
*A Review of the
Research Literature*

**Improving the Quality of
Family, Friend, and
Neighbor Care**

Executive Summary

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Improving the Quality of Family, Friend, and Neighbor Care:

A Review of the Literature on Quality Improvement Strategies

What We Know about Family, Friend and Neighbor Care

Family, friend and neighbor (FFN) care typically refers to home-based care that is not regulated. It includes care given in the home of the child or the caregiver and is provided by relatives, friends, neighbors, or nannies.

About 60% of Oregon children under age 13 are in nonparental care (paid and unpaid) (Weber & Vorpapel, 2011). In Oregon as in the nation as a whole, FFN is the most common form of nonparental care for children from birth to age five as well as for those ages birth through age 12 (Weber & Vorpapel, 2011; Laughlin, 2013). Fewer than 5% of Oregon children under age 13 receive care from a FFN caregiver who receives payment from DHS for that care.¹

Increased understanding of the importance of the early years to later success has brought attention to FFN care. Its prevalence indicates that it may be the only type of nonparental care a large number of children receive prior to kindergarten entry. Recent studies have used surveys to increase understanding of the characteristics of FFN caregivers. Two major statewide surveys (Brandon, 2002; Chase, 2006) have shown that relative is the most common form of FFN care and that grandparents are the most typical related caregiver. The majority of FFN caregivers do not charge parents, although parents are likely to provide nonmonetary support to the caregiver. Numerous studies have found FFN caregivers interested in training and support (Brandon, 2002; Chase, 2006; Clark & Hiatt-Michael, 2006).

In her summary of findings from numerous studies, Sussman-Stillman (2011) finds that FFN caregivers have:

- Generally lower levels of education than those of licensed providers;
- A range of experience from caring for children of their own to caring for children of others;
- A remarkable degree of stability as the child's caregiver, ranging to 12 months or more; and
- The desire to help the child's parent and child as the primary motivation for providing FFN care.

Studies that assess the quality of FFN care find low adult to child ratios, which is especially important for very young children (Shonkoff & Phillips, 2000). Levels of quality found are associated with the instrument used. For example, using the *Observational Record of the*

¹ Oregon Child Care Research Partnership calculation using usage 2008 child care usage estimates and July 2012 DHS subsidy data).

Caregiving Environment (ORCE), an instrument designed to measure quality across all types of care), the NICHD Early Child Care Network (1996; 2000) has found a range of quality in all types of care. Studies using the Family Day Care Rating Scale (FDCRS) (Harms & Clifford, 1989) find the overall quality to be inadequate (Fuller et al., 2004; McCabe & Cochran, 2008). Studies using the *Quality of Early Childhood Settings: Caregiver Rating Scale* (QUEST) (Goodson, Layzer, & Layzer, 2005) show levels of quality to be variable (Layzer & Goodson, 2006);. Even when using the *Child Care Assessment Tool for Relatives* (CCAT-R) (Porter et al., 2005), an instrument designed specifically to assess the quality of FFN relative care, areas of concern appear in areas that are likely to prepare children for school (Paulsell et al., 2006; Porter & Vuong, 2008;). Overall, when using a variety of assessment tools, studies find quality of caregiver-child interactions and levels of warmth at acceptable levels and positive caregiving possibly higher than that found in regulated care in at least one study (Sussman-Stillman, 2011). Studies also find variability in the level of quality and concern about how well children are prepared for school in this type of care.

Strategies for Improving the Quality of FFN Care

Strategies to support and improve the quality of FFN care have emerged across the country, most in the last ten years. In this literature review, examined programs are organized by the four major strategies that have emerged:

- Home Visiting
- Linking FFN Care with Publicly-Funded Center Care
- Play and Learn Groups
- Training and Distribution of Resources.

It is common to combine multiple strategies in the same program. For example, some home visiting programs offer training and support groups. Distributing resources is frequently a part of programs in each category. The mixing of strategies appears to have emerged from experience of what is needed to provide support and improve quality in FFN care.

Evidence of Effectiveness

Although all reviewed interventions have been evaluated, some evaluations provide stronger evidence of positive impact. Most researchers agree that evaluations are strongest when they:

- Measure changes in behavior in addition to changes in attitudes or knowledge;
- Provide evidence of positive impact on the target group; in this instance children rather than caregivers;
- Conduct measurements prior to as well as at the end of an intervention
- Use trained outside evaluators rather than program staff to conduct the evaluation;
- Use validated measures and persons trained to use them reliably; and
- Employ random assignment of participants to treatment and control groups.

Using these criteria, evidence was strongest for one of the home visiting programs and a play and learn group network. Evidence of effectiveness was also substantial for two other home visiting programs.

The full report and references are available upon request to Roberta Weber, Bobbie.Weber@oregonstate.edu