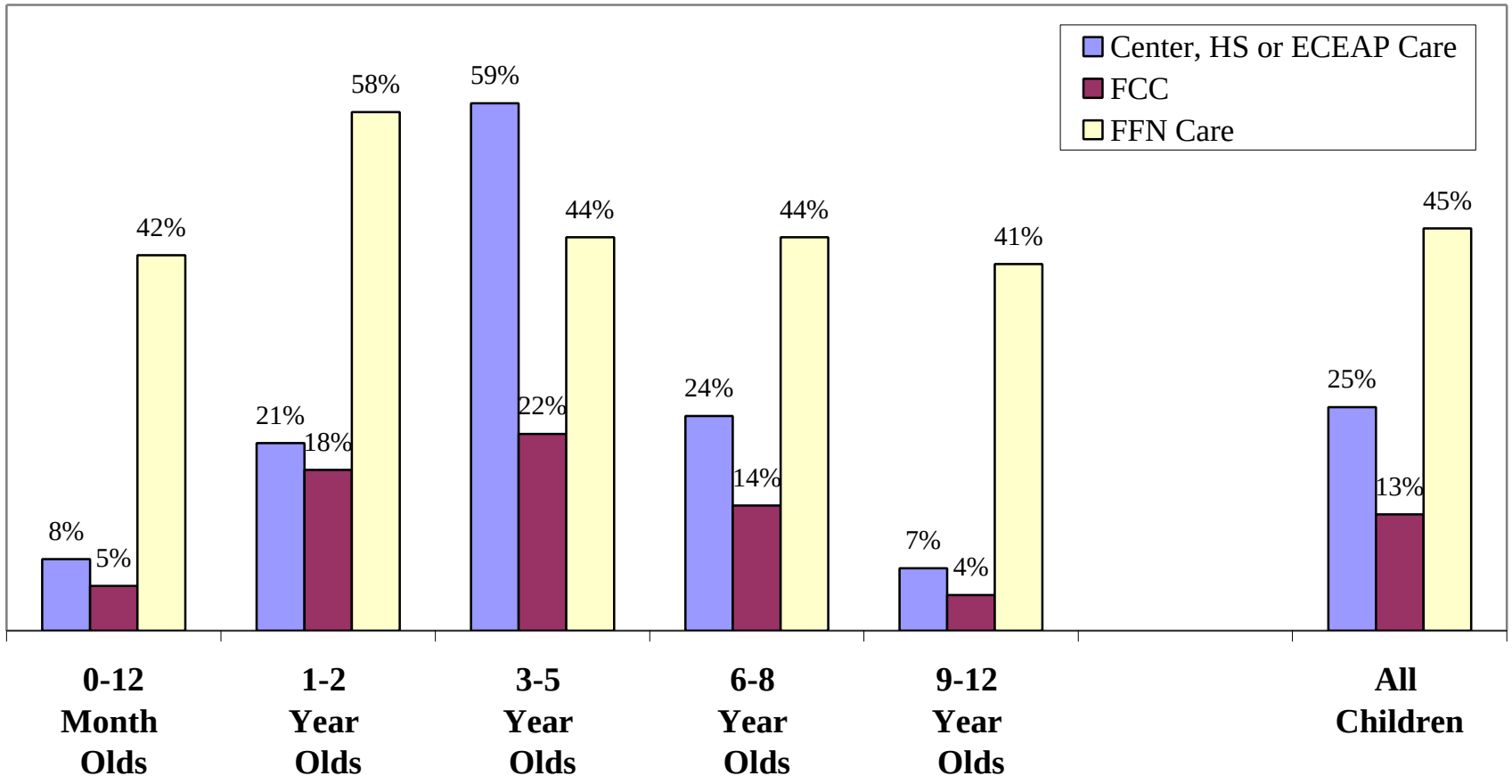
We know from the work of Hofferth (1998) and Capizzano and Adams (2000) that many children are cared for on a regular basis in more than one type of care arrangement, so we must also consider combinations of care. Chart 1b presents results on combinations of care arrangements. Our major findings are:

- A large percentage of children (twenty-six percent of 0-5 year olds and thirty-four percent of 6-12 year olds) use only FFN care and do not combine it with either center or FCC arrangements.
- A smaller percentage of children (twenty-four percent of 0-5 year olds and twelve percent of 6-12 year olds) use only center and FCC arrangements with no FFN care at all. Another twenty-two percent of 0-5 year olds and nine percent of 6-12 year olds combine FFN care with center and FCC arrangements.
- Twenty-eight percent of 0-5 year olds and forty-six percent of 6-12 year olds don't use any center care, FCC, or FFN care.

Given the number of children combining FFN care with center care and FCC arrangements, the amount of FFN care used could change if the relative price or other characteristics of center care or FCC were to change.

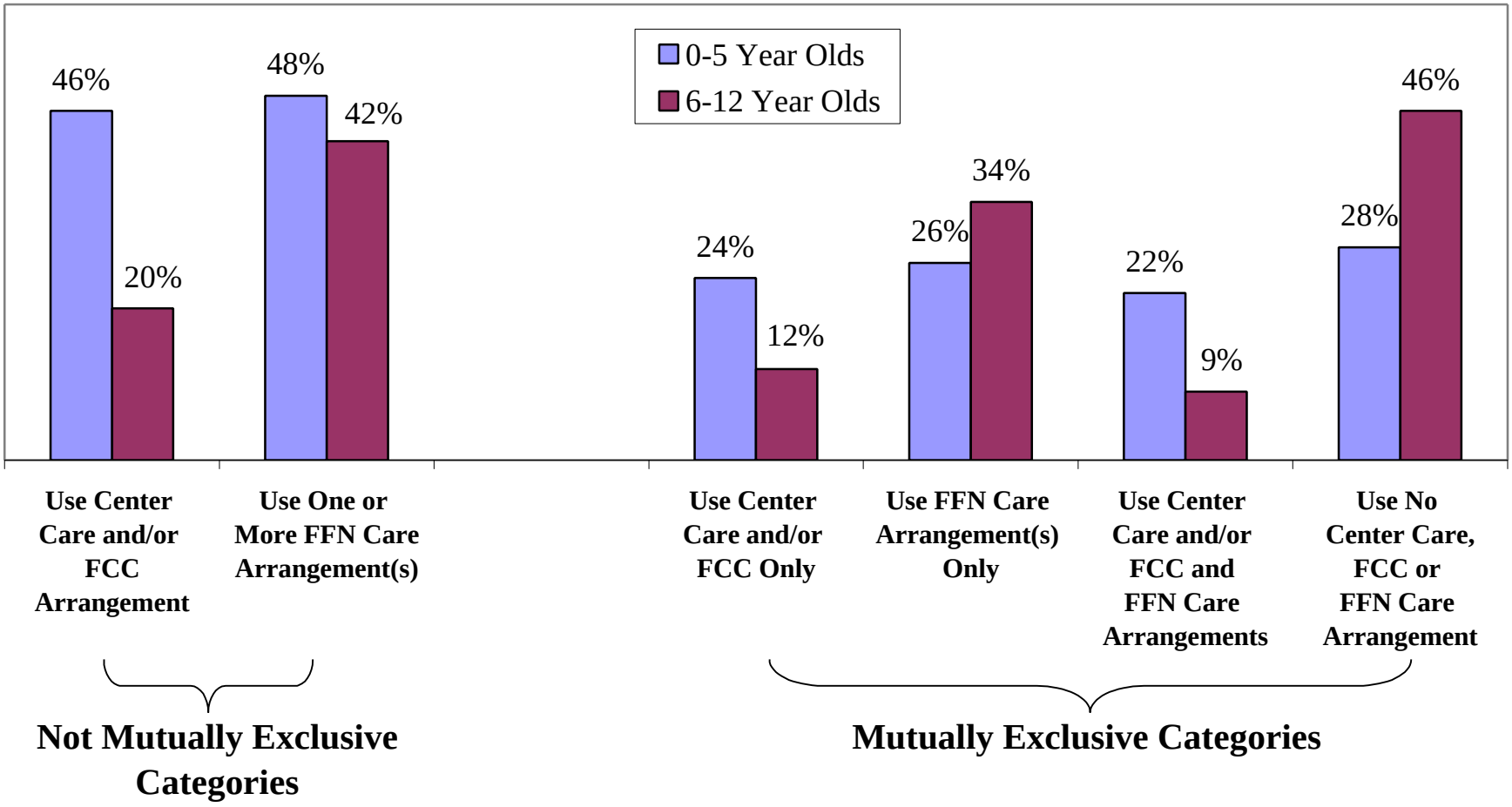
[5] Only three percent of 0-5 year olds are in Head Start or ECEAP. Almost half of these children are also in a non-Head Start child care center. Grouping Head Start together with center care for the descriptive analysisis appropriate since Head Start is considered center care. However, if patterns for center care use are different for children using Head Start, the results are not going to be affected by such a small number of children in Head Start.

Chart 1a: Percent of All Children in Any Amount of Center Care, FCC, or FFN Care by Detailed Age Groups



Note: Care categories are not mutually

Chart 1b: Percent of Children in Each Combination of Center Care, FCC, and FFN Care



Previous research documents a shift towards center-based care with children entering these more 'formal' types of arrangements at an earlier age (Hofferth, 1998). Multivariate analyses have suggested that an increase in maternal employment explains much, but not all, of this shift (Hofferth 1998). The percentage of Washington children younger than age 6 in center care (38%) is consistent with estimates from national data sources (NSAF, 1995, NHES, 1999), and higher than in Minnesota (Wilder (a), 2001), where twenty percent of 0-5 year olds are in center care. However, Minnesota has a unique program that pays low-income mothers to stay home with their infants, and this program may reduce the percentage of young children in center care. For school-age children, it is more difficult to make cross-survey comparisons because surveys differ in their definitions of center care for older children. And, not surprisingly, estimates from different surveys vary more widely for older children than for younger children. For reasons we are unable to determine, our estimate of the percentage of Washington school-age children in center care is higher than most other state and national estimates. Despite this apparent shift towards center care, a large number of children are in FFN care and many of them use it in combination with other types of care.

Population Totals

Chart 1c applies the percentage of children in each type of care to the 2000 Census estimate of the total number of children in Washington: 1,083,000 children age 0-12.[6] Our major findings are:

- Overall, the number of children in some form of FFN care for at least some time each week is higher than for any other type of care.
- Approximately 483,000 children are in FFN care for some time during a typical week; 228,000 of these are 0-5 year olds and 255,000 are 6-12.
- Approximately 272,000 children are in center care for some time during a typical week; 181,000 of these are 0-5 year olds and 91,000 are 6-12.
- Approximately 135,000 children are in FCC for some time during a typical week; 86,000 of these are 0-5 year olds and 49,000 are 6-12.

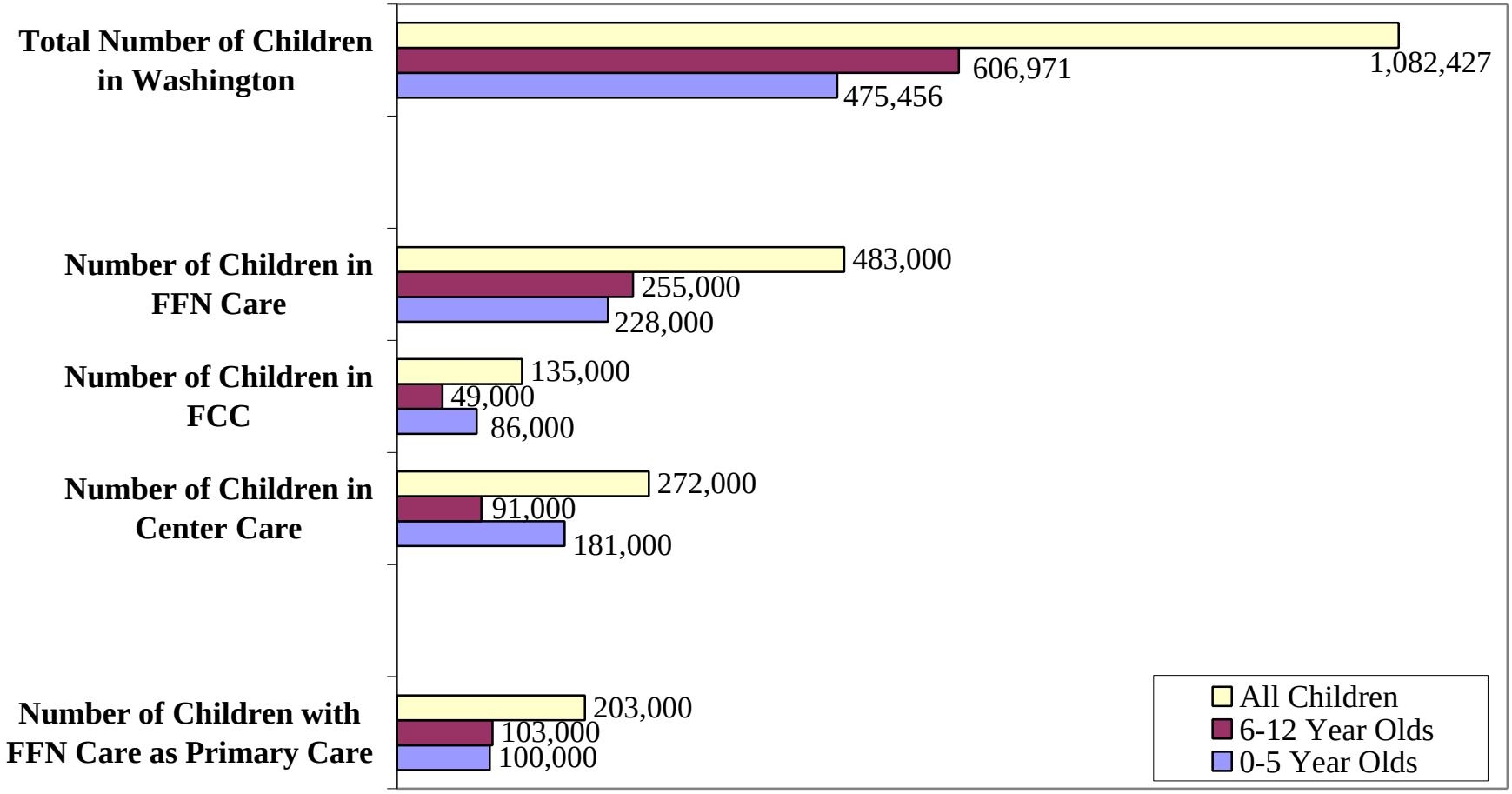
D.3. Amount of Care: How Much Care is Used?

Mean Hours in Each Type of Arrangement

In addition to knowing how many children are in each type of care for at least some time each week, we also want to know, on average, how much time children spend in each of these arrangements.

[6] Estimates of the population totals for the number of children in each age group come from the 2000 Census, Summary File 1, Washington State.

Chart 1c: Population Totals for the Number of Children in Center Care, FCC, and FFN Care and with a Primary FFN Care Arrangement by Age



Note: Care categories are not mutually exclusive.

Chart 2 presents information on the median weekly hours spent in FFN care compared to center care and FCC for detailed age groups. We report the median, rather than the mean (average) because most children (70%) in both age groups are in FFN care less than 10 hours a week. However, a small proportion of children (10%) are in FFN care more than 30 hours a week. These few cases increase the mean for all children and mask the actual distribution of children toward fewer hours. The median represents the number of hours per week at which half the children are in care *less than* that amount and half the children are in care *more than* that amount. In this instance, the median is a better measure of central tendency.

Chart 2 presents these results. Our major findings are:

- Children in FFN care spend about 4-7 hours per week in that care. The amount of time children spend in FFN care each week does not vary substantially by child's age.
- Infants (age 0-12 months) and toddlers (age 1-3) in centers and FCCs are in that care about 16-20 hours per week. After age 3, the amount of time spent in centers and FCCs decreases, while time spent in FNN care remains relatively constant.
- Because they spend many hours in school, school-age children spend fewer hours than younger children in child care, but still a considerable amount of time.
- In general, children in FCC and center care spend more hours per week in that care than children in FNN care.

Additional analyses reveal the following:

- The *average* (mean) amount of time spent in FFN care is higher than the median because the average takes into account the small number of children using FFN care for a significant amount of time each week. However, except for children nine to twelve years old, the *average* amount of time spent in FFN care is still lower than the time spent in center care and FCC. (Nine to twelve year olds spend, on average, the same amount of time each week in center care, FCC, and FFN care—8-9 hours.) However, we know from the previous set of analyses that more children use FFN care than center care and FCC, even if they tend to use it for less time each week.
- Finally, for both older and younger age groups, children spend more time per week in grandparent care than in other types of FFN care. [See Appendix A for additional charts.]

Overall Quantity of Care: What Percene of Total Care Hours is Spent in FFN Care?

Examining the percentage of children and the mean number of hours in each type of care provides useful descriptive data about the amounts and types of child care used. By calculating the percentage of total (aggregate) care hours for all children in each type of care, we can take into account both the percentage of children in each type of care and how much time they spend in that care.

Chart 3 presents, for each age group, the percentage of total child care hours by type of care. Our major findings are:

Chart 2: Median Hours per Week in Center Care, FCC, and FFN Care for Children in Each Type of Care by Detailed Age Groups

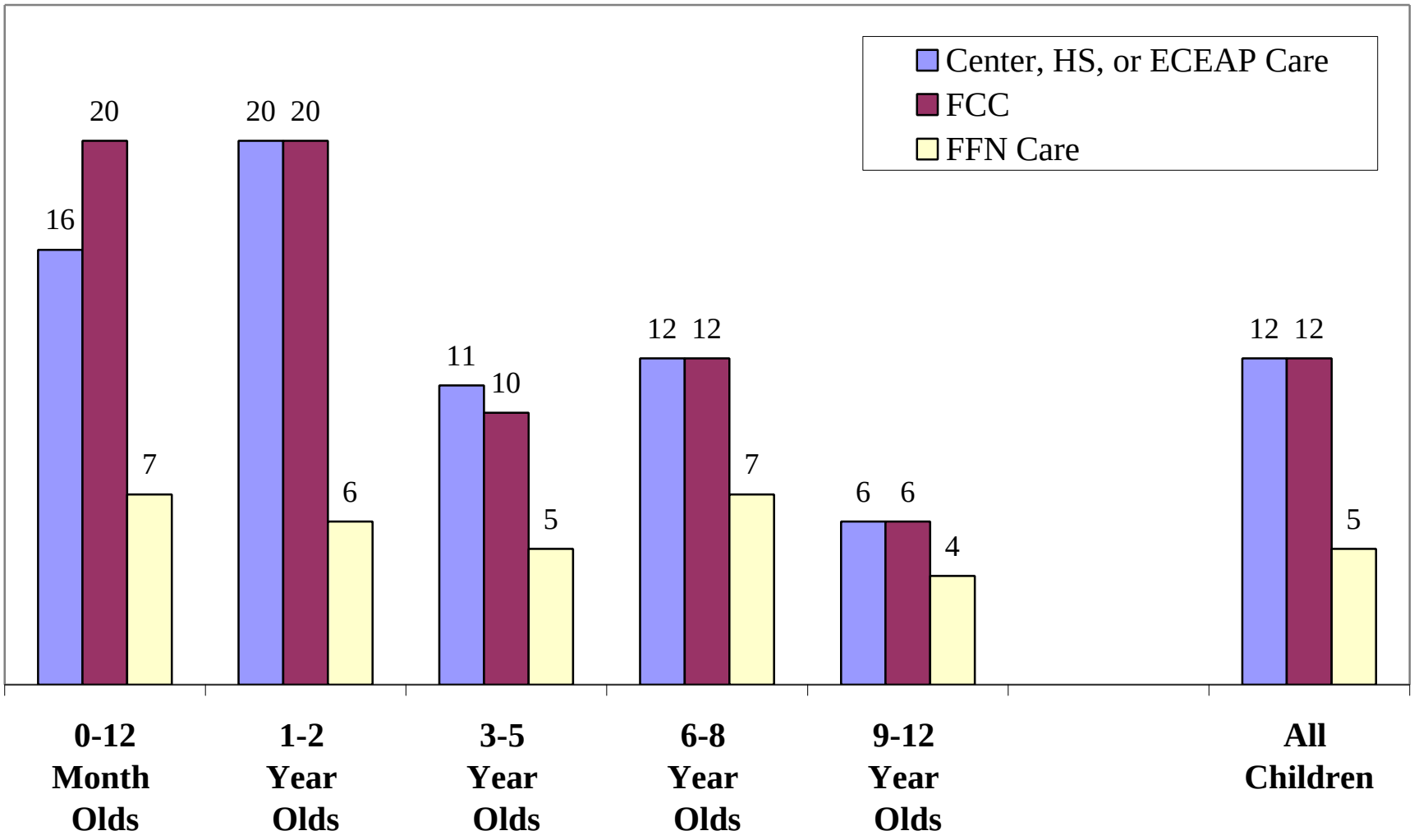
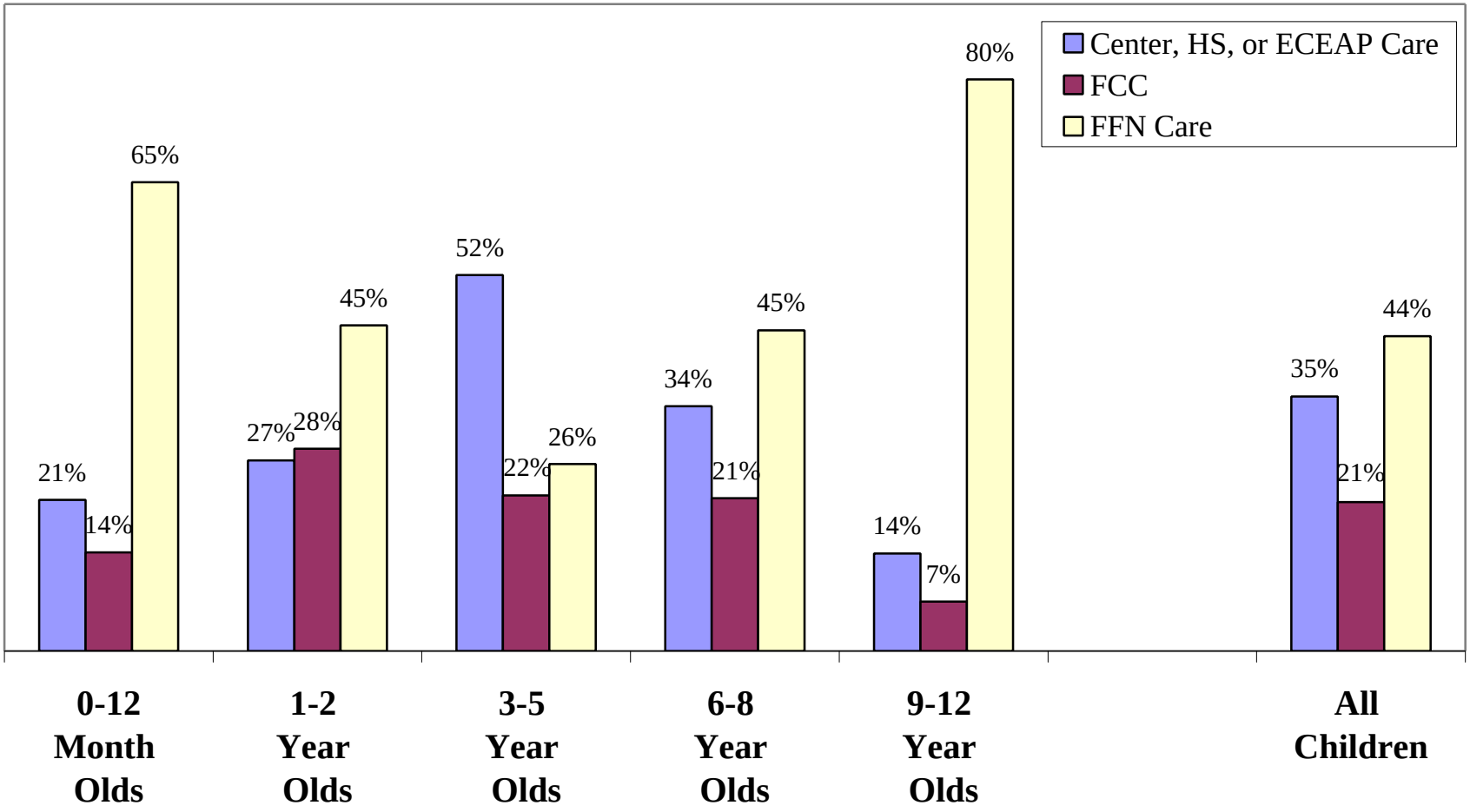


Chart 3: Percent of All Non-Parental Care Hours Each Week in Center Care, FCC, and FFN Care by Detailed Age Groups



- For children younger than one-year-old, toddlers (age 1-2) and school-age children (age 6-12), the highest proportion of all care hours (including center care, FCC, and FFN care) is in some form of FFN care. In fact, the percentage of all care hours in FFN care for children younger than 1 is almost double the percentage for center care and FCC combined. Furthermore, for children age 9-12, FFN care accounts for almost four times as much care as center care and FCC combined.
- This pattern changes for children age 3-5, for whom center care accounts for the highest proportion of all care hours (52%).
- Looking at the pattern for all children, FFN care again accounts for the highest proportion of all care hours (44%). The difference between the amount of care in FFN and center care, however, is small (less than ten percent). FCC provides less overall care hours than the other two types.
- FFN care makes up a substantial proportion of total care hours for children of all age groups.

Additional Findings:

- Looking specifically at different types of FFN care and the proportions of *total care hours* provided by each, we find, not surprisingly, that grandparent care makes up twenty-five percent of all care for 0-5 year olds and thirty percent of all care for 6-12 year olds.
- Or, stated another way, grandparent care accounts for sixty-nine percent *of all FFN care hours* for 0-5 year olds and forty-nine percent *of all FFN care hours* for 6-12 year olds. Six- to twelve-year olds are slightly more likely to spend more time in non-grandparent FFN care than 0-5 year olds. [See Appendix A for additional charts].

To summarize, even though children are generally in FFN care for fewer hours per week than other types of care, because so many children use FFN care each week, the percentage of all care hours provided by FFN care is quite high.

Primary Care Arrangements: What Percentages of Children are in FFN Care or Center Care or FCC?

A primary care arrangement is defined as the non-parental care arrangement used by children for at least five hours a week and more than any other non-parental, non-school arrangement. Investigating the primary care arrangements for children provides us with another way of looking at the prevalence of FFN care in relation to other types of care. These results compare the percentage of all children with a FFN primary care arrangement to children with other types of primary care arrangements or no primary care arrangement (no non-parental care arrangement for at least five hours a week). Please note that these categorizations can be somewhat arbitrary, as children's care may be split almost equally among two or more types.[7]

[7] In cases where a child was in two care arrangements with the same number of care hours (at least 5) per week, we randomly selected one of these as the primary arrangement in our descriptive statistics.

Chart 4 compares the percentage of all children with a FFN primary care arrangement to children with a center care or FCC primary care arrangement, broken down by detailed age groups. Our major findings are:

- When children of all age groups are considered together (age 0-12), the difference between the percentage of children with a FFN primary care arrangement and the percentage with a center care or FCC primary arrangement is small.
- Younger children (0-2 years) and older children (9-12 years) are more likely to be in a FFN primary care arrangement than a center or FCC primary care arrangement. This pattern changes dramatically for children age 3-5, who are much more likely to be in a center or FCC primary care arrangement.
- Finally, additional analyses indicate that grandparent care is the FFN care arrangement most likely to be primary. Grandparent care is the second most common type of primary care arrangement for children in both age groups (0-5 and 6-12). (Center care is the most common primary care arrangement for these age groups.) [See Appendix A for additional charts.]

D.4. Evening and Weekend Care

The availability of care during nonstandard hours on the evening and weekends is an important consideration for many parents. In fact, some studies indicate that eight to nine percent of mothers work in the evenings or at night, one-third to one-fourth of low-to-moderate-income mothers work on the weekends, and one-half of low-income parents have rotating or changing work schedules (Hofferth, 1998). Child care during these non-standard hours is a concern or necessity for many of these families. Nonetheless, as for care during standard hours, the quality of evening and weekend care – regardless of whether the mother is working, or whether it is the primary form of care – can affect children's development if they spend a substantial amount of time in such care on a regular basis.

For each type of care, we investigate the percent of children in care during non-standard, evening, and/or weekend hours; the number of hours children are in such care; and the proportion of care hours that take place during evenings and weekends. Finally, we examine simple associations between the use of evening and weekend care and mother's employment on evenings or weekends.[8]

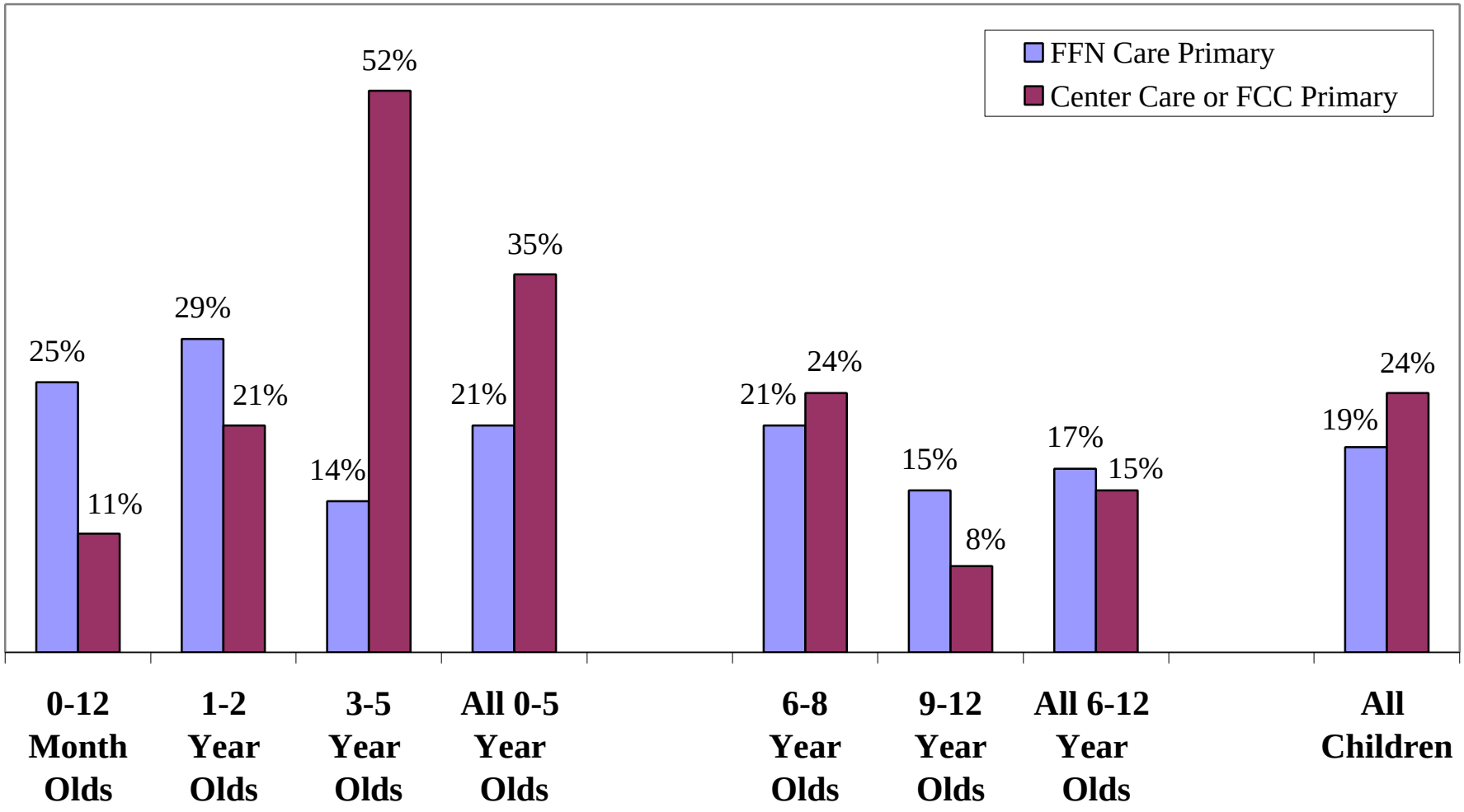
What Percentage of Children in Each Type of Care Use Evening or Weekend Care?

Chart 5a presents the percentage of children in each type of care, by detailed care types, that use at least some of that care on evenings or weekends. Our major findings are:

- Overall, about half of Washington children in non-parental care (forty-one percent of 0-5 year olds and fifty-four percent of 6-12 year olds) are in some care arrangement during evenings and/or weekends.

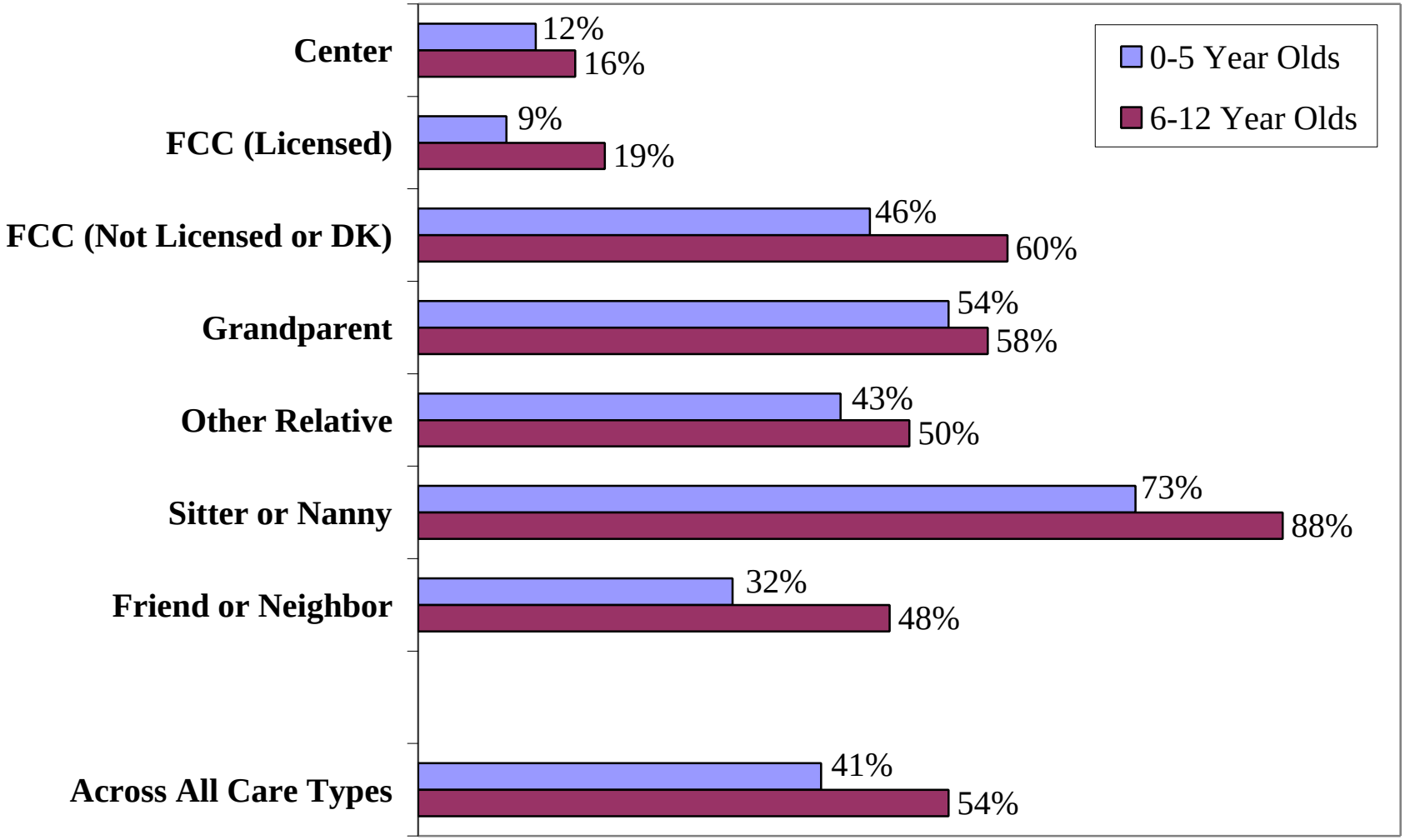
[8] We also conducted the analyses by including mothers who were in school or training on evenings and weekends with mofthers who worked on evening and weekends. Because only a small proportion of our sample is in school or training on the evenings and weekends, the results did not differ significantly.

Chart 4: Percent of All Children with Center Care, FCC, or FFN Care as a Primary Arrangement* by Detailed Age Groups



*No primary care arrangment is the omitted category.

Chart 5a: Percent of Children in Each Type of Care with Some Evening or Weekend Care Each Week



- Children in sitter or nanny care are the most likely to use some of this care on evenings and weekends. This finding is especially true for children age 6-12 years old, with approximately eighty-three percent of all children in sitter or nanny care getting at least some of this care on evenings or weekends.
- For children 6-12 years old, at least half in each type of FFN care get that care on evenings or weekends.
- *Only between nine to nineteen percent of children in either center care and licensed FCC receive care during evening and weekend hours. This result is consistent with previous research indicating that while only about thirteen percent of regulated family care providers and three percent of centers offer some evening care, a higher percentage of non-regulated family care providers offer evening care (Hofferth, 1998).

In summary, unlicenced FCC and FFN care are much more likely than centers or FCCs to serve children during evening and weekend hours.

How Many Hours Per Week Are Spent in Evening and Weekend Care?

Chart 5b presents the median number of hours per week spent in evening and weekend care for children who receive at least some evening and weekend care.[9] Our major findings are:

- Among children who are in care during evenings and/or weekends, the median number of hours of such care per week ranges from 3-9 hours.
- Children spend a greater median number of evening and weekend care hours (per week) with non-grandparent relatives than in other types of care, except centers for older children.
- The approximately half of all children in non-parental care who spend some evening and weekend time in care spend a median of 5-6 hours per week in all types of evening and weekend care.[10]
- For children in "sitter or nanny," " friend or neighbor," and "other relative" care on evenings or weekends, the median number of hours per week spent in this care is only slightly lower than the mean hours per week children spend in this care, regardless of whether they use evening or weekend care. [See Charts in Appendix A for comparison of mean and median hours in evening and weekend care].

What Percentage of Care Hours Is Spent in Evening or Weekend Care?

Chart 5c presents the proportions of all care *among children in at least some evening and weekend care* occuring on evenings and weekends. In contrast, Chart 5d presents the proportions of care *for all children* that occur on evenings and weekends for each type of care. Our major findings are:

[9] We present the median instead of the average because of the skewed distribution for some types of care based on a few children that are in evening and weekend care for a large number of hours per week. The median is a better measure, in this case, of the central tendency of the amount of time spent in evening or weekend care.
[10] Some children may be in more than one type of evening and weekend care and this estimate is a median of the sum of hours spent in all types of evening and weekend care.

Chart 5b: Median Hours per Week in Evening or Weekend Care for Children in at Least Some Care on Evenings or Weekends

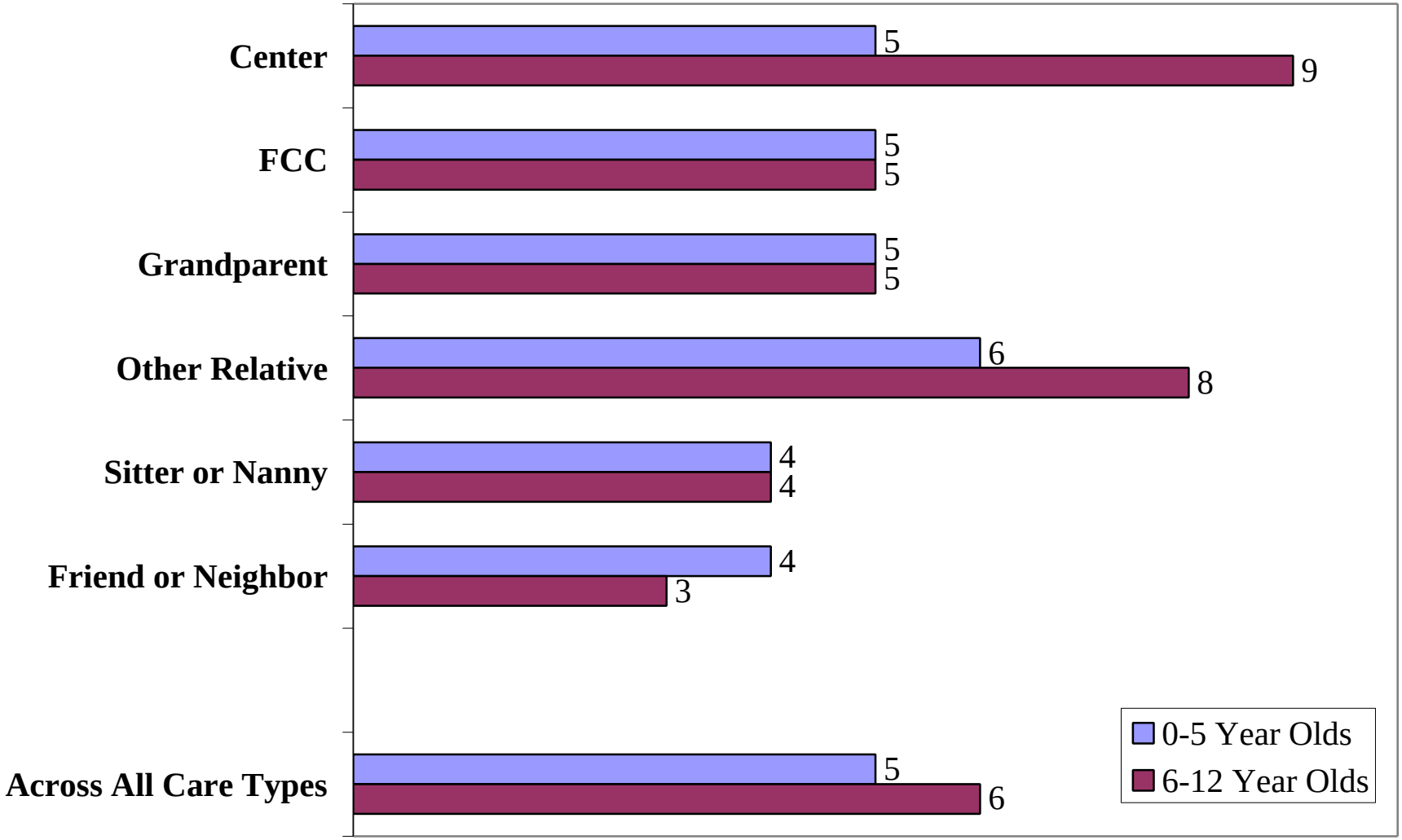


Chart 5c: Percent of All Care Hours per Week in Evening or Weekend Care Among Children in at Least Some Evening and Weekend Care

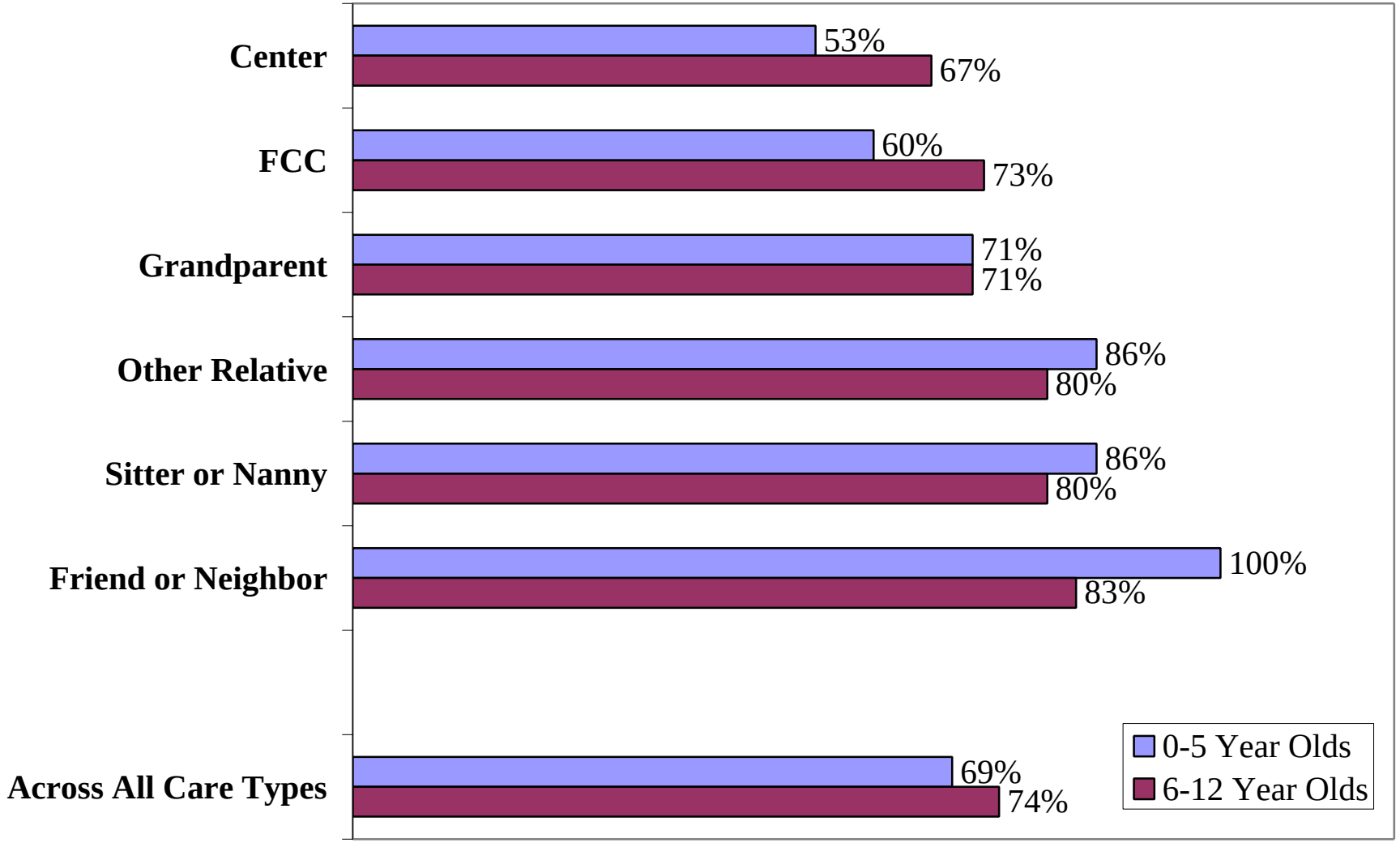
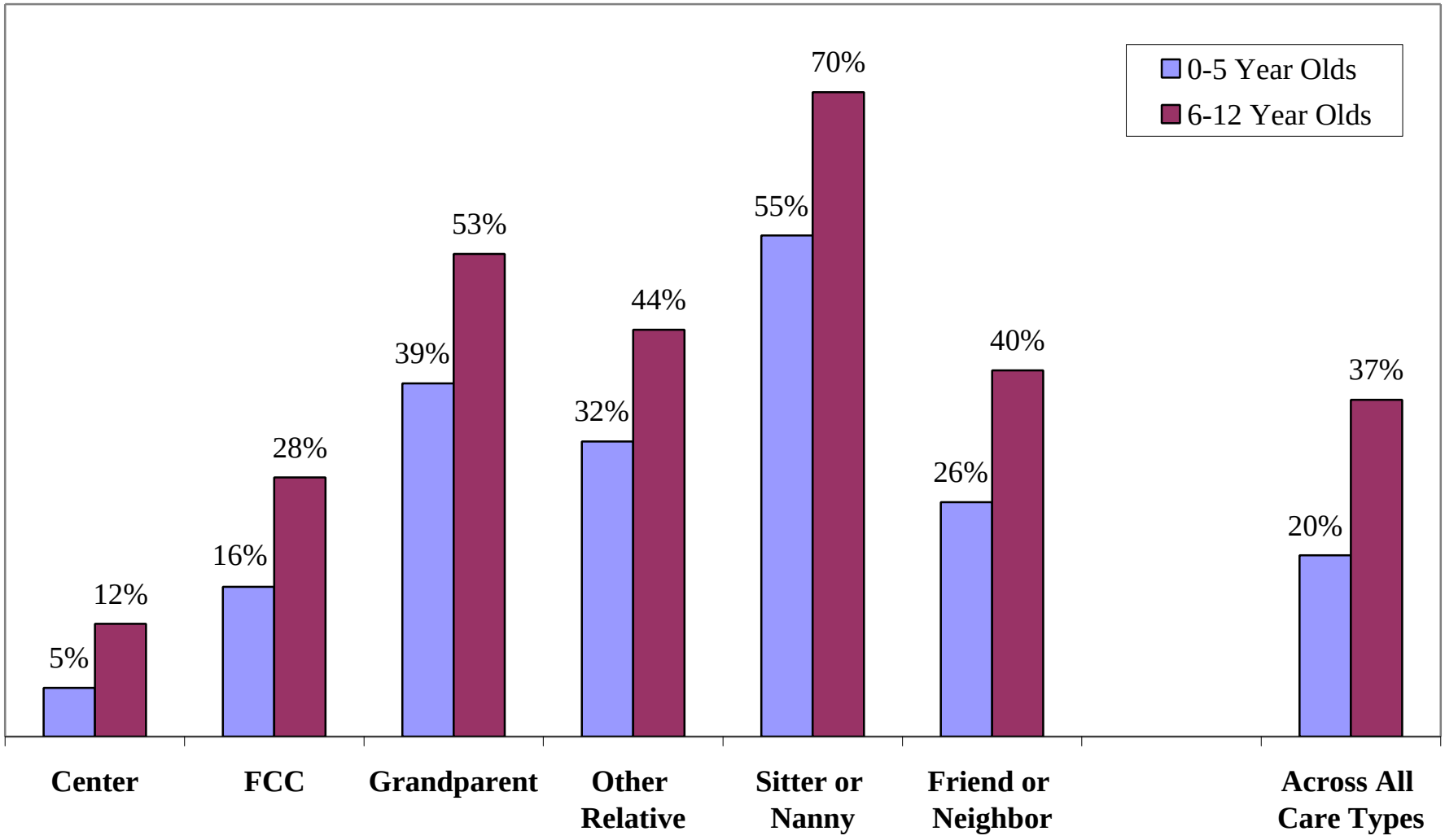


Chart 5d: Percent of All Care Hours per Week Spent in Evening or Weekend Care by Detailed Care Type



- On the whole, significantly more than half of all care among children getting evening and weekend care is spent on evenings and weekends. Parents who use evening or weekend care at all tend to use a lot of it.
- "Friends or neighbors," "non-grandparent relatives," and "sitters or nannies" are the care arrangements with the highest proportions of care hours on evenings and weekends. Children in these types of care on evenings and weekends are spending much more time in such care on evenings and weekends than during other times.
- Looking across all care types for all children, a significant proportion of all care takes place on evenings or weekends, especially for school-age children (20% for 0-5 year olds, 37% for school-age children); most of this is provided in a FFN care arrangement, as centers provide only a small percentage of all care hours on evenings and weekends (5-12%).
- For school-age children, the proportion of FFN care provided on evenings and weekends ranges from forty to seventy percent depending on the type. These percentages are slightly less for younger children, indicating that school-age children use a higher percentage of evening and weekend care.
- Grandparents and sitters or nannies provide the greatest proportion of care hours on evenings and weekends compared to other types of care.

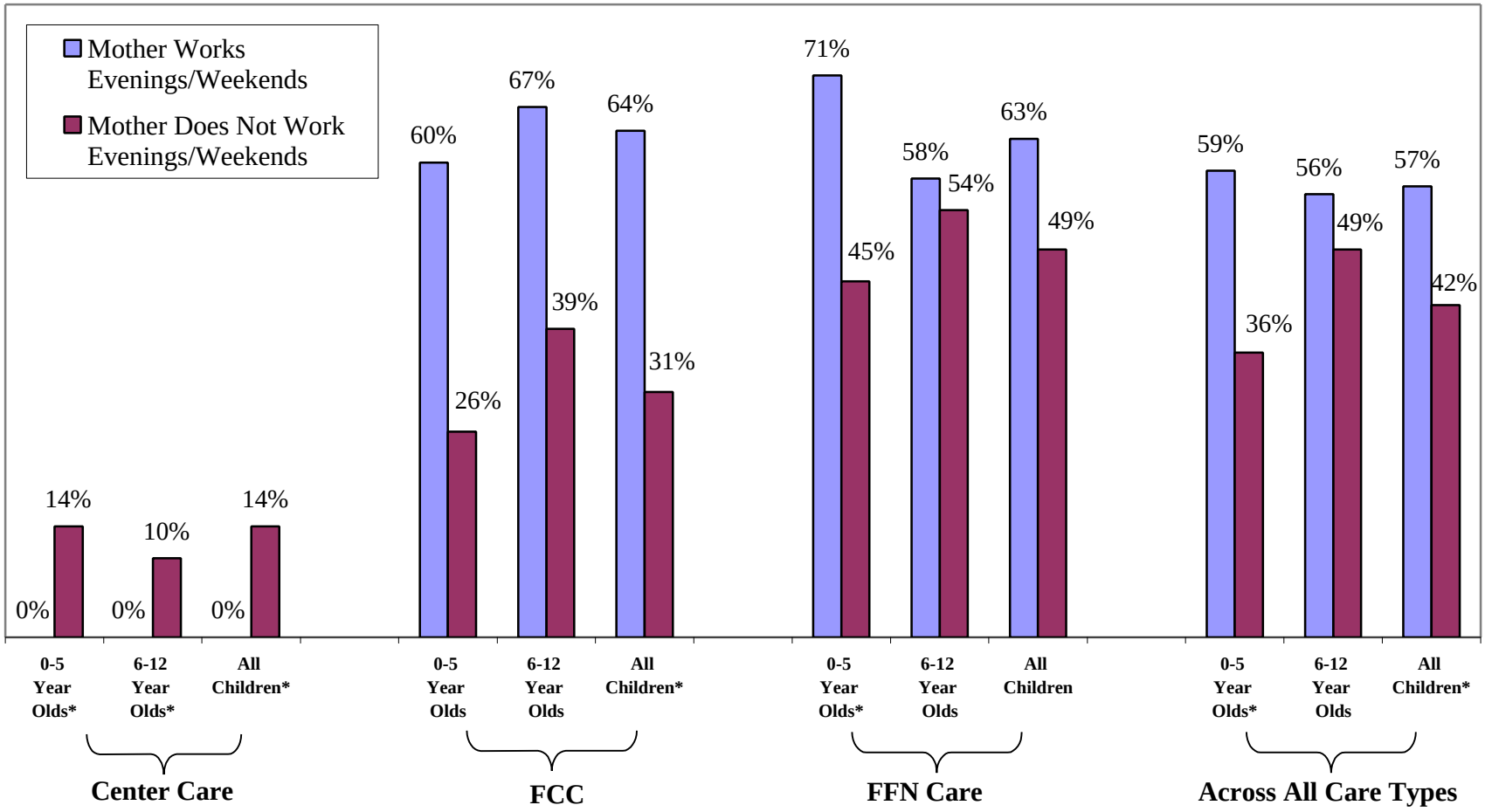
These results illustrate that children spend a significant amount of time in care, and especially in FFN care, during non-standard hours. While simple descriptive statistics do not enable us to determine causality in the relationship between FFN care and the availability of care during evening and weekend hours, it seems likely that parents who need child care during these times choose FFN care because it is available. We know from other studies that the availability of evening or weekend care among centers and licensed or regulated FCCs is relatively limited (Hofferth, 1998).

How Does Evening or Weekend Care Vary by Mother's Employment During Evenings or Weekends?

We examine whether parents' choices of type of care on evenings and weekends is significantly related to mothers' employment on evenings or weekends. Chart 5e presents these results. Our major findings are:

- While mother's evening or weekend employment status does not always contribute significantly to differences in the use of evening or weekend FFN care, the pattern of differences is similar across all types of FFN care. If the mother is employed during the evenings or weekends (and twenty one percent of mothers are), children are more likely to be in some evening or weekend FFN care.
- For center care, the pattern is reversed. Only those mothers *not* employed on the evenings or weekends use center care on the evenings and weekends. This pattern indicates that the small percent of families using center care on evenings or weekends are doing so for reasons other than the mother's work schedule.

Chart 5e: Percent of All Children in at Least Some Evening or Weekend Care by Mother's Employment Status on Evenings or Weekends



Note: 21% of mother's are employed on evenings or weekends.
*Differences are significant at $p < .05$

D.5. Variations in Care by Child or Family Characteristics

We also look at whether use of a particular type of care arrangement varies by the child's special needs status or family characteristics such as a parent's marital status and mother's employment status (not taking any other family characteristics into account). We must interpret these simple two-way associations with care because they do not take into account other factors that could explain the patterns we observe. In some cases, we find that the direction of a relationship or its significance is reversed when, in a multivariate analysis (Section E), we statistically control for the other factors that may also affect child care decisions.

Are Children with Special Needs More or Less Likely to be in Each Type of Care?

Chart 6 presents the percentage of children, within each age group and overall, with special needs. We identify a child as having a special need if the parent reports that the child has a physical, emotional, or developmental condition that affects decisions about child care.

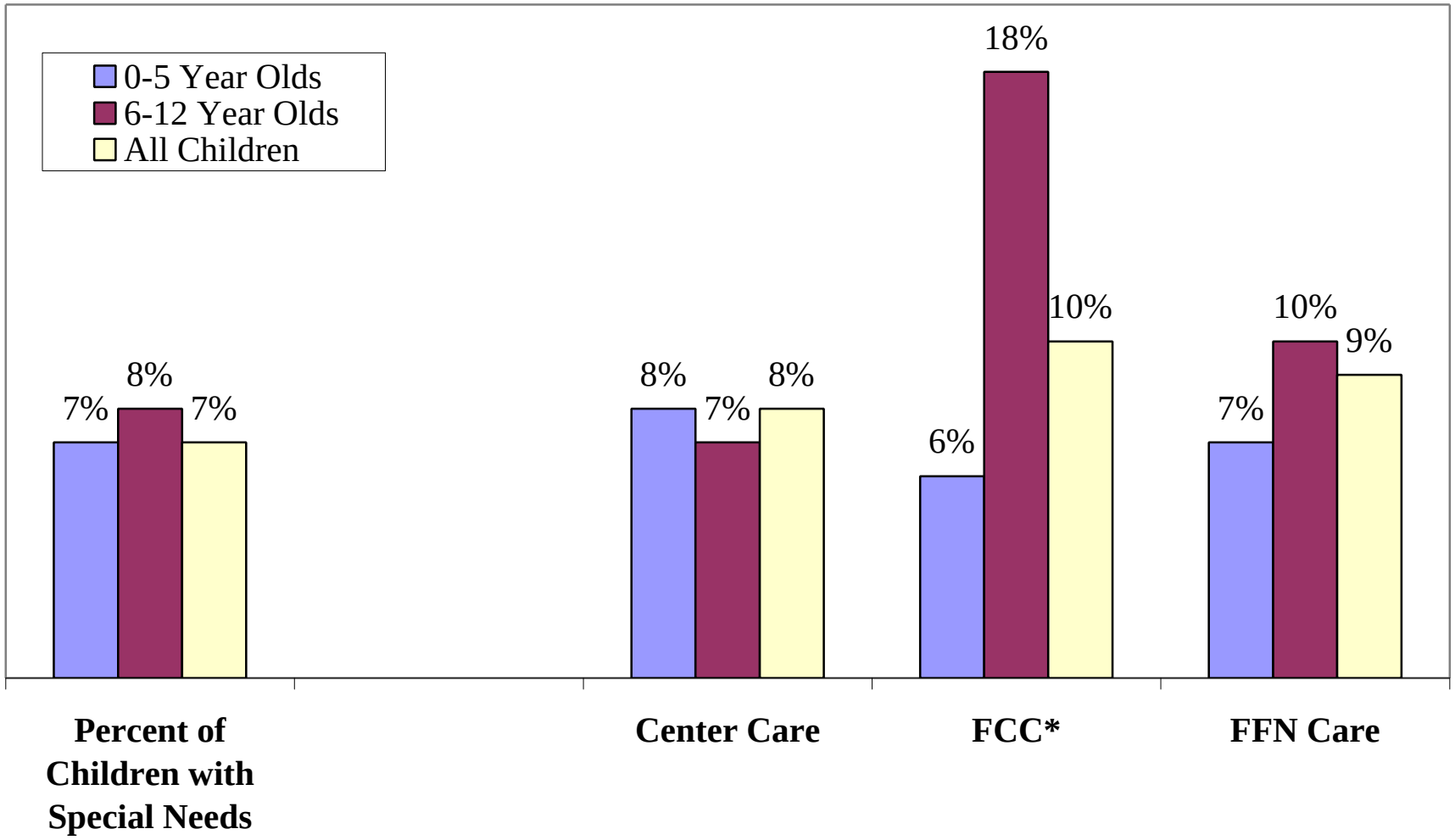
- In Washington State, seven percent of all 0-5-year-old children and eight percent of all 6-12-year-old children are identified by a parent as having a special need.[11]
- The percentage of children in each type of care with a special need is generally consistent with the prevalence of children with special needs in the population, with one exception. FCC arrangements serve a significantly higher percentage of 6-12-year-olds with special needs.
- We found no significant differences in the likelihood of parents using center or FFN care for children with or without special needs.

How Do Selected Family Characteristics Affect the Use of Care?

Without accounting for other factors that might also affect the likelihood of using particular types of care arrangements, the survey findings suggest that some family characteristics are significantly related to the type of care chosen for children of different ages. Charts 7a and 7b present differences by two key family characteristics hypothesized to relate to different child care patterns—single parenthood and mother's employment status. Our major findings are:

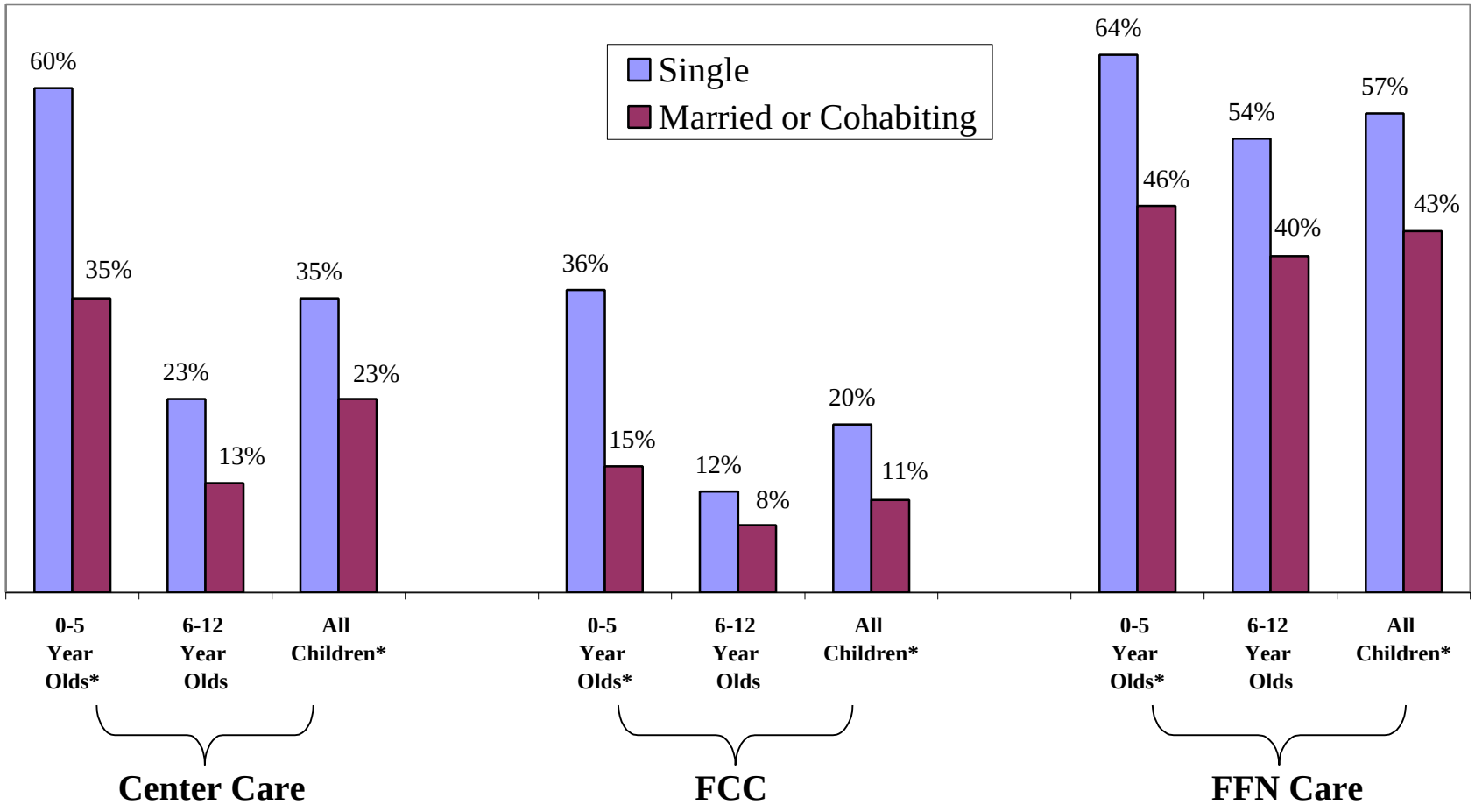
[11] We compared this estimate with a recent national parent survey—The 1999 National Household Education Survey (NCES 1999). According to these data, about nine percent of 0 to 5 year olds and nineteen percent of 6 to 12 year olds have a disability. This survey defines disability as a learning disability, mental retardation, speech impairment, serious emotional disturbance, deafness or hearing impairment, orthopedic impairment, or a health impairment lasting six months or more (NCES 1999). Differences in definition will result in different estimates of the prevalence of a special need or disability. Our estimates should therefore be considered at the lower range of incidence of special needs children.

Chart 6: Percent of Children In Center Care, FCC, or FFN Care with Special Needs



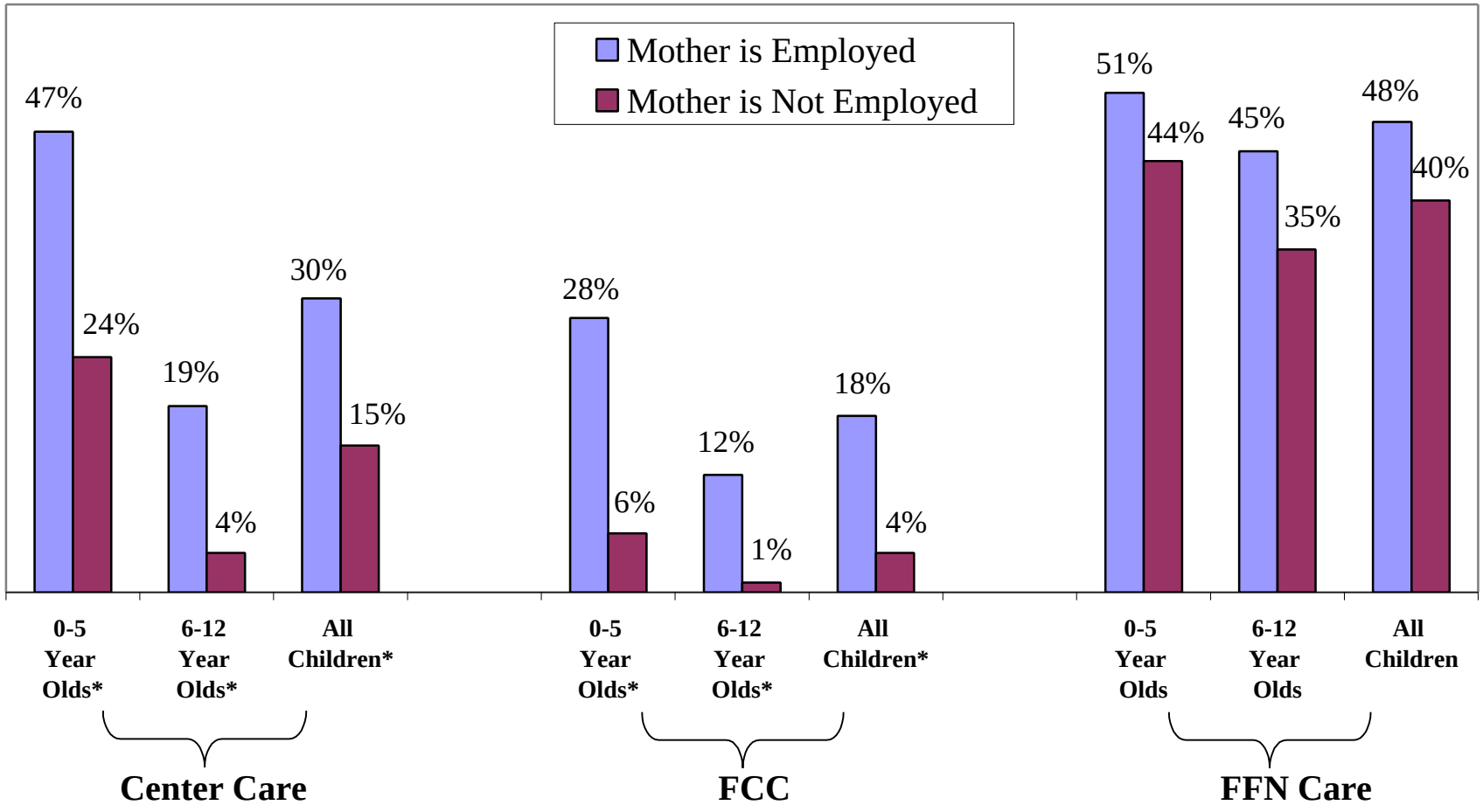
*Difference is significant at p < .10

Chart 7a: Percent of All Children in at Least Some Amount of Care by Parent's Marital Status



*Differences are significant at p < .05

Chart 7b: Percent of All Children in at Least Some Amount of Center Care, FCC, or FFN Care by Mother's Employment Status



*Differences are significant at $p < .05$

- Single parents, in general, are more likely to use each of the three main types of child care. However, these differences are only significant for younger children. That is, single parents are significantly more likely than married or cohabitating parents to use center care, FCC, and FFN care for 0-5 year old children. While the pattern is the same for parents of older children, the differences are not significant. This finding indicates the increased reliance of single parents on child care, probably due to the fact that partners and spouses provide some child care assistance in married and cohabitating families.
- For children in both age groups, mothers' employment is significantly and positively related to the use of both center care and FCC, but not FFN care. That is, while employed mothers appear to use FFN care more frequently than non-employed mothers, the difference is not large enough to be significant. This finding suggests that mothers' employment status bears a relationship to the types of care chosen, with employed mothers more likely to use more 'formal' types of care, regardless of the child's age. While both employed and non-employed mothers use FFN care at high rates, employed mothers do not appear to choose FFN care arrangements over other types of care for their children. Mothers use FFN care frequently, regardless of their employment status.

We also looked at differences in the use of care by household income groups, dividing the sample of households into low-to-moderate and middle-to-upper income groups depending upon whether family income was below or above 2.5 times the federal poverty level for families of their size. (In 2001, $36,575 was 2.5 the FPL for a family of three.)[12] The median income for our sample is $50,000, which is consistent with that reported in the 2000 US census.[13] Major finding:

- The only significant difference in child care use by household income group is the use of center care for 0-5-year-olds. Higher income families are significantly more likely to use center care for their 0-5-year-olds. No other clear pattern emerges. This finding confirms research indicating that child care preferences for low-income and middle-income families are similar (Hofferth, 1998), but suggests that the higher costs of center care may make it prohibitive for some families. [See Appendix A for additional charts.]

Once again, we should interpret these results with caution, as they present only the two-way relationships between family characteristics and usage patterns. They do not take into account the many other unexamined factors that might explain these relationships (for example, the fact that single parents tend to have lower incomes). In Section E below, we use multivariate statistical analyses to explore these interactions.

D.6. Variation in the Amount of Care and Primary Care by Family Characteristics

We also examine whether the mean number of hours in each type of care arrangement varies significantly by children's special needs status, mother's employment status, and household

[12] Our weighted sample is representative of the income distribution in WA state, as compared to similar estimates from the US census of median household income and percent of children below poverty.

income group in relation to the federal poverty level. As stated previously, these two way associations between child or family characteristics and child care use do not take into account other factors that might explain the observed relationship.

Does the Amount of Care Vary by Children's Special Needs Status?

We do not find that the amount of time children spend, on average, in each type of care per week varies significantly by children's special needs status. All children in center, FCC, and FFN care, regardless of special needs status, appear to be in, on average, the same amount of care each week.

Does the Amount of Care Vary by Mother's Employment Status and Household Characteristics?

Just as we found that employed mothers are more likely than non-employed mothers to use all types of care for their children, we also found that the amount of care used in some care types is higher among employed mothers. Chart 7c presents these results. Our major findings are:

- Though employed mothers are not significantly more likely than non-employed mothers to use FFN care for their 0-5-year-olds, those who do use FFN care use significantly more of that care each week than non-employed mothers. The same pattern is not true for mothers of 6-12-year-olds in FFN care.
- For both age groups, children of employed mothers in center care are in that care significantly more time per week than children of non-employed mothers in center care.
- For 6-12-year-olds in FCC, those with employed mothers are in care for significantly more hours per week than those with non-employed mothers.

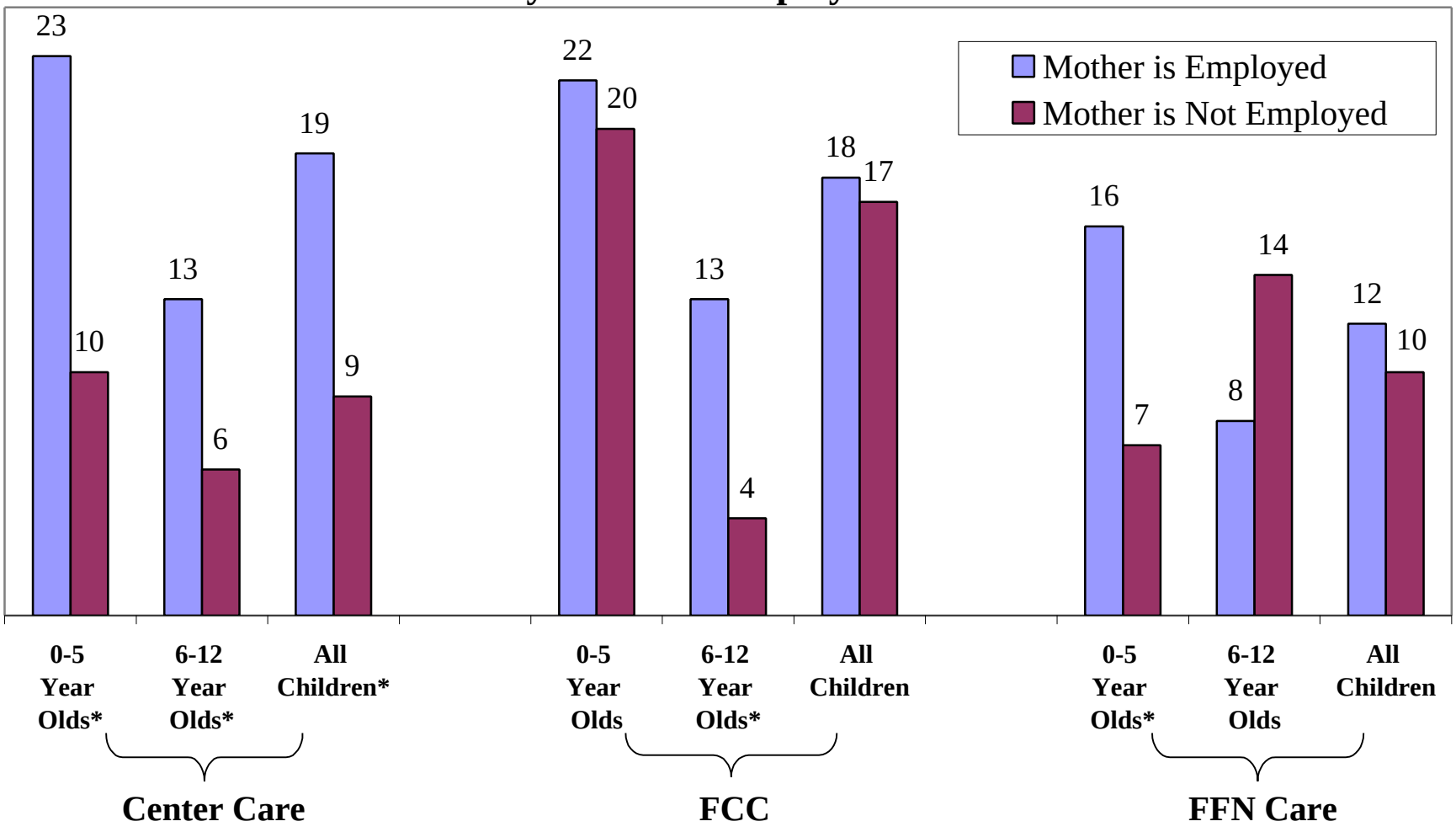
In summary, for almost all care types and both age groups of children, employed mothers use more care for more time each week. For FFN care, this pattern holds only for 0-5 year olds.

The observed differences in the hours spent in each type of care may be explainable by differences in family income rather than mother's employment status, as households with employed mothers are likely to have higher incomes than households with non-employed mothers. We looked at whether the amount of care differs according to household income group (below versus above 2.5 times the federal poverty line). Chart 7d presents these results. Our major findings are:

- The amount of FFN care used does not vary significantly by household income.
- Higher-income families are significantly more likely than low-to-moderate-income families to use more center care for their 0-5 year olds.

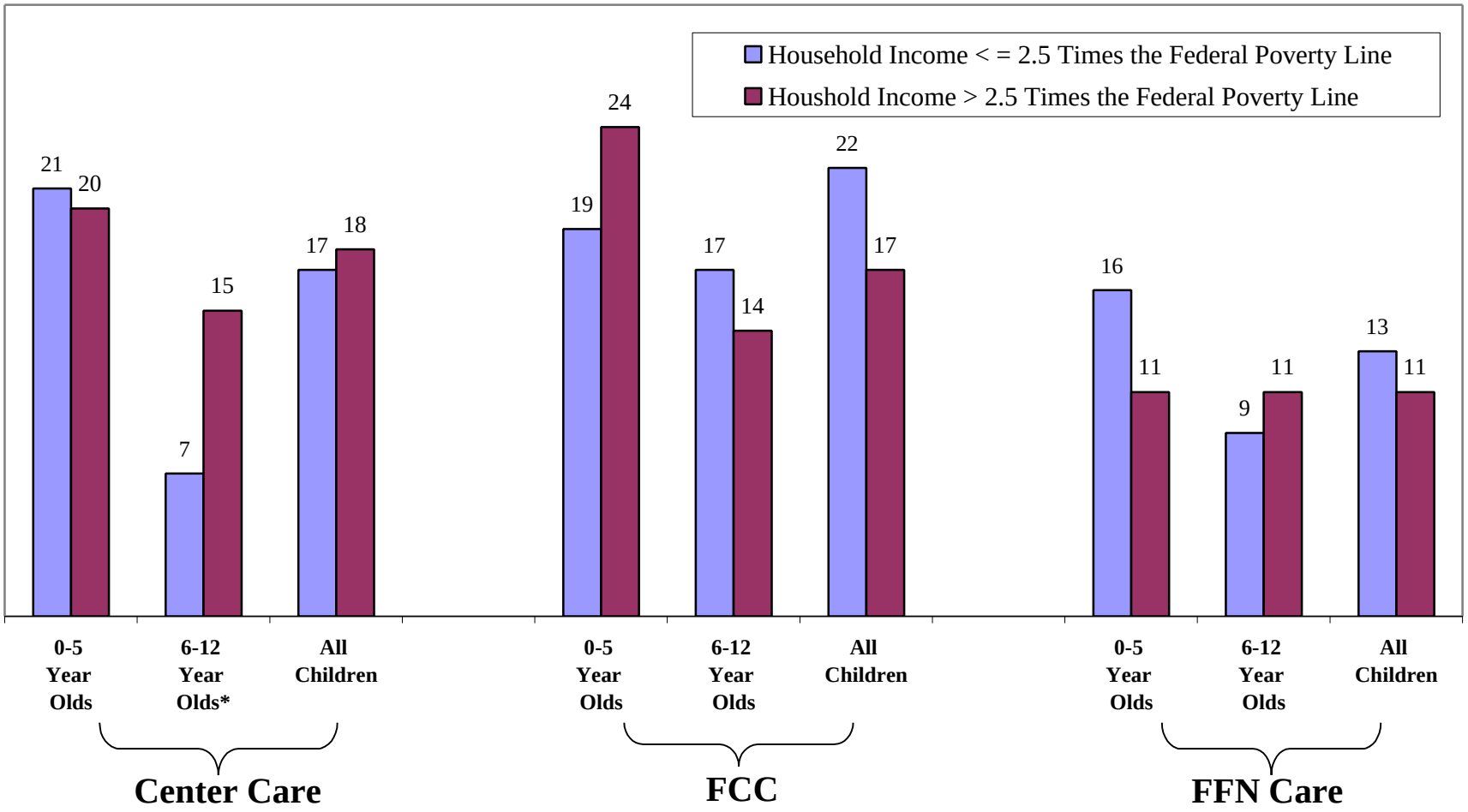
Finally, we conducted a supplementary analysis of the demographic differences among families who used more FFN care than most families. This analysis simply investigates whether or not certain household characteristics are significantly related to the likelihood of using above or below the median amount of hours per week of FFN care among families using FFN care. Our major findings are:

Chart 7c: Average Hours of Center Care, FCC, and FFN Care per Week by Mother's Employment Status



*Differences are significant at p < .05

Chart 7d: Average Hours in Center Care, FCC, or FFN Care Each Week by Household Income Group



*Difference is significant at p < .05

- Families with low-to-moderate incomes (below 2.5 times the FPL) are significantly more likely to use more than the median amount of FFN care for their 0-5 year olds than higher income families.
- Single parents are significantly more likely than married or cohabiting parents using FFN care to use more than the median amount of FFN care for children in both age groups.
- Among mothers using FFN care, those working in the evening or on weekends are not significantly more or less likely to use more FFN care than mothers not working on evenings or weekends.

Does the Choice of Primary Care Vary by Mother's Employment Status?

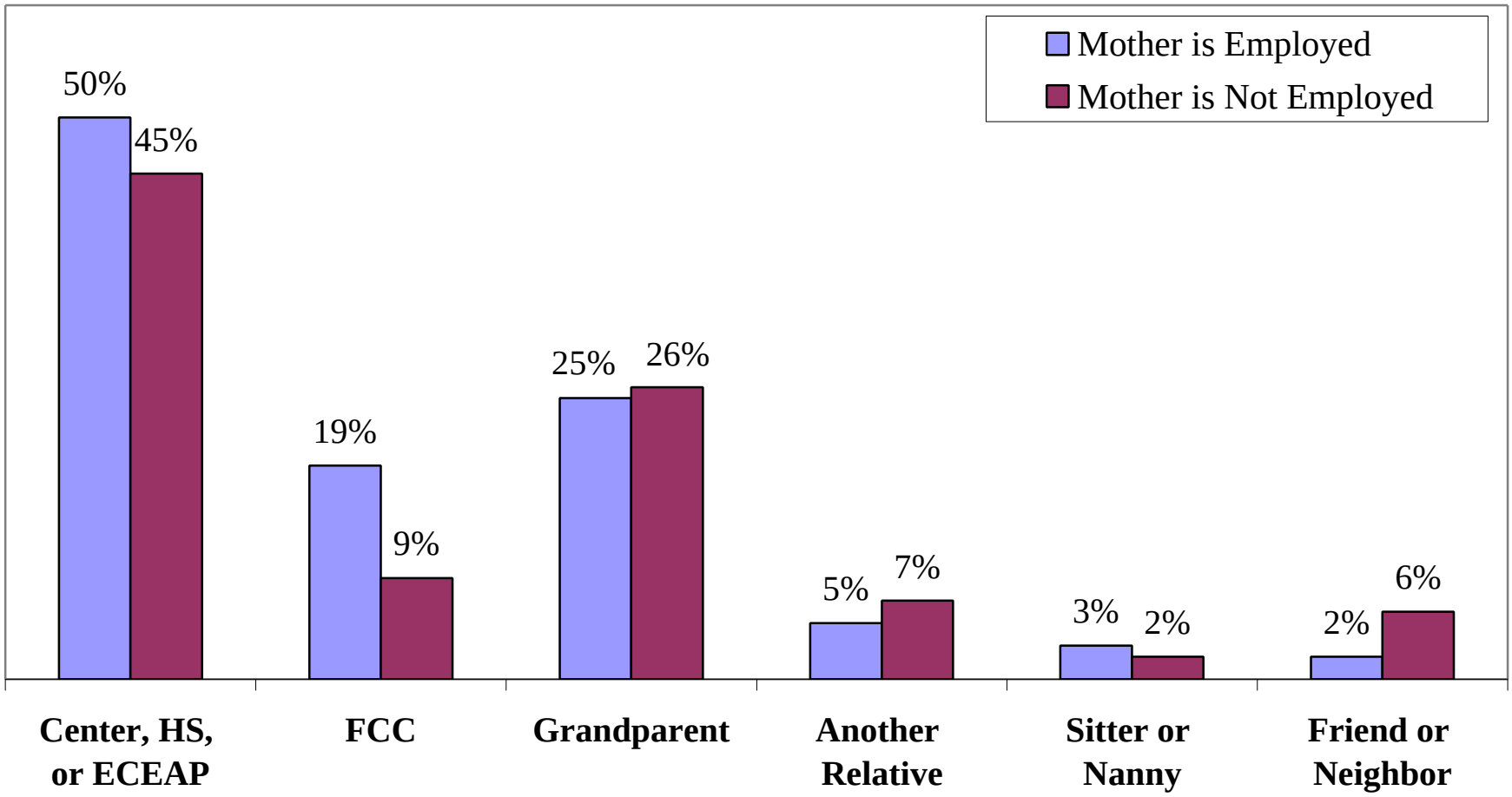
Finally, we investigate whether mothers' employment status is correlated with the most frequently used type of non-parental care arrangement. Mothers' employment decisions often depend upon the availability and feasibility of child care options (we discuss this at length in Section E), so we cannot definitively determine what causes associations between mothers' employment status and use of child care. Employed mothers may be more likely to use one form of care than non-employed mothers or conversely, mothers who have a certain type of care available to them may be more likely to become employed. Again, we want to emphasize the importance of interpreting these results with caution, as we do not control for other factors that may also be related to the child care and family characteristics we asked about.

Charts 7e and 7f present the results summarizing the primary care arrangements of employed and non-employed mothers separately for each age group. Our major findings are:

- For parents of younger children (0-5), the choice of primary care arrangement does not vary significantly by mother's employment status. That is, while employed mothers of young children are slightly more likely than non-employed mothers to use center or FCC as a primary care arrangement, the difference is not large enough to be statistically significant.
- While the pattern is the same as for parents of younger children, employment-status differences in choice of care are significant and larger for parents of 6 to 12 year olds. Employed parents of older children are much more likely than non-employed parents to choose center care and FCC as primary care arrangements and much less likely to use grandparent care as a primary care arrangement.

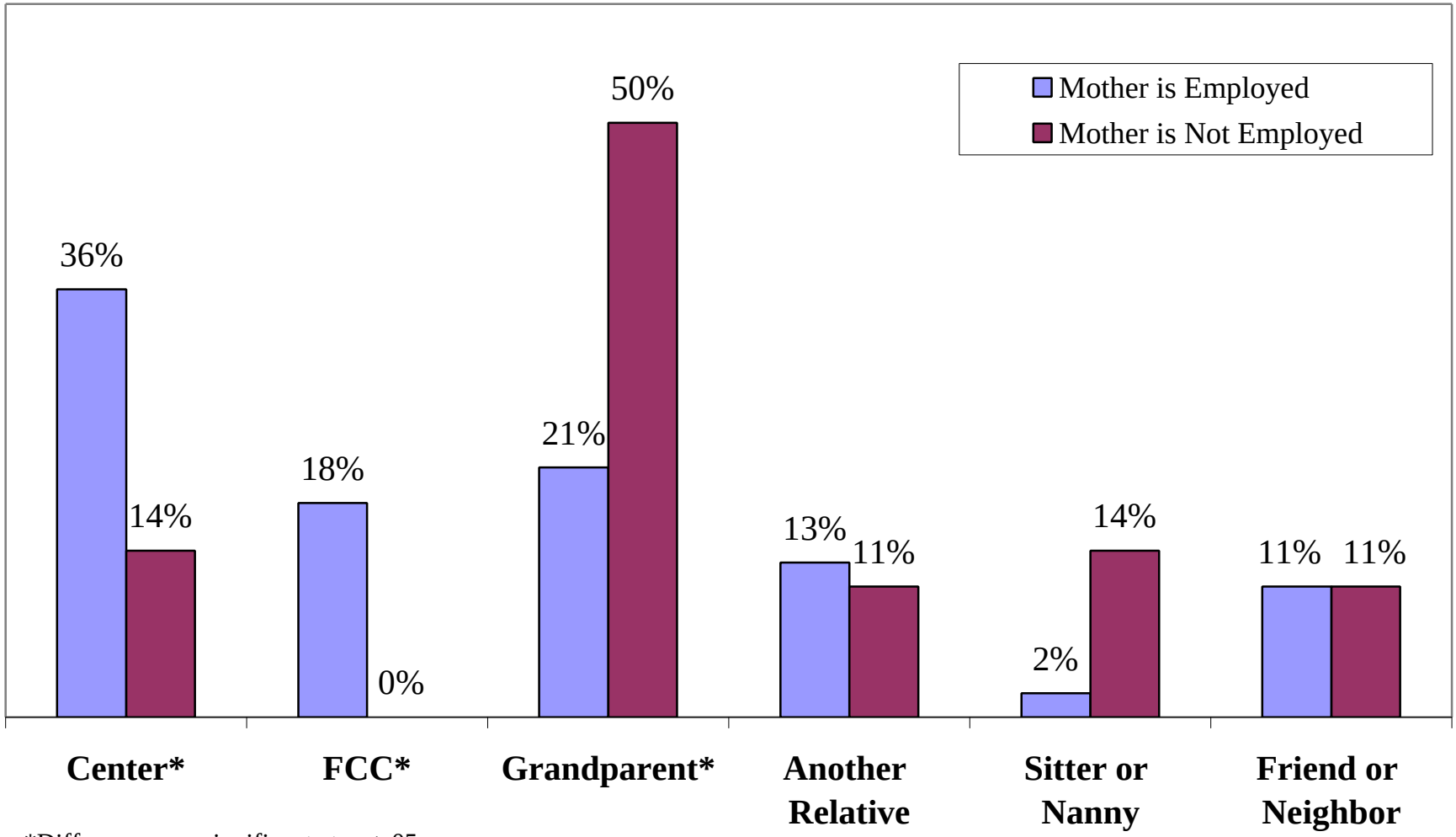
For their children's primary care arrangement, employed mothers seem more likely to choose center care or FCC and less likely to choose FFN care.

Chart 7e: Primary Care Arrangements of 0-5 Year Olds in Non-parental Care by Mother's Employment Status



Note: No differences between the primary care arrangements of employed and non-employed mothers are signficant for 0-5 year olds.

Chart 7f: Primary Care Arrangements of 6-12 Year Olds in Primary Care by Mother's Employment Status



*Differences are significant at p < .05

D.7. Estimating the Total Number of FFN Care Hours and Providers

We present estimates of the absolute numbers of FFN care hours and providers. Given the 228,000 children age 0-5 and 255,000 children age 6-12 in Washington using FFN care and the *average* amount of time per week these children use all types of FFN care (13 hours for 0-5 year olds and 10 hours for 6-12 year olds), the total number of hours spent in FFN care each week is estimated to be approximately:

- 3.0 million hours per week in FFN care for 0-5 year olds.
- 2.5 million hours per week in FFN care for 6-12 year olds.

To compute estimates of the number of caregivers providing this amount of care, we divide the number of children in FFN care by the average number of children cared for by each FFN caregiver, which is approximately two. Finally, we take into account the fact that 27 percent of FFN providers have an assistant who are most often relatives of the primary FFN provider and live in the same household. This information comes from the caregiver survey and is presented in Section F of this report. Thus, we estimate that in Washington State the average number of people providing FFN care in a given week is 295,000.

Thus, each week a substantial number of FFN caregivers provides many hours of FFN care to both younger and older children. And, assuming some turnover of caregivers during the year, an even larger number of adults provides FFN care for children on an annual basis. It is clear that FFN care is a substantial piece of the overall picture of child care in Washington.

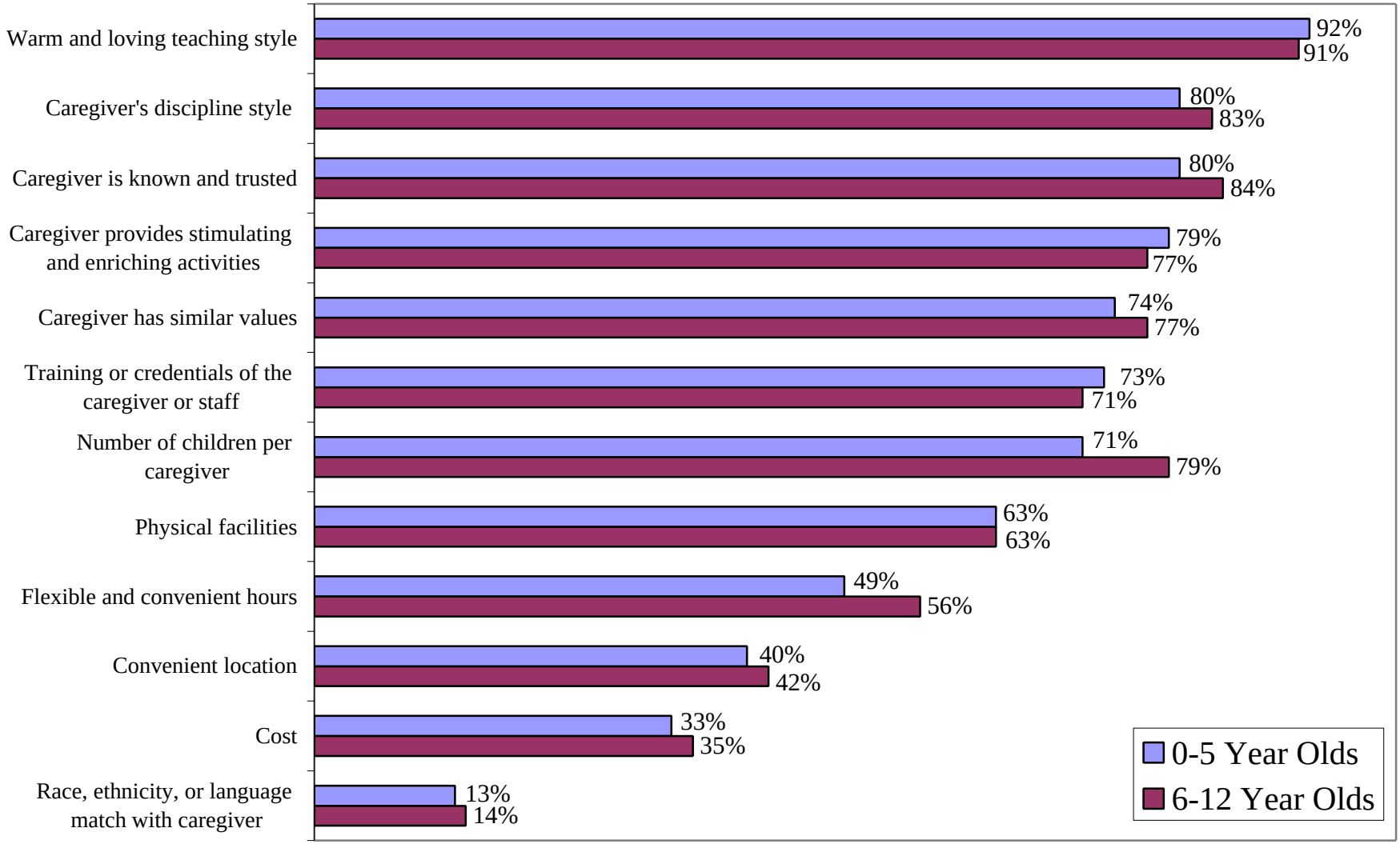
D.8. Reasons Why Parents Choose FFN Care

We use two approaches to explore the reasons parents choose certain types of care for their children. In the first, we focus on parents' reported values. We asked parents about the importance of selected characteristics of quality child care. We chose these characteristics on the basis of previous research and suggestions by the Systems Subcommittee of the Childcare Coordinating Committee. In our second series of questions, we asked parents why they selected a particular kind of non-parental care as primary (the most-frequently used care arrangement, used at least five hours a week). We asked open-ended questions designed to elicit parents' most salient reasons, which we then coded into standard categories. (In section E below, we take a behavioral approach to parent choice, using statistical techniques to relate family and child characteristics, as well as parents' expressed values, to the actual child care choices they reported.)

What Qualities of Child Care Do Parents Value?

In general, what qualities do parents value about child care? Chart 8 presents the percentage of parents placing great importance on each quality of child care. (We asked these questions of all parents, even those who did not use any non-parental child care arrangements.) Our major findings are:

Chart 8: Percent of Parents Responding that Each Quality of Child Care is 'Very Important' to Them



- In general, parents report that many qualities of good care are very important to them.
- Differences in the values placed on each quality of care do not vary much by age of child.
- The qualities that most parents rank as highly important are: warm and loving teaching styles, caregiver discipline styles, knowing and trusting the caregiver, and having caregivers who provide stimulating and enriching activities.
- The qualities that fewest parents rank as highly important are: racial, ethnic, and/or linguistic match; cost; and location. This finding is consistent with previous research suggesting that, despite the fact that price and convenience often show strong effects on actual choices about child care, parents often downplay the importance of these concerns in attitudinal surveys (Hofferth, 1998).

What Are Parents' Reasons for Choosing Their Primary Care Arrangements?

We asked parents to tell us their main reason for choosing a particular primary care arrangement. We requested that they focus on the type of arrangement, rather than the particular provider, although for many respondents provider characteristics and type of care go hand-in-hand (this may be especially true for FFN care). Chart 9a presents the main reasons parents gave for choosing a FFN primary care arrangement (broken down by age groups). Chart 9b does the same for parents who chose center care and FCC as their primary care arrangements. These charts list all reasons that were given by at least 5% of the parents (in one or both age groups). Our major findings are:

- Familiarity with the provider or a recommendation from someone else was the reason most frequently cited by parents who chose FFN care as the primary care arrangement. Although this was true for both age groups, parents of children age 0-5 gave this reason more frequently than parents of older children.
- Additional analyses indicate that parents of 6- to 12-year-olds who are in a FFN primary care arrangement more than 20 hours a week are significantly more likely to give familiarity as a main reason for choosing that arrangement (47%) than parents whose children are in a FFN primary care arrangement less than 20 hours per week (24%) [See Appendix A for additional charts].
- While location, cost, and convenient hours are also among the top reasons parents cite for choosing FFN care as a primary care arrangement, they are cited much less frequently than familiarity or recommendations.
- Familiarity or recommendations is also the predominant reason parents give for choosing center care or FCC as the primary care arrangement for their children (both age groups). The second most frequently cited reason for 0-5 year olds is that parents like specific aspects of the quality of care and/or the nature of the program (including the providers, the activities, or the curriculum). For 6-12 year olds, location is the second most frequently cited reason. For both age groups of children, fewer parents indicated that they chose FCC or center care because it reflected the family's religious background or values.
- Parents with a center care or FCC primary care arrangement provide a greater diversity of reasons for choosing this type of care than do parents choosing a FFN primary care arrangement.

Chart 9a: Percent of Parents Reporting Each as a Main Reason for Choosing FFN Care as the Primary Care Arrangement

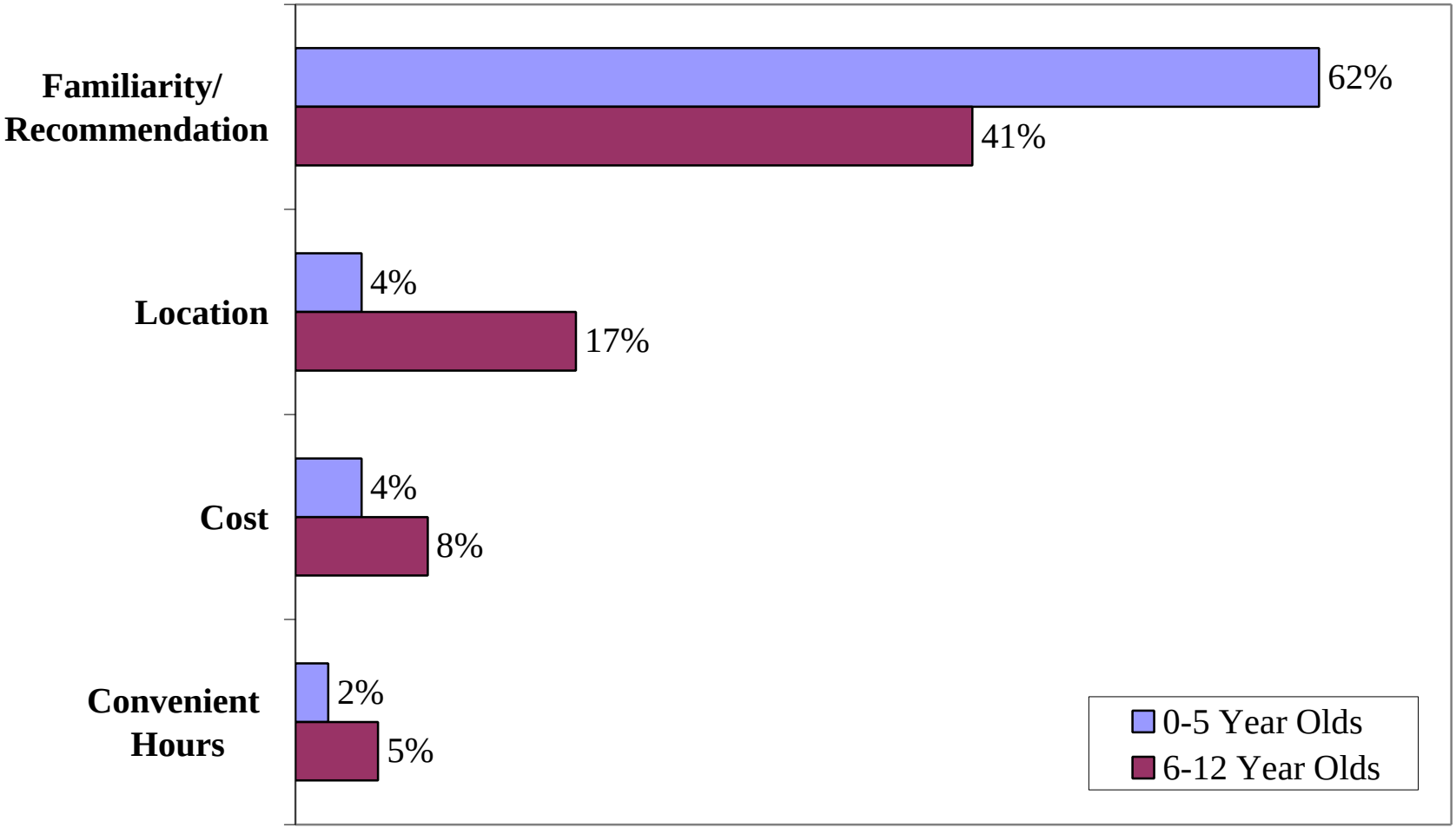
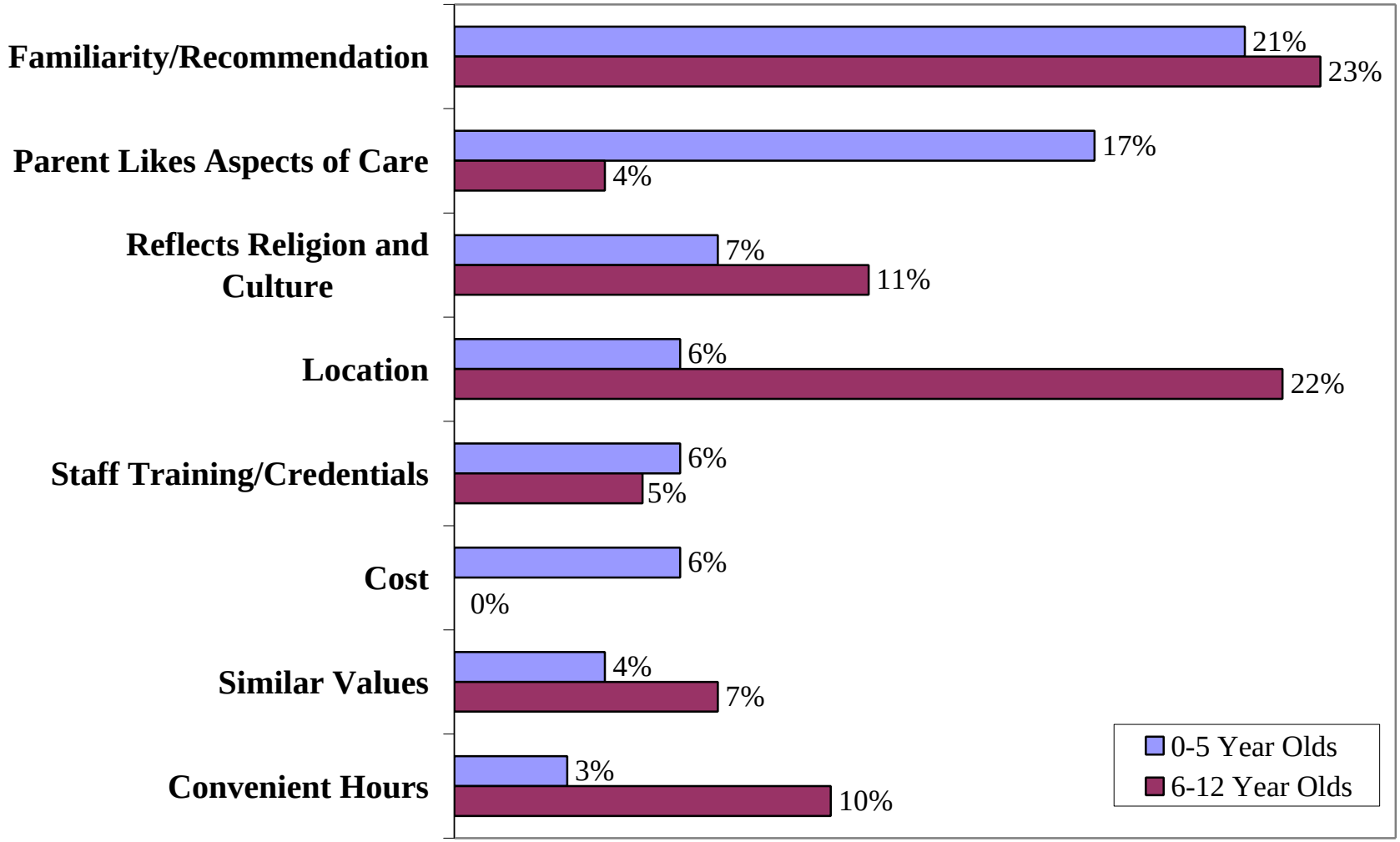


Chart 9b: Percent of Parents Reporting Each as a Main Reason for Choosing Center Care or FCC as the Primary Care Arrangement



D.9. Qualities of the Child Care Parents Use

We present data on two key features of child care that may influence parents' choice of care: child:adult ratios and the cost and financing of child care.

What Are the Average Child: Adult Ratios in Various Types of Child Care Arrangements?

Chart 10 presents, for children in both age groups, the average child:adult ratios for each detailed type of care. Note that these ratios are reported by parents. A major national study found that while parents are quite accurate in reporting ratios for FCC, they tend to overestimate the number of adults in center care (Willer, 1991). Our major findings are:

- FFN care has a ratio of about 1.3-1.4 children per adult, a significantly lower child:adult ratio than either center care or FCC for children in both age groups.

Additional analyses revealed the following:

- When examining differences in ratios by detailed age groups, we find that the child:adult ratios for center care are higher for children older than three, but relatively constant across age groups for FFN care. FCC ratios are substantially lower for 9 to 12 year olds, but this information is based on only a few cases. [See Appendix A for additional charts].

Since the child:adult ratios for the three types of care differ so greatly, especially for older children, and since many parents report that these ratios are "very important" to them, FFN care may remain a popular child care choice for this reason alone. To reduce child:adult ratios for center care and FCC to the levels reported for FFN care would be prohibitive in cost, and is not considered necessary by experts.

How Much and How Do Parents Pay for Child Care?

Cost also affects parents' child care choices. Chart 11a compares the average out-of-pocket costs, per hour of care, for center care and FCC (combined) to the costs of FFN care for most of the detailed age groups[14]. (We do not have sufficient data on out-of-pocket expenses for the 9-12 age group.) We present the information by detailed age groups so we can control for the possibility that a large number of children in one age group could inflate the overall average by both using more care and paying more for that care. This chart presents the out-of-pocket hourly rate paid by parents, regardless of how many hours they use the care, whether they receive financial assistance, or whether they pay a full or reduced fee. Finally, the average out-of-pocket amount reported here is only for parents who pay for care. Our major findings are:

[14] For parents who paid for more than one type of FFN care, we computed an average FFN care cost.

Chart 10: Average Child:Adult Ratio for Each Type of Care

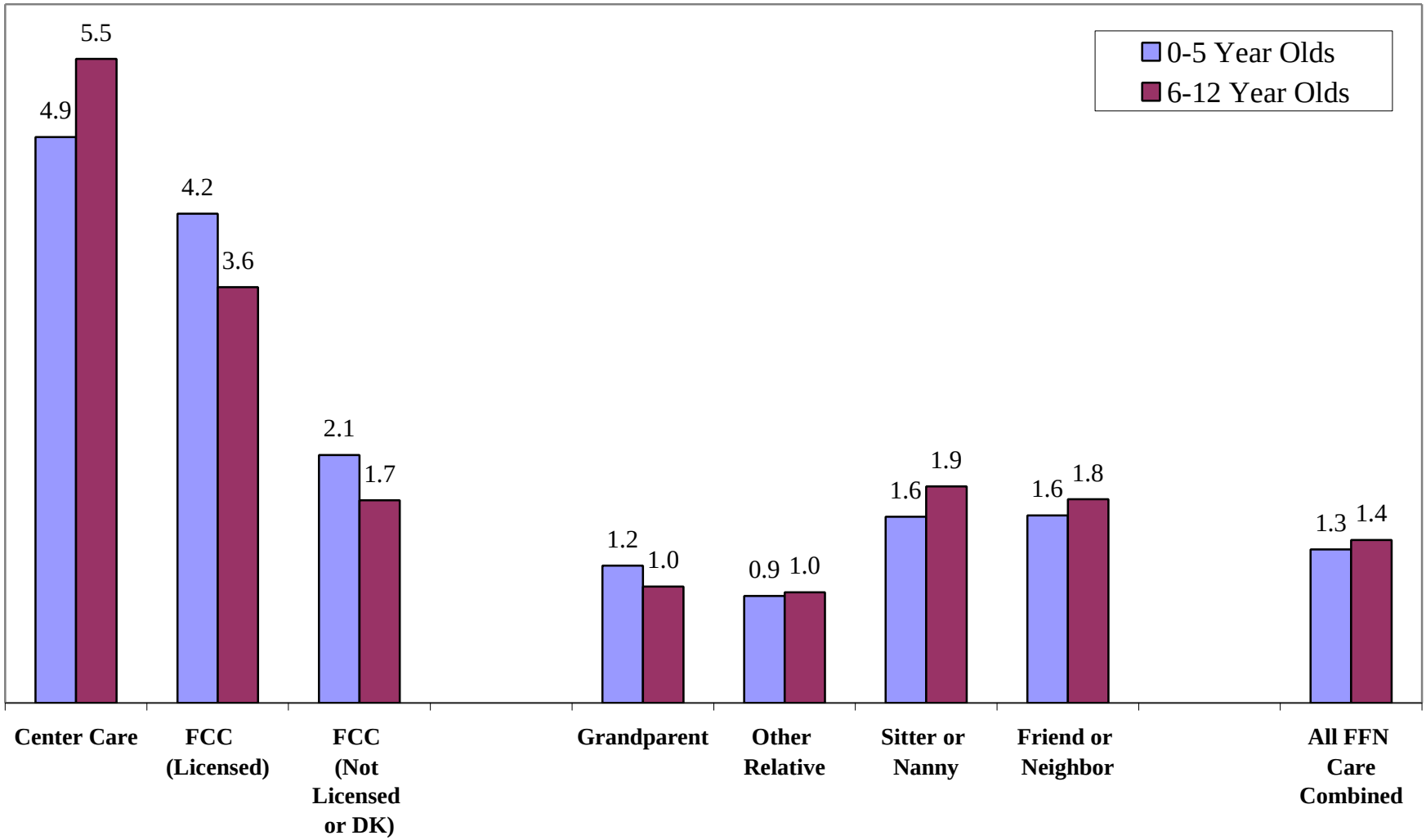
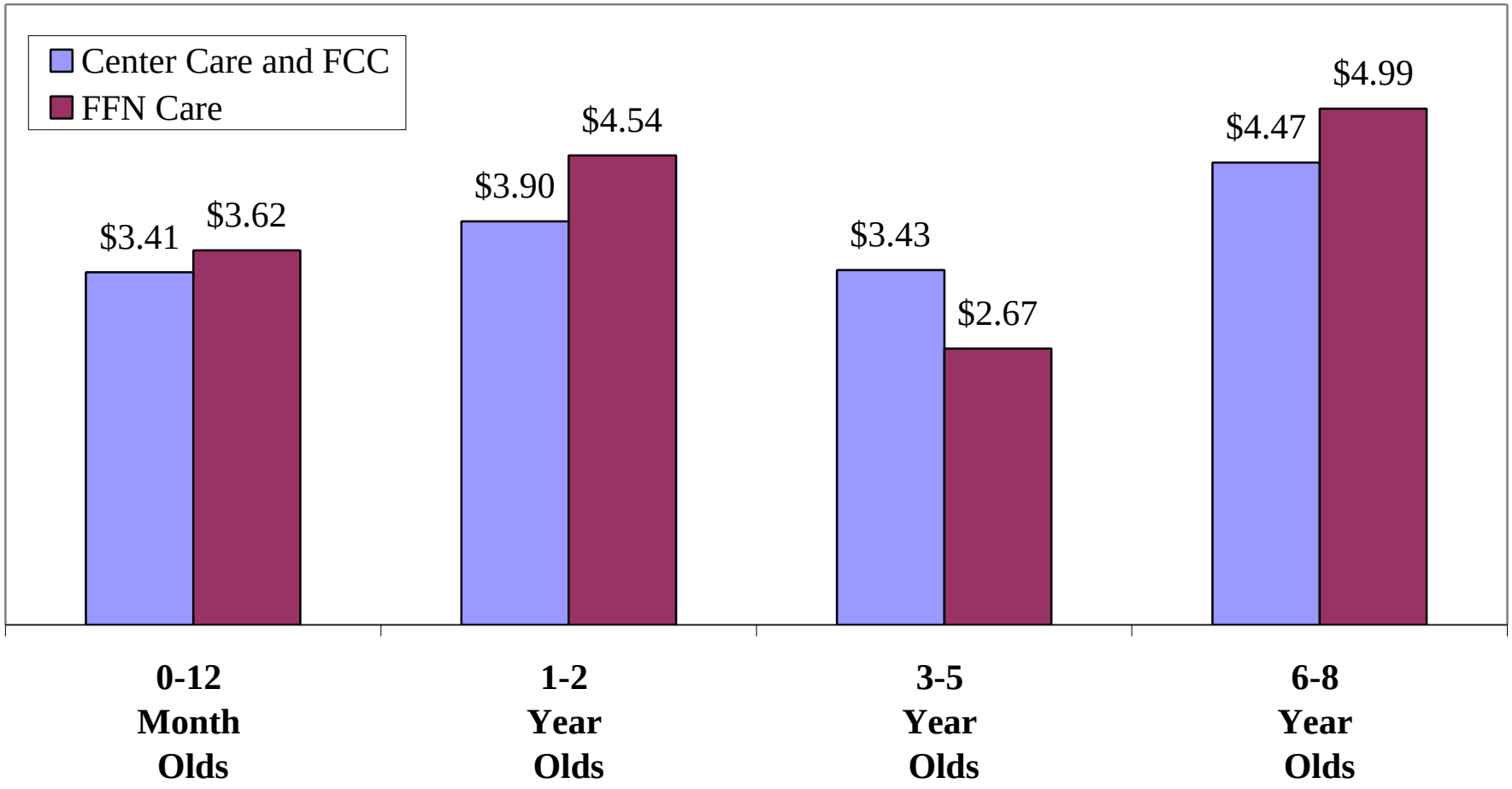


Chart 11a: Average Price Paid for Center Care, FCC, and FFN Care Among Parents That Pay for Each Main Care Type by Detailed Age Groups



Note: We do not report average cost of care for 9-12 year olds due to the small number of cases for computing estimates for center care and FCC.

- Across all age groups, the price paid for FFN care ranges from $2.67-$4.99 per hour. This is a broader range than that of the price paid for center care and FCC ($3.43-$4.47 per hour).
- For three of the four detailed age groups, parents who pay for FFN care are paying hourly rates that are the same or higher than what parents pay for center care and FCC. This result is reversed for 3-5 year olds, for whom the cost of FFN care is lower than the cost of center care and FCC.[15]

Possible explanations of the high cost of FFN care compared to other types of care include: a) The high FFN care costs reflect only the small proportion of parents (22%) who report paying anything at all for FFN care and probably include a high percentage using higher priced 'nanny' care; or b) Parents pay more per hour when they use less care. Thus, though the average hourly cost of FFN care is higher, the overall weekly cost is lower. For those who pay, FFN care costs about $44 per week for young children and $50 per week for school-aged children. This is less than the weekly costs for younger children in center care ($69) and FCC ($62), and for school-aged children in center care ($67) and FCC ($52). We did not find that higher-income families pay more for FFN care than lower-income families, so family income does not explain the higher out-of-pocket payments for FFN care. In fact, we found that higher-income families report paying significantly more than lower-income families only for center care.

Additional findings related to whether parents pay anything at all for the care they use:

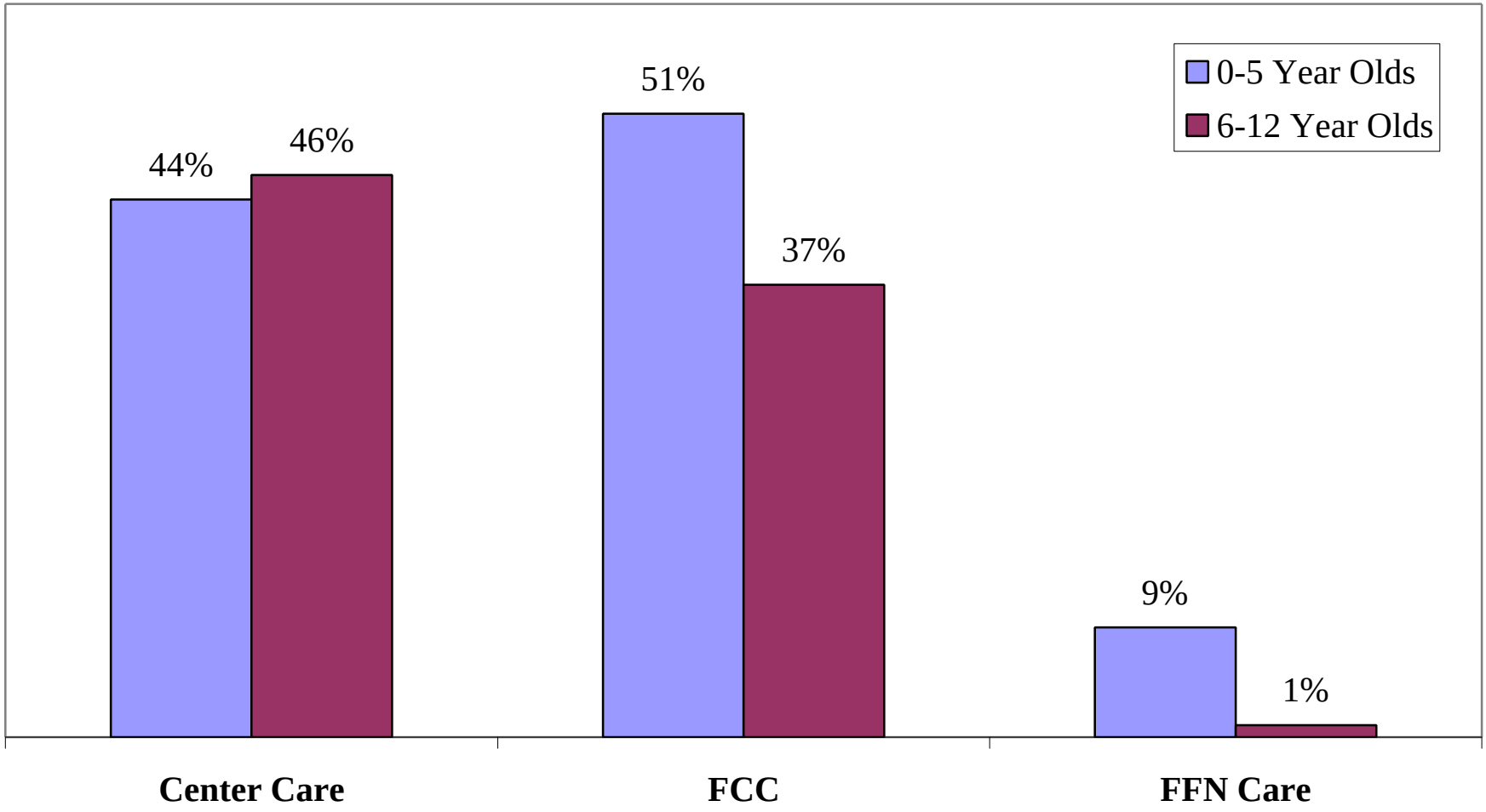
- Most parents (78%) do not pay for any of the FFN care they use. Within each type of care, 7 percent of parents pay for the grandparent care they use, 22 percent for other relative care, 16 percent for friend or neighbor care, and 83 percent for the sitter or nanny care they use.
- Parents of 0-5 year olds who use more than the median amount of FFN care are significantly more likely than other parents to pay for that care. The same is not true for parents of 6-12 year olds, for whom the number of hours in care is not significantly related to the likelihood of paying for that care.
- For all types of FFN care, parents are more likely to pay for that care if it is their primary care arrangement. An exception is sitter or nanny care, for which primary care arrangement does not affect parents' likelihood of paying.

Chart 11b shows the percentage of parents who report receiving outside help or reduced fees for child care costs. Outside help is defined as help from a person or agency outside the household, or participation in a parent co-op. Our major findings are:

- Depending on the age of the child, 37 percent to 51 percent of parents receive outside help or are charged reduced fees for center care or FCC. Only 1 to 9 percent of parents who pay for FFN care report receiving outside help or reduced fees.

[15] Statistical tests of significance indicate that for each of the two age groups, the cost of FFN care is not significantly different than the cost of center and FCC care.

Chart 11b: Percent of Parents Using Center Care, FCC, and FFN Care Receiving Outside Help* or Reduced Fees for Child Care Costs



*Outside help is defined as help from a person or agency outside the household or a parent co-op.

Additional findings:

- We do not find significant differences in out-of-pocket child care expenses between parents who and do not report receiving outside help or reduced fees. Parents who report receiving outside help pay about the same out-of-pocket amount as parents who do not report receiving outside help. The assistance they receive may allow them to purchase higher quality care. [See Appendix for additional charts.]

Chart 11c presents the percentage of parents receiving outside help from a public agency (primarily child care subsidies). Our major findings are:

- Parents using center care are most likely to receive subsidies (9% of parents of 0-5 year olds and 13% of parents of 6-12 year olds).
- Parents using FFN care are least likely to receive subsidies (4% of parents of 0-5 year olds and 0% of parents of 6-12 year olds).

Chart 11d presents, by type of care and household income group, the percentage of parents who report receiving subsidies for care of younger and older children. Our major findings are:

- Ten percent of parents of 0-5 year olds in low-to-moderate-income families receive subsidies for FFN care. No parents report receiving subsidies for their 6-12 year olds in FFN care.
- Subsidies are most likely to be used for center care. Among low-to-moderate-income families whose children are in center care, 21 percent of parents of 0-5 year olds and 44 percent of parents of 6-12 year olds receive subsidies for that care.

Additional Findings:

- Additional analyses indicate that 35 percent of all parents who receive a government subsidy for their primary care arrangement have a FFN primary care arrangement.
- Families in poverty are more likely to use subsidies than potentially eligible families above the federal poverty line. Nonetheless, public child care subsidies are only reaching 33 percent of families in poverty (with incomes below the federal poverty line) and 9 percent of families between poverty and 2.5 times the FPL. In other words, most parents are paying for care without public assistance.

This last finding validates what we know from previous research: Many low-income families do not use the subsidies for which they may be eligible. It also indicates that as household income increases in relation to the federal poverty level, the likelihood of receiving and using a subsidy to pay for care decreases, even among eligible families.

Chart 11c: Percent of Parents Using Center Care, FCC, or FFN Care Who Report Receiving a Government Child Care Subsidy

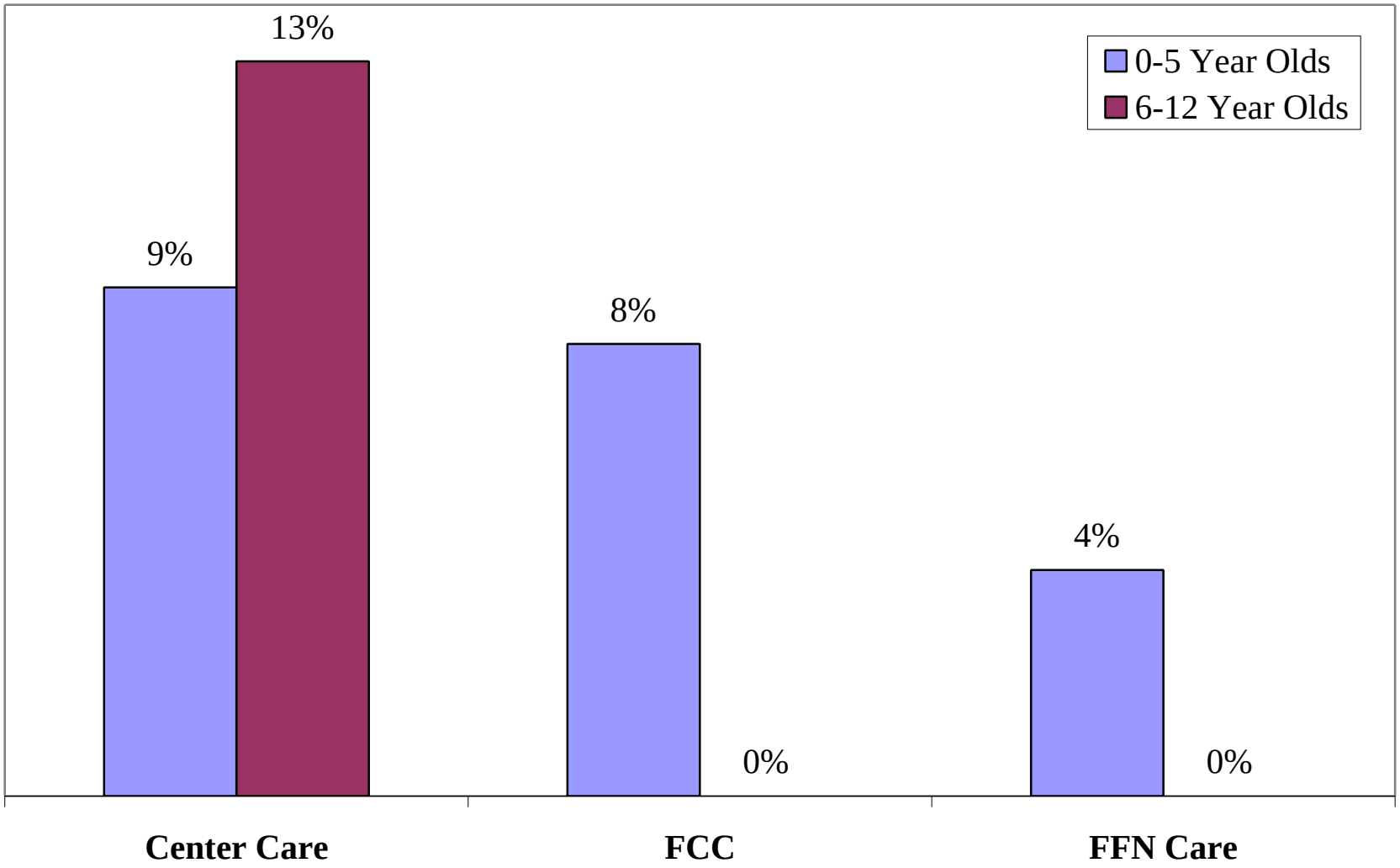
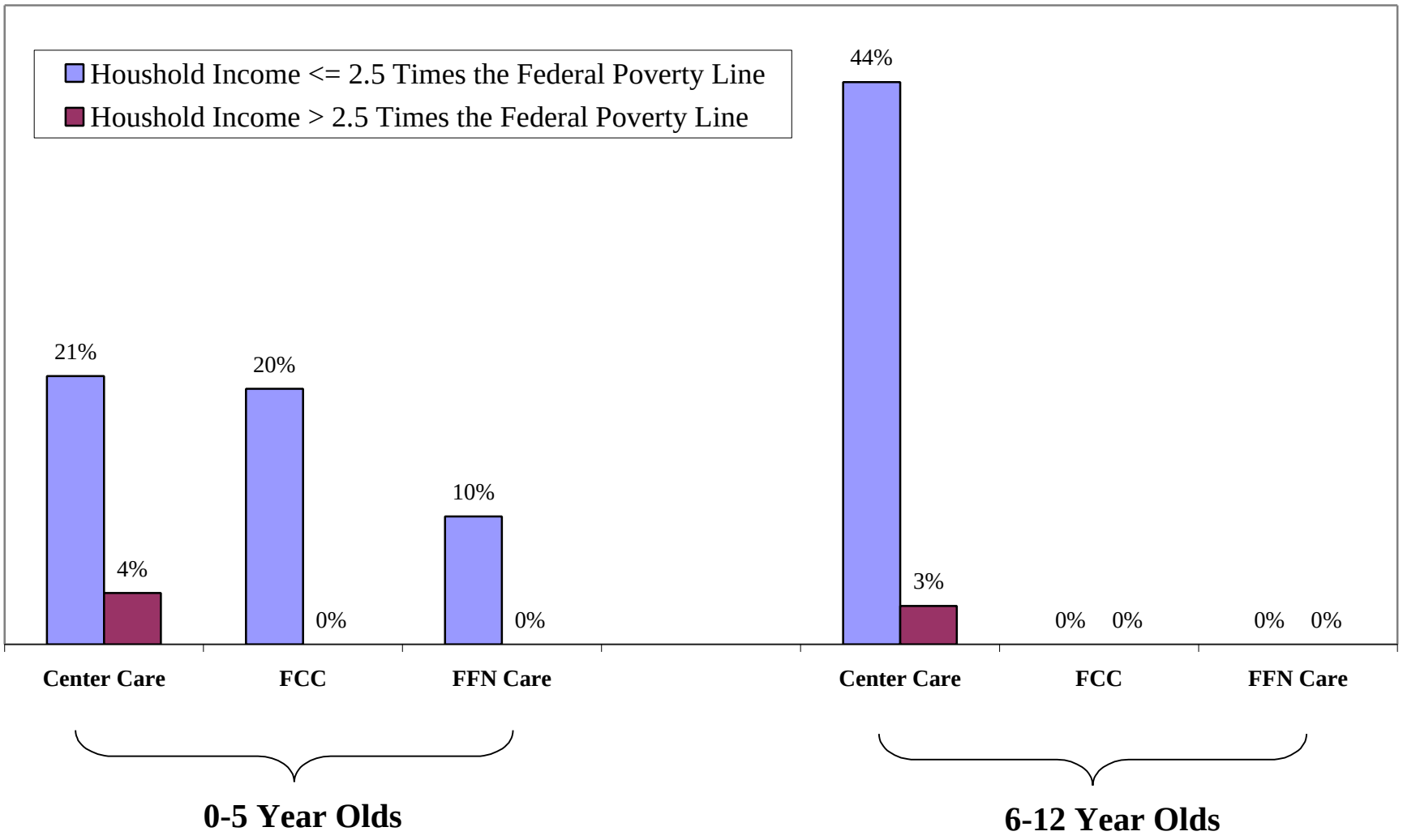


Chart 11d: Percent of Children in Each Type of Care Receiving a Government Subsidy for that Care by Household Income Group



D.10. Summary of Descriptive Analysis

In this section, we have presented descriptive results about the percentages of children of different ages in various types of child care. We have also described how much of each type of care is used and how this use varies as a function of key child and family characteristics. Combining these two sets of results, our summary tables show the percentage of all non-parental care hours spent in each type of care arrangement and the percentage of children in a FFN primary care arrangement. These results clearly demonstrate that FFN care, especially grandparent care, represents a substantial proportion of all child care arrangements for all ages of children. Using detailed age groups, we estimated the percentage of all children for whom FFN care is the primary care arrangement. And we presented parents' stated reasons for choosing either a FFN, center, or FCC primary care arrangement.

Because many of the factors affecting parents' choice of child care overlap, we conducted a multivariate analysis to help us better understand the independent contributions of each factor. We present these results in the next section.

E. MULTIVARIATE ANALYSIS RESULTS

In this section, we elaborate on the relationships described in Section D between families' use of FFN care and child and household characteristics. We describe the results of a multivariate analysis that predicts the likelihood of choosing one of three child care arrangements as the primary care arrangement for the youngest child in the family: FFN care, center care or FCC, or no non-parental care. Non-parental care arrangements have to be used for more than five hours a week to be considered in this analysis.

In the previous section, we presented information about the use and amount of FFN care by child and household characteristics, one characteristic at a time. As noted above, one should be hesitant to draw firm conclusions from these results, as they do not take into account the nature of the relationship between all characteristics of interest. For example, if single mothers are less likely to use FFN care, this relationship could be observed because single mothers have different child care preferences than married mothers. Alternatively, this relationship could be observed because single mothers are more likely to work and use formal care arrangements because they tend to have fewer financial resources than married mothers. Multivariate analyses simultaneously consider several characteristics of interest, such as the mother's marital status and her financial situation. This makes it possible to assess the unique contribution of each characteristic considered, as well as the relative importance of various characteristics in parents' child care decisions. Thus, the multivariate results complement and enhance the descriptive information presented earlier by isolating a relationship between a particular child or family characteristic and the use of type of care.

To better understand parents' selection of an FFN care arrangement, we compare families who use FFN care as their primary care arrangement with families who use center care or FCC as their primary care arrangement with families who use no non-parental care. We focus on the primary care arrangement of the youngest child in the family – that is, the non-parental care arrangement used regularly for the most hours. We estimate the multivariate model separately for families whose youngest child is under six years of age and for families with a youngest child between six- and twelve-years old. By estimating separate models, we allow for the possibility that the relationships between child and family characteristics and the choice of care arrangement vary by the child's age.

We considered a variety of factors as potentially relevant for parents' child care decisions. They include:

- *Family background characteristics*: the number and ages of children; whether the youngest child has special needs; family income; the survey respondent's race-ethnic group, marital status, age, and education level; whether a relative is available to care for the child; and whether relatives and/or non-relatives live in the household.
- *Parents' attitudes regarding several aspects of child care arrangements*: whether the following aspects of care are very important to the mother: cost, physical facility, staff/child ratio, convenient location, flexible and convenient hours, a staff/caregiver with a warm and loving teaching style, with training and credentials, with values that are

similar to the family's, with a similar discipline and guidance style, a similar race-ethnic background, who uses the same language as the family, and who is known and trusted.

- *The price of center care and family child care* is taken into account with two measures: the average price per county of full-time center care for preschoolers and the average price per county of full-time care for preschoolers in licensed family child care homes (Source: DSHS Research and Data Analysis; 2000 Survey of Child Care Centers and Homes).
- *The availability of formal child care arrangements* is taken into account in the multivariate analysis with measures of the number of licensed center care slots and the number of licensed family child care homes per child 0 to 12 years in the zip code area of each respondent's residence.

Absent from the above list is a measure of the mother's employment status. Work and child care decisions are clearly inextricably linked. When a mother works, somebody else typically looks after her children. Previous studies have taken one of three approaches to address the role of mothers' employment in child care decisions: they used it as a criteria for the selection of the analysis sample, they used it as an explanatory variable, or they conducted the analysis such that employment was jointly determined with the choice of type of care (Burstein & Hiller, 1999).

The following paragraphs describe the three approaches. After reviewing their advantages and disadvantages, we decided to focus the multivariate analysis on child and family characteristics other than the mother's employment status. Since our interest is parents' selection of FFN care, we follow the approach others before us have taken (Blau and Robins, 1988, 1991; Michalopoulos et al., 1992; Ribar, 1992) and do not use the mother's employment status or job characteristics to explain parents' child care decisions in the multivariate model. As noted by Burstein and Hiller (1999), this approach is less ambitious, but it is also more robust.

Many previous studies on the choice of type of child care limit their sample to families in which the mother works. This approach greatly simplifies the analysis. However, it implicitly assumes that mothers make their employment decisions first, before deciding on child care arrangements. It is just as likely, if not more likely, that mothers decide at the same time whether to work and what care arrangements to use for their children. In addition, limiting the sample to working mothers excludes the child care arrangements of families in which the mother does not work. Such families also enroll their children in non-parental care arrangements.

Other studies have used a measure of the mother's employment status as an explanatory variable in their analyses. The advantage of this approach is that it does not require excluding from the sample those families in which the mother is not employed. The main disadvantage of this approach is that it may produce invalid estimates of the relationship between the explanatory factors (e.g., work hours) and the choice of child care due to simultaneous equations bias. Consider the following equations:

(1) $\text{Child Care Hours} = a_0 + a_1 * \text{Work Hours} + a_2 * X + u$
(2) $\text{Work Hours} = b_0 + b_1 * \text{Child Care Hours} + b_2 * Z + e$

Equation (1) states that how much time a child spends in non-parental care depends on, among other things, how many hours the mother works. According to equation (2), how many hours the mother works depends, among others, on how many hours her child spends in non-parental care. Each outcome also depends on unknown and unmeasured factors captured by the error terms u and e. The statistical technique typically used to estimate a1 (the influence of Work Hours on Child Care Hours) requires that the error term, u, is independent of other factors in the equation (e.g., work hours). It is difficult, if not impossible, to fulfill this requirement in this particular case. The following example attempts to explain why this is so. It is likely that a mother's beliefs about the benefits (or detriments) of non-parental child care influence her decision to use such care for her child. In particular, mothers who believe that child care is beneficial for their child's development are more inclined to use such care. Unless there is a measure of each mother's beliefs about the benefits of non-parental care, this factor is implicitly captured by the error term in equation (1). Since according to equation (2) the number of child care hours influence how much time the mother works, her beliefs about the benefits of non-parental care indirectly also influence her work decision. This circular set of relationships can cause the estimate of a1 to be invalid (that is, biased and inconsistent), as Work Hours and the error term u are no longer independent.

Finally, a third option is to consider both the mother's employment status and the type of child care as outcomes of interest. One way in which this approach can be implemented is by creating a composite variable that takes into account employment status as well as child care type. For example, if employment is coded as working versus not working and three types of child care are distinguished (A-C), then the outcome variable consists of six possible options: working and using child care type A, not working and using child care type A, working and using child care type B, not working and using child care type B, and working and using child care type C, not working and using child care type C.

After reviewing the advantages and disadvantages of the three approaches to addressing the mother's employment status in families' child care decisions, our preferred approach would have been the third option. However, our sample was not large enough to accommodate this approach. We do not find the other two approaches acceptable, as they are very likely to generate invalid results. As noted above, we, therefore, decided not to include information about the mother's employment status into the multivariate model. Table B1 in Appendix B describes the variables used in the multivariate analyses. Tables B2 and B3 in Appendix B present the mean, standard deviation, and range for each of the variables in each age group's sample. The multivariate results are shown in Tables B4 and B5 in Appendix B. We describe main findings from the multivariate analyses next.

According to the estimates from our multivariate models, family characteristics as well as parents' values are related to selecting FFN as the primary arrangement for the youngest child in the family. As expected from the child care research literature, the multivariate results indicate that some of the factors differ between the two age groups considered here. We therefore present the results separately by age group.

E.1. Relative Importance of Factors Affecting Parent Choice

Youngest Child Zero to Five Years Old

With respect to family background characteristics, compared to otherwise similar families with a youngest child under six years, families are more likely to use center or FCC than FFN care as their primary care arrangement, the older the youngest child. The more children between 13 and 18 years of age there are in a family, the more likely it is that the youngest child under six is in FFN primary care than cared for by the parents, other factors the same.

Families with more income are less likely to use FFN as their primary care arrangement than otherwise similar families. Not surprisingly, having a relative available to care for the child and having non-relatives live with the family both increase the probability that a family uses FFN as their primary care arrangement. Single parents are more likely to use FFN as their primary care arrangement than to be the only one to take care of their youngest child. Compared to families in which the mother is Caucasian, otherwise similar families with a Hispanic or Black mother are less likely to rely on FFN than center care or FCC as their primary care arrangement.[16] In contrast, families in which the mother is Native American are more likely to use a primary FFN than a center care or FCC arrangement than families with a Caucasian mother.

With respect to values regarding child care, otherwise similar families whose youngest child is under six are less likely to choose FFN care over parental care when the training/credentials of the staff is very important to the mother. However, they are more likely to choose FFN care over parental care when flexible and convenient hours are very important to the mother or the facility where the care arrangement is housed. Families are more likely to choose FFN as their primary arrangement over center care or FCC, when cost considerations are very important to them. When a convenient location and discipline matter very much to the mother, the family is less likely to select FFN than center care or FCC as their primary arrangement than otherwise similar households.

Finally, families are less likely to use FFN than center or FCC primary care when more licensed center care slots are available in their area of residence, everything else the same. However, they are more likely to use FFN the higher the average price of center care in the county, everything else the same. Parents are less likely to use FFN over center care or FCC, the higher the average price of care in licensed family child care homes in the county. While this last result may seem counter-intuitive, it is important to recall that the multivariate model distinguishes between (a) parental care only, (b) FFN primary care, and (c) FCC or center primary care. It is possible that parents who are faced with a higher price of FCC decide to use center care. In this case, we would observe that a higher price of care in licensed family child care homes is associated with parents choosing center or FCC, all other factors the same. Additional multivariate analyses could investigate this possibility.

[16] We combined Black and Hispanic respondents into one group as models estimated with each included separately show similar patterns for both groups.

Youngest Child Six to Twelve Years Old

Children who are between six and twelve years old are generally less likely to spend time in a non-parental care arrangement than younger children. The multivariate results for youngest children who are between six and twelve years old are therefore based on fewer data points than in the case of younger children. Fewer data points provide less reliable estimates.

Compared to otherwise similar families with a youngest child between six and twelve years, the older the youngest child, the less likely families are to use FFN as primary care. Families are also less likely to use FFN care when a non-relative lives with the family; other factors the same. Not surprisingly, families who have a relative available to care for the child are more likely to use FFN as primary care than otherwise comparable families. As in the younger age group, single parents are more likely to turn to FFN as the primary care arrangement than to be the sole care provider for their youngest child. Families whose child has special needs are also more likely to use FFN than no non-parental care arrangement. The higher the mother's education level, the less likely FFN is the primary arrangement compared to center and FCC. Compared to families in which the parent is Caucasian, otherwise similar families with an Asian mother are more likely and families with a Black mother are less likely to rely on a primary FFN arrangement than on parental care.

Regarding families' values with respect to child care characteristics, otherwise similar families are more likely to choose FFN as their primary care arrangement when the child/staff ratio is very important to them. However, families are less likely to choose FFN care over parental care when cost considerations are very important to the family. When stimulating and enriching activities are very important, then families are less likely to use FFN than center or FCC as their primary care arrangement.

Finally, families are more likely to use FFN than center or FCC primary care when the average price of full-time care in licensed family child care homes in the county is higher, other factors the same.

Tables 1 and 2 outline the significant variables and the direction of their effects for each age group.

Table 1: Factors Affecting Parental Choice of Care by Direction of the Effect and Significance Levels for the Youngest Child (0-5 Year Olds)

Variable Name	Significant Positive Effects	Significant Negative Effects	No Significance
Comparison: No Care vs. FFN Care			
Independent Variables			
Youngest Child			
Age_youngest child			n.s.
Sex_youngest child			n.s.
Special needs			n.s.
Mother			
Age			n.s.
Single parent		-	
Education			n.s.
Black			n.s.
Hispanic			n.s.
Asian			n.s.
Native American			n.s.
Household			
Income	+		
Quadratic Income Term			n.s.
Number children 0-5 in HH			n.s.
Number children 6-12 in HH			n.s.
Number children 13-18 in HH		-	
Relative care available		-	
Non-Parental Relative Adults in HH			n.s.
Non-Relative Adults in HH		-	
Care Characteristics			
Ratio_important			n.s.
Loving_important			n.s.
Hours_important		-	
Training_important	+		
Facilities_important		-	
Values_important			n.s.
Location_important			n.s.
Cost_important			n.s.
Trust_important			n.s.
Similar race_important			n.s.
Discipline_important			n.s.
Activities_important			n.s.
Center Availability			n.s.
FCC Availability			n.s.
Center Market Rate			n.s.
FCC Market Rate			n.s.

Table 1: Factors Affecting Parental Choice of Care by Direction of the Effect and Significance Levels for the Youngest Child (0-5 Year Olds)

Variable Name	Significant Positive Effects	Significant Negative Effects	No Significance
Comparison: Center or FCC vs. FFN Care			
Independent Variables			
Youngest Child			
Age_youngest child	+		
Sex_youngest child			n.s.
Special needs			n.s.
Mother			
Age			n.s.
Single parent			n.s.
Education			n.s.
Black	+		
Hispanic	+		
Asian			n.s.
Native American		-	
Household			
Income	+		
Quadratic Income Term			n.s.
Number children 0-5 in HH			n.s.
Number children 6-12 in HH			n.s.
Number children 13-18 in HH			n.s.
Relative care available		-	
Non-Parental relative adults in HH			n.s.
Non-Relative adults in HH		-	
Care Characteristics			
Ratio_important			n.s.
Loving_important			n.s.
Hours_important			n.s.
Training_important			n.s.
Facilities_important			n.s.
Values_important			n.s.
Location_important	+		
Cost_important		-	
Trust_important			n.s.
Similar race_important			n.s.
Discipline_important	+		
Activities_important			n.s.
Center Availability	+		
FCC Availability			n.s.
Center Market Rate		-	
FCC Market Rate	+		

Table 2: Factors Affecting Parental Choice of Care by Direction of the Effect and Significance Levels for the Youngest Child (6-12 Year Olds)

Variable Name	Significant Positive Effects	Significant Negative Effects	No Significance
Comparison: No Care vs. FFN Care			
Independent Variables			
Youngest Child			
Age_youngest child	+		
Sex_youngest child			n.s.
Special needs		-	
Mother			
Age			n.s.
Single parent		-	
Education			n.s.
Black	+		
Hispanic			n.s.
Asian		-	
Native American			n.s.
Household			
Income			n.s.
Quadratic Income Term			n.s.
Number children 6-12 in HH			n.s.
Number children 13-18 in HH			n.s.
Relative care available		-	
Non-Parental relative adults in HH			n.s.
Non-Relative adults in HH	+		
Care Characteristics			
Ratio_important		-	
Loving_important			n.s.
Hours_important			n.s.
Training_important			n.s.
Facilities_important			n.s.
Values_important			n.s.
Location_important			n.s.
Cost_important	+		
Trust_important			n.s.
Similar race_important			n.s.
Discipline_important			n.s.
Activities_important			n.s.
Center Market Rate			n.s.
FCC Market Rate			n.s.

Table 2: Factors Affecting Parental Choice of Care by Direction of the Effect and Significance Levels for the Youngest Child (6-12 Year Olds)

Variable Name	Significant Positive Effects	Significant Negative Effects	No Significance
Comparison: Center or FCC vs. FFN Care			
Independent Variables			
Youngest Child			
Age_youngest child		-	
Sex_youngest child			n.s.
Special needs			n.s.
Mother			
Age			n.s.
Single parent			n.s.
Education	+		
Income			n.s.
Quadratic Income Term			n.s.
Black			n.s.
Hispanic			n.s.
Asian			n.s.
Native American			n.s.
Household			
Number children 6-12 in HH			n.s.
Number children 13-18 in HH			n.s.
Relative care available		-	
Non-Parental relative adults in HH			n.s.
Non-Relative adults in HH	+		
Care Characteristics			
Ratio_important		-	
Loving_important			n.s.
Hours_important			n.s.
Training_important			n.s.
Facilities_important			n.s.
Values_important			n.s.
Location_important			n.s.
Cost_important			n.s.
Trust_important			n.s.
Similar race_important			n.s.
Discipline_important			n.s.
Activities_important			n.s.
Center Market Rate			n.s.
FCC Market Rate		-	

F. DESCRIPTIVE RESULTS: CAREGIVER SURVEY

We now turn to data from the caregiver survey. This survey provides unique information on FFN caregivers, a group of people about whom we know little. Our study uses a representative sample drawn randomly from the general population as opposed to the 'convenience samples' of cooperating FFN caregivers used in most previous studies on this population. From this random sample, we identified and interviewed FFN providers who indicate that they provide care for someone else's children, outside of a licensed center, on a regular basis.

In this section, we present information on the people who deliver FFN care, how they deliver care, why they provide the care they do, the problems they experience, and the kinds of supports they would like to have. Note that these data are based on caregiver reports. We did not have sufficient resources to directly observe the care provided. For direct observations of the quality and outcomes of relative care in a national sample, please consult publications of the NICHD Early Child Care Research Network.

F.1. Characteristics of FFN Caregivers

First, we describe the relationship of the caregiver to a child in her/his care. (If a FFN caregiver cares for more than one child, our survey instrument randomly selects one child to ask about.) Chart 12 presents this information. Our major findings are:

- The majority (58%) of FFN caregivers are related to the children in their care; a third (36%) are grandparents, a fifth (22%) are other relatives.
- Another third (32%) are friends or neighbors.
- The smallest category of non-center providers (10%) does not fit into either category of grandparent, other relative, friend or neighbors and are classified as other paid caregivers and likely include sitters and nannies.
- The finding that grandparents comprise the largest percentage of FFN providers is consistent with results from the parent survey, which found that the largest category of FFN care is grandparent care. In addition, a national survey of grandparents found that 8 percent of all grandparents provide regular child care (AARP, 1999).

Next, we describe the demographic background of FFN caregivers. These estimates differ from those reported in the description of the sample (Section D) because they correct for over-sampling in low-income areas and are therefore representative of the general population. Chart 13 presents the age distribution of these caregivers. Chart 14 presents their marital status. Our major findings are:

- The mean age of the caregivers is 41 years old, and more caregivers (22%) are between 36 and 45 years old than in any other group. Caregivers are fairly evenly split across age categories, although few (8%) are older than 65.
- Since 36 percent of the caregivers are grandparents, many of them are older than 45.
- Most caregivers are currently married (57%), although a large proportion are single (25%), divorced (9%), or widowed (5%).

Chart 12: Percent of Caregivers with Each Relationship to Random Child

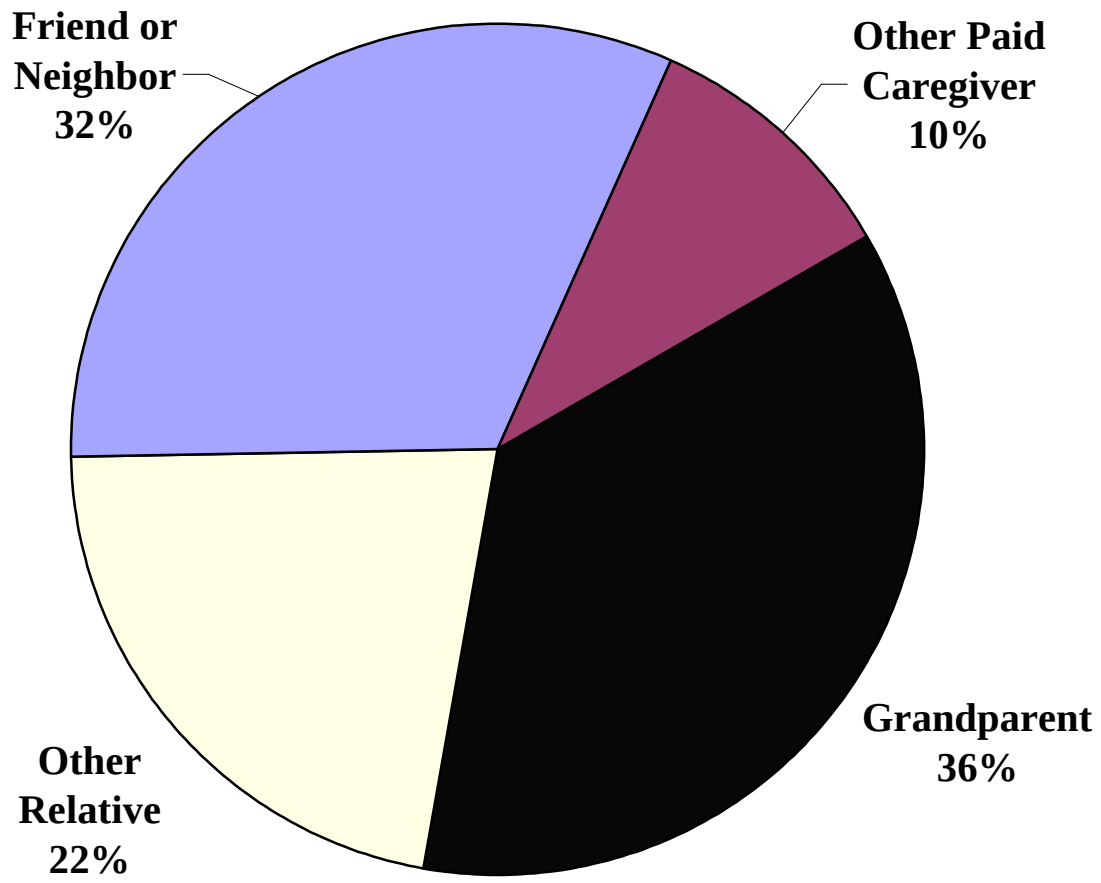


Chart 13: Percent of FFN Caregivers in Each Age Category

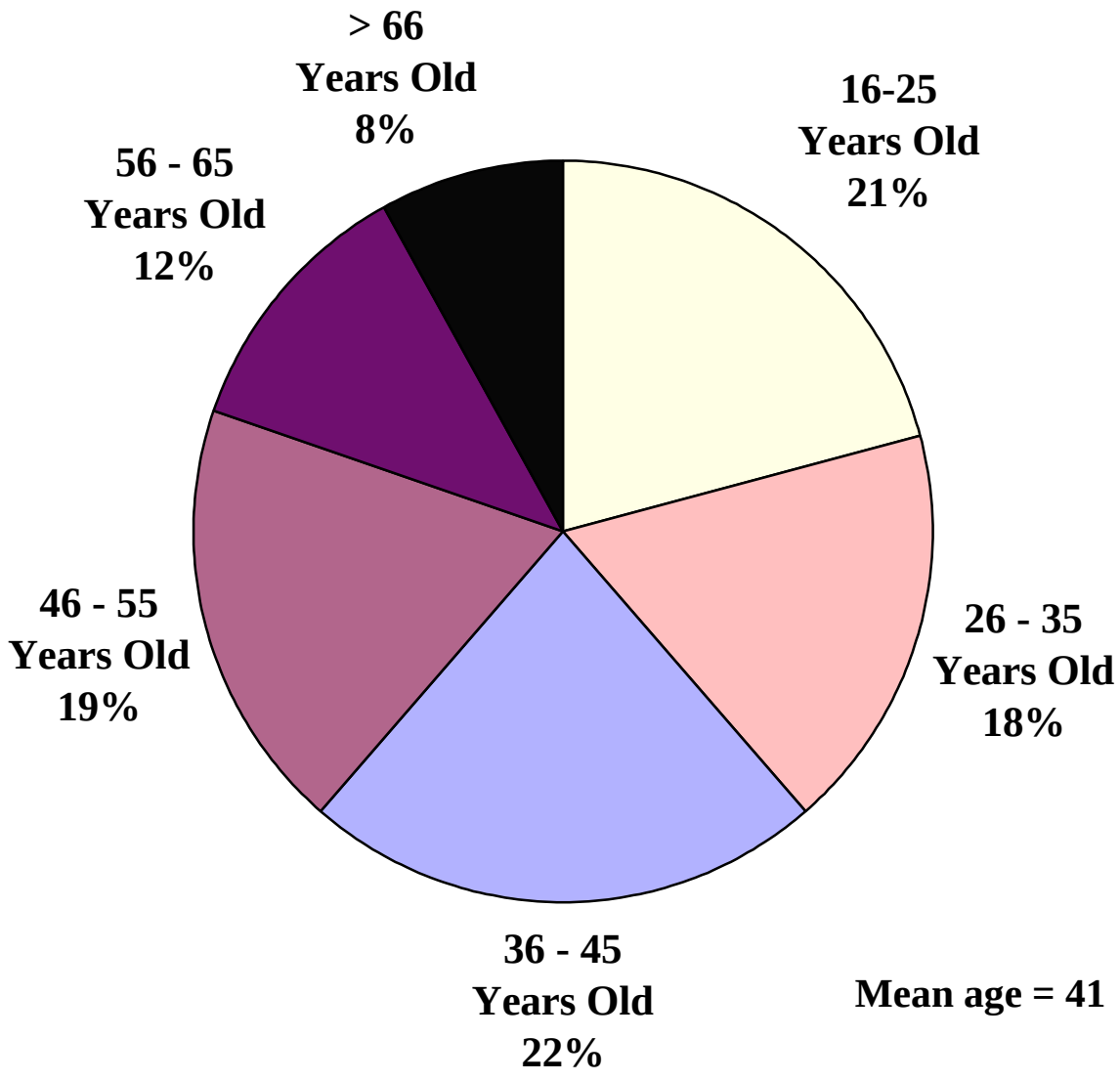


Chart 14: Percent of FFN Caregivers within Each Marital Status Category

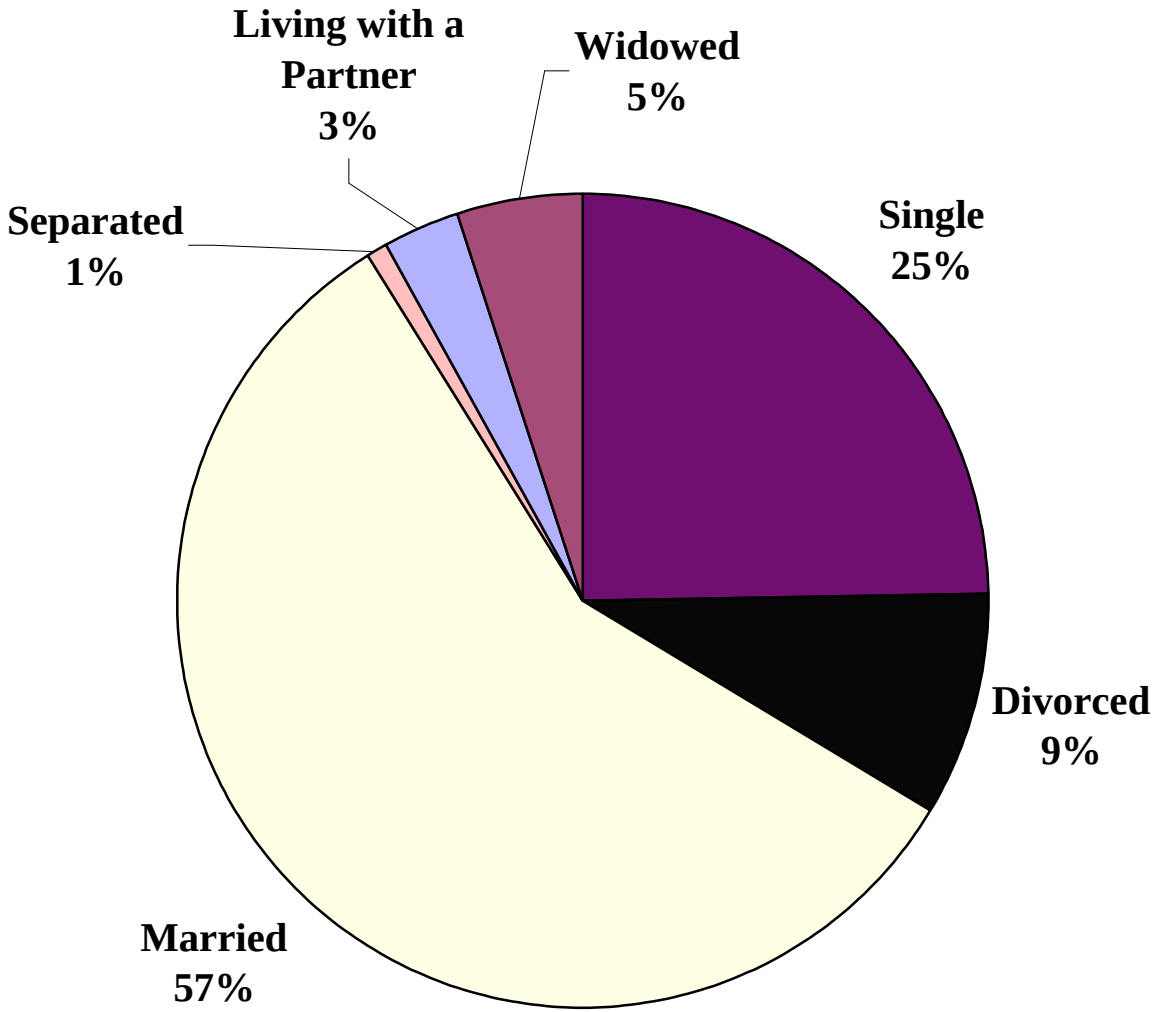


Chart 15 presents the household income of FFN caregivers. Our major findings are:

- Median household income for caregivers in Washington is $30,282, which is significantly lower than the Washington state median income of $47,000 in 2000. (Source: US Census Bureau, State and County Quick Facts, 2000).
- Most caregivers (32%) have annual household incomes between $30,000 and $50,000.
- While FFN caregivers tend to have lower incomes than the general population in Washington State, only a fifth are considered 'poor' or low income, and another fifth are considered 'moderate income.' The majority of FFN caregivers are middle or upper middle income.

Chart 16 presents the race and ethnic distribution of FFN caregivers in Washington. Our major findings are:

- Most caregivers are white (81%) with a small percentage of other minorities.[17]
- Overall, the distribution of white caregivers in Washington State is similar to the distribution of the adult population of Washington, which is about 82% white. (Source: US Census Bureau, State and County Quick Facts, 2000).

Chart 17 presents the educational attainment of FFN caregivers. Our major findings are:

- While most caregivers have completed high school, only 15 percent have attained – or gone beyond – a four-year degree. This finding is consistent with other studies' reports that 11 to 20 percent of home-based child care providers are college-educated (Burton, Whitebook, & Sakai, 1994; Kontos, Howes, & Shinn, 1992; Willer, Hofferth, Kisker, Divine-Hawkins, Farquar & Glantz, 1990; Minnesota Department of Children Families and Learning, 2001).
- Caregivers' educational attainment is significantly lower than that of the adult population (age 25 and older) in Washington State, among whom 30 percent have at least a four-year college degree.[18]

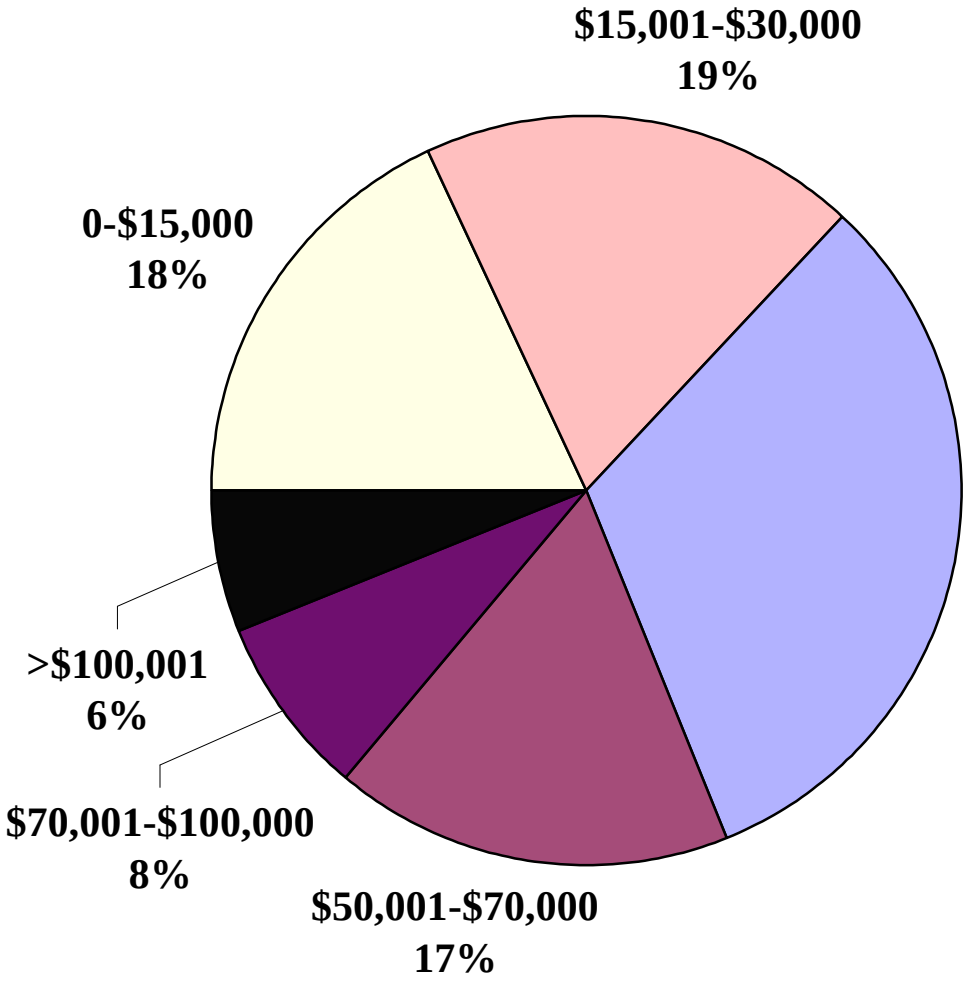
F.2. FFN Caregiver's Motivation for Providing Care

We also asked caregivers to tell us their main reason for providing care. Chart 18 presents these results. Our major findings are:

- A majority of the caregivers (57%) say they are providing care to help out a relative or friend.
- A quarter of the caregivers provide care because they enjoy being with the child or children.
- Only a small proportion of caregivers (4%) say they provide care for the income it provides.

[17] Due to a programming error in the CATI instrument, we are unable to determine the race of the eight percent of respondents answering 'other.'
[18] However, it should be noted that 25 percent of our sample is between sixteen and twenty-five years old.

Chart 15: Percent of FFN Caregivers in Each Household Income Category



Median Income for FFN Caregivers = $30,000

Washington State Median Income = $42,000

Chart 16: Percent of FFN Caregivers in Each Race and Ethnic Group

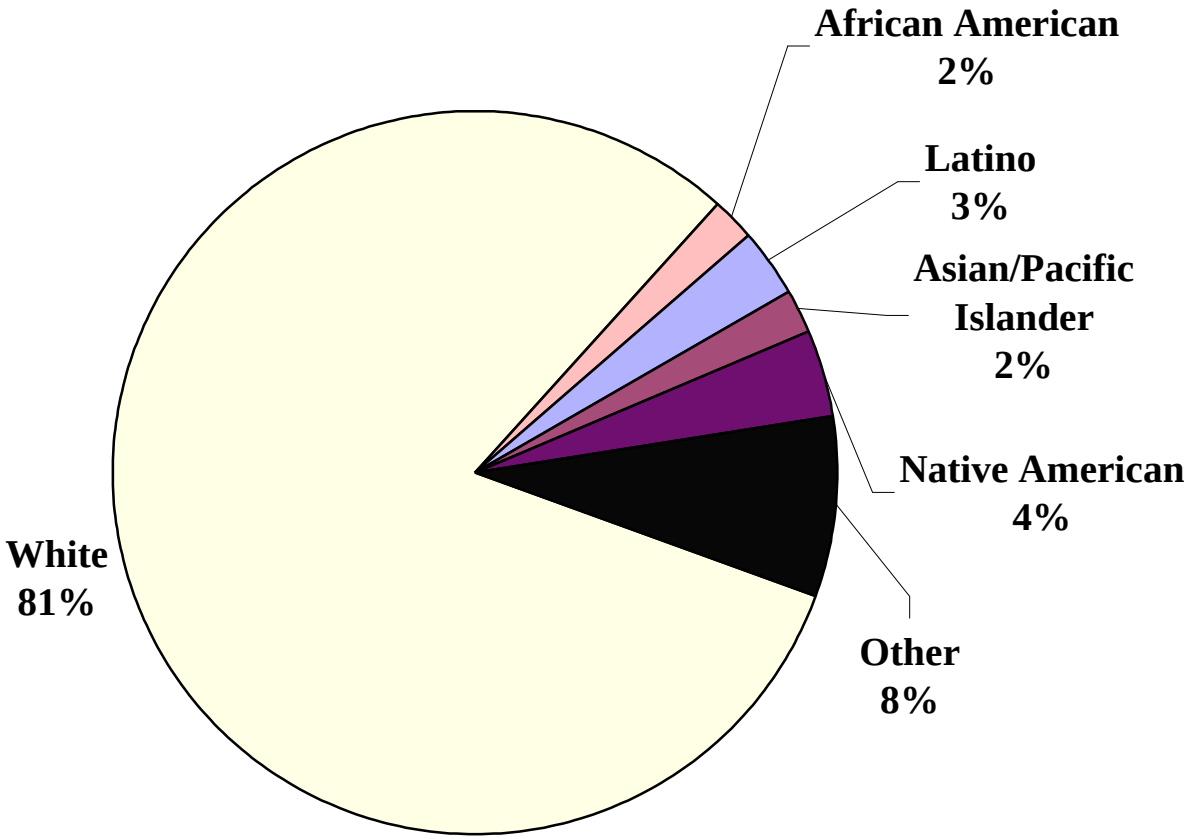


Chart 17: Percent of FFN Caregivers with Each Amount of Educational Attainment

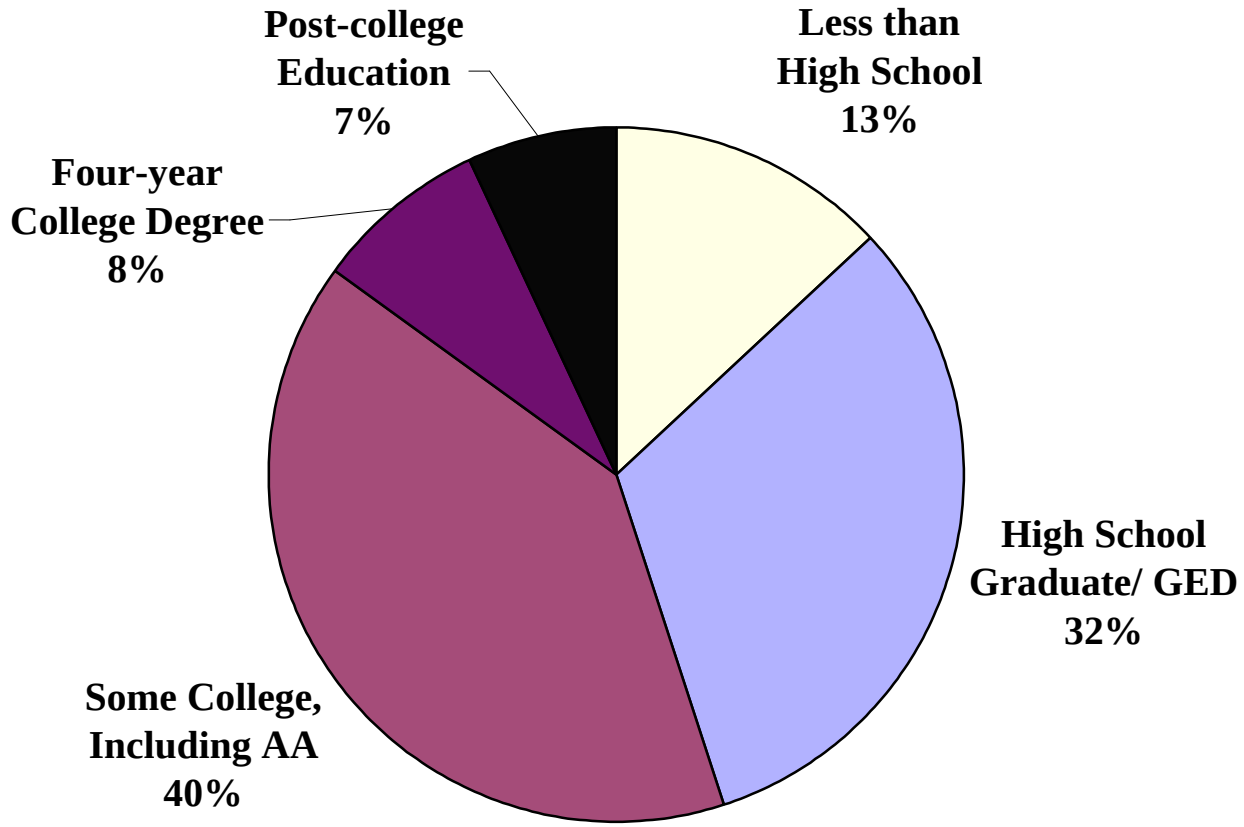
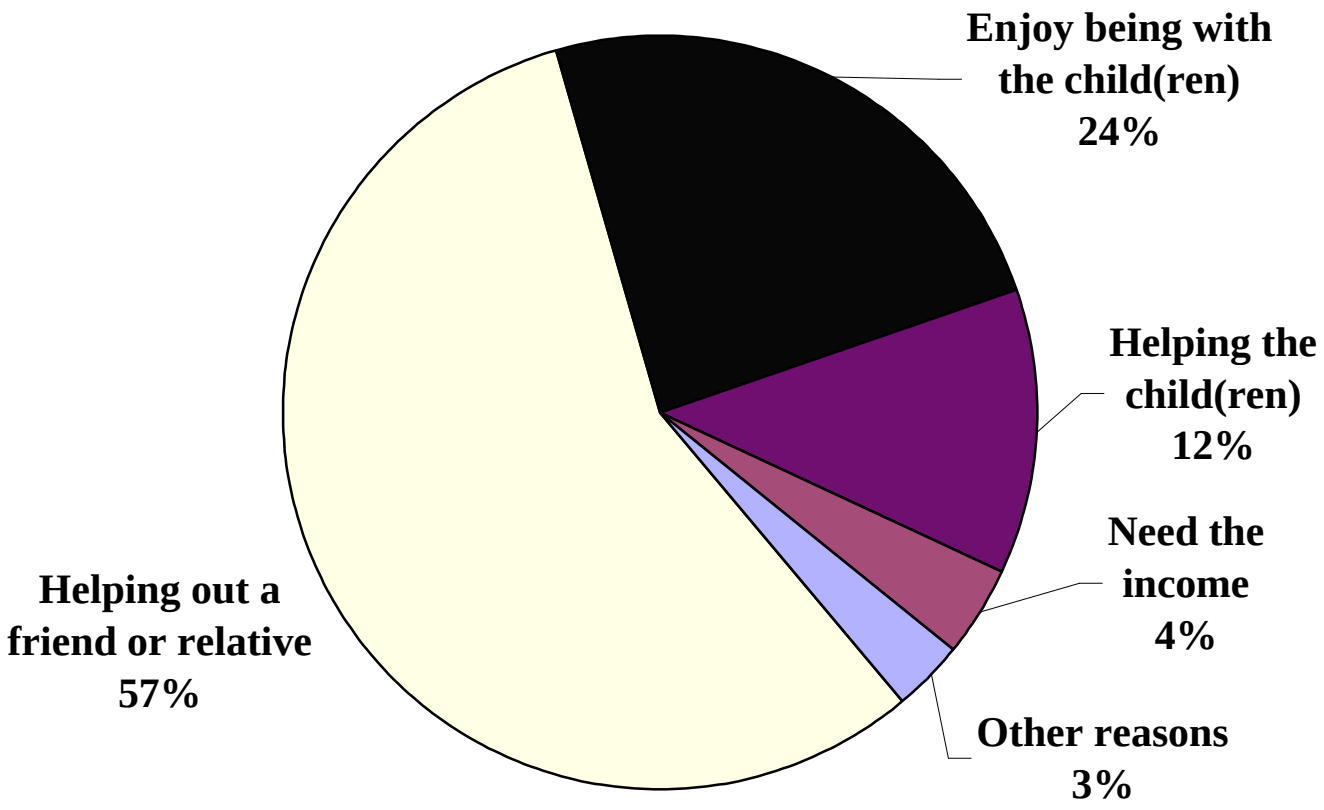


Chart 18: Percent of FFN Caregivers Reporting Each as Main Reasons for Providing Care



F.3. The Nature of FFN Care

We also asked FFN caregivers to describe various components of the care they provide, including how many children they care for, how many hours they provide care each week, whether they get paid or have an assistant, and what types of activities they participate in with the children. These results provide us with a picture of the nature of the FFN care. The next series of charts presents this information.

How Many Children Do They Care for?

Chart 19 shows the percentage of FFN caregivers who care for various numbers of children (not including their own children) on a weekly basis. Those who care for more than one child may do so either concurrently, or at different times during the week. Thus, the number of children cared for is not the same as the child:adult ratio described in the previous section of the report. Our major findings are:

- While most caregivers (almost half) care for only one child, many also care for two (31%) and three (18%) children.
- The average number of children cared for each week is approximately two.

How Many Hours Per Week Do They Provide Care?

Chart 20 presents the distribution of care hours provided by caregivers each week. This care may be provided to more than one child. Our major findings are:

- Just under half of all caregivers provide care between one and ten hours per week.
- However, about half provide child care for more than ten hours a week and twenty-five percent of the caregivers provide care for more than 30 hours per week, the equivalent of a full-time job.

What Are Other Characteristics of the Caregiving?

Chart 21 shows several other characteristics of the caregiving context. Our major findings are:

- Almost half of the caregivers have children of their own children under 13 years old living in their house. However, only 6 percent of these caregiver's children are usually at home when the care is taking place.
- Twenty-seven percent of the caregivers have an assistant. Eighty-nine percent of these assistants are related to the caregiver and, in many cases, are probably the adult spouse of the primary caregiver.
- A relatively high percentage of the FFN caregivers (18%) care for a child with special needs.[19]

[19] This percentage is higher than the seven percent of children with special needs in WA State as estimated in our parent survey. However, many caregivers care for more than one child and only one of these children is likely to have special needs.

Chart 19: Percent of FFN Caregivers Caring for Each Number of Children per Week

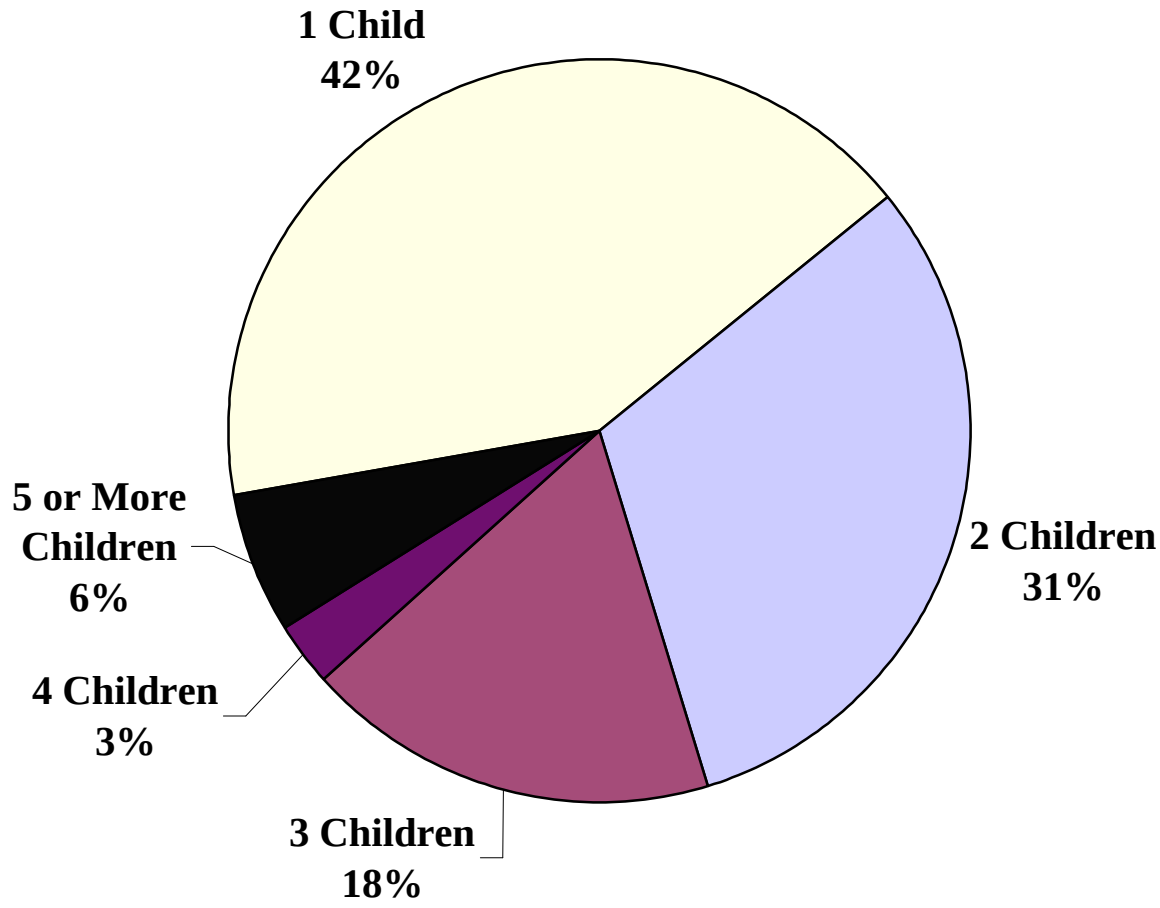


Chart 20: Percent of FFN Caregivers Providing Care for Each Number of Hours per Week

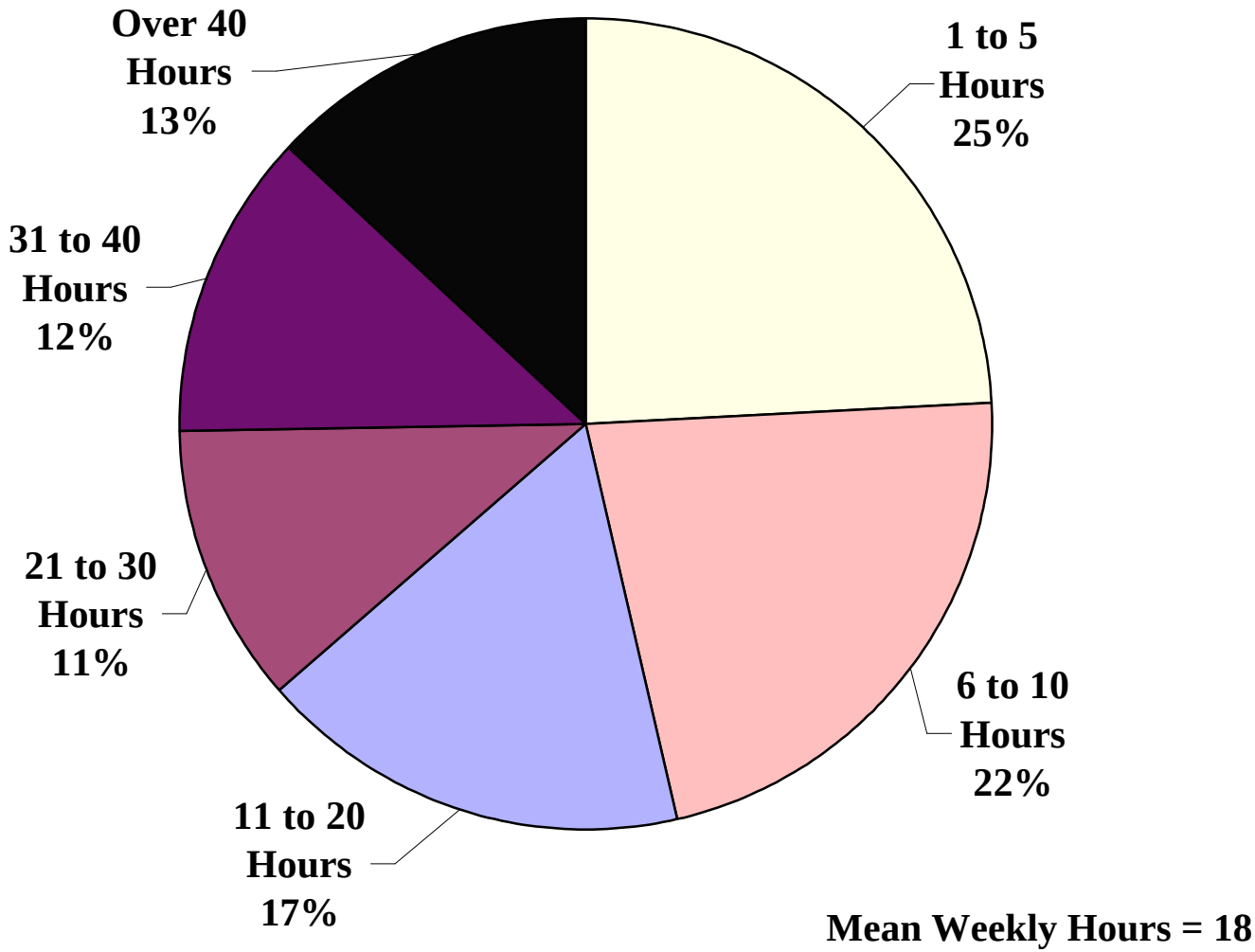
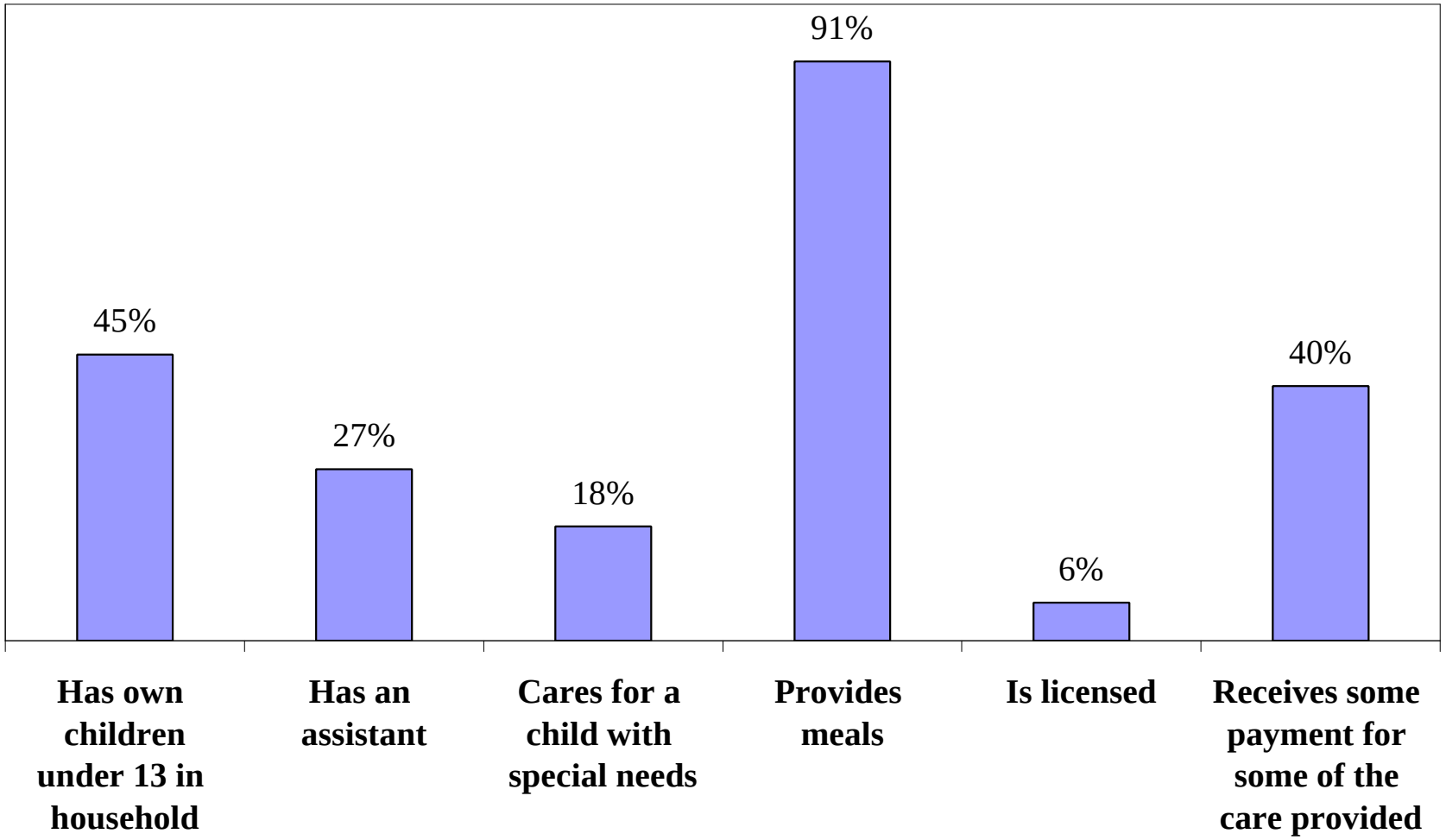


Chart 21: Percent of FFN Caregivers with Each Feature of Caregiving



- Non-relatives are significantly more likely to care for a child with special needs (32%) than are relatives (7%). And, additional analyses indicate that FFN caregivers who care for children with special needs do not differ significantly from those who do not care for such children in the number of hours they provide care each week.
- Almost all (91%) FFN caregivers provide meals to children during care.
- Six percent of FFN caregivers report being licensed.
- Forty percent of the caregivers receive some payment for at least one of the children in their care. Earlier we reported that only 22 percent of parents report paying for the FFN care they use. Given that FFN caregivers, on average, care for more than one child and may get paid for only one of these children, we cannot directly compare these two percentages. The fact that more caregivers report receiving payment than parents report paying for care is reasonable because caregivers did not report on whether they were paid for individual children in their care. In some cases, caregivers may be paid for only half of the children in their care.
- For the FFN caregivers who receive some payment, that payment averages about $168 a week. Non-relative caregivers are significantly more likely to be paid than relative caregivers: 63 percent of non-relative caregivers receive some pay for at least one child in their care compared to 21 percent of relative caregivers. The amount of time that caregivers provide care each week is unrelated to the likelihood that they are being paid.

In What Activities Do FFN Caregivers Participate with the Children?

To better understand the nature of FFN care, we asked caregivers if they engaged in various activities that child development experts consider important for children in the two age groups (Bredekamp and Copple, 1997; Eliason and Jenkins, 1999; Morgan, 2000; National School-Age Care Alliance). Charts 22 and 23 present detailed information on the percentage of caregivers reporting that they participate in each activity for at least some time with the child in their care (or with a randomly selected child if they care for more than one child). Some activities are listed for both age groups, but many differ. Chart 22 presents activities for children age 0-5 and Chart 23 presents activities for 6-12 year olds. Our major findings are:

- Most caregivers participate in many types of activities with the child(ren) they care for, including activities focusing on self care, language and reading skills, social skills, gross and fine motor skills, and recreational activities, such as watching TV and videos.
- For younger children (age 0-5), 94 percent of the caregivers participate in language development activities and more than 70 percent of the caregivers participate in all of the following activities: helping to take care of toys and materials; reading to children; playing outdoors; performing art and music activities; watching TV and videos; helping children to get along and joining activities with others; self-care activities; and climbing, running, jumping and hopping.
- The percentages of caregivers who participate in reading (83%) and building (51%) with children 0-5 years old are too low. These activities should be a core part of care for all 0-5 year olds.

Chart 22: Percent of FFN Caregivers Who Report Participating in the Following Activities with Child (Age 0-5)

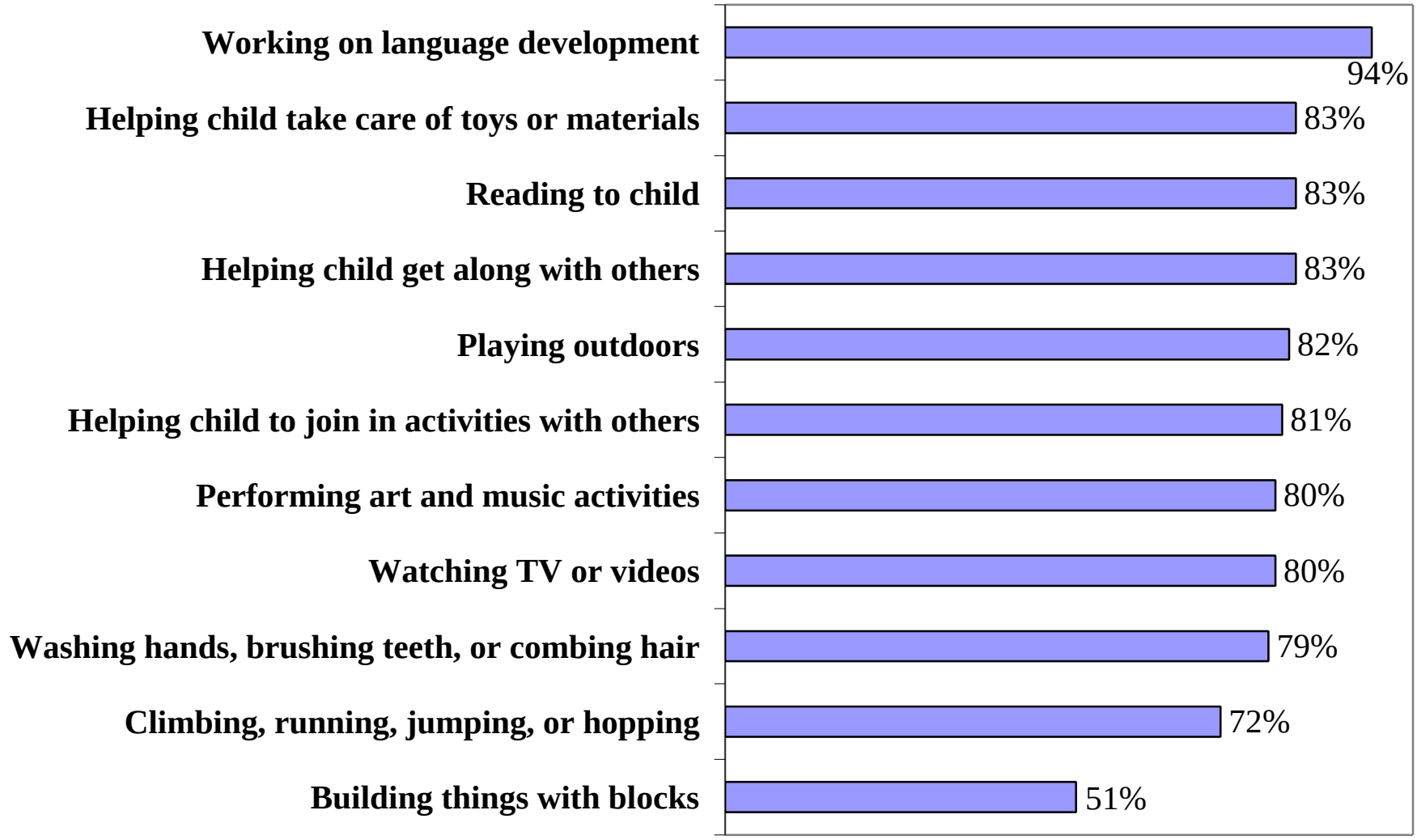
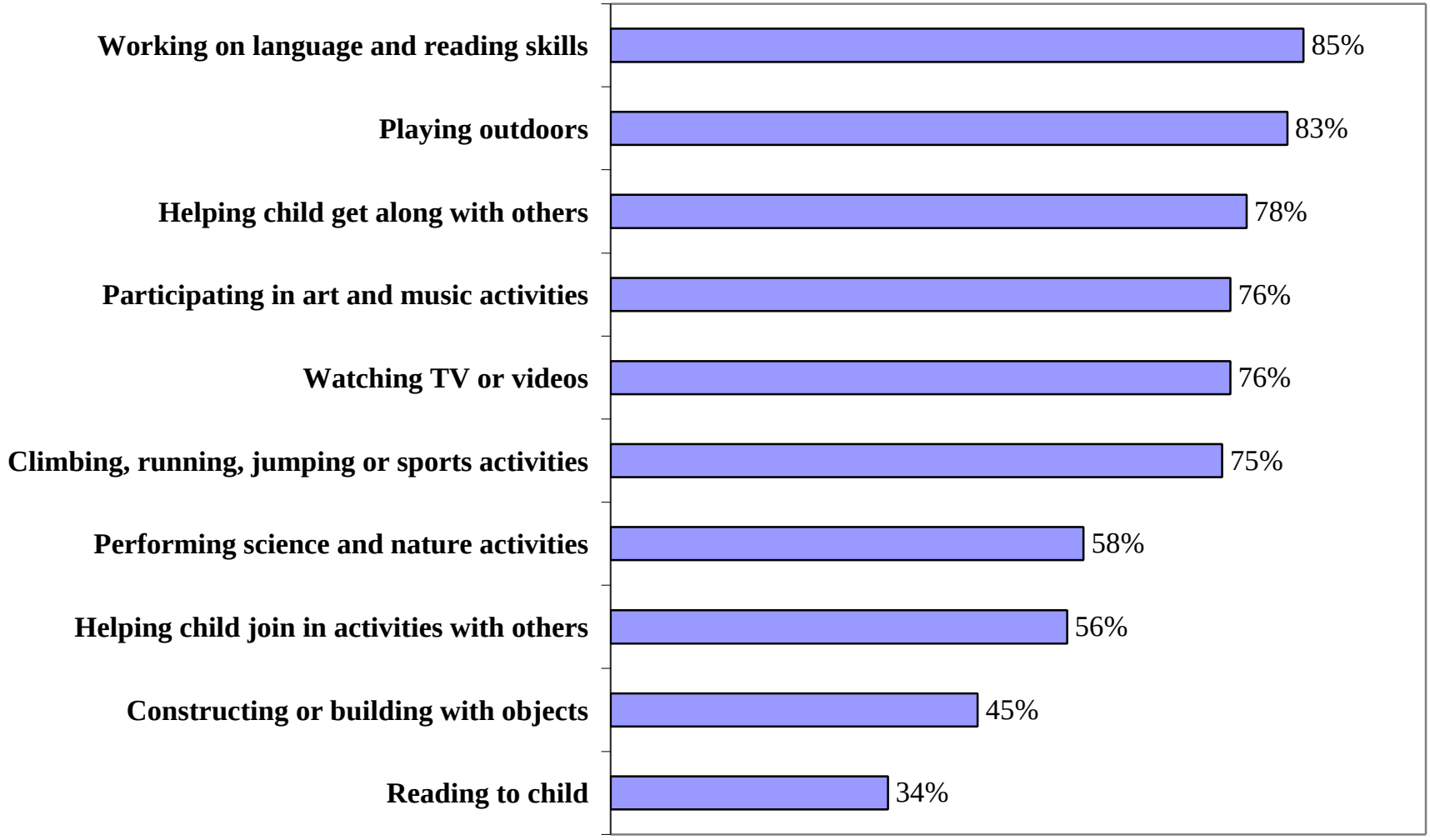


Chart 23: Percent of FFN Caregivers Who Report Participating in the Following Activities with Child (Age 6-12)



- With the exceptions of reading to the children (34%) and constructing or building with objects (45%), more than 50 percent of FFN caregivers participate in each of the activities selected for school-age children (age 6-12). Although fewer than half the caregivers participate in reading and building activities with children in this age group, older children are less likely to need caregiver participation in these activities.

What Are FFN Caregivers' Main Discipline Methods?

A caregiver's approach to discipline is important to parents and to people interested in children's development and well-being. Chart 24 presents the percentage of caregivers who report using each of nine discipline methods as their main method. Our major findings are:

- The three most commonly used discipline methods involve talking with the child about the problematic behavior, putting the child in a time-out, and encouraging the child to talk with other children to resolve conflict.
- Very few caregivers (less than 3 percent for each method) use the harsh disciplinary techniques experts say to avoid – withholding activity or food, yelling or spanking – as their main form of discipline. However, few (1%) use recommended distraction methods to divert a child from inappropriate behavior.

In sum, FFN caregiver reports of their interactions with children indicate that most engage in some amount of stimulating activity and use appropriate methods of discipline. However, they also indicate that there is considerable room for improvement -- in avoiding TV and encouraging exploratory learning through construction, reading, and science- and nature-oriented activities. Caregivers could also benefit from learning about a range of desirable methods of discipline and guidance.

F.4. The Training Background of FFN Caregivers

We know that caregivers' general education background and their degree of specific early childhood training are significantly and positively related both to quality of care and to outcomes for children (NICHD, 2001; Peisner-Feinberg et.al., 1999; Galinsky, Howes, Kontos, and Shinn, 1994). However, we know very little about the training background of FFN caregivers. We asked caregivers what training, if any, they had in child-care-related topics, including knowledge of child development and parenting skills. Chart 25 presents these results. Our major findings are:

- Only 39 percent of caregivers have any training specifically related to caring for children.
- Twenty-three percent of FFN caregivers have participated in each of the following: parenting training, courses in early childhood education, courses in child development, and workshops related to these topics.
- Of the minority of caregivers who have participated in some training, most have participated in three or four of these different types of training.
- Six percent of all caregivers have participated in the training offered through the State Training and Registry System (STARS), which is required for all licensed caregivers in Washington.

Chart 24: Percent of FFN Caregivers Reporting Each as Their Main Method of Discipline

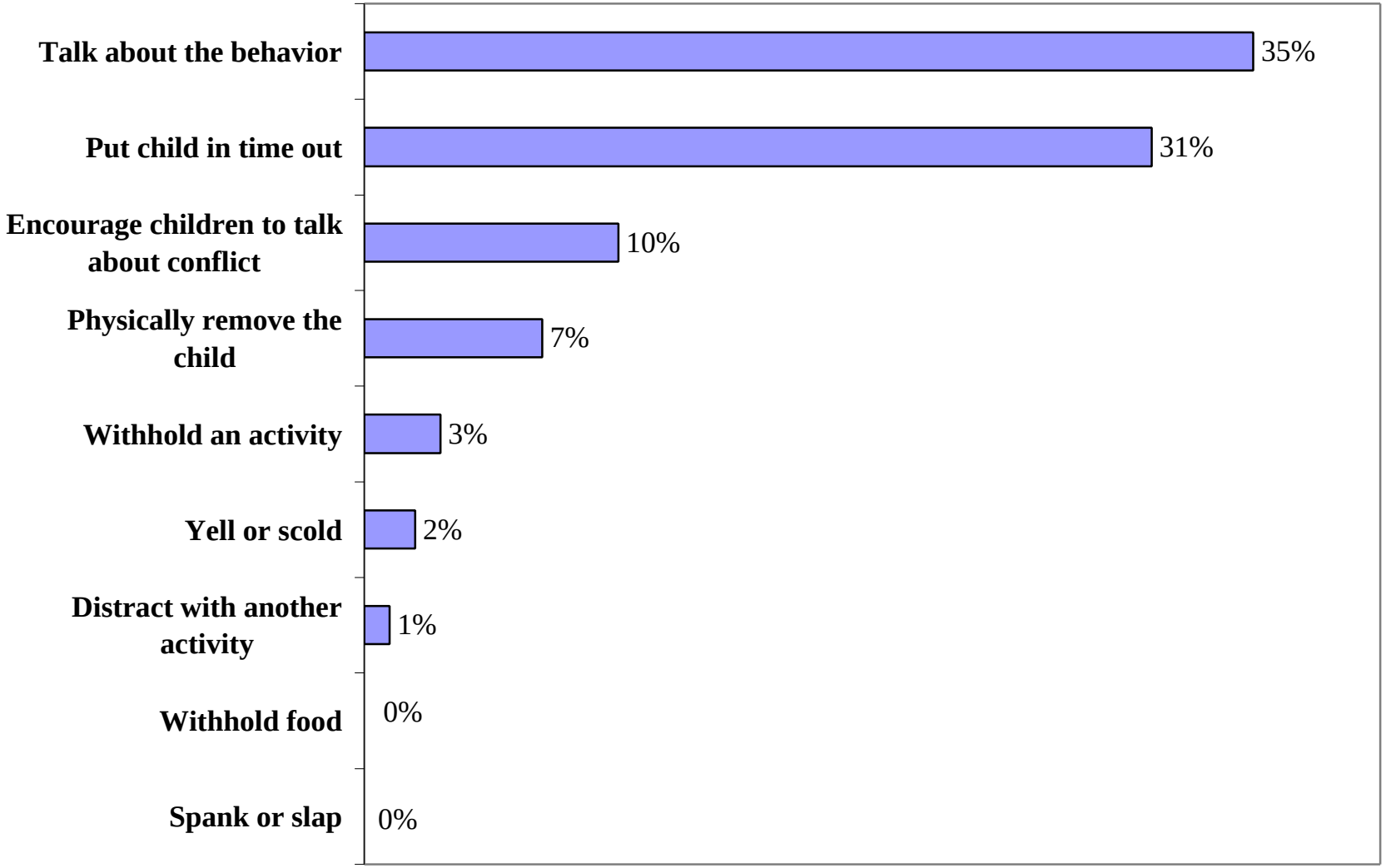
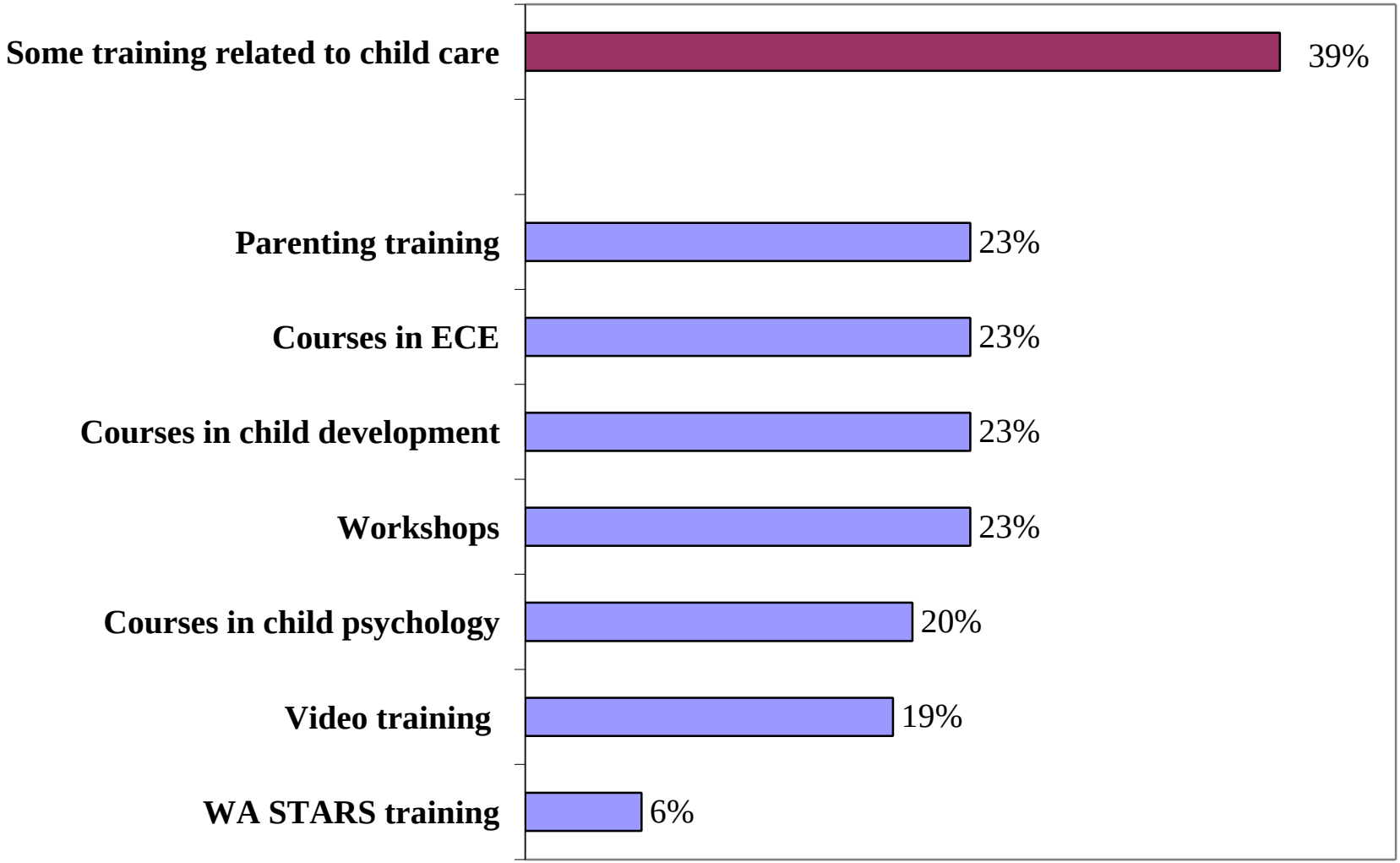


Chart 25: Percent of All FFN Caregivers with Each Type of Training in Child Care and Related Topics



We also investigated whether licensed caregivers are more likely to have participated in child care training than caregivers who are not licensed. The results of this analysis are presented in Chart 26, and the major findings are provided below:

- We found several significant differences in the training backgrounds of licensed and unlicensed FFN caregivers. Licensed caregivers are much more likely than unlicensed providers to have received at least some training related to child care, and licensed providers are more likely than unlicensed providers to have received training in each of the specific training types that we asked about.
- Many unlicensed child care providers also have some training in child care, but not to the same degree as licensed providers.

Finally, we investigated the association between the relationship of a FFN provider to a child in her/his care and the likelihood that the FFN caregiver had received some training related to child care. Chart 27 presents this information. Our major findings are:

- Paid FFN caregivers who are neither related to the child in her/his care nor a friend or neighbor to that child are most likely to have received some training related to child care. In fact, more than two-thirds of this group reports having received some training.
- Almost half (47%) of the friends or neighbors caring for children on a regular basis report having received some child care training.
- Relatives are least likely to have received child care training, with only 27 percent of grandparents reporting some child care training.

F.5. FFN Caregiver's Problems and Supports

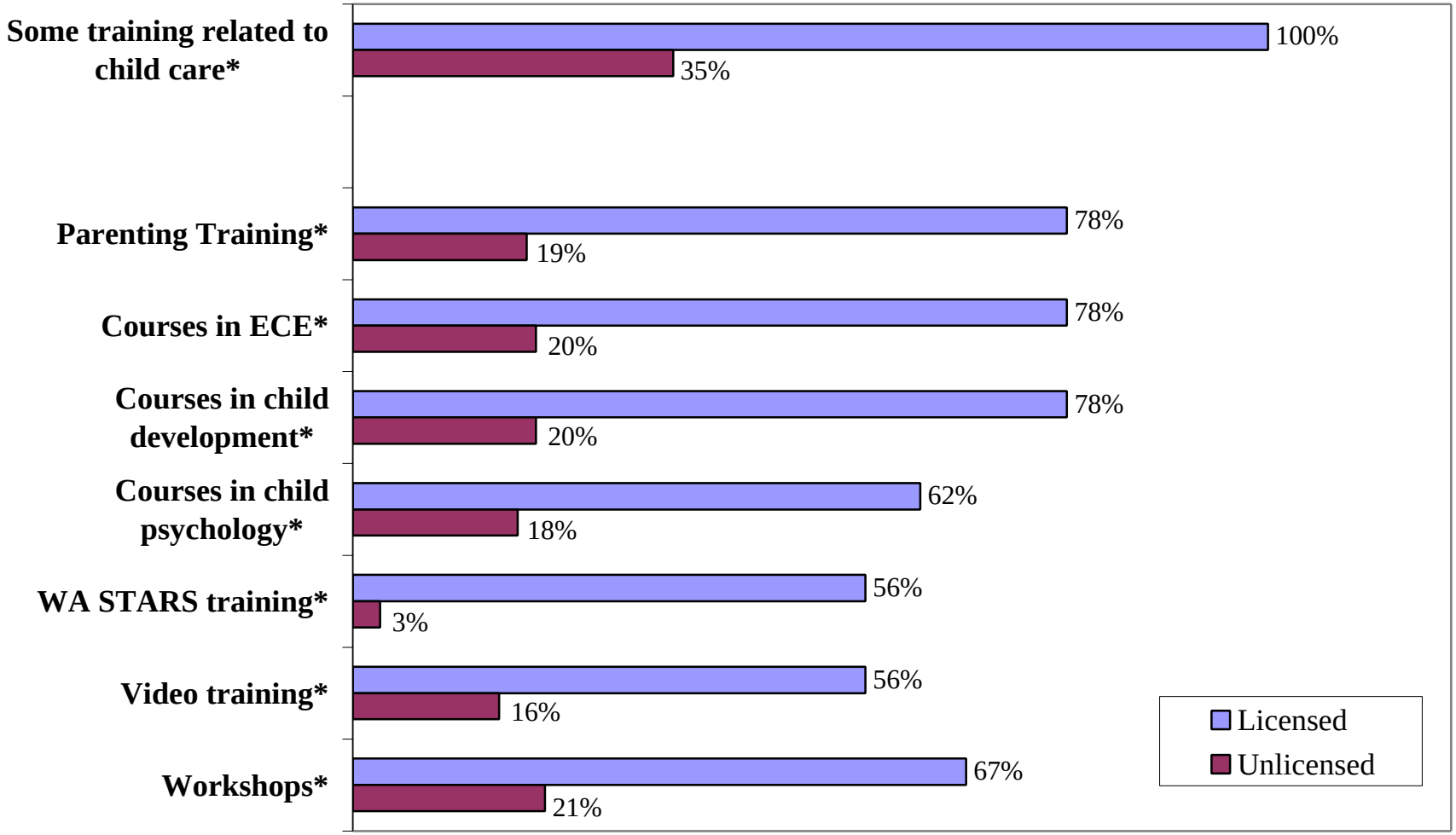
This section presents information on the percent of caregivers who experience different types of problems related to caregiving. We also examine the types of support caregivers want.

What Child Care Problems Do FFN Caregivers Report?

Chart 28 illustrates the percentages of caregivers who report experiencing each of a variety of caregiving problems. Our major findings are:

- A majority (58%) of FFN caregivers report experiencing at least one problem with caregiving.
- The problem experienced by more caregivers than any other is not having enough time to her/his self (25%). The next most commonly experienced problem is having long or irregular work hours (23%).
- Sixteen percent of caregivers report not having enough interaction with the parents of the children.
- Of the eight main problems identified in this survey, only "not enough toys" is experienced by fewer than 12% of caregivers. The percent of caregivers reporting experiencing each type of problem are pretty evenly distributed.
- Among caregivers who report experiencing a problem, most experience about two problems each.

Chart 26: Percent of FFN Caregivers with Each Type of Training by License Status



*Differences are significant at p < .05

Chart 27: Percent of FFN Caregivers Having Received Some Training Related to Child Care by Relationship to Random Child

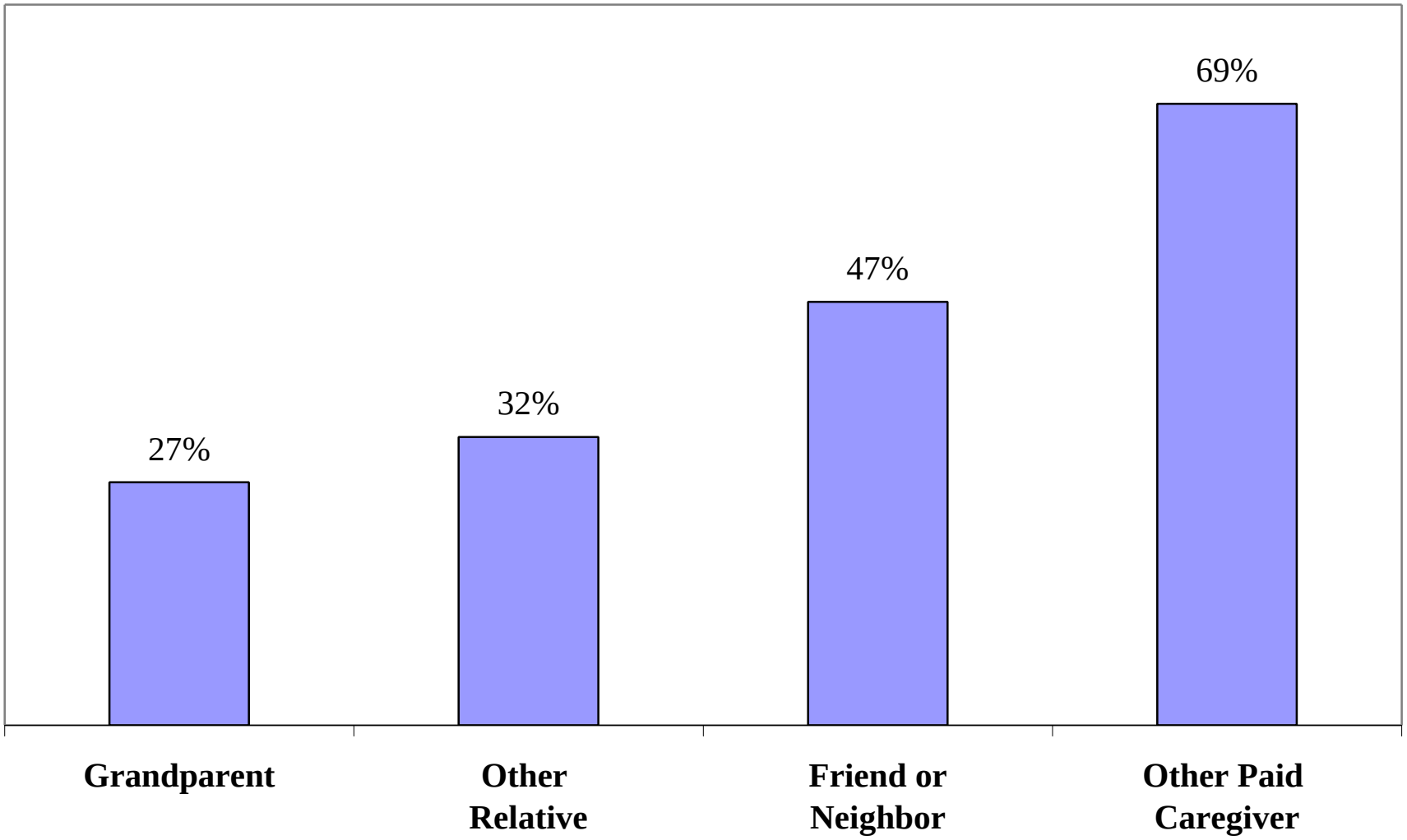
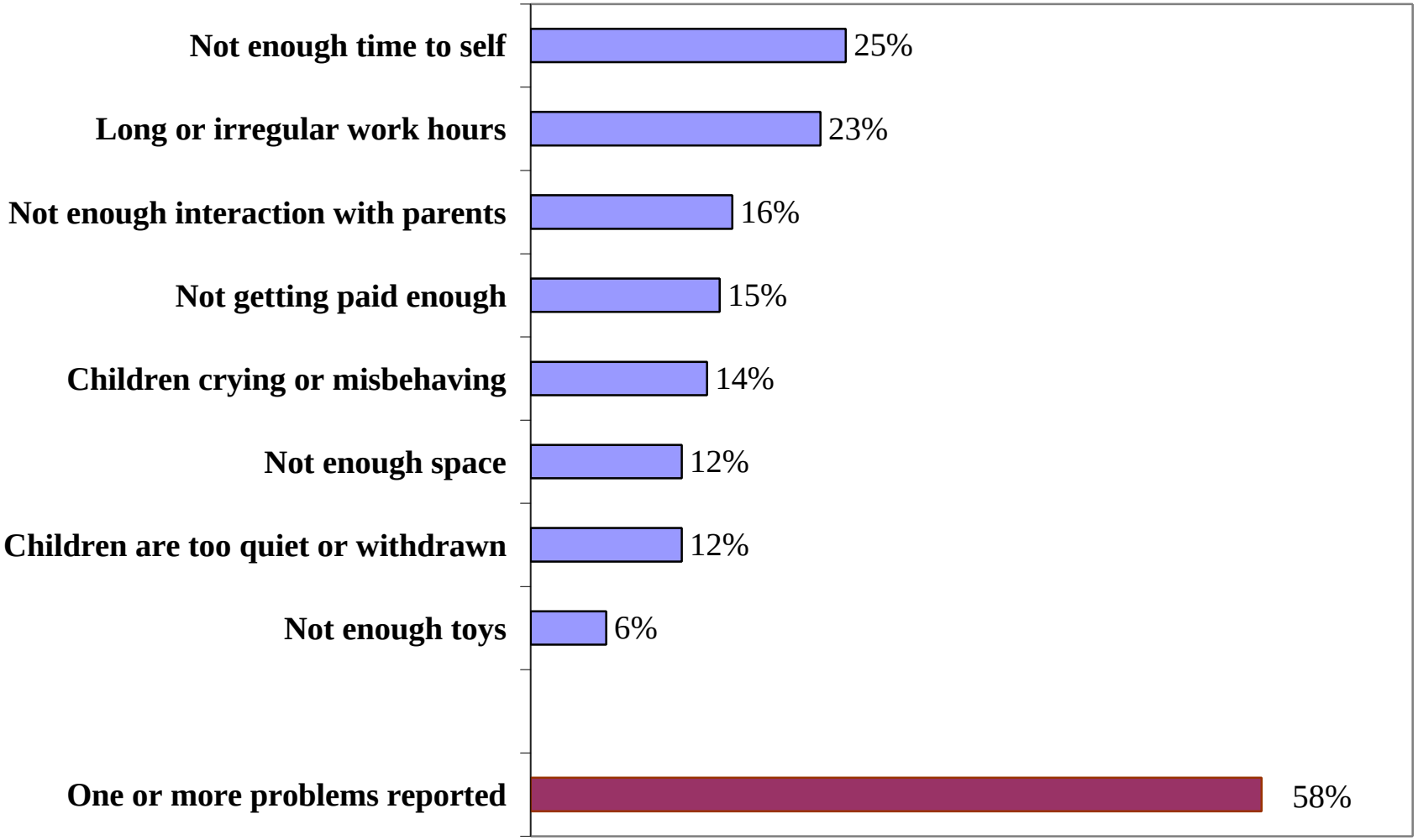


Chart 28: Percent of FFN Caregivers Reporting Each of the Following Child Care Problems



What Supports Do FFN Caregivers Want?

We also asked detailed questions about the supports caregivers might want. Chart 29 presents the percentage of caregivers who want each type of support. Our major findings are:

- The types of supports and services caregivers want is widely distributed across the support options.
- Sixty-five percent of all caregivers are interested in at least one of these support items, and the average number of support and service items wanted by these caregivers is four.
- A newsletter with tips and resources is the most commonly requested type of support or service. Just over half (53%) of the caregivers are interested in this service.
- About a third of all caregivers are interested in toys or play kits, home safety kits, having someone to call when facing a problem with a child, having a short-term-care arrangement for times when the caregiver is unavailable, and being able to meet with other caregivers.
- Fifteen percent of caregivers are interested in training to become licensed, even though most say they are not interested in actually becoming licensed.

Would FFN Caregivers Like to Attend Meetings? Where?

We asked FFN caregivers how likely they would be to meet with other caregivers if such meetings were convenient for them. We also asked about the locations where they would feel most comfortable attending these meetings. Chart 30 presents these results. Our major findings are:

- Thirty percent of the caregivers said they would be likely to attend meetings or get together for programs.
- For caregivers likely to attend meetings, the preferred meeting places are schools, libraries, and places of worship.
- For 33 percent of the caregivers likely to attend meetings, having to pay for the meetings would negatively impact their willingness to participate. The other two-thirds report that a fee would have little or no effect on their likelihood of attending meetings.

What Supports Are Wanted by FFN Providers Caring for Children with Special Needs?

Finally, we examine whether FFN providers who care for children with special needs want different supports than FFN caregivers who do not care for such children. We found some significant and important differences between the supports desired by these two groups of caregivers. These are presented in Chart 31 and include the following major findings:

- Caregivers responsible for a child with special needs are significantly more likely to want transportation help, short-term care arrangements, in-home visits for help with a particular child, and meetings with other caregivers.
- Caring for a child with special needs does not affect the likelihood that FFN caregivers want newsletters, home safety kits, toys and play kits, someone to call, and training to become licensed.

Chart 29: Percent of FFN Caregivers Who Report Wanting Each of the Following Child Care Supports

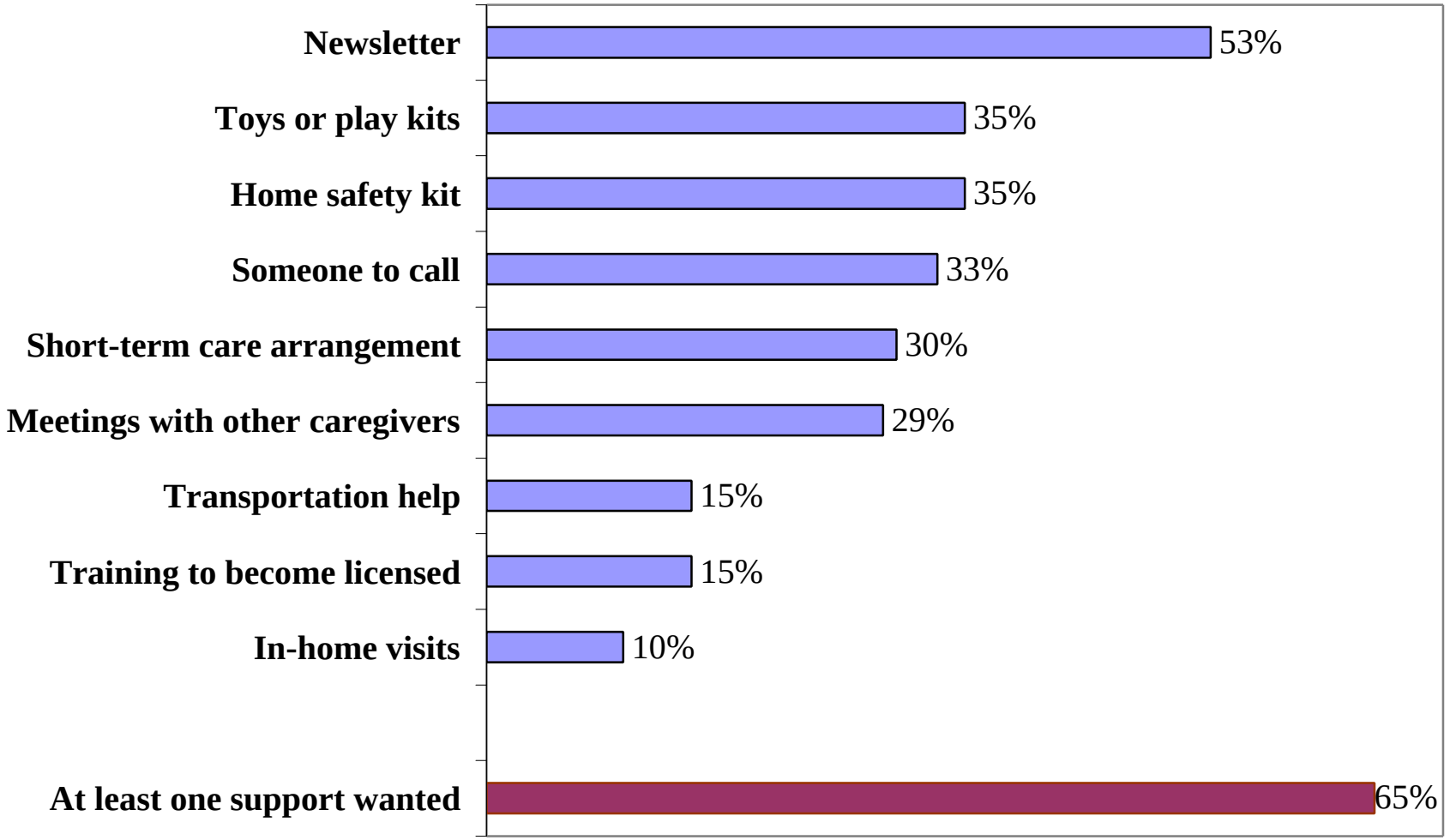


Chart 30: Percent of FFN Caregivers Reporting a Likelihood of Attending Caregiving Meetings and Where They Prefer Meetings to be Held

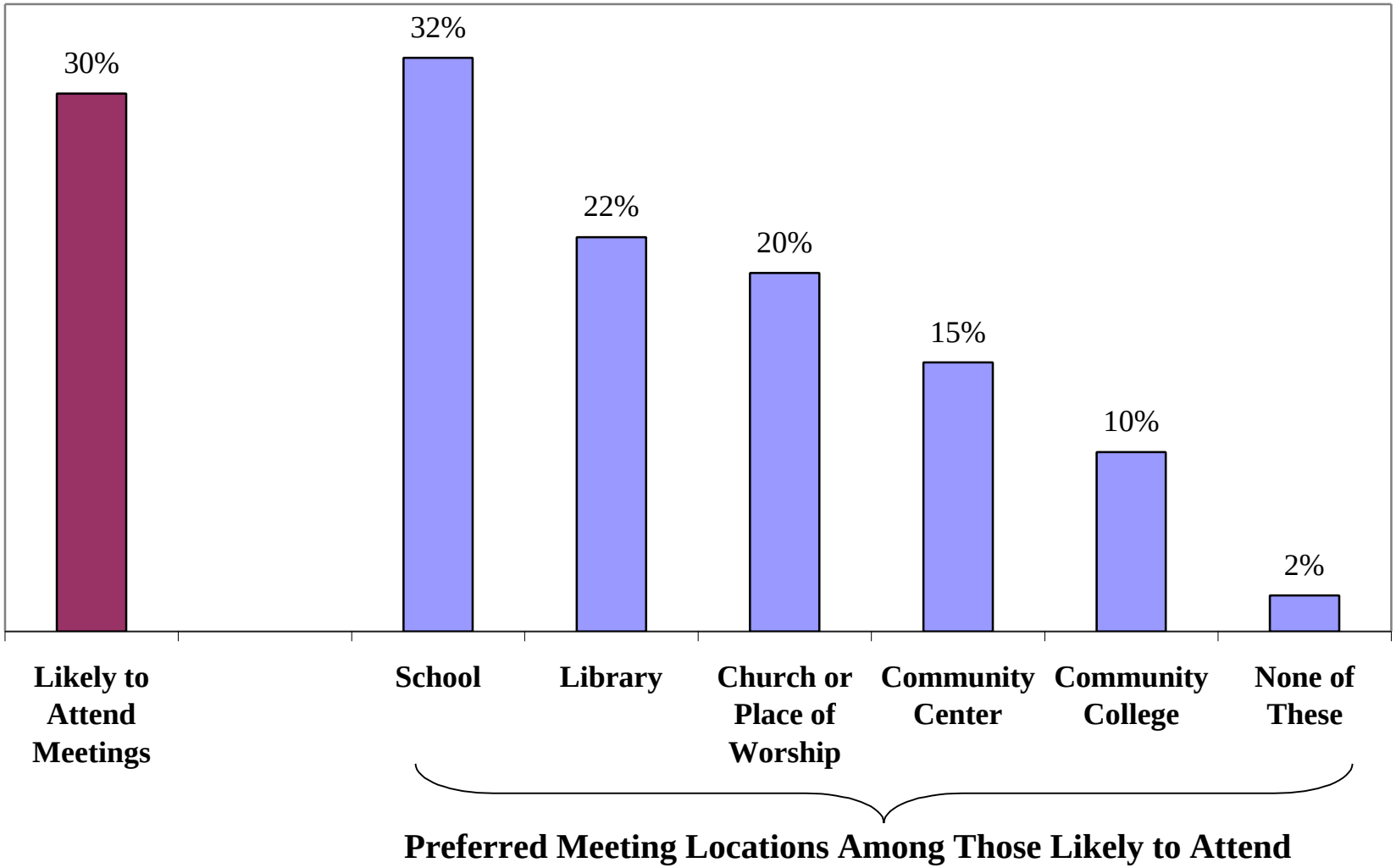
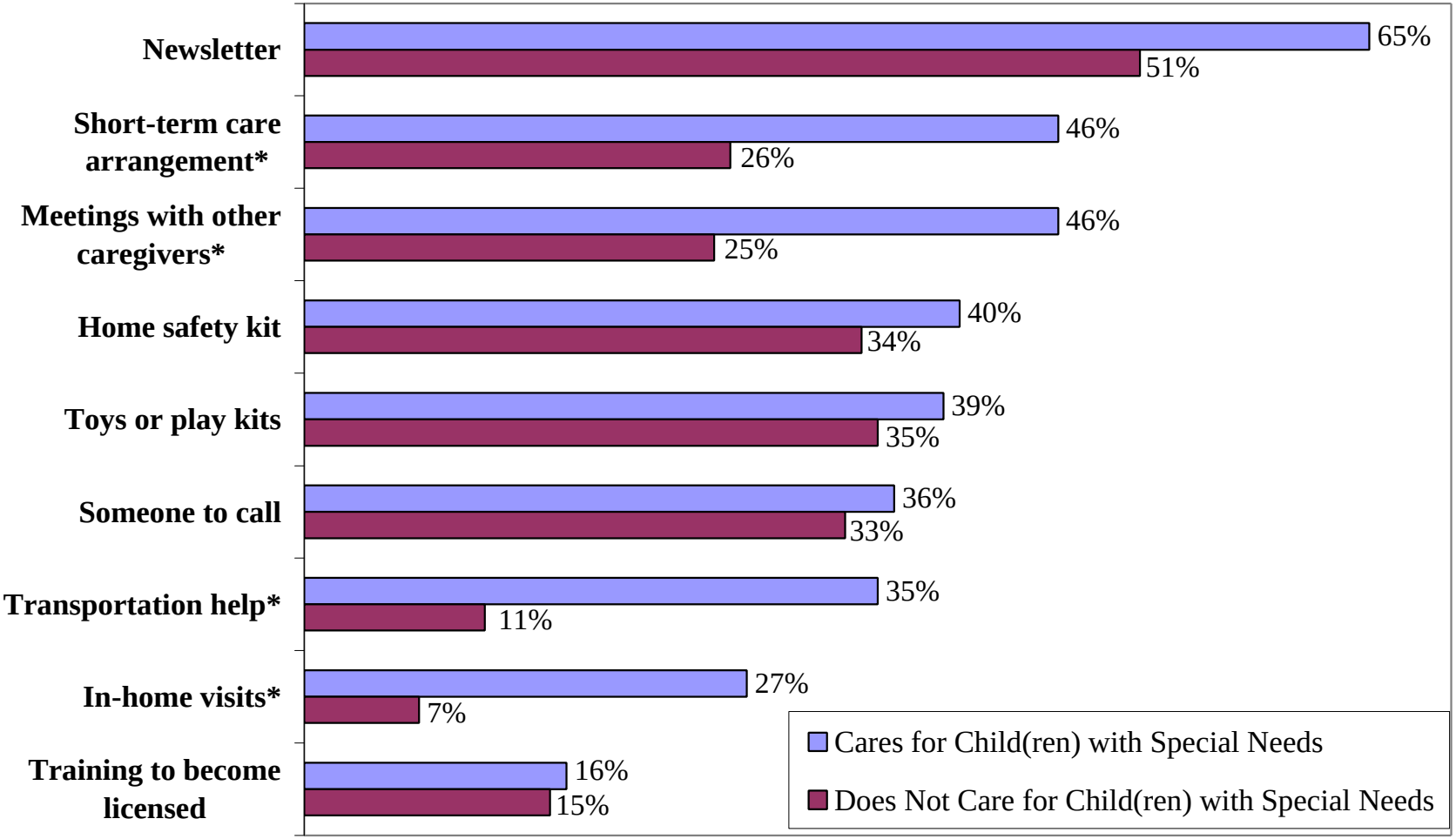


Chart 31: Percent of FFN Caregivers Who Report Wanting Each Support by Whether or Not They Care for a Child with Special Needs



*Differences are significant at $p < .05$

In summary, FFN caregivers represent a broad spectrum of characteristics, types of care provided, problems experienced, and desired supports. Our results clearly indicate that many FFN providers need and/or want support, both to assist them in their caregiving responsibilities and to improve the overall quality of care for the children they serve.

G. VARYING PERSPECTIVES ON FFN CARE: QUALITATIVE FINDINGS

G. 1. The Forum

In addition to conducting the parent and caregiver surveys, we convened a daylong forum on the topic of "informal child care." (For a more detailed description of the forum and its participants, please refer to Section C.4.) Key points of the discussions in this forum were:

- *Terminology.* This kind of child care has been called "informal care," "kith and kin care," and "family, friends and neighbors child care" (FFN). We adopted the latter term as most appropriate, although this choice was not universally embraced.
- *Who Are the FFN Caregivers?* According to research presented by Bank Street College's Toni Porter, these caregivers range in age from their late 30s through 50s; 40 percent are heads of household; 40 percent are married; and they provide care for an average of two to four years.
- *Do These Caregivers Want Support?* Porter maintains that these caregivers are interested in support groups, but not in formal training workshops. If training is framed as support it meets with less resistance.
- *What Kinds of Support Are Already Being Provided?* The Child Care Coordinating Committee (CCCC) of San Mateo County, CA is offering an "Exempt Provider Training Program." This bilingual effort has resulted in a very successful program that offers FFN caregivers early care and education classes at the local community college. Also in California, Trustline (www.trustline.org) was established to provide information on regulations and offer optional finger printing for non-licensed caregivers. In Portland, OR the Enterprise Foundation has combined the needs of FFN caregivers with housing and community development efforts. They work with landlords on child care issues; hold monthly support and networking meetings for parents; distribute information packets on child care options and housing safety information (on topics such as lead poisoning); and maintain a child care library for parents, landlords, and FFN caregivers.

Throughout the day we found ourselves returning to the theme of finding ways to develop trusting relationships with families and communities in order to reach FFN caregivers and the families they serve.

Several Washington organizations presented information on current projects related to FFN caregivers:

- The Child Care Resource & Referral Network (CCRR) functions as a community-based hub for discussing issues and exploring solutions to problems. Local CCRR offices offer alternative ways of working with communities on FFN (and other) child care issues. The national association, NACCRA, has developed a model contract to guide parents and caregivers in defining their relationships.
- The Puget Sound Education Service District Head Start office was initiating a new program for parents and FFN caregivers. The program is designed to facilitate networking among parents, caregivers, and the broader community. It will also provide

play groups for children in FFN care, and offer general support, especially for parents who are still on waiting lists for Head Start care. They hope their program will offer flexibility, cultural sensitivity, continuity, and trust.

- Healthy Child Care Washington, a program in the Department of Health, has developed a consultation system to provide technical training and assistance for child care providers regardless of licensing status. The program addresses the health needs of caregivers as well as children. This organization has successfully served families with special needs (for example, families concerned with mental health, emotional, and behavior issues).
- Rachael Langen of the Office of Child Care Policy, DSHS, explained that the state functions in several roles: ensuring regulatory compliance, running a subsidy program, and funding the child care system of which FFN care is a part. License-exempt care providers are classified in up to 40 categories, and those who receive subsidies are subject to criminal background checks. According to Langen, DSHS recognizes that children and families who use FFN care are as much a part of the system as any other families. DSHS also recognizes that families need flexibility as parents struggle to balance work schedules with child care. DSHS wants to increase its understanding of FFN care and is building incentive programs (such as subsidy and food programs) for FFN care providers. Currently, funding is the biggest challenge.

At the conclusion of the forum, Porter reiterated that, whatever direction we take next, we must emphasize the children and how best to allocate limited resources to assist all children, regardless of the kind of child care they are receiving.

We identified five key challenges for future discussions:

- How to allocate resources across the continuum of child care.
- How to integrate FFN caregivers into the child care system.
- How to incorporate FFN caregivers who want to become licensed into career-development systems.
- How to define FFN caregivers and determine their expectations.
- How to evaluate the quality of FFN care.

G.2. Focus Group

We also convened a focus group of FFN caregivers to discuss issues they might have about caring for children. Most participants were grandmothers; nearly all participants indicated that they were providing care on a permanent basis. Many of the reasons they gave for providing care were specific to an individual child or situation, but more than one caregiver cited the high cost of "daycare" and/or the fact that they did not want their grandchild in "daycare" as reasons for providing child care.

Focus group participants felt that child care providers should have an understanding of child developmental stages; have good teaching abilities; love children; be patient, playful, nurturing, and flexible; and have a good sense of humor.

Focus group participants identified obstacles to providing good child care. Many of these fell into two main categories: 1) inadequate pay; and 2) problems with the parents of the child, including the challenges of balancing the needs of the caregiver with the needs of the child (and family) for whom they provide care.

Most participants stated that they were not being paid, or not being paid enough, to care for the children. Caregivers said it was difficult for them to discuss issues of payment for the care they provided. One participant said that it was a "sticky issue." A grandparent who provided free care for her grandchild stated that the issue of payment "never came up" with her daughter-in-law. For other caregivers, payment came in the form of an exchange of services ("I take care of grandson, my son mows my grass and maintains my car.") or small gifts such as gift certificates to restaurants. Those who were paid reported low wages. One grandparent receiving a subsidy from DSHS reported being paid $2.05 per hour to care for her grandchild.

From the perspective of our focus group participants, some of the most difficult aspects of child care concern the child's parents. FFN care providers are unique in that they have multiple relationships with the families for whom they provide care. Although this may be a strength, it can also create problems between the parents and the care provider. As one caregiver noted, " My role is different now. My child is the parent, not me." Focus group members said that differences in child-raising philosophies and discipline styles, problems with personal boundaries, and struggles to balance their needs for personal time with the family's need for child care were all serious problems.

Many participants felt that meetings where they could get together with other FFN caregivers would be very helpful. They also were interested in having speakers and/or classes during these meetings so they could discuss issues related to child development and safety (including CPR training). Focus group members also suggested the following ideas for help/support of FFN care providers:

- A newsletter.
- Materials such as toys, books, or play kits.
- A resource phone line (for information).
- Access to a free breakfast/lunch program.
- Reduced fees at museums and community centers.
- Assistance with transportation, including reduced bus fares.
- Greater opportunities for the child(ren) in their care to socialize with other children.

None of the focus group participants wanted training to become a licensed provider, nor did they want someone coming into their homes to help with problems with specific children.

G.3. Key Informant Interviews

As described in Section C.3., we conducted interviews with six child care policy makers and professional advocates. The interviewees felt that a good child care facility needed to be safe and clean; have appropriate child:staff ratios; have trained, high-quality staff; and provide a curriculum or activities that were appropriate to the developmental level(s) of the child(ren).

According to the interviewees, a high-quality child care provider would be nurturing and formally trained in childhood learning and development, have personal skills such as flexibility and sensitivity, be consistent, and – very importantly – pass a criminal background check. Interviewees felt that high-quality care providers should also be adequately compensated.

Although many FFN caregivers have the skills of a high-quality care provider and often have a nurturing relationship with the child, interviewees believed that FFN care providers were less likely to have formal ECE training. This lack of training could hinder their ability: 1) to make developmentally appropriate decisions about activities for the children in their care; and 2) to respond constructively to the children's behavior. One interviewee, however, said that, given the high staff turnover rates in centers, the overall quality of care provided by FFN caregivers was probably not much different from that in centers.

Opinions of interviewees regarding the role of the State in supporting FFN caregivers varied widely. Some interviewees felt that the choice of a child care arrangement should be left exclusively to parents, and that the State should not be involved in these decisions. Other interviewees argued that since FFN caregivers represent a large segment of the continuum of child care in Washington State, the government should respond to the needs of FFN caregivers. Interviewees suggested that one starting point for support would be for the State to work with community-based organizations to determine what FFN caregivers in specific communities need. Nearly all interviewees stated that any governmental help or support should be offered, not mandated.

All interviewees identified funding as a major obstacle to governmental FFN support. However, several interviewees felt that, within the current budget limits, the State could afford to provide some support and training to FFN caregivers.

Few interviewees thought that Washington State should mandate licensing for FFN caregivers. One interviewee noted that the current exclusion of FFN care providers from state licensing requirements was a deliberate decision and argued against changing existing law. Interviewees suggested that the State focus on helping parents make informed choices about child care. Several interviewees felt it was important that parents have access to criminal background checks on FFN caregivers. In fact, the public does have access to criminal history information through the Washington State Patrol (www.wa.gov/wsp/crime/crimhist.htm), but many parents are not aware that this information is available to them.

Table 3 presents a more detailed summary of the main categories of interviewees' responses to each question.

Table 3: Summary of Policy Makers and Advocates Interviews by Question

1a. What do you think constitutes a quality child care setting?
• Caring, consistent, nurturing, respectful caregivers • Well-trained caregivers, having basic knowledge of child development and learning and good skill level, ability, and knowledge • Age-appropriate activities • Low ratio of kids to staff • Safe, clean environment
1b. Does the definition of quality child care change depending on the age of the child? (Prompt—for instance, for children 0-1, 2-3, 4-6, 6-10, 10-12)
• Lower child:staff ratio for younger children • Different activities/equipment based on age of child
2. What do you think constitutes a quality child care provider?
• Having formal training in child development to help anticipate needs of kids as they grow • Participating in on-going professional development • Providing support and information to parents • Intentionally caring for kids • Being responsible, flexible, passionate, not easily flustered, and sensitive to each child • Being adequately compensated • Passing a background check (criminal)
3. To what extent do you think some/many/most FFN care providers have these characteristics? Why or why not?
• Some. Nannies more intentional, FFN tend to be less intentional professionally; e.g., someone going into this as a profession is more willing to access training than others may be. • Many. Many are parents themselves so they have experience in raising children. In a greater sense, we can't know for sure. But they are probably not much different than center staff with high turnover, etc. • They often do have the relationship but may not have the knowledge and training to make developmentally appropriate decisions, activities, etc. • Don't know ---all anecdotal information for me
4. What kind of support do you think these caregivers should receive? (Prompt if necessary with toy lending library, newsletter, home visits, play kits, chance to meet with other FFN caregivers.)
• These caregivers are part of the system; the system should be open to providing what they want regarding resources. Whatever they think they need we should offer, then can perhaps do more training. ECE training. Encourage first aid and CPR for caregivers and parents. All training open to parents as well. • In an ideal situation (with adequate funding) all of the things mentioned—toy lending library, newsletter, play kits, etc. All would be lovely to offer, given adequate funding. Child Haven used to have a van staffed by a knowledgeable person. This provided valuable support, materials. Provide a resource center – much better than training. Allow anonymity. The cost should be modest for caregiver. Toy lending library? No, this is just bringing bacteria into the home • Reading times in libraries so they aren't so isolated. Peer groups and play groups tend to be isolated so this would help • Would want to make sure that home visit, if offered, is initiated by caregiver, not mandated. Do they want support? If State is involved this will scare them away. When government gets involved people feel they lose their privacy and their rights.
5. What should be the role of the state, if any, in providing these supports?

Table 3: Summary of Policy Makers and Advocates Interviews by Question

• All kids deserve access to good quality care. Responsibility of the state is to reach out to all caregivers and partner with others including foundations/community-based organizations to provide support/assistance. Connect with Community Networks; they know their communities and can find out what is most needed. All help should be community-based and driven. Could do much more. Need wider support for training. Support would make a big difference in quality. Child Care Resource and Referral Network is doing a good job. • Can encourage inclusion of FFN caregivers in state quality contracts**,** must meet the federal regulations regarding state standard. State standard has narrow definition of what is legal. • People don't want the government involved. (as above… When government gets involved people feel they lose their privacy and their rights.)
6. What do you see as obstacles to the state providing this support?
• Funding, lack of resources. • Political framework. Many state legislators feel that this is none of the state's business so any strategy to support or help must take this into account. It may be better to focus on the parents – parents have a right to work and know that their children are in safe quality care. Should be careful to not be seen as intrusive. Shouldn't have government terribly involved. • The potentially contentious issue of licensing. • Can do some things right now. Open the door to those who do meet the state regulations to have opportunity for state support (can't be a business; can't earn more than $1,000 a year; must care for children from only one family).
7. What is your view on licensing these caregivers?
• It is not our goal and not necessary. Background checks are essential. Trustline in California is a good model consisting of background checks and registry to protect kids also. • This was dealt with when the exemption was defined - felt strongly that FFN should be excluded. This is parental choice issue. When state gets involved in imposing rules, the caregiver can say he/she will not do this anymore.
8. In general, what do you think the state policy should be regarding providing support and assistance to all of these caregivers?
• It is the responsibility as a State to do what we can with revenue we have. The growth and development of kids in poor quality care is hampered. We must support good quality care. We fund public education, and this is the earliest form of education and should be supported. More funding is needed but the political climate is not right for this change at this time. It is an issue of allocation of resources. • It is the state's responsibility to ensure adequate levels of child care that is good quality, safe, and affordable. Criminal checks very important. Support should include all caregivers and consist of a pyramid of benefits for all levels of caregivers. Child care assistance must be provided to low income families, not just those on TANF. • The state should be careful regarding the issue of licensed FCC providers not thinking this is fair since they have jumped through all the hoops and paid the money, taken care of the zoning issues etc. to be licensed. • The current law reflects the state's policy.

G.4 Comparing the Perspective of Parents, Experts, Policy-Makers, and Caregivers

Parents' perspectives on what they are looking for in care and why many of them choose FFN care are discussed at length above. A high percentage of parents select FFN care because it offers a combination of desirable features. The main reasons parents give for selecting FFN care as their primary type of care are: familiarity and recommendations, location, cost, and convenient hours. Parents who are more concerned with staff training/credentials, stimulating or enriching activities, and location tend to choose center care or FCC arrangements. However, almost three-quarters of all parents think that caregiver training and skills are important, so even those selecting FFN care are likely to respond positively to training and support efforts for FFN caregivers.

Most policy makers and advocates contend that high-quality care depends upon caregivers who have appropriate skills and knowledge of child development. They also stress the importance of caregivers who truly care about children, are sensitive to children's and parents' needs, and offer low child:adult ratios.

A strong body of research by ECE experts indicates that the following factors – knowledge and skills imparted by formal training and education, caring attitudes, personal flexibility and responsiveness, and low child:adult ratios – all contribute to positive developmental outcomes for children, both in the near and long term (NICHD Research Network, 2001; Shonkoff and Phillips, 2001).

Most FFN caregivers have moderate levels of formal education, and a majority of them lack the specific training suggested by policy makers and experts (and desired by many parents). However, FFN caregivers are aware of their limitations. The majority report experiencing problems in providing care, and two-thirds would welcome various kinds of training and support.

Neither policy makers nor advocates support a move toward licensing FFN caregivers, and very few FFN caregivers want to become licensed. These views converge on a voluntary set of training and support offerings. If we could embed knowledge of child development, enrichment skills, and disciplinary techniques into informal support groups rather than formal training or classes, we could implement the suggestions of experts without putting off the caregivers.

This report highlights at least one additional significant issue: Almost one in five FFN caregivers provides care for a child with special physical or emotional needs. These caregivers expressed the greatest desire for training and support. Appropriate offerings should be tailored to their needs.

H. RECOMMENDATIONS FOR A TRAINING AND SUPPORT PROGRAM FOR FFN CAREGIVERS IN WASHINGTON

We know that parents want high quality care for their children. Professionals, policymakers, and caregivers are concerned that Washington State's approximately 295,000 FFN caregivers do not have access to training and supports that would enable them to deliver the highest quality care to children. We base the following recommendations for support and training on the input we gathered from parents, FFN caregivers, focus group participants, and professionals and policymakers in the child care field. We propose the following support/training options:

- Opportunities to meet with other FFN caregivers.
- Newsletters, booklets, and tip sheets.
- Activity boxes/toy or play kits.
- Home safety kits.
- Short-term help/respite care.
- Training to become licensed.
- Opportunities to get help with specific children: Resource line and home visits.

Throughout this next section, we outline the content and costs associated with a one-year, ten-county pilot project to reach a small portion of FFN care providers in Washington State.

H.1. Organizational and Operational Considerations

Inclusion and Distinction

FFN caregivers in Washington fall into the following categories: grandparents, other relatives, and friends and neighbors (including nannies and babysitters). Most of the training/support activities we propose include all categories of caregivers. Some types of caregivers, however, could benefit from support/training tailored specifically to their needs.

Grandparents constitute the largest group of caregivers. From our own and other studies, we know that grandparents, even more than other relatives, are determined to "do well by" their grandchildren, (Morgan, 2001). As a group, grandparents have many common concerns and interests, so some supports could address their specific needs (for example, their desire to get together with other grandparent caregivers).

One in six FFN providers cares for children with special needs (defined as emotional, developmental, behavioral, or physical problems). This number is quite high, and may warrant supports designed especially for these caregivers. Other groups needing individualized supports may include non- English speaking communities and communities of recent immigrants.

Existing Training, Materials/Supports

Some of the supports and materials we discuss may already exist for other populations (e.g. licensed care providers, parent education groups, parents of newborns). It may be possible to adapt relevant materials (for example, those on child development, child health, cognitive

development, language development, and school- age children's activities) for use with FFN caregivers, especially if the materials reflect sensitivity to the child rearing values and practices of diverse families in the state. Materials on family relationships and communication with parents (how to handle being the "parent of the parent," for instance) may need to be developed. It may be possible to open some existing supports to interested FFN caregivers. Dr. Jean Kelly of the University of Washington's Department of Family and Child Nursing heads a project (*Promoting First Relationships)* that trains child care consultants and child care providers. This training is designed to enhance caregivers' ability to provide an emotionally safe and secure environment and to improve the knowledge and skills caregivers need to address behavioral and emotional difficulties experienced by the children in their care. This training could possibly be adapted to FFN caregivers (especially those caring for children with special needs).

When using existing materials or opening existing supports, we must remember that FFN caregivers do not appreciate the implication that they need "training." However, FFN caregivers are eager for support (Porter, 2001). Therefore, all activities designed for the use of FFN caregivers should be framed as "support" rather than "training," and all materials should be developed in ways that are acceptable and meaningful to this population.

Partnerships/Community Voice

During our interviews, policy specialists recommended that community-based organizations and existing entities (such as local resource and referral agencies, community networks, ECEAPs, Head Start programs, Education Service Districts [ESDs], and the School's Out Washington) become partners in creating supports/training for FFN caregivers in their own communities. These supports should be "community-based and community-driven."

Community Facilities

The locations most favored by FFN caregivers for meetings/gatherings/support groups are local schools, libraries, or faith-based centers. These locations are free of the stigmas of poverty, failure, or family problems.

Finding the "Invisible Supply"

It is difficult to identify FFN caregivers unless they are receiving public subsidies. Morgan notes that, "All research studies since the sixties that have attempted to gather data from this 'invisible supply' have spent significant funds in finding this supply in the first place" (Morgan, 2001). Costs for finding FFN caregivers should be factored into all support efforts. We experienced this problem when recruiting participants for our focus groups. Many methods for outreach will have to be explored. Some methods that have proven effective in previous efforts to reach FFN caregivers include:

- Placing ads in local newspapers, especially weeklies.
- Running public service announcements (in appropriate local languages) on local radio stations.

- Posting notices in community gathering places, including laundromats, copy centers, libraries, supermarkets, playgrounds, and schools.
- Relying on church/synagogue/temple bulletins and interviewing the secretaries of these faith-based organizations.
- Recruiting through Head Start and other part-day programs.
- Targeting housing projects and apartment complexes.
- Using word of mouth with other caregivers.

In Ithaca, New York, an enterprising resource center called The Gathering Place raised money from merchants to pay for a dinner to celebrate the caregivers of the community. The project succeeded wonderfully in getting community members to tell them about caregivers.

Pilot projects might be most effective if they focus initially on only one or two types of support. The supports chosen for various communities in the state could differ according to local needs.

Criminal Background Checks

The public can obtain criminal history records through the Washington State Patrol. Details on how to access this information is available on the Washington State Patrol website at www.wa.gov/wsp/crime/crimhist/htm.

Costs

In Table 4 at the end of this section, we provide cost estimates for the recommended supports. We present both development and annual implementation costs, with implementation costs shown both on a per-county basis and for a one-year 10-county pilot program.

FFN caregivers indicated that they were willing to pay for these supports. Seventeen percent of the caregivers have an annual household income between $50,000 and $70,000 a year, and 14 percent have annual household incomes greater than $70,000. Overall, however, the household income of FFN caregivers is lower than the Washington State average.

H.2. Training and Support Recommendations

Opportunities to Meet with Other Caregivers

Creating opportunities for FFN caregivers to get together offers many advantages beyond decreasing the isolation that many of these caregivers experience. The meetings would provide a venue for delivering information to enhance caregivers' knowledge of child development and help them hone their caregiving skills.

The Program for Early Parent Support (PEPS) might serve as a model for this form of support. PEPS offers choices among programs that meet for a couple of hours once a week for 10 weeks, or drop-in sessions open to anyone. Each group determines what topics will be discussed in a session, and a trained volunteer facilitates the sessions.

Offering child care (for caregivers' own children) and refreshments at gatherings should be considered. Specific concerns and interests can be addressed by offering targeted support groups for grandparents, for caregivers caring for children with special needs, for caregivers serving non-English-speaking communities, and for other groups with special needs.

Developing entirely new materials for these meetings should not be necessary since so much excellent material is already available. However, adapting materials may incur some development costs. For three series of classes, estimated development costs are approximately $1,200.

Implementation costs would include facility rental, provisions for child care, refreshments, materials, and payment of a facilitator. We estimate the annual implementation cost at $6,000 per county (for three series of 10 sessions each). Therefore, for the 10-county pilot, annual implementation costs are estimated at $60,000.

These costs do not include marketing, occasional guest speakers, or training of facilitators. It may be possible to reduce these costs in a number of ways, including in-kind support (such as free meeting space from local organizations, refreshment donations from local businesses, and nominal fees collected from participants).

Newsletters/Booklets/Tip Sheets

Fifty-three percent of FFN caregivers expressed interest in newsletters/booklets/tip sheets on topics relevant to caring for children of different ages. This form of support is very cost effective and, assuming widespread distribution and translation into several languages, can potentially reach the greatest number of FFN caregivers. The topics in these print materials could include play activities, science and reading activities/information, and music and art activities. The materials could also cover the kinds of developmental crises that can potentially harm children and stress their caregivers (i.e., colic, toilet training, biting, bed wetting, bullying, resistance to homework, and defiance). Contracting with New York's State Office of Children and Family, Cornell University's early childhood program, Extension and Outreach, developed resources for FFN caregivers. Currently these resources include six newsletters/bulletins that are distributed throughout the state. More information on this program can be found at www.human.cornell.edu/hd/cecp/caregiver.html.

Development costs for these materials include research and writing time and are estimated at $3,000 for four newsletters per year, $5,000 for two booklets per year, and $800 for four tip sheets per year. Implementation costs include costs for production and distribution of these printed materials, and would vary according to format (for example, booklets cost more than newsletters; newsletters cost more than tip sheets). Annual implementation costs for each county are estimated as $1,500 for four newsletters per year, $3,000 for two booklets per year, and $500 for four tip sheets per year. For a 10-county pilot, estimated implementation costs are $15,000 for newsletters, $30,000 for booklets, and $5,000 for tip sheets.

Activity Boxes/Toy or Play Kits

Thirty-five percent of FFN caregivers said they would like access to activity boxes/toy or play kits. These boxes would include self-contained, age-appropriate activities for caregivers to use with the child(ren). They could be made available for loan through community resources such as family support centers, libraries, or local schools.

Development costs, which include designing, acquiring, and testing materials, plus research and writing, are estimated at $2,000 to $4,000 per activity kit ($20,000 to $40,000 for 10 different kits). Estimated implementation costs, including materials and distribution of 100 kits, would be $2,700 per county or $27,000 for the 10-county pilot. Costs associated with promoting the activity kits are not included in this cost estimate.

Home Safety Kits

Home safety kits were requested by 35 percent of FFN caregivers. These kits could contain written information on topics such as lead-based paint, age-appropriate techniques for delivering CPR or rescue breathing, and identification and prevention of common household dangers for children. They could also include safety devices such as child-proof door latches and covers for electric outlets.

Initial costs for developing these kits from scratch could be substantial. However, it may be possible to lower development costs by using the resources of organizations such as the Red Cross and the American Academy of Pediatrics. Development costs of a home safety kit are estimated at $2,000. Annual implementation costs (distribution) for 100 kits per county are estimated at $1,000 per county. The estimated annual implementation costs for the 10-county pilot are $10,000. Costs associated with promoting the activity kits are not included in this cost estimate.

Short-Term Help/Respite Care

Thirty percent of FFN caregivers said they would like to have someone available to care for the child(ren) for short periods when they were unable to do so

Costs would include the administrative logistics of finding and listing substitutes; assessing their credentials; coordinating the service; and arranging payment, liability insurance, etc. We estimate that the annual cost for a 10-county pilot would be between $20,000 and $40,000.

Training to Become Licensed

Training to become licensed was requested by fifteen percent of FFN caregivers. In general, the caregivers requesting this training are not grandparents, and, although they may be other relatives, they are more often friends and neighbors. It is in the State's interest to offer this training in order to increase the supply of licensed caregivers. Assessment tools are available (from the Work/Family Institute for example) that may help these caregivers determine if

licensing is what they actually want. Access to existing training for FCC providers and center teachers could be opened up more intentionally to FFN caregivers.

Opportunities to Get Help with Specific Children: Resource Line and Home Visits

Although 33 percent of FFN caregivers would like a resource line, the cost for a resource line with knowledgeable staff to respond to inquiries 24 hours a day would be prohibitive. However, it may be possible to set up a voice- mail system that would enable staff to respond to callers within a designated period of time. Staffing this line and responding to inquiries would require access to specialists and a good knowledge of available resources.

Development costs (establishing the voice-mail system) are estimated at $2,000. The annual estimated implementation costs for returning calls are estimated at $3,600 per county. The annual implementation cost for the 10-county pilot are estimated at $36,000.

Ten percent of FFN caregivers want in-home visits to help with a particular child**.** The costs of providing this service/support would be high, but the service would be especially welcome for FFN caregivers who care for children with special problems. One in six FFN caregivers reports carrying for a child with emotional, behavioral, developmental, or physical problems. According to our survey, FFN caregivers serve approximately 76,000 children with special needs.

Annual implementation costs for in-home visits are estimated at between $2,500 and $5,000 per county. Annual implementation costs for the 10-county pilot are estimated at $25,000 to $50,000.

H.3. Additional Supports Suggested by Key Informants and Others

A Mobile Toy and Book Lending Library

Mobile toy and book lending libraries would be especially helpful in rural communities. This service would consist of a van that travels to homes or neighborhood/community gathering places (community centers, churches or other places of worship, or local grange halls), enabling caregivers to access materials and information on a regular, on-going basis. A driver who is also knowledgeable about child development and/or local resources could staff the van.

Existing programs with these services could potentially be adapted for FFN caregivers. Alabama has two programs that provide mobile-van service to rural counties (WOW Mobile, Kim Collins, 334-473-1313; Mobile Resource Library, Barbara Scott, 205 795-2303). These vans, staffed by child care specialists, provide service to licensed family child care providers and child care centers and staff. The annual budget for these programs ranges from $45,000 to $70,000.

Development costs include a substantial initial investment to purchase a vehicle and outfit it with toys and books ($30,000-$50,000). The annual implementation costs would include the salary of the driver/consultant, insurance, fuel, maintenance of the vehicle and replacement/ maintenance of equipment. The annual implementation costs are estimated at $50,000 per county. For the 10-county pilot, we assume that one or two vans will be used to serve all 10 counties; therefore,

the annual implementation costs for the 10-county pilot are estimated at between $50,000 and $100,000.

Access to State and Federal Programs by FFN Caregivers

We know that FFN caregivers are minimally involved in state-subsidized child care. Allowing caregivers with low to moderate incomes to take advantage of available state subsidies such as Community Development Block Grant (CDBG) programs and free or reduced-cost food programs would be helpful. Ninety-one percent of FFN caregivers said they provide food for the children in their care. Some states have been able to tap into the federal child care food program for this support. Most FFN caregivers are not paid or are paid poorly for the child care they provide. Wrap-around care for Head Start/ECEAP could also be used to assist FFN caregivers.

H.4. Summary

Designing and implementing a training and support system for up to 300,000 people a year would be a complex and expensive enterprise. We do not know how many people would actually participate, whether they would participate on an ongoing basis each year, how they would respond to various offerings, or what impact those offerings would have on the quality of care experienced by children. Given this level of uncertainty, we recommend that the state use the information in this report to design a substantial pilot effort and evaluate the responses to and impacts of this pilot program before committing to a large-scale system. In support of this recommendation, Table 4 presents a summary of the estimated costs for each of the supports/training for a one-year, 10-county pilot program.

Table 4: Summary of Cost Estimates for Types of FFN Caregiver Supports

Type of Support	Estimated Development Costs	Estimated Implementation Costs per County	Estimated Implementation Costs for 10 County Pilot
Opportunity to meet with others	Materials gathering/adapting = **$1,200** for 3 classes	Facilitator, handouts, room rental, refreshments, and child care (30 participants each session) = $2,000 for 10 sessions X 3 classes = **$6,000**	$6,000 per county X 10 counties = **$60,000**
Newsletter	Research and writing (40 hrs. each issue) = **$3,000** for four issues	Printing and distribution = $0.75 per newsletter X 500 newsletters = $375 per issue or **$1,500** for four issues	$1,500 per county X 10 counties = **$15,000**
Booklet	Research and writing (120 hrs each issue) = **$5,000** for two issues	Printing and distribution of 20 page booklets = $3.00 per booklet X 500 booklets = $1,500 or **$3,000** for two sets of booklets	$3,000 per county X 10 counties = **$30,000**
Tip sheets	Research and writing (10 hrs each issue) = **$800** for four issues	Printing and distribution = $0.25 per sheet X 500 sheets = $125 or **$500** for four sets of tip sheets	$500 per county X 10 counties = **$5,000**
Activity boxes/ toy or play kits	Designing, acquiring, and testing materials and research and writing = $2,000-$4,000 each kit designed X 10 activity kits = **$20,000-$40,000**	Materials and distribution = $27 per kit X 100 kits = **$2,700**	$2,700 per county X 10 counties = **$27,000**
Home safety kits	Compilation from existing resources = **$2,000**	Distribution = $10 per kit X 100 kits = **$1,000**	$1,000 per county X 10 counties = **$10,000**
Short term/respite care			**$20,000-$40,000** for administrative logistics, coordination, and insurance for 10 counties

Table 4: Summary of Cost Estimates for Types of FFN Caregiver Supports

Type of Support	Estimated Development Costs	Estimated Implementation Costs per County	Estimated Implementation Costs for 10 County Pilot
Someone to call when needing help with a particular child	Set-up with VoiceMail = **$2,000**	Call back with resources/referral = 60 calls X $20 per call = $1,200 Call back from expert/specialist = 60 calls X $40 per call = $2,400 Total cost = **$3,600**	$3,600 per county X 10 counties = **$36,000**
In-home help with a particular child		10 visits per year X $50 per visit = $500 per family X 5-10 families = **$2,500-$5,000**	$2,500-$5,000 per county X 10 counties = **$25,000-$50,000**
Mobile toy and book lending library	Initial investment for vehicle, books, and toys = **$30,000-$50,000**	Salary, maintenance of vehicle, insurance, gas, replacement/maintenance of equipment = **$50,000**	1-2 vans per pilot operating in multiple rural counties = **$50,000-$100,000**
Subtotal	**$64,000-$104,000**		**$268,000-$353,000**
Administration and Coordination (@ 20%)	**$12,800 - $20,800**		**$55,600-$74,600**
TOTAL	**$76,800-$124,800**		**$333,600-$447,600**

Approximated Total Pilot Costs for One-year Pilot for 10 Counties:

$410,000-$575,000 for development and implementation plus **$150,000** for evaluation

I. CONCLUSION: RECOMMENDATIONS FOR A TRAINING AND SUPPORT PROGRAM FOR FAMILY, FRIEND AND NEIGHBOR CAREGIVERS IN WASHINGTON STATE

We believe that the pattern of our findings builds a compelling case for the Washington Department of Social and Health Services to implement a pilot program to support family, friend and neighbor caregivers. Our starting point is the well-being of Washington's children: Research has clearly demonstrated that the training and skills of caregivers affect the social, emotional and cognitive development of children, regardless of the setting in which care is provided (Shonkoff and Phillips, 2000; NICHD, 2001; Peisner-Feinberg et.al., 1999). Fortunately, the data presented in the previous sections demonstrate that the interests and concerns of caregivers and parents converge on the well-being of children and point in the same direction – toward greater engagement by DSHS in supporting FFN caregivers. Our specific recommendations are based on the nature of those interests and concerns as revealed by the data we collected and analyzed, including recommendations from experts engaged as consultants to the project.

FFN care is a vital policy issue for the state because it affects so many children in Washington – approximately 480,000. It is the most prevalent form of non-parental care for infants (age 0-1), toddlers (1-2) and school-age (6-12) children. We found that a large number of children in Washington spend enough time in FFN care that the quality of that care can affect their development (145,000 children are in FFN care more than ten hours a week, and 87,000 more than 20 hours a week). The combination of these factors – the high prevalence of FFN care and the amount of time many children spend in that care – leads us to conclude that we can only assure the well-being of those children by promoting the quality of FFN care.

For the foreseeable future, FFN care is likely to continue as an important component in the diverse set of care arrangements used by Washington families. Parents choose FFN care for a variety of reasons. Those whose choices are influenced by cost or availability of licensed care may reduce their use of FFN care as the provision and financing of licensed care evolves. Parents who have chosen FFN care because of familiarity with the caregiver or a low child: adult ratio, or those seeking care for very young children are likely to continue using FFN care.

We found that FFN caregivers have lower levels of general education than the adult population of Washington State, and that a majority of FFN caregivers have none of the specific training in child care, child development, or parenting skills that are known to affect children's cognitive, social and emotional outcomes. Despite these deficits in training and education, FFN caregivers provide a significant amount of care – an average of 18 hours a week. One in four provides care for more than 30 hours a week, the equivalent of a full-time job. Given the potential long-term impact of this relationship – which is both educational and custodial – it makes sense to approach FFN caregivers as regular providers and offer them, on a voluntary basis, support that will help them perform their tasks well.

Such an effort would respond to the expressed desires of the caregivers. A majority of FFN caregivers report problems in providing care, and two thirds say they would like some type of training or support. Those who want support indicate a desire for, on average, four types of support. The forms of support mentioned most commonly are: a newsletter with tips and resources, kits (with toys, play materials or home safety materials), someone to call for assistance with challenging situations posed by a particular child, short-term care arrangements, and opportunities to meet and discuss their concerns with other caregivers.

Since we found such a wide range of backgrounds, problems, and desires for support by FFN caregivers, we recommend offering a flexible menu of voluntary training and support options. The packaging of this support is quite important: FFN caregivers prefer that information be built around the specific problems they face, and they want to get that information in a context of peer support rather than in formal classes. They would be much more likely to attend sessions in community settings (such as schools, libraries, and places of worship) than in more formal educational settings (such as community colleges).

While the numbers of children and caregivers involved indicate that this is a large-scale concern, we did not find models for large-scale training or support programs in other states. We did find many useful small-scale efforts, plus a wealth of training and support materials that are available for adoption or adaptation. To develop a cost-effective state-wide program that takes advantage of existing models and materials, we recommend starting with a 10-county pilot program that offers a range of training and support options. An important of component of the pilot program would involve experimenting with different ways to reach and engage FFN caregivers. The specific supports and training opportunities we suggest include offering: opportunities to meet with other FFN caregivers; newsletters, booklets and tip sheets; activity boxes/toy or play kits; home safety kits; opportunities (such as home visits and a resource line) of getting help with a particular child; short-term respite care; and training to become licensed.

This pilot program would provide an opportunity to formally evaluate the effects of support and training on FFN caregiving. It would also facilitate the assessment of various approaches to engaging FFN caregivers. Finally, a 10-county pilot would enable the Department to determine how to most effectively bring such an effort up to the scale suggested by the number of children and caregivers affected.

WORKS CITED OR CONSIDERED IN PROJECT DEVELOPMENT

American Association for Retired Persons. 1999. The AARP Grandparenting Survey: The Sharing and Caring between Mature Grandparents and Their Grandchildren.

Blau, D. M. 1992. The child care labor market. Journal of Human Resources 27: 9-40.

Blau, D. M. & A. P. Hagy. 1998. The demand for quality in child care. Journal of Political Economy 106(1): 104-147.

Blau, D.M. & P.K. Robins. 1988. Child care costs and family labor supply. Review of Economics and Statistics 70: 374-381.

Blau, D.M. & P.K. Robins. 1991. Child care demand and labor supply of young mothers over time. Demography 28: 333-351.

Blau, D. M. & E. Tekin. 2001. The determinants and consequences of child care subsidies. Poverty Research News 5(3).

Brayfield, A. & S. Hofferth. 1995. Balancing the family budget: differences in child care expenditures by race/ethnicity, economic status, and family structure. Social Science Quarterly 76: 158-177.

Bredekamp, S. & Copple, C. 1997. Developmentally Appropriate Practice in Early Childhood Programs. Washington, DC: NAEYC

Bromer, J. & J. R. Henly. 2002. Policy initiatives for the informal child care sector. Policy Research News 6(1): 15-16.

Brown-Lyons, Melanie, Anne Robertson, and Jean Layzer, 2001. Kith and Kin—Informal Child Care: Highlights from the Research. National Center for Children in Poverty, Mailman School of Public Health, Columbia University. New York, NY.

Burstein, N.R., & J. Hiller. 1999. National Study of Child Care for Low Income Families: Review of the Literature on Determinants of Child Care Choices. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Burton, Alice, Marcy Whitebook & Laura Sakai. 1994. Valuable Work, Minimal Rewards: A Report on the Wisconsin Child Care Workforce. Washington, DC: Center for the Child Care Workforce.

Capizzano, J. & Adams, G. 2000. The Number of Child Care Arrangements Used by Children Under Five: Variation Across States. Issue Brief. Washington, DC: Urban Institute.

Crawford, D. L. & R. A. Pollack. 1990. Child Care Policy. Washington, DC: US Department of Health and Human Services.

Eliason, C. & L. Jenkins. 1999. A Practical Guide to Early Childhood Curriculum. Upper Saddle River, NJ: Merrill.

Fuller, B. & S. L. Kagan. 2000. Remember the Children: Mothers Balance Work and Child Care under Welfare Reform. Growing Up in Poverty Project 2000, Wave 1 Findings. University of California, Berkeley and Yale University: 1-115.

Galinsky, E., C. Howes, S. Kontos, and M. Shinn. 1994. The Study of Children in Family Child Care and Relative Care: Highlights of Findings. New York: Families and Work Institute.

Hofferth, S.l., K. A. Shauman R. R. Henke, & J. West. 1998. Characteristics of Children's Early Care and Education Programs: Data from the 1995 National Household Education Survey. NCES 98-128. Washington, DC: U.S. Dept. of Education, National Center for Education Statistics, 1998.

Hofferth, S. H. 1999. Child care and maternal employment, and public policy. The Annals of the American Academy of Political and Social Science 563: 20-38.

Kontos, Susan, Carollee Howes, Marybeth Shinn & Ellen Galinsky. 1992. Quality in Family Child Care and Relative Care. New York University: Families and Work Institute.

Michalopoulos, C., P.K. Robins & I. Garfinkel. 1992. A structural model of labor supply and child care demand. Journal of Human Resources (27): 166-203.

Minnesota Department of Children, Families, and Learning (a). 2001. Child Care Use in Minnesota. Saint Paul, MN: Wilder Research Center.

Minnesota Department of Children Families and Learning (b). 2001. Staff Recruitment and Retention in Early Childhood Care and Education and School Age Care. Saint Paul, MN: Wilder Research Center.

Morgan, Gwen. 2000. Personal Communication.

Morgan, Gwen. Recommendations for Training and Support for FFN Caregivers in the State of Washington. 2001.

National Center for Education Statistics. 1999. National Household Education Survey.

National School-Age Care Alliance. www.nsaca.org

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.

NICHD Early Child Care Research Network. 2000. The relations of child care to cognitive and language development. Child Development 71(4): 958-978.

NICHD Early Child Care Research Network. 2001. Structure, Process, Outcome: Direct and Indirect Effects of Caregiving Quality on Young Children's Development. Paper presented at Society for Research in Child Development Meeting, April 2001, Minneapolis, MN.

Peisner-Feinberg, E.S., M.R. Burchinal, R.M. Clifford, M.L. Culkin, C. Howes, S.L. Kagan, N. Yazejian, P. Byler, J. Rustici & J. Zelazo. 1999. The Children of the Cost, Quality, and Outcomes Study Go To School: Executive Summary. Chapel Hill, NC: University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center.

Porter, Toni. 2001. Proceedings from the HSPC and Child Care Resource and Referral Network Forum. University of Washington, April 2001.

Ribar, D.C. 1992. Child care and the labor supply of married women: Reduced from evidence. Journal of Human Resources 27: 134-165.

Roschelle, Anne R. 1997. No More Kin: Exploring Race, Class, and Gender in Family Networks. Thousand Oakes: Sage.

Shonkoff, J.P. and D. Phillips, Eds. 2000. From Neurons to Neighborhoods: The Science of Early Child Development. Washington, D.C.: National Academy Press.

Vandell, D. L. & B. Wolfe. 2000. Child Care Quality: Does it Matter and Does it Need to be Improved? Washington, D.C., Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services.

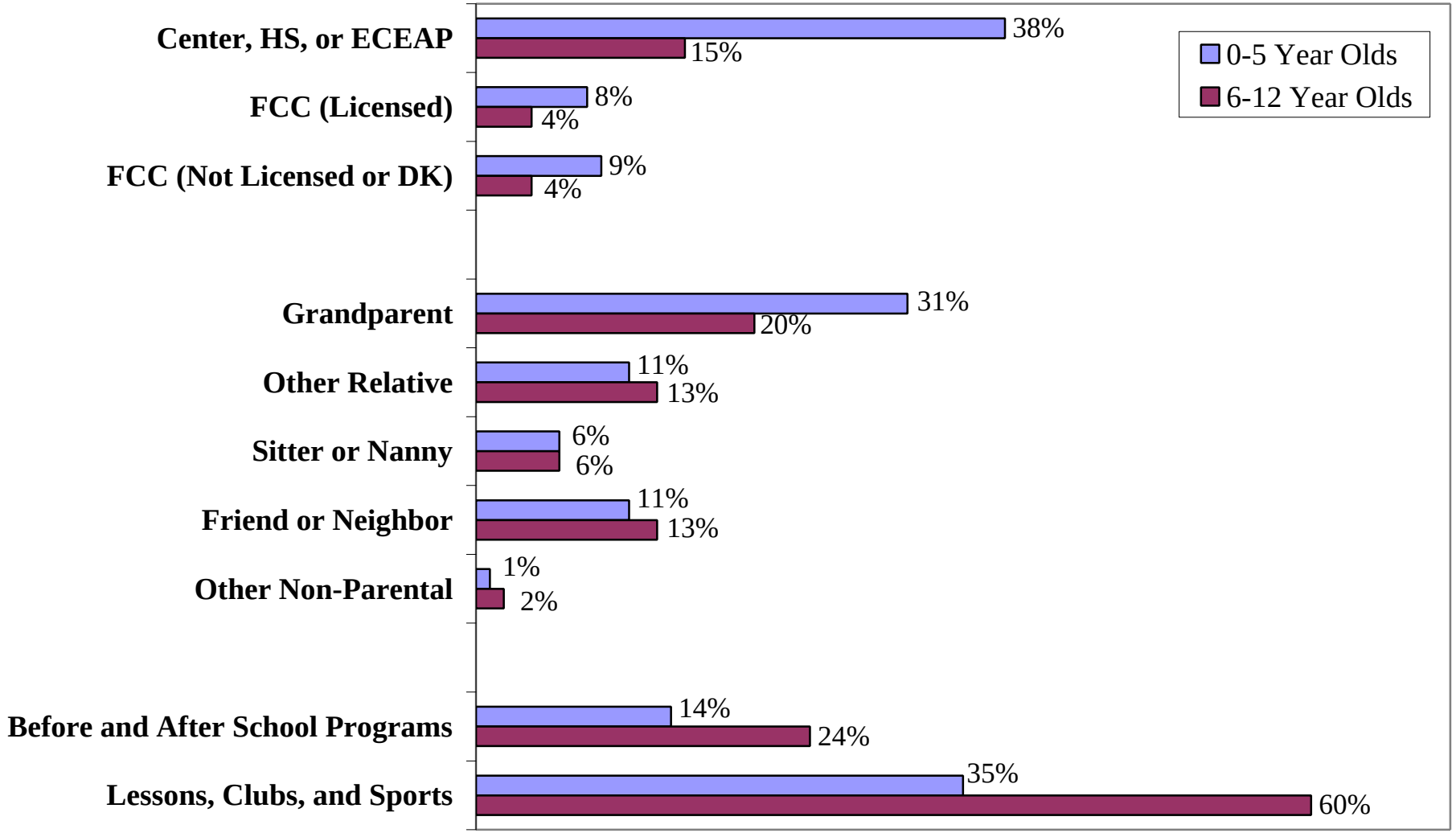
Willer, Barbara, Sandra L. Hofferth, Ellen Eliason Kisker, Patricia Divine-Hawkins, Elizabeth Farquhar & Frederic B. Glantz. 1990. A Profile of Child Care Settings: Early Education and Care in 1990. Washington, DC: National Association for the Education of Young Children.

Willer, B., S. Hofferth, E. E. Kisker, P. Divine-Hawkins, E. Farquahar, & F. Glantz, 1991. The Demand and Supply of Child Care in 1990: Joint Findings from the National Child Care Survey 1990, and A Profile of Child Care Settings. Washington, DC: National Association for the Education of Young Children.

APPENDIX A

ADDITIONAL DATA CHARTS

Chart A1: Percent of All Children in Any Amount of Each Type of Care by Detailed Type



Note: Care categories are not mutually exclusive.

Chart A2: Percent of Children in FFN Care by Number of Hours of Care per Week

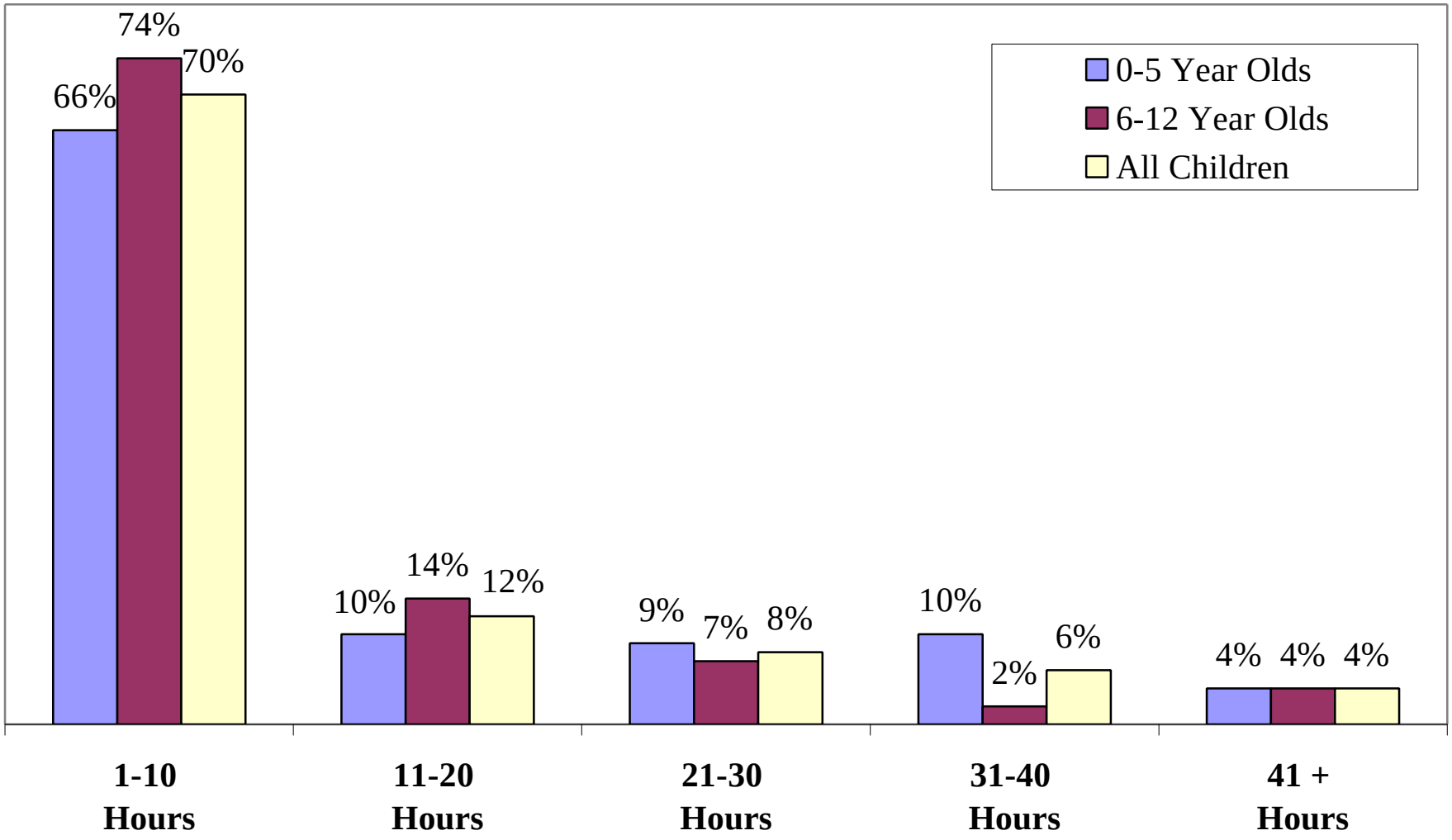


Chart A3: Average Number of Hours Children Spend in Each Type of Care per Week by Detailed Type

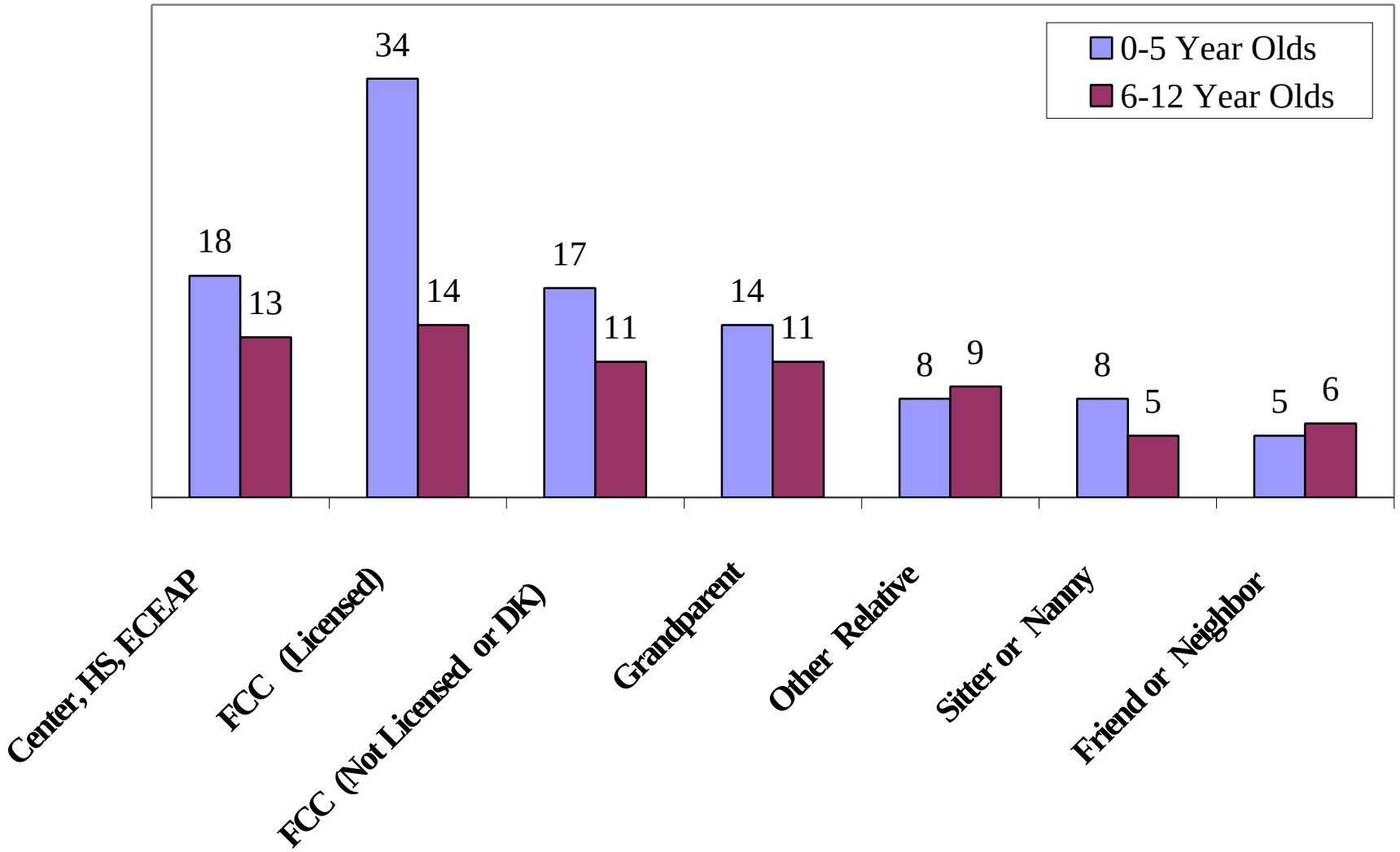


Chart A4: Percent of All Care Hours Each Week in Each Type of Care by Detailed Care Type

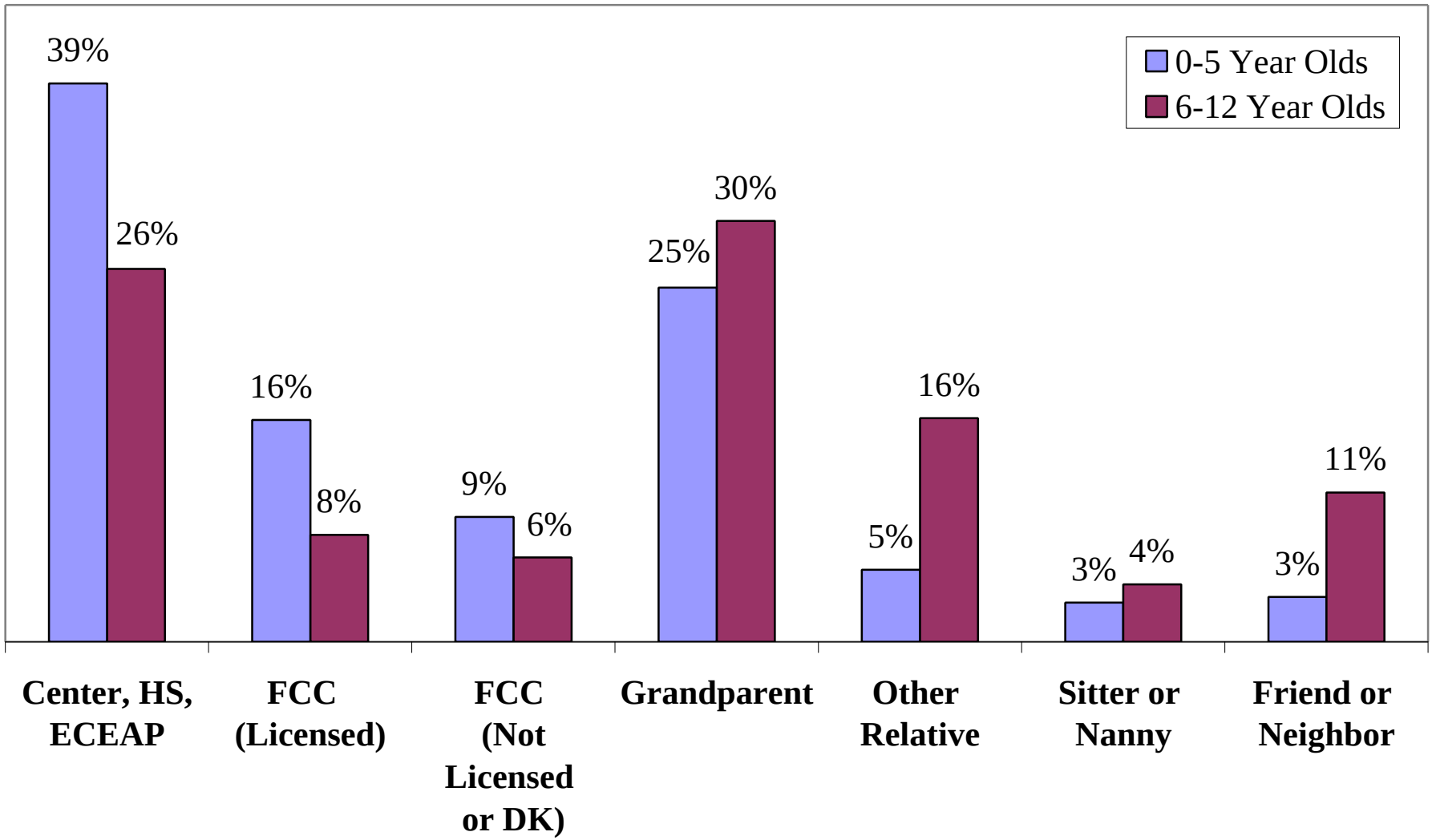


Chart A5: Percent of All Children with Each Type of Primary Care Arrangement by Detailed Care Types

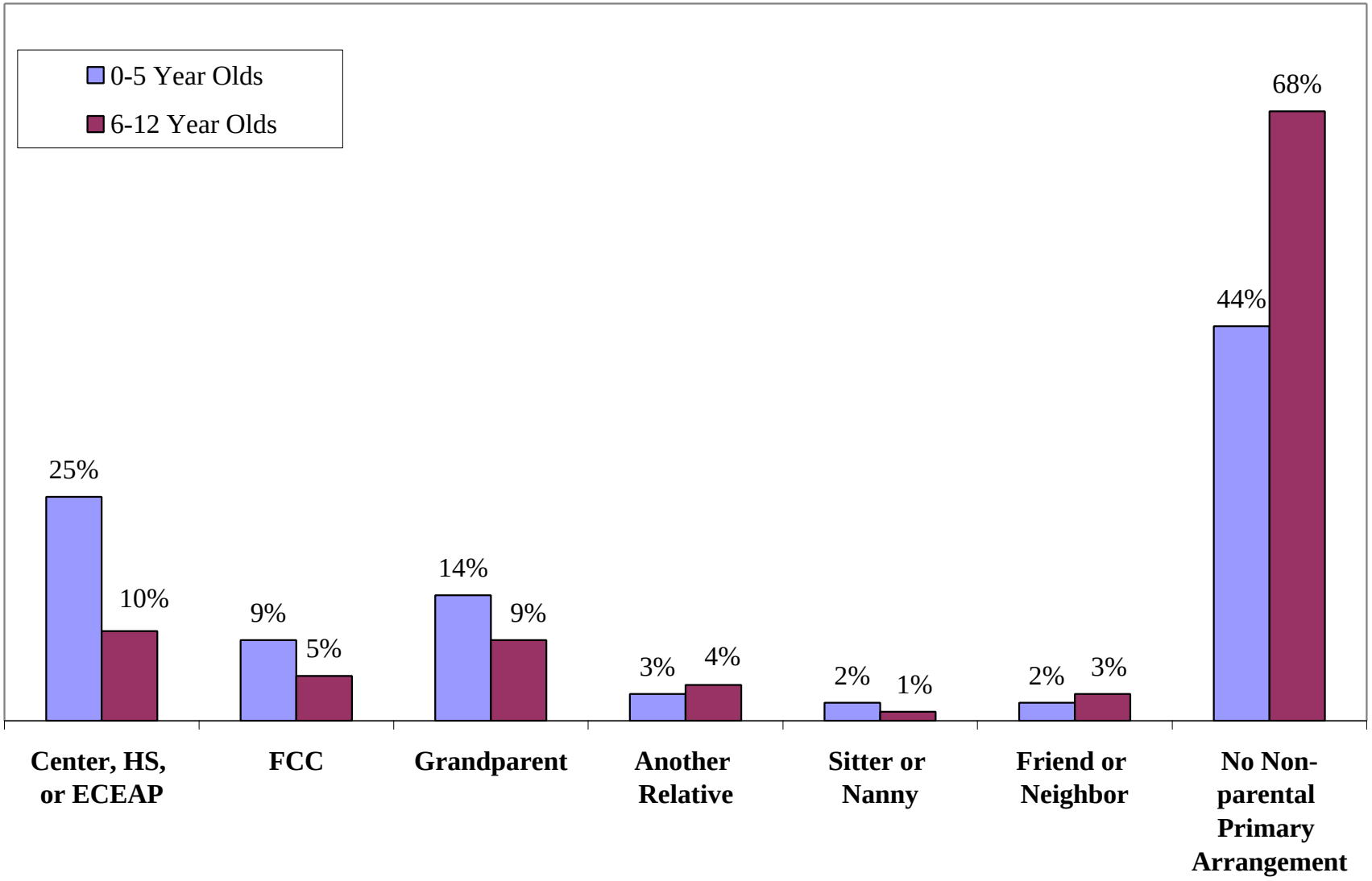
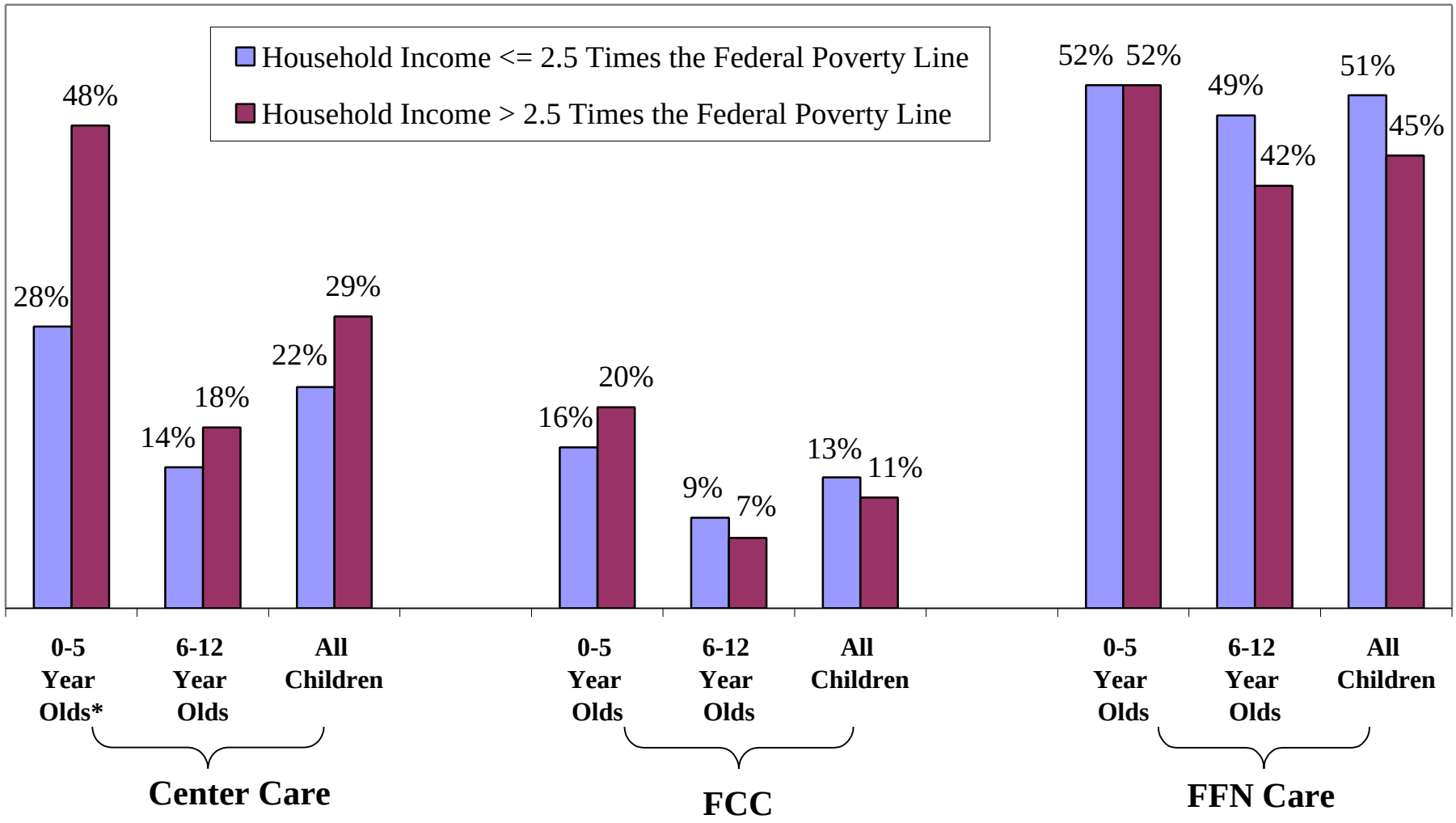


Chart A6: Percent of All Children in Some Amount of Center Care, FCC, or FFN Care Each Week by Household Income Group



*Difference is significant at p < .05

Chart A7: Average Hours in Center Care, FCC, or FFN Care per Week by Parent's Marital Status

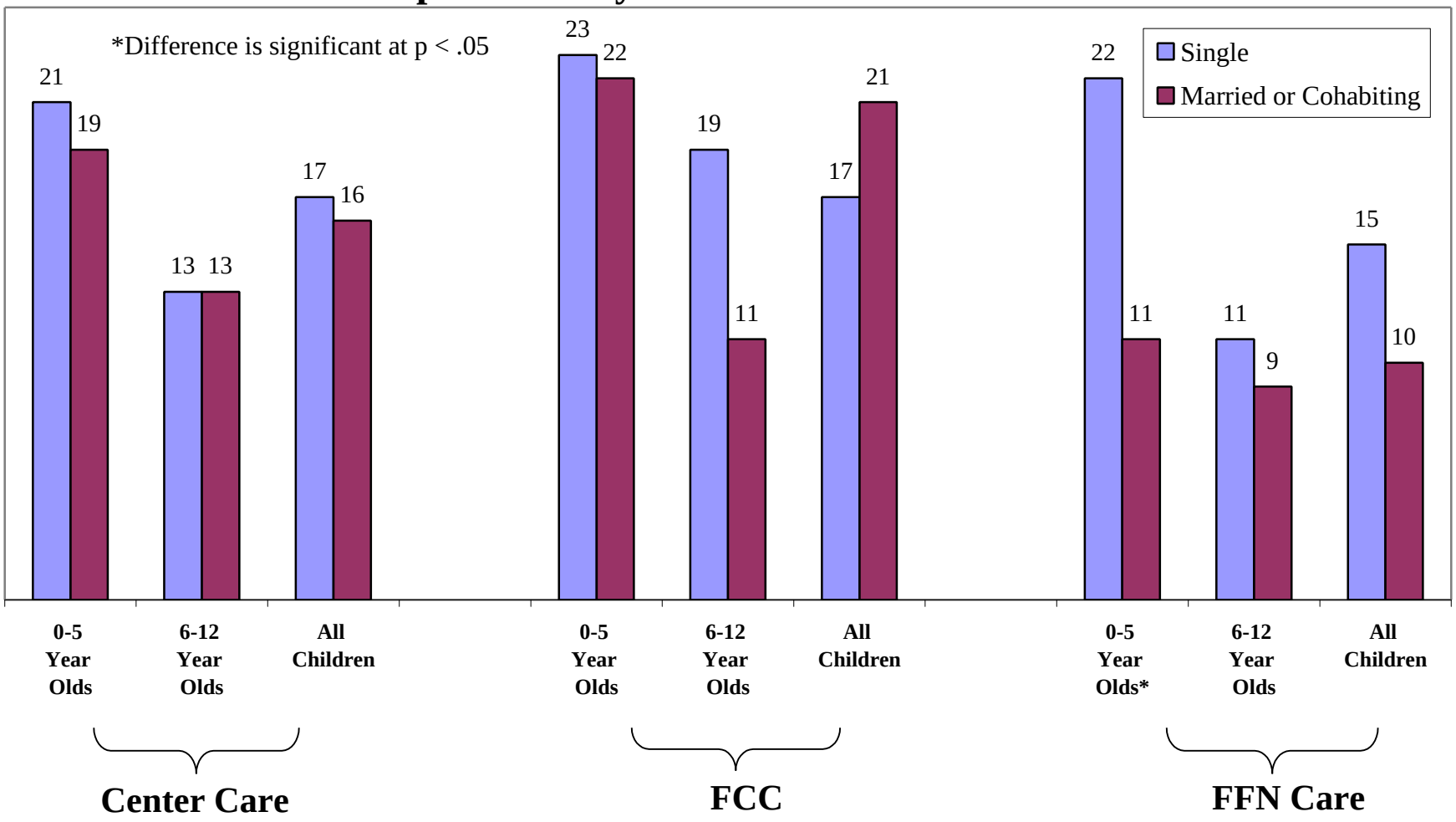
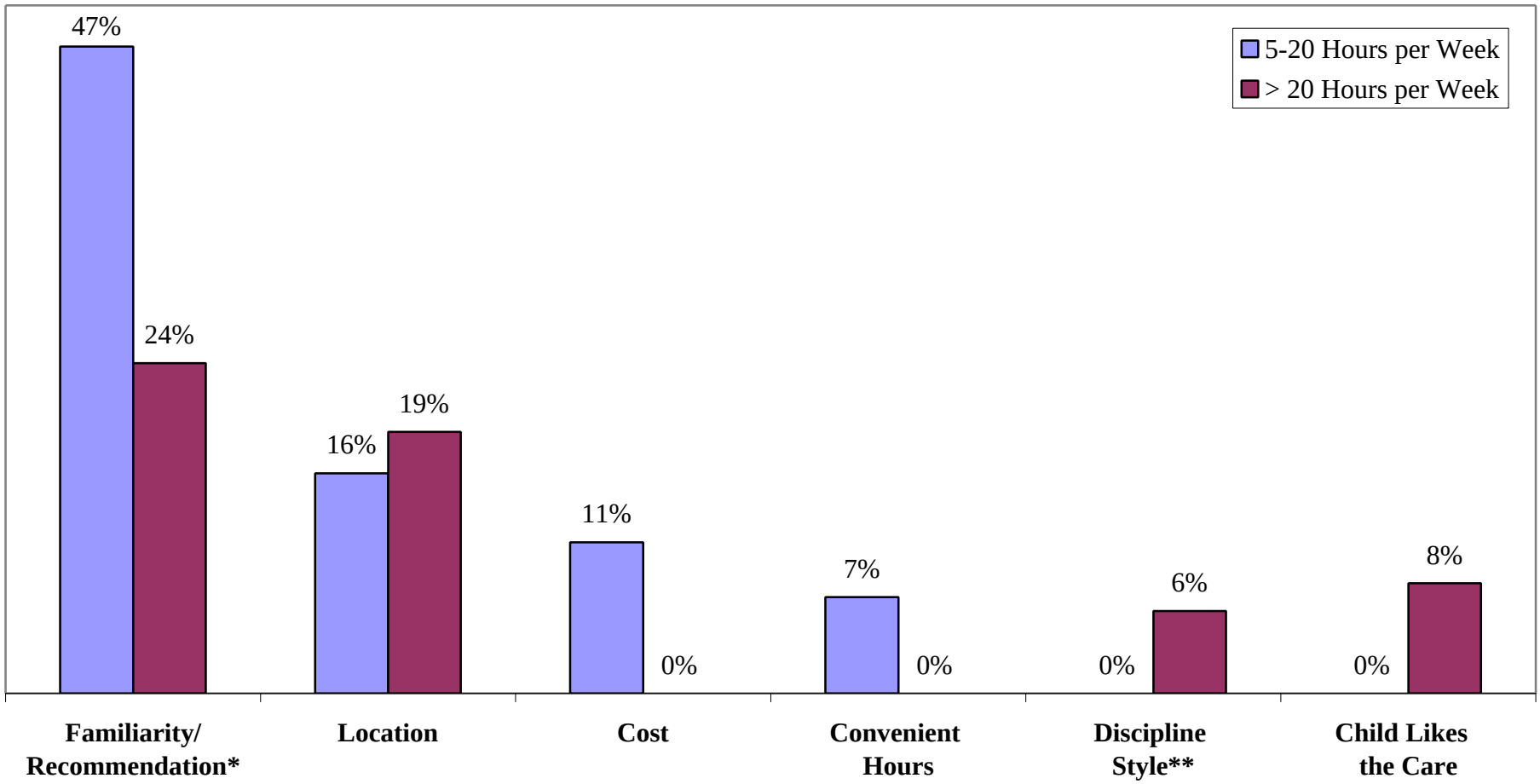


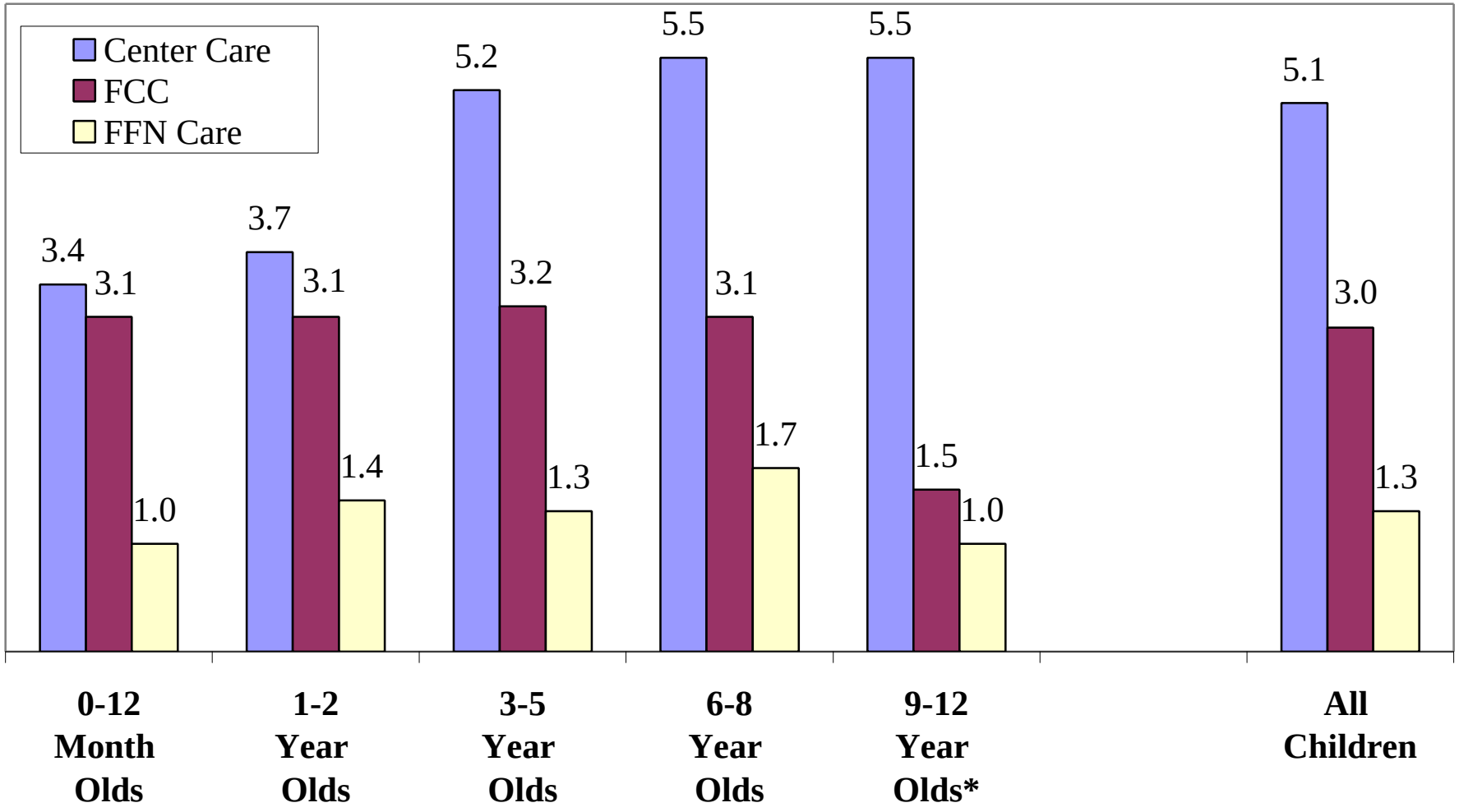
Chart A8: Percent of Parents Reporting Each as a Main Reason for Choosing FFN Care as Primary Care for 6-12 Year Olds by the Number of Hours in Care



*Difference is significant at p < .10

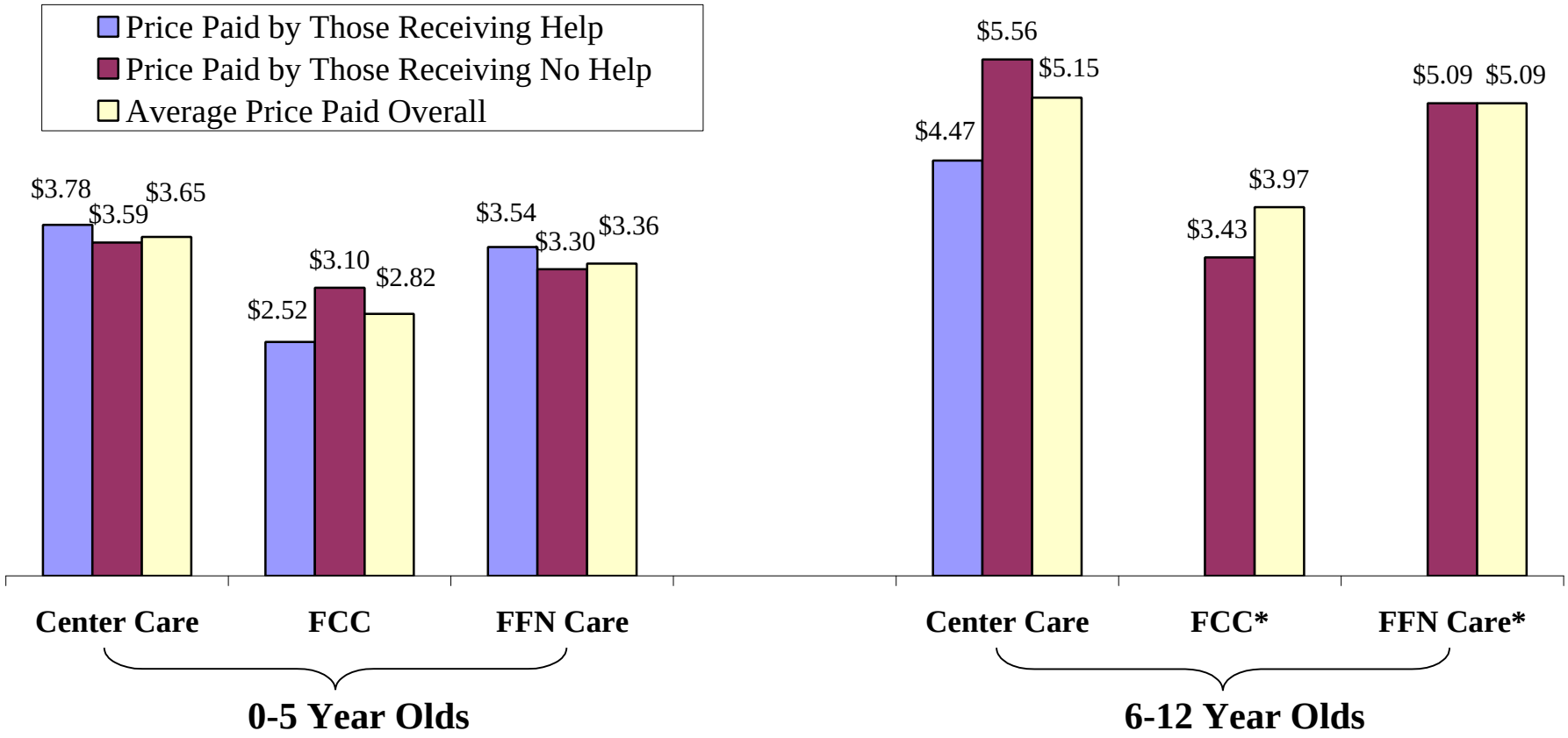
**Difference is significant at p < .05

Chart A9: Average Child:Adult Ratio in Center Care, FCC, and FFN Care for Detailed Age Groups



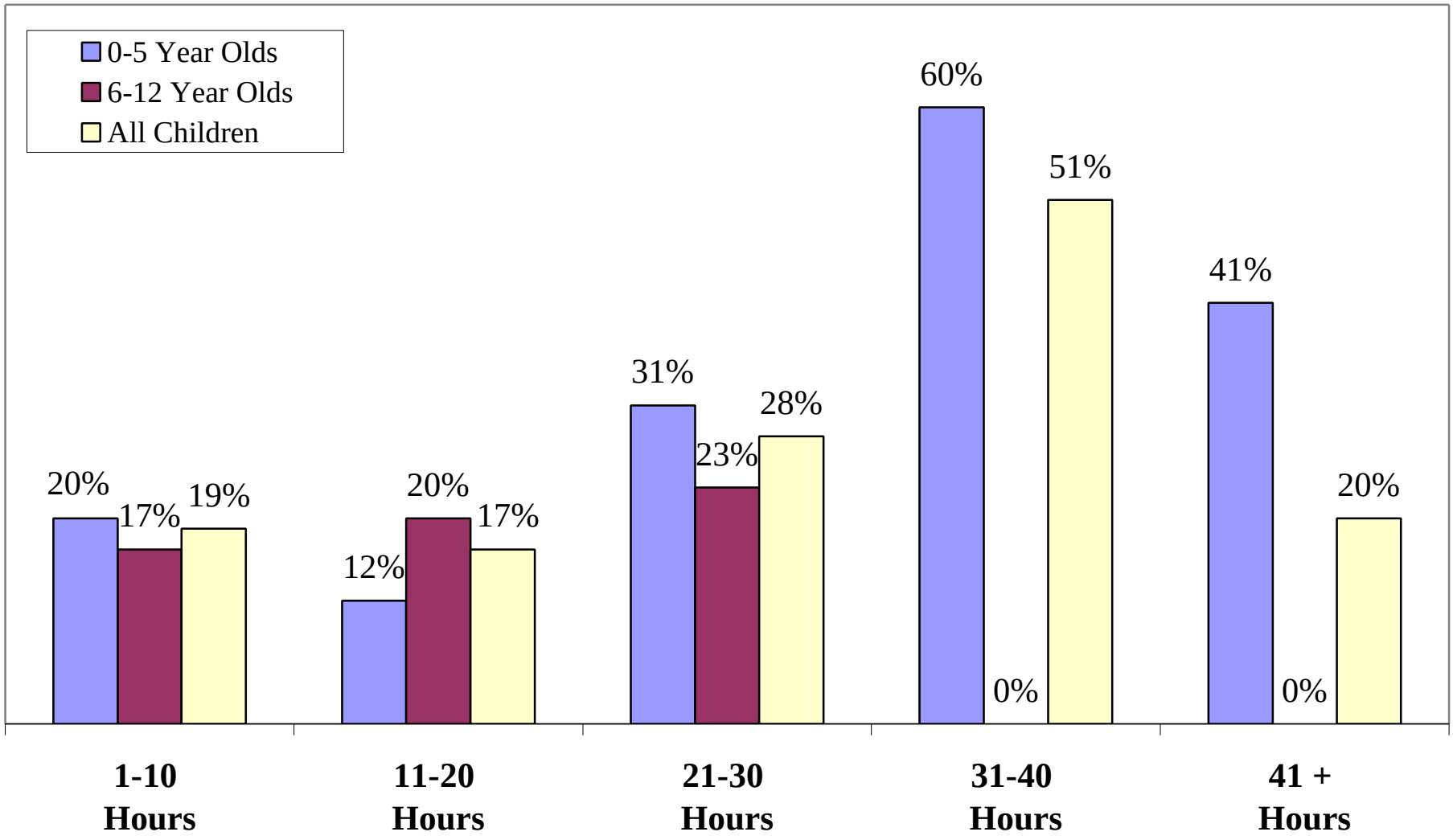
*Based on less than 10 cases for FCC ratio.

Chart A10: Average Amount Parents Report Paying for Care per Hour for Those Receiving Help or Charged Reduced Fees, Not Receiving Help, and Overall



Note: No differences in parent reports of payment for care between those receiving and not receiving outside help are significant at $p < .05$.
*Not enough cases to report price for those receiving help for FCC and FFN care for 6-12 year olds.

Chart A11: Percent of Parents Paying for FFN Care by Hours per Week in FFN Care



APPENDIX B

MULTIVARIATE ANALYSIS

The multivariate analysis is based on a multinomial logit model that distinguishes three types of primary care for the youngest child in the family: (1) FFN care, (2) center care or FCC, and (3) parental care. The multinomial logit model is a nominal regression model in which the effects of the independent variables are allowed to differ for each outcome.

Table B1. Variable Definitions for Variables used in the Multivariate Analysis

Table B2. Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (0-5 Year Olds)

Table B3. Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (Age 6-12 Year Olds)

Table B4. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (0 and 5 Year Olds)

Table B5. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (6 to 12 Year Olds)

Table B1: Variable Definitions for Variables used in the Multivariate Analysis

Variable Name	Definition	Code
Dependent Variable		
Primary care	Primary child care for youngest child is center or FCC, FFN, or none.	0 = no primary care 1 = FFN care primary 2 = center care or FCC primary
Independent Variables		
Youngest Child		
Age_youngest child	The age of youngest child in household.	Continuous
Sex_youngest child	The sex of the youngest child in household	0 = Male, 1 – Female
Special needs	The youngest child in the household has a physical, emotional, developmental, or behavioral condition.	1 = youngest child has special needs
Mother		
Age	The age of the respondent.	Continuous
Single parent	The respondent is a single parent.	1 = respondent is a single parent
Education	The respondent's highest level of educational attainment.	1 = less than high school 5 = some graduate or professional school
Black	Respondent is Black	1 = respondent is Black
Hispanic	Respondent is Hispanic	1 = respondent is Hispanic
Asian	Respondent is Asian	1 = respondent is Asian
Native American	Respondent is Native American	1 = respondent is Native American
Household		
Income (in thousands)	Household income	Continuous
Quadratic Income Term	Quadratic income term	Continuous
Number children 0-5 in HH	The number of children in the household age 0-5, including the youngest child.	Continuous
Number children 6-12 in HH	The number of children in the household age 6-12, including the youngest child.	Continuous
Number children 13-18 in HH	The number of children in the household age 13-18.	Continuous
Relative care available	A relative is available to provide child care.	1 = relative is available
Non-Parental relative adults in HH	There is one or more adult relative in the household.	1 = there is one or more adult relative in the household
Non-Relative adults in HH	There is one or more adult non-relative in the household.	1 = there is one or more adult non-relative in the household
Care Characteristics		
Ratio_important	The number of children per caregiver is	1 = very important

Table B1: Variable Definitions for Variables used in the Multivariate Analysis

Variable Name	Definition	Code
	very important to the respondent.	
Loving_important	A warm and loving teaching/parenting style in a caregiver is very important to the respondent.	1 = very important
Hours_important	Flexible and convenient caregiver hours are very important to the respondent.	1 = very important
Training_important	The training or credentials of the caregiver or staff is very important to the respondent.	1 = very important
Facilities_important	The physical facilities and equipment for play and learning of the caregiver is very important to the respondent.	1 = very important
Values_important	A caregiver that has similar values is very important to the respondent.	1 = very important
Location_important	The location of a caregiver is very important to the respondent.	1 = very important
Cost_important	The cost of the caregiver is very important to the respondent.	1 = very important
Trust_important	It is very important to the respondent that the caregiver is someone they know and trust.	1 = very important
Similar race_important	It is very important to the respondent that the race/ethnicity or native language of the caregiver matches their own or their child's race/ethnicity or native language.	1 = very important
Discipline_important	It is very important to the respondent that the caregivers' discipline and guidance styles are consistent with their own	1 = very important
Activities_important	It is very important to the respondent that the caregiver provides stimulating or enriching activities or programs.	1 = very important
Center Availability	The number of licensed child care slots divided by the number of children age 0-12 in the parent's zip code.	Continuous (variable can range from 0 to 1 depending on the proportion of licensed spot per child)
FCC Availability	The number of licensed child care slots divided by the number of children age 0-12 in the parent's zip code.	Continuous (variable can range from 0 to 1 depending on the proportion of licensed spot per child)
Center Market Rate	Average price of full-time pre-school center care by county.	Continous
FCC Market Rate	Average price of full-time pre-school FCC by county.	Continuous

Table B2: Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (0-5 Year Olds)

Variable Name	Mean (Standard Error)	Range
Dependent Variable		
Primary care	Percentages: No Primary = 43.48% FFN = 21.45% Center or FCC = 35.08%	0-2 (0 = No Primary, 1 = FFN, 2 = Center or FCC)
Independent Variables		
Youngest Child		
Age_youngest child	2.49 (.11)	0-5 (Age continuous)
Sex_youngest child	.50 (.03)	0-1 (1 = female)
Special needs	.07 (.02)	0-1 (1 = child has a special need)
Mother		
Age	31.60 (.48)	18-77 (Age continuous)
Single parent	.10 (.02)	0-1 (1 = single parent)
Education	3.05 (.07)	1-5 (1 = less than high school, 5 = some graduate or professional school)
Black	.01 (.01)	0-1 (1 = respondent is Black)
Hispanic	.06 (.01)	0-1 (1 = respondent is Hispanic)
Asian	.04 (.01)	0-1 (1 = respondent is Asian)
Native American	.02 (.01)	0-1 (1 = respondent is Native American)
Household		
Income (in thousands)	49.90 (2.10)	.9-300 (continuous)
Quadratic Income Term	3624.34 (404.61)	.81-90,000 (continuous)
Number children 0-5 in HH	1.35 (.03)	1-4 (continuous)
Number children 6-12 in HH	.56 (.05)	0-4 (continuous)
Number children 13-18 in HH	.18 (.05)	0-2 (continuous)
Relative care available	.13 (.02)	0-1 (1 = relative care available)
Non-Parental relative adults in HH	.13 (.03)	0-1 (1 = adult relative in household)
Non-Relative adults in HH	.04 (.01)	0-1 (1 = adult non-relative in household)
Care Characteristics		
Ratio_important	.75 (.03)	0-1 (1 = very important)
Loving_important	.94 (.01)	0-1 (1 = very important)
Hours_important	.50 (.03)	0-1 (1 = very important)
Training_important	.73 (.03)	0-1 (1 = very important)
Facilities_important	.64 (.03)	0-1 (1 = very important)
Values_important	.78 (.03)	0-1 (1 = very important)
Location_important	.39 (.03)	0-1 (1 = very important)

Table B2: Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (0-5 Year Olds)

Variable Name	Mean (Standard Error)	Range
Cost_important	.32 (.03)	0-1 (1 = very important)
Trust_important	.82 (.02)	0-1 (1 = very important)
Similar race_important	.14 (.02)	0-1 (1 = very important)
Discipline_important	.83 (.02)	0-1 (1 = very important)
Activities_important	.79 (.03)	0-1 (1 = very important)
Center Availability	.09 (.01)	0-.67 (variable can range from 0 to 1 depending on the proportion of licensed spot per child)
FCC Availability	.05 (.00)	0-.67 (variable can range from 0 to 1 depending on the proportion of licensed spot per child)
Center Market Rate	479.26 (4.47)	$157.29 - $590.15
FCC Market Rate	455.09 (4.45)	$344.36 - $563.24

Table B3: Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (6-12 Year Olds)

Variable Name	Mean (Standard Error)	Range
Dependent Variable		
Primary care	Percentages: No Primary = 68.36% FFN = 19.16% Center or FCC = 12.48%	0-2 (0 = No Primary, 1 = FFN, 2 = Center or FCC)
Independent Variables		
Youngest Child		
Age_youngest child	9.02 (.15)	6-12 (age continuous)
Sex_youngest child	.55 (.04)	0-1 (1 = female)
Special needs	.1 (.02)	0-1 (1 = child has a special need)
Mother		
Age	38.74 (.49)	17-57 (age continuous)
Single parent	.15 (.03)	0-1 (1 = single parent)
Education	3.26 (.08)	1-5 (1 = less than high school, 5 = some graduate or professional school)
Black	.00 (.00)	0-1 (1 = respondent is Black)
Hispanic	.03 (.01)	0-1 (1 = respondent is Hispanic)
Asian	.06 (.02)	0-1 (1 = respondent is Asian)
Native American	.02 (.01)	0-1 (1 = respondent is Native American)
Household		
Income (in thousands)	60.31 (3.21)	.642-300 (continuous)
Quadratic Income Term	5581.22 (854.27)	.41-90,000 (continuous)
Number children 6-12 in HH	1.46 (.05)	1-4 (continuous)
Number children 13-18 in HH	.47 (.05)	0-2 (continuous)
Relative care available	.15 (.03)	0-1 (1 = relative care available)
Non-Parental relative adults in HH	.11 (.03)	0-1 (1 = adult relative in household)
Non-Relative adults in HH	.01 (.01)	0-1 (1 = adult non-relative in household)
Care Characteristics		
Ratio_important	.79 (.03)	0-1 (1 = very important)
Loving_important	.94 (.02)	0-1 (1 = very important)
Hours_important	.59 (.04)	0-1 (1 = very important)
Training_important	.70 (.03)	0-1 (1 = very important)
Facilities_important	.66 (.04)	0-1 (1 = very important)
Values_important	.80 (.03)	0-1 (1 = very important)
Location_important	.44 (.04)	0-1 (1 = very important)
Cost_important	.36 (.04)	0-1 (1 = very important)
Trust_important	.84 (.03)	0-1 (1 = very important)

Table B3: Descriptive Statistics for Variables in Multinomial Regression of Primary Care Arrangement of the Youngest Child in the Family (6-12 Year Olds)

Variable Name	Mean (Standard Error)	Range
Similar race_important	.14 (.03)	0-1 (1 = very important)
Discipline_important	.86 (.03)	0-1 (1 = very important)
Activities_important	.78 (.03)	0-1 (1 = very important)
Center Market Rate	479.60 (5.83)	$157.29 - $590.15
FCC Market Rate	459.28 (5.36)	$336.62 - $563.24

Table B4. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (0-5 Year Olds)

Variable Name	Coefficient (Standard Error)
Comparison: Parental Care vs. FFN Care	
Independent Variables	
Youngest Child	
Age_youngest child	.01 (.18)
Sex_youngest child	-.04 (.47)
Special needs	.39 (.74)
Mother	
Age	-.04 (.04)
Single Parent	-1.97 (.91)
Education	-.17 (.31)
Black	1.25 (1.86)
Hispanic	2.01 (1.12)
Asian	-.9 (1.00)
Native American	-1.48 (1.78)
Household	
Income (in thousands)	.04 (.02)
Quadratic Income Term	-.00 (.00)
Number children 0-5 in HH	.67 (.51)
Number children 6-12 in HH	.59 (.34)
Number children 13-18 in HH	-.67 (.31)
Relative care available	-3.47 (.68)
Non-Parental relative adults in HH	.7 (.72)
Non-Relative adults in HH	-3.68 (1.18)
Care Characteristics	
Ratio_important	-.11 (.64)
Loving_important	-.15 (1.2)
Hours_important	-.89 (.46)
Training_important	1.79 (.57)
Facilities_important	-1.21 (.57)
Values_important	.00 (.65)
Location_important	.73 (.51)
Cost_important	-.57 (.50)
Trust_important	.99 (.83)
Similar race_important	.81 (.88)
Discipline_important	.73 (.67)
Activities_important	-.36 (.64)
Center Availability	4.34 (2.85)
FCC Availability	.17 (10.50)
Center Market Rate	-.02 (.01)
FCC Market Rate	.01 (.01)

Table B4. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (0-5 Year Olds)

Variable Name	Coefficient (Standard Error)
Comparison: Center or FCC vs. FFN Care	
Independent Variables	
Youngest Child	
Age_youngest child	.58 (.19)
Sex_youngest child	-.82 (.52)
Special needs	-.35 (.85)
Mother	
Age	-.04 (.04)
Single Parent	.16 (.79)
Education	.22 (.33)
Black	9.37 (2.21)
Hispanic	2.35 (1.18)
Asian	-.61 (.88)
Native American	-3.88 (1.49)
Household	
Income (in thousands)	.03 (.02)
Quadratic Income Term	-.00 (.00)
Number children 0-5 in HH	.06 (.50)
Number children 6-12 in HH	.41 (.35)
Number children 13-18 in HH	-.42 (.23)
Relative care available	-3.00 (.72)
Non-Parental relative adults in HH	.80 (.75)
Non-Relative adults in HH	-5.25 (1.56)
Care Characteristics	
Ratio_important	-.34 (.71)
Loving_important	-.89 (1.15)
Hours_important	-.69 (.53)
Training_important	1.16 (.63)
Facilities_important	-.78 (.70)
Values_important	.10 (.63)
Location_important	1.43 (.55)
Cost_important	-1.80 (.62)
Trust_important	-.20 (.76)
Similar race_important	1.27 (.89)
Discipline_important	1.43 (.69)
Activities_important	-.15 (.75)
Center Availability	6.90 (2.90)
FCC Availability	1.92 (10.63)
Center Market Rate	-.03 (.01)
FCC Market Rate	.02 (.01)

Table B5. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (6-12 Year Olds)

Variable Name	Coefficient (Standard Error)
Comparison: Parental Care vs. FFN Care	
Independent Variables	
Youngest Child	
Age_youngest child	.33 (.17)
Sex_youngest child	.04 (.58)
Special needs	-1.97 (.96)
Mother	
Age	.07 (.04)
Single Parent	-1.62 (.92)
Education	.01 (.31)
Black	6.56 (1.78)
Hispanic	.15 (2.50)
Asian	-2.00 (.94)
Native American	-.19 (1.17)
Household	
Income (in thousands)	-.01 (.02)
Quadratic Income Term	-.00 (.00)
Number children 6-12 in HH	-.31 (.62)
Number children 13-18 in HH	-.73 (.55)
Relative care available	-3.73 (.80)
Non-Parental relative adults in HH	.55 (.79)
Non-Relative adults in HH	7.13 (2.43)
Care Characteristics	
Ratio_important	-1.92 (.88)
Loving_important	1.27 (.77)
Hours_important	-.36 (.64)
Training_important	-.04 (.70)
Facilities_important	-.45 (.61)
Values_important	.87 (.61)
Location_important	.26 (.60)
Cost_important	1.29 (.66)
Trust_important	.87 (.78)
Similar race_important	.35 (.69)
Discipline_important	-.36 (.67)
Activities_important	.48 (.75)
Center Market Rate	-.00 (.01)
FCC Market Rate	.00 (.01)

Table B5. Multinomial Regression Results: Primary Care Arrangement of the Youngest Child in the Family (6-12 Year Olds)

Variable Name	Coefficient (Standard Error)
Comparison: Center or FCC vs. FFN Care	
Independent Variables	
Youngest Child	
Age_youngest child	-.95 (.31)
Sex_youngest child	.83 (.87)
Special needs	-.61 (1.18)
Mother	
Age	-.03 (.06)
Single Parent	1.85 (1.35)
Education	1.23 (.55)
Black	2.22 (2.10)
Hispanic	1.95 (2.40)
Asian	-1.33 (2.80)
Native American	1.82 (1.55)
Household	
Income (in thousands)	-.00 (.04)
Quadratic Income Term	-.00 (.00)
Number children 6-12 in HH	-.81 (.77)
Number children 13-18 in HH	-1.16 (.96)
Relative care available	-2.86 (1.06)
Non-Parental relative adults in HH	1.48 (2.11)
Non-Relative adults in HH	10.24 (2.98)
Care Characteristics	
Ratio_important	-5.04 (1.41)
Loving_important	-.48 (1.30)
Hours_important	-1.22 (1.02)
Training_important	-.19 (.93)
Facilities_important	-.34 (1.07)
Values_important	-1.34 (.84)
Location_important	-.10 (1.08)
Cost_important	-.71 (1.06)
Trust_important	1.91 (1.12)
Similar race_important	.55 (1.25)
Discipline_important	1.85 (1.25)
Activities_important	2.98 (1.30)
Center Market Rate	.02 (.01)
FCC Market Rate	-.02 (.01)