NO PLACE LIKE HOME

A STUDY OF SUBSIDIZED IN-HOME AND RELATIVE CHILD DAY CARE

Funding for the study was provided by the Administration for Children and Families, U.S. Department of Health and Human Services

Prepared for the Rhode Island Department of Human Services by Rosenblum & Associates

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INTRODUCTION

Background

This report documents the results of a study of in-home and relative child care that was conducted by Rosenblum & Associates for the Rhode Island Department of Human Resources (DHS) Office of Child Care from August 1, 1991 through November 30. The study breaks new ground as the first systematic examination of a system for providing child care that exists in all states, generally without regulation and without scrutiny. DHS set us three major tasks in the study:

- To describe the system of care that exists in the state of Rhode Island;
- To explore the system of in-home and relative care in the other states with an eye to discovering exemplary practices; and
- To examine the impact of federal policy on the system.

To carry out the tasks, we designed three separate investigations or sub-studies, which we referred to as the Vendor Study (the Rhode Island system), the National Survey, and the Policy Review. Within this report are the findings of these three sub-studies presented in a nested fashion with the Policy Review, which is the most global examination of issues first, followed by the National Survey, and then by the results of the Vendor Study. Throughout all three investigations, we have remained true to the concerns that are of greatest interest to DHS–quality of care, fiscal issues, and regulatory issues. We have done so by assigning quality, fiscal, and regulatory issues among the three investigations as shown in the table below.

Primary Data Source

Issue Type	National Survey	Policy Review	Vendor Study
Quality		x	x
Fiscal	x	x	
Regulatory	x		x

In this way, we have been able to give appropriate dimensions of breadth and depth to our study of all the issues. The Policy Review covers a variety of issues in the broad context of federal impact on all the states. The National Survey focuses on fiscal and regulatory issues, which fall under the jurisdiction of state governments, and the Vendor Study yields a wealth of information on the quality of care in the state of Rhode Island. Our approach to conducting the study contained two additional elements that we considered enhancements to the interests of DHS. Both are system-enhancements and are detailed in this report.

The first is a set of recommendations to strengthen the existing child care system through training and support. The ideas that are contained in this section stem from all three sub-studies and focus on communication, collaboration, and support. The second is a set of recommendations to bring the computer system used by the DHS Office of Child Care closer to a "seamless system", by synthesizing the information that is relevant to child care in the state. The focus in this section is on inter-departmental collaboration and the development of an integrated information system.

Methodology

The three sub-studies employ differing but related methodologies, customized to their special interests. Each is described briefly below.

Policy Review. This was the most open-ended, qualitative sub-study. It consisted of telephone and personal interviews with experts in the policy arena, all of which were conducted by the Project Director. The information from these interviews was amplified by an all day meeting with Gwen Morgan, nationally known researcher and consultant in the field of child day care, who contributed a policy-oriented perspective to the data from the National Survey and the Vendor Study.

The National Survey. The National Survey was based on a survey instrument that was developed especially for this project. It was intended to elicit comparable data on information elements across the states with an aim to informing Rhode Island's efforts. Time constraints did not allow for a complete picture of all the states. Using

a list of state contacts compiled by the Children's Defense Fund, more than forty-five state licensing agencies were contacted through the course of the study and interviews were conducted with individuals in both the licensing and social services departments in thirty one states. The survey instrument appears in Appendix A.

The Vendor Study. The design of the Vendor Study was the most complex of the methodological tasks. This study required an approach that would serve several purposes at once: conducting anecdotal personal interviews, acquiring comparable data, and observing quality and safety indicators during the course of interviews. The solution was to use a semi-structured instrument, which contained standardized general questions and a series of probes to record the most predictable answers. The instrument also left room for recording other responses by respondents and was thus able to capture some of the anecdotal richness of personal interviews. In addition to questions, the instrument contained an observation checklist to record information about safety, the environment, and interactions between vendors and children. The Vendor Study instrument also appears in Appendix A.

To conduct the interviews, we used three teams of senior researchers, two in each team and scheduled interviews with vendors at times when they had children in their care. One member of the team conducted the interview while the other recorded information on the observation checklist. Following the interview, both team members discussed their judgement of the safety, environment, and types of interaction to make sure that they were in agreement on what they had heard and observed.

A total of 50 vendor interviews were conducted, ranging from twenty minutes to an hour in length. The data, both anecdotal and observational, were then entered on a data base that allowed us to calculate simple frequencies and percentages. Based on hypotheses formed during the study that the key determinants of differences in vendor responses were in-home providers vs. relative providers and urban providers vs rural/suburban providers, many of the variables were broken out and examined in those categories.

We felt that it was important to complement the perspective of the vendors with that of parents of the children in care, and therefore selected a subset sample of 26 parents who have children in the care of vendors in the study. These parents who are the "clients" of the welfare system became a secondary focus of the study. Telephone interviews with them sought to elicit information on the same topics that we had investigated with the vendors and, more importantly, focussed on the process of choosing in-home and relative care. Our interest was in how and why parents chose this type of care and the kind of information that was available and used to make that decision. The Client Survey Instrument also appears in Appendix A. The parent information was also entered onto the data base for analysis.

The same teams who interviewed the vendors carried out the telephone interviews with the parents of children in that vendor's care. Thus, each team was able to become "experts" on eight or nine families and develop an understanding of the larger family system in which the child care is taking place.

Explanation of Key Terms

Child Care Certificate

As defined by the Child Care and Development Block Grant regulations, it refers to a certificate, (which may be a check or other disbursement) that is issued ". . . directly to a parent who may use such certificate only as payment for child care services." R.I. issues parents a letter authorizing payment for child care services.

Child Care Center

Child care centers are licensed by the R.I. Department for Children, Youth and Families. Child care centers offer group care to 12 or more children in a center based setting. Center licensing standards address the following: Enrollment, Staff, Health, Safety, Nutrition, Physical Facilities, Equipment and Materials, Program, Parent-Center Relations and Administration. Inspections by various state departments in addition to the R.I. Department for Children Youth and Families are conducted annually. All caregivers and staff with direct responsibility for and unsupervised access to children must be fingerprinted and undergo a criminal records check.

Early Childhood Programs

"Generally includes prenatal, perinatal, and postnatal services, pediatric care, child assessment, child care and development services for infants and toddlers as well as preschool children, transition to school activities, parent education and support and collaborating health, mental health, education, and social service programs" (Sugarman, 1991, p. 111).

Family Day Care Home

Family day care homes must be certified by the Rhode Island Department for Children Youth and Families. They include any home other than a child's natural or adoptive home in which child care is provided for four or more children who are not related to the caregiver. Family day care home providers are certified to provide care in their own homes, and along with household members present while care is being given, must be fingerprinted and undergo a criminal records check.

In-Home Child Care Provider

An in home provider is an individual who provides child care services in the child's own home. Generally unregulated, Rhode Island Department of Human Services purchases child care only from providers with DHS approval. Approval includes a criminal records check (but not fingerprinting as is the case with regulated caregivers), age, and access requirements. No visit is made to the home.

Relative Care Provider

Relative care has numerous definitions depending on the source that funds it. Rules governing the Child Care and Development Block Grant define relative care purchased under this program as "a child care provider who is 18 years of age or older who provides child care services only to eligible children who are, by marriage, blood relationship, or court decree, the grandchild, niece, or nephew of such provider, if such provider is registered." Other programs allow a far more liberal interpretation of the term relative. Approved relative care providers funded through DHS are required to be 18 years old and must pass DCF masterfile and BCI checks.

Seamless Service

The Family Support Administration defines seamless service as "providing eligible parents access to and payment for child care services and programs which bridge and supplement the parents' child care needs, even as eligibility changes over time: this is done without the necessity of changing the child care provider" (Federal Register, Vol. 56, No. 122 , June 25, 1991, p. 29960).

School Age Child Care

School age child care is licensed by the R.I. Department for Children, Youth and Families and is defined as any program which provides care for school aged children on a regular basis before and/or after school and/or during school vacations. School age child care programs are child care centers, whether or not they are based in schools, and are required to meet similar, modified standards.

Vendor

For the purposes of this report, vendor is a term used to describe any provider of child care, whether regulated or unregulated, who has agreed to provide services for a child or children funded by the R.I. Department of Human Services and with whom the department maintains an agreement for the provision of services.

Voucher

The term voucher is often used interchangeably with "certificate" (as in the federal register: "Many States are using some form of voucher/certificate system.") although it is unclear whether that implies they are considered to mean the same thing. It appears to mean that by possessing a voucher or certificate, a parent is enabled to present it as guarantee for timely payment to any child care provider. The value of the voucher or certificate is determined by the rate paid for each type of service and whether the vendor of service is willing to accept its value.

"Rearing children in a personalized network of kin and kith
is a venerable American tradition."
(Powell, 1987, p. 12)

Introduction

Although friends and relatives have historically played a predominant role in enabling families to meet their child care needs, this form of care remains relatively unexamined by researchers and regulators alike. "A nagging issue in the public debate about child care has been the lack of attention to care provided by relatives as a part of the picture" (Sonenstein & Wolf, 1991, p. 28). By their very nature, in-home and relative child care beg us to back off lest we intrude upon the rights of a family and the privacy of the home.

Use and Cost of Relative and In-Home Care

Major differences exist between families' use of relative and in-home care. Relative care is the most common child care arrangement, in-home care is the least (Morgan, G. 1991, pp. 7,13). The National Child Care Survey 1990 (NCCS) provides the most up-to-date data available about the use of in-home and relative care:

(NAEYC, 1991b, p. 12)

Type of Supplemental Care	<Age 3	Ages 3-4	Ages 5-12	Total All Ages
Relative	21%	16%	25%	22%
In-home	3%	2%	3%	3%
Center	20%	43%	14%	21%
Family day care	22%	17%	7%	13%
No supp. care	32%	21%	44%	37%
Other	2%	1%	7%	4%

The survey also indicated a steady decline in the use of both in-home and relative care since 1965 when 33% of employed mothers of preschool children relied on relative care and 15% relied on in-home care (NAEYC, 1991b, p. 44). Gwen Morgan has attributed decreases in the use of relative care to three factors:

> (1) In an economy where most households need two incomes, relatives like parents, are likely to be employed, and fewer are available to provide care.
>
> (2) Many families do not have a viable arrangement within the family. Families have become smaller, and may live far from one another. Care in the family may be the preferred arrangement of many parents, but not all parents have a relative willing and able to provide the care.
>
> (3) Care by relatives and friends tends to be the least stable form of care. As parents move out of marginal employment to stable jobs, they look for more stable child care that they can count on over time (Morgan, 1991, p. 8).

Relative care is generally provided without compensation, however, the NCCS revealed that "21% of families using relative care, paid for care, making it in some sense a market service" (NAEYC, 1991b, p. 22). Even when paid for, relative care is the least expensive form of care available and on average costs a mere $1.11 per hour (NAEYC,1991b, p. 47). Regionally, child care in the northeast is typically more expensive. For example, recent data from Massachusetts indicate that "25% of adult relatives are paid for their services, an average of $2.13 per hour" (Child Care Affordability Task Force, 1988, p. 5).

In-home care is the most costly of all forms of child care at $2.30 per hour in 1990. Center based child care, the second most expensive form of care, costs 27% less or $1.67 per hour (NAEYC, 1991b, p. 47). It is not surprising then to find in-home care the "smallest segment of the child care field" and largely used "in the upper income levels" (Morgan, 1991, p. 13). Child care cost statistics, however, may be less reliable as they do not necessarily take into account the funds supplied to parents through sliding fee scales and subsidy programs. The amount that a parent pays for child care and the actual cost of care may differ greatly depending on the degree of subsidy the parent receives.

Choosing Care

Relative care is popular for many reasons. Families trust other family members to provide care in their own cultural context. If, as cultural anthropologists suggest, culture represents the behaviors a group of people devise in order to survive and perpetuate the group, then relative care accomplishes more than the simple task of keeping children safe while parents work and has a vital role in supporting both family and community life. From an ideal perspective, relative care allows for care in settings where children's native language and customs are understood and parent's child rearing practices are respected.

Douglas Powell's research indicates that "parents begin to search for child care with nuclear family members and/or close friends, acquaintances from work or other organization . . . These findings suggest a tendency for parents to view child care as a private family matter." Parents trust that their own family and social networks will lead to "a caregiver whose child-rearing values are compatible with their own" (Powell, 1987, p. 120-1). Indeed, even among those who choose care from the regulated system "over half (55%) of parents using centers and nearly three-quarters (71%) of those using family day care learned about their primary care arrangement from friends, neighbors or relatives" (NAEYC, 1991, p. 24).

Choice of care within the family results from the natural support system that families traditionally provide but it is also influenced by fear of other care and often means the dreaded stranger (Morgan, 1991, p. 7). Love and trust are powerfully motivating factors and new parents may rationalize that no one could possibly love their child as much as her/his grandparents. Fear of center-based and family day care is also exacerbated by media reports that sensationalize instances of abuse and/or neglect. In addition, there has been a failure to provide information and assurances to parents that children are less likely to be abused in child care centers than they are in their own homes, and that regulatory safeguards (fingerprinting is the most common) established in most states further reduce the risk of abuse.

The pain of leaving a child in another's care upon return to work is undoubtedly assuaged by the knowledge that a family member has taken over. Many parents painstakingly juggle work shifts to assure that one or the other is available to provide care whenever possible. Relative care is also chosen for practical reasons. It

is convenient and takes place during hours when regulated care is often not available–in the early morning or late evening. It is provided at low or no cost. Late charges are unlikely and if perchance "you pay your mother last," she is more likely than others to understand.

Choice and Income

According to the National Center for Health Statistics (NCHS) "the probability of a child's being related to his or her main care provider was inversely related to the child's socioeconomic status" (Dawson, 1990, p. 5). Families with income under $10,000 are twice as likely to use relative care than those with incomes above $40,000. Given the fact that African-American children are three times as likely to be poor as white children, (CDF, 1991, p. 147) it is not surprising that they are more than two times as likely to be cared for by relatives than are white children.

Income greatly limits the child care choices of poor women.

> The primary influence that poverty has on child care choice is that it heightens the urgency of adult needs, turning them into constraints that limit child care options. The different constraints are fairly obvious: low-income families have less money to spend on child care; they are likely to have low-skill, low-wage, unstable jobs with nontraditional work hours; they are less likely to have reliable transportation; and they tend to live in poor neighborhoods with dilapidated or dangerous housing and inferior services. All these characteristics directly limit the real choices that are open to a low-income parent who needs child care (Mitchell, 1991, p. 6).

In addition, the purchasing power reflected in the market value of each state's rate of reimbursement for child care rarely matches market rates. In some cases, it is not even possible for regulated providers to offer low income children care. Poor economic conditions and high unemployment mean less demand for child care services. To continue operating and maintain a balanced budget, program directors, like any other small business persons, lay off staff and eliminate classrooms, resulting in a reduction in the number of child care slots. Offering program openings to low income families paying less than the market rate, presents a dilemma, even for non-profit providers committed to serving the poor. Unable to

rely on a shrinking pool of charitable dollars to make up the difference between the rate of reimbursement and actual costs, the painful but logical choice is to reduce the number of low income families served. Thus, rates of reimbursement, the generosity of the state sliding fee scale, parent co-payment levels and income eligibility criteria all impact the real choices of low income families seeking child care.

Nevertheless, it appears that in-home and relative care have an appeal beyond affordability. Morgan (1982) states that "public policy should, and does, encourage parents who want to choose relative care, if it is freely chosen from among affordable options. Evidence indicates that parents will not be attracted away from in-family types of arrangements, even by high quality free care in their community" (p. 5). Choice of relative care undoubtedly plays an important role in the child care decision-making process for both the poor and the non-poor. Recent research has attempted to focus on the degree to which AFDC mothers are satisfied with their child care arrangements. Sonenstein and Wolf (1991, p. 25) found that for AFDC mothers "no particular arrangement emerged as a clear winner" although convenience, quality, ratios, and learning opportunities were all considered important.

In an effort to estimate the degree to which the regulated child care market meets the needs of low income women, the Rockefeller Foundation, as part of its Minority Female Single Parent Demonstration (MFSP) project, sampled 25 Providence area center based child care providers and 13 family day care home providers identified by the staff of the Opportunities Industrialization Center as "most suitable for the MFSP program participants in terms of their accessibility and fees" (Handwerger, 1989, p. 7). They found that 55% of center based providers offered formal education or development activities vs. 8% of family day care home providers. None of the sampled centers and only eight percent of family day care providers offered transportation. Sixty-four percent of centers had bilingual staff while this was the case in only eight percent of homes (Handwerger, 1989, p. 16). These findings point, in part, to the fact that many providers in the regulated care market are not likely to be providing services compatible with the needs of many low income families.

Compatibility issues aside, low income mothers understand and value the promise of early care and education programs. When asked to describe ideal child care

settings, minority women participating in New Jersey's JOBS program cited the importance of patient and loving caregivers who understand children and possess the ability to work with them, plenty of adults to care for the children, and clean, safe, well equipped settings. Relative care was largely preferred for infants and toddlers, but, mothers indicated a preference for the learning opportunities provided by center-based early care and education programs for their preschool aged children. Like other low income parents, however, they were disappointed with the quality of affordable and available center-based care in their neighborhoods. Specific concerns related to rates of staff turnover, levels of staff training, lack of supervision, and "crummy" environments (Porter, 1991.).

AFDC mothers are not alone in maintaining that just *any* care will not suffice. Ample evidence corroborates their concerns. Child care program staff turnover at rates of 30-40% nationally. These disturbing rates are largely attributed to inadequate compensation and benefits. Research indicates that levels of staff training and turnover rates are key indicators of program quality.

Advantages of Regulated Care

Despite its strengths, experts with whom we spoke agreed that for poor families the unqualified choice of relative care may have consequences for children. It was particularly troublesome for experts to find any comfort with a parent's choice of unregulated, in-home care. Despite its flaws, the system of regulated early care and education programs is a vital resource, particularly for children at risk for school failure. Sonenstein & Wolf (1991) conclude that if "AFDC parents are to be empowered to choose their own child care, new approaches are needed to enhance the existing care system so that it is more responsive to the preferences" of low income parents (p. 29).

Quality Early Care and Education. The "system" must be capable of responding to the needs of children as well. The early years of life are a critical period in a child's development. Research findings indicate that "it is precisely among poorer infants and children that the need for preschool experience is greatest, and it is among them that the evidence is strongest for the major positive impact of good early childhood development programs" (Ford Foundation, 1989, p. 17). It is unfair to assume that the circumstances of poverty automatically result in parents' provision of less than

optimal early experiences for their young children. It is equally unwise to ignore the effects of poverty on children. When families choose child care they not only select a service that enables them to go to work, they select an environment that effects their children's experience at a critical point in their development. Bernice Weissbourd (1991) puts it this way:

> Meeting the needs of the child in a program doesn't necessarily meet the needs of the parent. Meeting the needs of the parent in a program also doesn't necessarily meet the needs of the child. Parents and children's needs are not always identical at the same time.

The most substantial evidence of the effects of a high quality preschool experience on the lives of poor children resulted from the study of the Perry Preschool Project conducted by David Weikart in Ypsilanti, Michigan. Weikart's long term study of 123 disadvantaged black youths was designed to explore whether their participation in a high quality early education program would have long term effects. The results through age nineteen were statistically significant.

> In education, fewer children were classified as mentally retarded, more completed high school, and more attended college or job-training programs;
>
> In the world of work, more now hold jobs, more support themselves by their own or spouse's earnings, and there is more satisfaction with work; and
>
> In the community, fewer have been arrested for criminal acts, there has been a lower birth rate, and fewer have needed public assistance.
> (Weikart, 1989, p. 5-7).

Weikart's research resulted in enormous public interest and support for Head Start and other early care and education programs, however, he offers two cautions. High quality programming is crucial if similar outcomes are to be expected and early care and education alone cannot and should not be expected to overcome all social ills.

Burton White, director of the Center for Parent Education, concurs. White asserts that only if Head Start and other programs are operated at the high level of quality of Weikart's Perry Preschool Program, will they be able to make a difference. By age

three, many poor children are nine months or more behind in cognitive and language development. White posits that intervention at age three is not preventive, but compensatory and helps poor children to catch up rather than keep up with their more advantaged peers. He believes intervention programs must begin earlier to enable children to get off to a good start (White, 1991).

Jule Sugarman, Chair of the Center on Effective Services for Children and former director of the National Head Start Program, strongly urges that all child care programs have a developmental focus. In a recent Child Welfare League of America publication he writes:

> Every publicly funded child care program should include developmental activities. It is time to put to rest the old notion that protecting the child from harm is the prime purpose of child care. In fact, care with developmental activities produces a double dividend - for the family who must work and for the child who prospers. All federal laws permit developmental activities. None of them sets dollar limits on program costs which would prohibit developmental activities . . .
>
> The presumed economy of $2.00-an-hour child care is a snare and a delusion. It is almost guaranteed to increase the risks of damaging the child's future and to require higher expenditures in later years (Sugarman, 1991, p. 3-4).

Regulated early care and education programs stand a better chance of meeting Weikart and White's quality criteria than unregulated programs do and have proven to be of higher quality when compared to less regulated care. The National Child Care Staffing Study found that staff in more highly regulated programs were "more sensitive, less harsh, and engaged in more appropriate caregiving with the children" (Child Care Employee Project, p. 14).

Licensed child care centers and family day care homes generally offer families a dependable and reliable service. Regulatory requirements help to assure parents that a floor of acceptable care has been established below which no licensed or certified program may fall and that factors closely associated with child care quality have been addressed.

Nutrition. In addition to education and development programs, regulated care also offers nutrition assistance. Many states rely on the attractiveness of the U. S.

Department of Agriculture's Child Care Food Program (CCFP) to entice unregulated providers into the regulated system. CCFP provides vendors with funds for food and is not available to unregulated caregivers. Colorado markets participation in the Child Care Food Program as "The Best Thing Since Sliced Bread" in a brochure that discusses other incentives for providers to become part of the regulated system. These benefits include listing in the resource and referral system, workshops, access to a reference library, technical assistance, and support/networking opportunities. For example, Colorado's CCFP providers are reimbursed more than $650.00 a year for each full-time child for whom they provide breakfast, lunch, and a snack. They also receive a nutrition newsletter, menu planning ideas, and attend workshops throughout the year. The program is targeted to reach children from low income families. The National Black Child Development Institute (NCBDI) (1989) believes nutrition to be "a critical component of any child program, especially for programs serving disadvantaged children whose families may be unable to provide for their dietary needs." Following passage of the Family Support Act, NBCDI urged that parents "not be required to accept care that fails to guarantee adequate nutrition to children by participating in federal and state nutrition assistance programs" (p. 9).

Availability of Care. The number of early care and education programs for preschool children has grown dramatically over the past decade, in response to the growing number of women entering the workforce. Lest we forget, policy cannot create relatives for those who do not have them (Morgan, 1982, p. 57). Nor can we assume that every grandparent or relative is eager, able, willing, and in some cases suitable, simply by virtue of a blood relationship, to take responsibility for the care of grandchildren. Caroline Zinsser's (1990) recently published case study of informal and unregulated child care, Born and Raised in East Urban, pointedly addresses this issue:

> . . .One grandmother would not help her daughter-in-law, a factory worker, because of her hours, which interfered with babysitting for another family. The grandmother, who was single and depended on her babysitting income, refused to give up the more lucrative work. She told her daughter-in-law, "I'm not going to lose out on $100 a week to babysit for you so that you can make all the money." (Her son had offered to pay only $40 a week.) She complained, "If you babysit for your relatives, they don't pay you nothing of what you think you should get, because your related to them." Another

grandmother, who babysits in a middle class home and whose daughter-in-law is now pregnant, said she is not interested in becoming a babysitter for her grandchild. "I don't want any more kids in the house messing it up," she says. "Now my house is clean" (p. 68).

Monitoring for Child Protection. Finally, while it would be unjustifiable to suggest that all unregulated care is harmful, there is evidence to suggest that most harmful care is unregulated. In-home care "is clearly the most expensive form of care to monitor" (Morgan, 1982, p. 48). The National Committee for the Prevention of Child Abuse estimates that over 90% of sexual abuse offenders are relatives or close friends of their victims. Most offenders are also believed to have no criminal record. And, to the extent the in-home care is regulated, regulations are only as good as the enforcement system that backs them up.

Matching Needs and Resources

Child care resource and referral, while a relatively new part of the child care delivery system, plays a key role in matching parents' needs for child care with the existing community supply. In some states (Illinois, California, Maryland, Rhode Island, Texas, and Massachusetts) child care needs resulting from welfare reform efforts inspired the development of enhanced resource and referral services for some AFDC and low income parents whose limited purchasing power and special needs require additional attention if a successful child care match is to be found. "Low-income parents, especially those on welfare, are not used to having a choice in most aspects of their daily life and are thus unprepared to deal with the complex choice that child care presents" (Mitchell, 1991, p. 8-9). Responsive, respectful, consumer-focused resource and referral systems are familiar with the provisions and pitfalls of child care subsidy programs and assist low income parents by offering services that enhance each parent's ability to make well informed choices (Mitchell, 1991, p. 9). Very few states, however, use local resource and referral agencies to assist all of their JOBS clientele in finding child care. Instead they often rely on welfare case managers to assist clients in choosing care options. Resource and referral agencies that do take on responsibility for counseling JOBS participants must be committed to making a considerable effort, often with limited resources.

Porter suggests that case managers counseling JOBS participants make an effort to describe all the child care options. Mothers she interviewed reported that once they had identified relative care as a possible choice, counselors offered no further information about alternative forms of care (Porter, 1991). Heavy case loads coupled with limited tools and information may be the cause. Child care options should be discussed from the start, ". . . not after the recipient has exhausted relatives and neighborhood babysitters" (Morgan, 1982, p. 64). As the federal government presses states to offer parents the right to child care choices, it is imperative that parents be given information that enables them to be wise consumers of child care.

Becoming more responsive to families takes a variety of approaches. Early care and education programs serving low income families will require resources if the ability to provide transportation and improve program quality are to become a reality. And Morgan recommends that family day care home providers review the way they market their services to low income families to assist parents in understanding that learning also occurs in family day care settings. It would be naive, however, to make such recommendations without bearing witness to the dilemmas so many providers face when state rates of reimbursement fail to allow regulated programs to offer the quality of care that parents seek and children deserve. Offering less money to parents seeking child care may lead to care of poorer quality for the neediest young children and have consequences that no degree of future public expenditure will counteract.

Supporting Relative Care Providers

How little is known about relative care! Exhaustive examinations of the child care system, while recognizing the significant role played by relative care providers, have rarely looked beyond the basic statistics. Asked in telephone interviews, to wrestle with issues related to the in-home and relative care population, experts generally yielded first impressions, fresh and without the benefit of consideration over time. In-home and relative care, while a huge part of the child care delivery system, has gone unnoticed and largely unexamined.

Support for these providers is best modeled on programs developed for parents. Designed to build on family strengths, effective family resource and support programs aim to treat parents with equality and respect and recognize them as a

vital resource to both the program and to one another. Community-based as well as culturally and socially relevant, they arm parents with knowledge about human development and seek to build skills. Finally, and perhaps most importantly, parent participation is voluntary (Family Resource Coalition, 1990).

Training approaches and resources developed to meet the need for early childhood professional development are less likely to be relevant for many relative care providers. Even so, enhanced training and technical assistance efforts resulting from the quality provisions of the Child Care and Development Block Grant have the potential of indirectly benefitting providers in the unregulated system. Increased provider recruitment efforts and the availability of training and technical assistance will undoubtedly draw some interest from those unregulated providers who have grown to depend on their earnings and have an interest in becoming certified family day care home providers.

Indiscriminately including unregulated care providers in the training system for regulated providers could be counterproductive to further professionalizing the early care and education system. Inappropriate resources, provided in an professional fashion, could dilute efforts to improve overall system quality by including in an emerging professional pool those who either perceive caregiving as merely custodial or those for whom other resources and support are more appropriate. The "training" approach with relative care providers, one expert suggested, was unlikely to be well received.

The literature is replete with approaches and advice for building a dynamic early childhood training system. The newly created Center for Career Development in Early Care and Education at Wheelock College in Boston attests to the growing interest in this area. The Center's first challenge will be to issue a "State of the States" report that tracks new developments in training and career development for early care and education practitioners. CCDBG funds will provide states with training dollars, often for the first time. Beginnings are a creative phase in the development of programs and the proposed report promises to be interesting reading.

Taken together, evolving early care and education training systems and family resource and support programs may offer insight as we seek to develop a system of

support for in-home and relative caregivers. Meeting the needs of regulated and unregulated providers requires a collaborative approach if all the children in child care are to be well served. A history of limited fiscal, physical, and human resources naturally draws child care delivery systems into collaborative action (Kagan, 1991). As such, they are ripe for the challenge.

THE NATIONAL SURVEY

Introduction

This section details the investigation of the state of the art of in-home and relative care in 31 states outside of Rhode Island. With the new federal commitment to parental rights in choosing day care providers, we found that most states are struggling to redefine both literally and ideologically their approach to this type of care. The difficulties inherent in maintaining a balance between parental rights to choose a provider and a state's right to ensure quality of care has resulted in a situation in which every state has developed a different system of coping. This study attempted to disclose both the discrepancies and the common threads that occur across states. While some respondents were more confident than others about the quality of care being offered in these settings, the almost unanimous opinion was that the key to ensuring quality of care now lies in increasing parental awareness of available choices coupled with better relations between state or local officials, their clients, and the providers.

Using a list of state licensing contacts compiled by the Children's Defense Fund, over forty-five state licensing agencies were contacted. By the end of the study, interviews were conducted with individuals in both the licensing and social service departments of 31 states. The remainder of the states were contacted several times but did not respond. The following is a summary of the major findings of this national survey. Where appropriate, the individual states are mentioned by name.

Distinguishing Between In-Home and Relative Care

Many states either do not use the term "in-home and relative care" at all or, if the term is used, define it differently. For example, some states included family day care in the category "in-home care" while other states included non-relatives caring for children who were related to *each other* in their definition of relative care. Overall, ten states treated in-home and relative care as separate entities in terms of definition, regulations, and/or reimbursement rates, while twenty-one states did not distinguish between the two. Of the ten states, seven states required in-home care to be either registered (Arkansas, Georgia, Oklahoma, and Maine), or certified (Arizona, Ohio, and Vermont). However, it is important to bear in mind that registration/certification usually entails a simple signing of a statement by the

provider, so that the distinction between the two types of care can be quite minimal. Oklahoma proved to be an exception to this general rule, as it requires relative providers to be *licensed,* as opposed to the registration of in-home providers. Michigan also has radically different regulations for these two categories of care, as all "family day care aides" (the state's version of in-home care) must meet strict regulations. The state of West Virginia can be said to distinguish between the two on the basis that it does not offer in-home care at all at this time.

The twenty-one states which do not distinguish between in-home and relative care constitute a very eclectic group. For example, Idaho, Oregon, and North Dakota only regulate child care when the provider cares for seven or more children, thus making the two categories basically equal by default. In stark contrast, Wisconsin has strict regulations for *all* child care. Several states, including Texas and Utah, include in-home and relative care in the broad general category of "informal care" and "licensed-exempt care", respectively.

Definition of Relative

Of the 31 states interviewed, 20 states had formal definitions of "relative," with 12 of these either using the Child Care and Development Block Grant (CCDBG) definition of aunt, uncle, and grandparent or moving toward adopting this definition in the near future. The remaining seven states were using a somewhat broader definition, with the upper limit being the fourth degree of consanguinity (Utah). Three states (Maine, New Hampshire, and Wisconsin) are currently using the definition of parent, sibling, niece, nephew, or first cousin by blood or adoption. Of the five states that do not currently have a definition, three (Idaho, Wyoming, and Montana) either do not subsidize in-home and relative care, or else offer it only in a limited capacity. Oklahoma, because of its stringent regulations, proved to be the only state with no need to define this particular population, since in-home and relative providers are treated in the same manner as licensed providers. Four states (Indiana, Kentucky, Missouri, and North Dakota) currently have different definitions across various funding streams, but, for the most part, are moving in the direction of the CCDBG definition.

A significant number of the respondents mentioned that the past few months have been a time of flux, with many states changing their definitions and guidelines to fit those of the CCDBG. Only one state (North Dakota) asserted that the Block Grant guidelines would only apply to that particular funding stream (and thus not be adopted across different programs), so it remains to be seen what will happen in the states that either have no formal definition, or none other than the definition delineated in the CCDBG guidelines.

Reimbursement

In over fifty percent of the states, it is the vendor, and not the parent, who is likely to receive the reimbursement. Two states (New Mexico and Arizona) mentioned that the vendor is paid in all cases except for those clients who receive Transitional Child Care (TCC) funds. Five states (Michigan, Oklahoma, Florida, Nevada, and Oregon) operate on a case-by-case basis, either paying the vendor or the client. In California, the party who is reimbursed varies by county. Only four states (Ohio, Idaho, New Hampshire, North Dakota), pay the client in all cases, while Texas does so unless the vendor is registered. To ensure that vendors are actually receiving the proper payment, North Dakota requires that both the client and the vendor sign the receipt of the payment slip before the client can receive the next month's payment. According to the respondent, this strategy has worked quite well. The state of Wisconsin used to reimburse the client, but has decided to switch to pay the vendor instead because, in the respondent's words, reimbursing the client was a "disaster." Oregon is currently moving away from paying the client because of similar concerns of inappropriate handling of money on the part of the client.

Department(s) Responsible and Level of Responsibility

In the vast majority of the states, the state department responsible for the in-home and relative child care system is their equivalent of the Department of Human Services. One exception to this is the state of Arizona, where the Department of Economic Security is responsible. Three states (California, Connecticut, and Indiana) have two different departments involved, with one department handling only the IV-A programs, while New Mexico has a unique link between their Department of Human Services and the Department of Health (see section on qualifications of vendors).

Because most of these states have separate divisions within the same department that handle the different programs, the net result can be a far cry from a comprehensive system. It was not uncommon for a respondent to be unaware of the appropriate person to contact regarding, for example, a different funding source, due to the fact that this involved a wholly separate division or office. This lack of interdivisional collaboration helps to explain the inability of many states to give an accurate account of the number of children involved in subsidized child care in the state, let alone the number involved in in-home and relative child care.

While over fifty percent of the respondents indicated that major responsibility lies at the state level, this figure is complicated by the problems inherent in defining "responsibility." For example, policy decisions, are generally made at the state level, but counties and local agencies have varying levels of responsibility in carrying out these decisions and otherwise regulating this type of child care. Indiana has developed a program entitled Step Ahead, which aims to provide "one-stop shopping" at the local level, yet this local responsibility is considered subordinate to the state input. Respondents from six states indicated that major responsibility was at the county level while only one state (Michigan) indicated that local responsibility was dominant.

Numbers of Children and Vendors

Few states have accessible information on the number of children in subsidized care in general, and in-home and relative care specifically. With a few exceptions, most respondents noted that children in this type of care were basically an unknown population. One major reason given for this was a computer network inadequate to handle this type of information. In several states, the interviewer was told that while this information existed "somewhere" it would take hours to retrieve it. Many states are hoping to use part of their CCDBG funds to make their records more comprehensive by extending their tracking system to all forms of child care, whether regulated or not. A key phrase that occurred over and over again was the need for a "seamless system" for subsidized child care, although many respondents were less than optimistic about their chances of achieving such a system without a complete overhaul of their computer data base.

Rates of Reimbursement

Many states are in the process of raising their reimbursement rates–modifications that, for the most part, are being spurred by the CCDBG guidelines. All states have conducted, or are currently conducting, market surveys to determine what the 75 percentile cut-off will be. In almost all cases, this has meant an increase in the reimbursement rate. While there are a few states that pay a flat rate across the different counties or regions, they vary according to the type of child care setting (licensed vs. unlicensed). Several states have taken this breakdown a step farther, with the highest rate going to licensed centers, followed by day care homes, and then "unregulated" care, which includes in-home and relative care. A smaller number of states reimburse family day care homes and in-home or relative providers at an equal rate. The state of Arizona reimburses in-home providers at the same rate as family day care home providers while relative providers receive less, the opposite is true in Oklahoma.

A theme expressed by many respondents was the unwillingness to pay unregulated providers at the same rate as family day care home providers, who often must have a certain number of hours of training and/or meet other qualifications. Several respondents indicated that an equal payment rate would eliminate all incentives on the part of the providers to become registered, thus doing away with a state's right to monitor the quality of the care provided. At this point, several states still have reimbursement rates that vary according to the funding source, although the drive to create "a seamless system" may soon result in the elimination of these differences.

Across states the range in reimbursement rates is quite broad. For example, New Jersey reimburses its in-home and relative providers at a rate of $55/week for infants and toddlers, while registered family day care providers receive $90/week. In contrast, Georgia, while reimbursing at a lower rate, treats relative providers and family day care home providers almost equally ($40 and $42/week respectively). In New York City (which has the highest reimbursement rate in the state), informal care providers receive $85.50/week for children under the age of eighteen months, while family day care providers receive $114/week. The state of Pennsylvania has decided that unregulated care shall be reimbursed at a rate that is 95% of the least expensive regulated rate in that county, not to exceed 98% of the Title XX contracted

rate. This results in a ceiling rate of $223/month. While many states are currently recalculating their rates to comply with federal guidelines mandating that relative and family day care home providers be paid at an equal rate, it should be noted that there are also a number of states which are continuing to protest this decision.

Qualifications of Providers

States in general have minimal qualifications for providers. Fourteen states unequivocally stated that in-home and relative care was "unregulated" and thus the state could not legally impose any restrictions except for the minimum age of providers. In the remaining 17 states, there was a wide range of required qualifications, ranging from a self-declaration statement of no past history of child abuse conviction, to a comprehensive criminal check of all adult household members. Michigan requires its in-home providers (family day care aides) to have a Social Security Number, be able to read and write, and have no physical impairment that would interfere with their ability to care for children. Oklahoma imposes the same standards as it does for licensed day care providers, while New Mexico, through its Child Care Food Program, requires immunization and a TB test as well as no past record of abuse. Arizona also requires that providers be fingerprinted. New Hampshire was unique in that providers need only be sixteen years old; most other states set the lower limit at age eighteen.

Monitoring

States which imposed some qualifications on prospective providers also conducted some on-site monitoring, most of which is very limited in nature. Two notable exceptions are Oklahoma, which visits all providers three times a year and New Mexico, which conducts home visits and imposes safety and sanitation standards that allow for participation in the Child Care Food Program (CCFP). While most respondents indicated that they wished they had both the funds and the legal right to monitor in-home and relative care more closely, others replied that it was a question of parental rights, in which the state had no right to interfere even were there funds to do so.

Training/Education Programs

Only a few states have developed training programs that are aimed specifically at reaching in-home and relative child care providers. Two notable exceptions include Wisconsin, which has developed a series of videotapes and offers television courses through vocational and technical education schools; and Oklahoma, which through a program entitled the Rainbow Fleet, has traveling vans manned by child development specialists which go into the community to distribute toys, reading materials, and other resources. Several other states (including Kentucky) are recognizing the important role that state universities and local colleges can play in providing training and educational materials for in-home and relative providers.

Virtually every respondent had definite ideas as to what the key topics should be if the money and the staff were available to provide training/informational sessions. The top three priorities listed overall were health and safety issues, teaching developmentally appropriate practices, and nutrition. Other issues raised included the importance of instilling a sense of professionalism in the provider, so as to elevate this type of care to a status higher than "babysitting"; teaching the providers how to work within the system; and focusing on developing the child's language and communication skills.

THE RHODE ISLAND SYSTEM

Introduction

In order to understand the similarities and differences between the Rhode Island system regulating in-home and relative care and that of other states, this section details current circumstances in the state. It provides the background against which we conducted the study of service providers, which is detailed in the next section.

Background

The Family Support Act of 1988 (FSA), implemented by the Rhode Island Department of Human Services (DHS) through its Pathways to Independence Program, requires that the department guarantee child care to AFDC recipients who accept employment, who are employed, or who participate in an approved educational/training activity. AFDC recipients with children over the age of three, unless exempt, are required to participate in the Pathways to Independence Program. The new At-Risk child care funds complement Rhode Island's existing low-income sliding scale child care assistance program, as they share the goals of helping families work and avoid welfare dependency. As such, Rhode Island requires a varied system of readily available, affordable, high quality child care.

Obtaining Subsidized Care

AFDC parents find out about the availability of child care assistance through their Pathways case manager. Low income parents may request assistance at welfare offices but many find out through less formal means, often through relatives and friends, and sometimes serendipitously. Parents qualifying for child care assistance through the low income subsidy program complete an application form and supply necessary documentation of work or school to the department. AFDC parents meet at Pathways to Independence offices with Pathways case managers. Case managers/day care social workers are responsible for asking qualifying parents if they plan to place their children in regulated care or in in-home and relative care. What follows are three possible scenarios, depending on the parent's answer:

- If the parent chooses in-home or relative care, the case manager/social worker supplies her with an In-Home and Relative Care Provider Form that the parent and the provider must sign. The parent then is expected to return the completed form and other documentation to the case manager or social worker. (Further aspects of this process are discussed under the next section heading.)

- Parents who choose regulated child care and who have already selected a licensed center-based or family day care program receive a form to be completed in conjunction with the regulated provider and returned to the case manager/social worker.

- Parents who have not made a decision about child care receive both forms and are advised to contact Options for Working Parents (OWP), an independent resource and referral agency funded in part by DHS and operated by the Greater Providence Chamber of Commerce. Using a database that includes all regulated child care providers in Rhode Island, OWP attempts to maintain up-to-date data on program openings by regular contact with providers, allowing them to serve as a matchmaker. When parents follow through and contact an OWP counselor by phone, the counselor assists parents by offering information about child care choices and gathering key information about parent preferences and needs. Based on the parent's preferences, children's ages, transportation options, work/school schedules, availability of care, and other factors, OWP counselors attempt to find at least three programs with openings that meet parent/child needs. Counselors encourage parents to visit each of the programs to facilitate the decision making process. If the parent finds no program satisfactory, OWP will attempt to make another match and will explore other avenues for care. OWP does not supply parents with names of unregulated child care providers nor does it rate any of the regulated providers it maintains on its database. Counselors do not distinguish between the quality of care that may exist in one program or another. However, they will describe the general benefits and drawbacks of each form of care in terms of

convenience, hours of operation, and other factors. In cases where OWP is unable to find a match, the parent remains on the list of clients needing care and is contacted as soon as an opening occurs that may meet their needs.

Regulated and Unregulated Care in Rhode Island

Historically, the most common forms of child care services purchased by DHS have been licensed center-based child care and certified family day care. Each of these forms of care is regulated by the Rhode Island Department for Children, Youth and Families (DCYF) Licensing Unit. DHS officials report that some Pathways case managers and day care social workers admit to a greater sense of comfort about children's safety and well being when a parent chooses regulated care over relative care.

The aim of regulation is to assure that a floor of acceptable care has been established below which no regulated program may fall. Standards are promulgated through the democratic process in which public hearings offer all interested citizens the opportunity to influence the standard setting process. Standards are based on the ages of the children in care and address areas critical to maintaining quality such as: staff qualifications; staff/child ratios and group sizes; health issues (e.g. physical exams for children and staff, records of immunization); safety requirements (e.g. storage of dangerous materials, staff supervision, emergency procedures); physical plant requirements; parent and program relations; program features; and administration.

Many of Rhode Island's regulated centers also operate kindergarten programs and therefore meet R.I. Department of Education (DOE) standards for approval as well. Both DCYF and DOE require that employees who are in charge of a group of children or who are left alone with children at any time submit to an employment background and criminal records check. The criminal records check process requires that each employee file a notarized affidavit and be fingerprinted by the Bureau of Criminal Identification (BCI) of the state police. Local police may also take fingerprints. DCYF runs the names through its Child Abuse and Neglect Tracking System (CANTS) and

does FBI checks as well. DCYF also monitors programs by making both announced and unannounced visits as required by law.

A small but growing number of child care centers in the state choose to exceed these basic standards and seek national accreditation by meeting the criteria for high quality specified by the National Academy of Early Childhood Programs. Discussions have begun at the national level that will likely lead to the development of a similar system for accreditation of family day care homes.

Current weekly rates of payment per child for regulated child care are as follows:

	Center Based	Family Day Care
Infants and Toddlers	$96.00	$79.00
Preschoolers	66.00	53.00
School Age	31.50	26.00

DHS formerly paid relative care and in-home care providers at the same rate as family day care home providers until recent revisions in payment schedules created differential rates. Relatives continue to be paid at the same rate as family day care home providers. In-home providers, however, are now paid at 93% of the newly established family day care rate or $73.00 per week.

Most recent local figures (1989), collected by the Rhode Island Association for the Education of Young Children, indicate that regulated child care providers in Rhode Island are predominantly female (98%) and white/Caucasian (88%). Starting salaries for day care teachers ($6.69/hour) possessing the same degree as their public school peers ($12.53/hour) point out the challenge child care program directors face in luring recent graduates into positions of head teachers in their programs. Assistant teachers earn $4.78/hour and turnover takes place at an annual rate of 31% to 57% depending on program type. Turnover rates in Rhode Island follow national patterns with highest

turnover where salaries are lowest. Family day care home providers generally operate ten hours a day, five days per week and earn $4.30 per hour.

While licensed center based and family day care providers make up the largest percentage of vendors from whom DHS purchases services, Rhode Island also purchases services from providers not subject to state regulation. These vendors fall into the category of in-home or relative care. DHS estimates that approximately 200 to 300 persons provide in-home or relative care at any one time, serving as many as 1,100 children.

Regulated care offers some assurance to parents that minimum standards of quality are met in licensed center care and certified family day care. However, parents of children in unregulated care bear the burden of assuring that their children's experience is of reasonable quality.

In-home care, as its name suggests, must be provided to a child in his/her place of residence. In-home care providers do not meet the DHS definition of relative and must be 18 years of age. The practice of conducting criminal records checks of these unregulated providers was spurred by the efforts of a DHS case work supervisor. While in-home care providers are not required to be fingerprinted, they must agree to allow the department to conduct a search of the DCYF masterfile and BCI records. DHS also checks the files of anyone residing in the home in which the care is to be given. Providers sign a form allowing the DHS to inspect the home in which care is provided (Note: The DHS signature form reads "I understand that *my* home may be inspected," however, it is assumed that DHS's intention is to allow access, in the case of in-home care, to the *child's* home). Despite this requirement, DHS conducts no monitoring visits to providers of in-home care at the present time, although it was a practice to do so in the past. Relative care is defined as care provided by a grandmother, grandfather, aunt or uncle, and relative caregivers are subject to the same approval process as in-home care providers.

DHS begins paying in-home and relative care providers once the criminal records check has been cleared. They are paid at the same rate as family day care home providers. Department officials estimate that ten percent of the criminal records checks done on potential in-home and relative care

providers (or residents in their home) result in denial by the department of payment for service. While this does not preclude the parent from choosing to use the caregiver, DHS will not pay for the service. The ten percent figure is an estimate as DHS does not keep records on those for whom payment has been denied. (Note: DHS does maintain a list of more than 600 approved caregivers. Its purpose is to assist case managers and social workers in expediting the approval process).

DHS has received dozens of requests for Fair Hearing (a process that allows clients to challenge DHS rulings), from parents dissatisfied with the department's decision to deny payment due to the failure of a provider or resident in the providers' home to pass the criminal records procedure. In every instance, the fair hearing process has upheld the department's decision to deny payment. The department also has more than one lawsuit pending as a result of the criminal records check procedure. DHS officials pointed out, however, that at one point the department was unable to conduct approvals in a timely fashion, providers might possibly have cared for children for a few months before learning that they would not be paid. They feel this, in part, explains many of the requests for fair hearing as compromised parents attempted to obtain payments for services relatives and friends had already rendered. Lawsuits have also been filed to challenge departmental procedures and the legality of the process.

THE VENDOR STUDY

Introduction

The centerpiece of this research effort was a study of the vendors who provide child care through the in-home and relative care system in Rhode Island. We undertook this study to examine the provision of care from both a descriptive and policy perspective, and to answer the following questions.

- What are the characteristics of the people providing care under the system?
- How does the system of care "work" in terms of activities, relationships, reimbursement, and role of DHS?
- What support and training do vendors want/need?
- What is the quality of the care provided?
- What are the components of parental choice of this type of care?

Methods

Using the most recent list of vendors, available from DHS in September 1991 but covering the vendors that were paid for providing care in August, we sought to interview a sample of 50 vendors who are currently providing care under the program. Although there were 214 vendors listed as providing care in August, sampling was not a straightforward task because of 1) vendor turnover and 2) problems in contacting vendors.

It was necessary to contact 150 of the 214 vendors on the September list in order to reach the sample of 50 that were eventually interviewed. Of these 150, 49 were no longer providing care under the program; 16 had unlisted telephones, and 17 had telephones that had been disconnected. We dealt with each of these problems somewhat differently.

When we reached vendors who were no longer providing care under the program, we asked them why and when they had ceased to do so. The principal reason was that these were summer vendors who cared for children when they were out of school and, because of the timing of the study, we were reaching them just as school began and they stopped providing care.

The 16 unlisted telephone numbers represent an important segment of the vendor population and we attempted to obtain the number from the social workers who serve the parents of the children in care. In this way, we were able to include five of the vendors with unlisted telephone numbers in the 50 who were in the final interview sample.

Similarly, we believed that it was important to make special efforts to reach the vendors with disconnected telephones since they too represent a segment of the total population that is of particular interest. Through a series of "drop by" visits, we were also able to include two of these vendors in the interview sample.

The interview sample, in its final iteration, consisted of 50 vendors in 17 Rhode Island communities. Of these communities, eight were classified as urban while the remainder were classified as rural and suburban. Three interviews were conducted in Spanish with the assistance of a translator provided through DHS. Eleven of the vendors were in-home providers while the remainder were relatives, which reflects the proportions of the universe of providers in the state. All interviews were conducted in person at the vendor's home or the child's home, depending on whether the care was in-home or relative, and all interviews were conducted by two person teams of senior researchers.

Ninety children were in the care of the 50 vendors. Of these, 21 were low income and 58 were AFDC recipients, which represented an over-sampling of low income children and an under-sampling of AFDC recipients in the system. Our hypothesis is that this resulted from the tendency of AFDC recipients to have unstable child care arrangements and enter and exit the system quickly; thus in our attempts to reach the vendors with AFDC children, we were, in effect, trying to hit a moving target.

To explore the quality of care, we augmented the verbal interview with observational data testifying to the safety of the environment, the degree to which the environment supported literacy development, and the apparent approach to discipline. To make the observational component possible, we interviewed vendors while the children were present and we assigned one of the two team members to the role of observer while the other was the interviewer.

Finally, we rounded out the picture of the in-home and relative care system by interviewing 26 parents of the children who were in the care of the sample of providers. These interviews were conducted by telephone and by the same researchers who had interviewed the vendors involved with these parents. The focus was on how the parents had made the choice to use this type of care and on their perceptions of the child care experience.

Findings from the Vendor Study

The findings from the vendor interviews and parent surveys are reported in the remainder of this section under headings that represent the key domains of investigation. In some areas, we found it informative to examine the responses in a way that differentiated urban and rural/suburban care providers; in other areas we examined findings separately for in-home and relative care givers. Two caveats are in order at the outset. The numbers are small; however, since Rhode Island too is small, they are sufficient to represent the universe. The second caveat has to do with the observational data; we have reported what we saw but we could not see beyond the room or area in which the interview took place and we were not always privy to informative interactions between vendor and child.

Background of Vendors. The average age of vendors is 48 years with a considerable difference between relatives (average age of 54 years) and in-home providers (average age of 36 years). Ninety-two percent of the providers are females and they report an average of 30 years (relatives) and 16 years (in-home providers) experience in child care when they include the experience of raising their own children. Ninety-six percent have children of their own with the average age of the relatives' children ranging from 23 to 27 years old and the in-home providers' children averaging 11 years.

When we asked vendors about their experience in caring for children other than their own, 83% reported that they had at least some experience, most of which (63% was in the category of babysitting. Twenty-three percent reported some special training in child care or parenting but the specific instances of training tended to be ancillary (CPR) or one-shot, (a workshop given by a local department store).

Vendors reported their formal schooling as follows: 41% had not completed high school; 44% were high school graduates or had earned a GED; and 15% had some college or post secondary education. The education level of child care providers appears from the literature to be a critical variable. Therefore, we examined this information further in terms of the education patterns of relatives and in-home providers. Eighteen percent of the in-home providers had less than a high school education in comparison with 51% of the relatives. In-home providers accounted for six of the seven vendors in the sample who had "some college."

Sixty percent of the vendors who are relatives are the grandparents or great-grandparents of the children whom they care for. While the children are in care, their parents are either at school (38%) or at work (60%).

In 94% of the cases, English is the language spoken in the vendor's home, the child's home, and in communicating with the child. This is representative of the population of Rhode Island, which, according to 1990 census data, is 4.6% Hispanic and 1.8% Asian–the most likely non-English speaking populations.

Children in Care. The maximum number of DHS-funded children we found in the care of any one vendor was four, and the average number was two, with an age range of one to twelve years. The majority of children in care were three years old and under (45%) or age six and over (41%). Fourteen percent were four and five year olds. On average, the children had been in care under DHS funding for four months.

Children were receiving more care in terms of hours and days than is funded through DHS. We found, in fact, that vendors reported that they care for children an average of 4.4 days a week with DHS funding and three quarters of a day without DHS funding. Relatives appeared to be about twice as likely to care for children without DHS funding than in-home providers. Vendors have the children in care an average of five days a week, which testifies to the importance of examining the safety and quality of care. This implication is reinforced by the report of vendors that they care for children an average of 7.0 hours a day, 5.7 hours with DHS funding and 1.3 hours without. Eighty-six percent of the parents stated that in-home and

relative care is the only form of child care that they use–thus confirming that vendors are a major presence in the lives of the children who are in care.

A related issue is *when* the in-home and relative providers care for children, based on our hypothesis that one reason for selecting this type of care is that it is available at times when center-based care or family day care is not available. Of the 26 vendors who reported the times of the day they provided child care, 38% provided care before 7:00 AM or after 6:00 PM.

We asked vendors if they were likely to continue to provide child care for these children after the availability of DHS funding is over. Approximately 77% said "yes," 13% said "no," and 10% said that they "don't know." There was no differences in response between relative and in-home providers.

There were some differences in the responses of the two groups concerning the extent to which they cared for children other than those funded (at least in part) by DHS. Overall, the response was that 47% did other paid or unpaid babysitting; 42% of relatives and 64% of in-home providers did so. However, the response to the question, "What is the greatest number of children that you ever care for at one time, including DHS-funded children and others (including your own)?" was virtually identical, with both relatives and in-home providers reporting an average of three to four children. In a few instances, vendors appeared to have more children in care than Department of Children and Their Families standards permit.

A concern of DHS is the extent to which other adults, who have not necessarily been submitted to a criminal records check, are not only present while children are in care, but are actively involved in the child care. We found that in 71% of cases, other adults were likely to be present when the vendor was caring for children. In 74% of the cases where such adults were present, they did indeed assist with child care with the likelihood being much greater among relatives (76%) than among in-home providers (24%). A closer examination of the adults who are present reveals that 85% of them are blood or legal relatives either of the children in care or the vendor while 15% are outside the family system (vendor's boyfriend or mother's boyfriend).

Parent-Vendor Interactions. Another area of interest was the interactions about children that take place between vendors and the parents of the children. We found that there is ample opportunity for interaction since 92% of vendors report that they, the child(ren) and the parent are together at least "some of the time." Discussions of how they child should be reared or cared for took place between 78% of the vendors and parents, with in-home providers somewhat more likely to hold these discussions (92%) than relatives (72%). This makes intuitive sense in that families are likely to have an implicit understanding of their own child-rearing practices, while outsiders require explanations.

Daily Activities. Most vendors provide both meals and snacks for the children. In-home and relative care providers serve breakfast (61%), lunch (64%) and snacks (83%) about equally. However, when it comes to supper, relatives are much more likely (53%) to provide it than in-home providers (9%). There are several implications of these data. First, the fact that the children are in the care of relatives at supper time reinforces the finding that relatives are likely to have the children at hours when center-based care is generally unavailable. Second, the number of meals provided by relatives is such that the cost, which is not covered by a separate DHS stipend, is likely to reduce noticeably whatever earnings they may be realizing from providing care. This supposition is supported by the catalog of foods that relatives provided to us as daily meals for children–bacon and eggs, french toast, hamburgers, steak and potatoes, homemade desserts and store-bought treats.

Positive\Negative Aspects. We asked vendors "What are the most positive aspects of providing child care through the program?" The answers showed a tension between love and money with 28% mentioning reasons that refer to the gratification of providing care and 15% mentioning the money as a "most positive" thing. However, the single most frequent response (36%) was "having the children with someone they know, "a response that implies a concern for safety, familiarity, and the importance of family. Parents overwhelmingly agree that safety is a key concern with them; in fact "safety", "convenience" and "love" account for 100% of the responses in this category from the parents.

The converse question about "what has been hard for you" about providing care elicited a prevalent response of nothing is hard or negative. This question contained a probe concerning approach to discipline but it too yielded no

information beyond the line of "no problem." Again, parents agree that the experience is positive–the responses say that there is nothing negative for the child (81%) and nothing negative for the parents (91%) when the children are in in-home and relative care.

Similarly, issues of where respondents get help with issues of eating and sleeping habits, health, and toilet training were met with a general response of "not a problem." However, the person most frequently turned to when there was a problem was the child's mother unless the issue was health in which case 16% of vendors contacted a doctor or hospital.

Reimbursement. Fifteen percent of the vendors said that money was the most positive aspect of providing child care. Eighty-four percent said that, although they could manage if they were not reimbursed for child care, there might be some trade-offs involved. Responses such as "have to cut down on food," "take another child," "find another source of income," "stop going out myself, like to the movies" convinced the researchers that there would be more hardship involved in managing without DHS payment than was being stated.

Increases in co-payments (the parent's portion of child care cost) have the potential to create special problems for relative care providers. In more than one instance, vendors raised concerns about DHS established co-payment amounts. Two relative care providers agreed to accept less money for child care as their relative (one a daughter, the other a niece) was unable to manage the increase in co-payment resulting from DHS policy changes. One mother (vendor) indicated that she "used to get $73.00 a week but now it's $52.00. My daughter has to pay the rest. She can't do it. She was a nervous wreck." The mother accepts the lesser amount but believes DHS should pay the full amount. Another vendor was clear that the money she earned went into the family "pot" and as her niece was unable to pay the additional $24.00 now required as her co-payment amount for two children, there would have to be cutbacks in the quantity and quality of food she was able to purchase for the family. We worried, in several instances, that some providers did not understand that they were entitled to a co-payment from the parent. Another provider, lamenting the low rate of pay, was unaware that she was providing more care than DHS had authorized she be paid for. As parents often process paperwork

for their relative caregivers, these providers may have limited access to information about how the program is intended to work.

An issue that straddles the line between money and quality of care is that of vendor interest in moving from their currently unregulated status into that of family day care provider, where on the one hand they could earn more money but on the other would have to adhere to higher safety and health standards. Here, the overall response from vendors was that 46% had "thought about becoming a family day care home provider" and 52% had not. However, when this response was broken down into rural/suburban and urban responses, 51% of urban vendors were interested while only 33% of rural/suburban vendors were interested.

Program Participation. Almost all vendors (83%) learned about the program from the mother of the child(ren) they were caring for. They have been involved with the program for an average of one year and nine months with a range from one month to nine years. Asked how long they think they will continue to provide care, 83% said indefinitely or as long as they were needed. (One grandmother, who was weary that day, said, "Probably until I die.")

Resources/Support. One component of the vendor study was how to help or support vendors. Seventy-three percent of all respondents said there was "no information or assistance" that would be helpful to them. Parents, on the other hand, did not agree with those of vendors. Seventy-three percent of the parents thought it would be "helpful to offer training in child care for vendors" in the area of discipline and child rearing (63%), and in the areas of health and nutrition (31%). Interestingly, even among parents who said it would not be helpful to offer such training, several responses were qualified by statements like "I wouldn't want to suggest it" or "She wouldn't want to" or other suggestions that there was hesitancy rather than objection in the mind of the parent.

The vendors, when asked that question directly, said they emphatically did not need training ("I raised nine of my own," " I could give the experts lessons," "I've seen it all"). However, when we rephrased the question in terms of "get togethers" so that it was no longer based on a deficit model, there was a great upsurge in interest. Eight-seven percent of all vendors expressed interest in get-togethers or support groups with little difference between in-home and relative care providers. Among

urban vendors, 92% thought they would be able to attend; among rural and suburban providers, it was 70%. As to the location of such sessions, (church, school, welfare office), the vendors didn't care as long as it was convenient or close to home.

Relationship with DHS. Vendors responses about dealing with the state (DHS) on issues related to in-home and relative care were positive, with 65% of vendors reporting "no problems." Eighty-seven percent reported that the state staff was helpful or somewhat helpful in dealing with paperwork and payments. Where there were problems, they seem to be around two issues–payment (primarily late checks) and communication (particularly reaching staff by telephone). When we asked "Are there some things that the state could do better?," 61% said "yes" and most said that what the state could do better was 1) pay more, 2) pay more quickly, and 3) pay more frequently than once a month. Our final question, which asked if respondents had "other comments" about the program elicited unsolicited praise for the program from 29% of the respondents–it's a "wonderful program," "an important program," "a critical program for our family" and a program that "would have made a difference in my life if it had been around when I was younger."

Parents were also positive about the importance of the program itself (according to one parent, "It saved my life.") and about their dealings with DHS. Sixty-two percent said that there were no problems. Ninety-two percent said that the paperwork they completed when they began using in-home or relative care was "not difficult." Staff, when contacted, were considered by parents to be helpful (74%, but 60% believed there were things that the state could do better, especially in the areas of communication and conveying program information.

Observations on Safety. We asked the observers to note instances of peeling paint, electrical outlets without caps, open windows on upper floors, dangerous objects within a child's reach and other safety problems. Overall, we saw 48 instances of safety problems that affected a total of 21 homes (42%). More importantly, 44% (40) of the children in in-home and relative care were exposed to at least one safety hazard, based on our observations. Here there was a significant difference between the homes of vendors in urban areas and those in rural/suburban areas, with 85% of the safety hazards observed in urban areas. On the positive side of the ledger,

virtually all the homes (or at least the portion we observed of them) were clean and tidy.

Observations on Quality. To the extent that was possible, we observed the environment to find out what kinds of materials and activities were available for children. Bearing in mind that we could not observe the entire house or even the complete contents of any one room, we saw the following objects in the homes we visited:

- Books in 42% of homes;
- Paper for writing/drawing in 35% of homes;
- Crayons/pencils in 29% of homes;
- Toys in 95% of homes;
- Children's drawings or other child-made decorations in 15% of homes;
- A television set in 94% of homes;
- A VCR in 60% of homes;
- A cable box for the television set in 45% of homes; and
- An outdoor play area in 51% of homes.

The children appeared to be clean and well-cared for physically in 92% of the homes and we judged that they were "happy" in 81% of the homes and "passive" or somewhat passive in the remainder. There were no instances in which interviewers believed that children were "afraid." Interactions around discipline and reinforcement concerning behavior generally were positive in 89% of the instances that we observed. A "harsh" tone of voice was used in one instance and in two others, the provider "swatted" a child in the presence of the interviewers.

Additional Findings from the Parent Interviews

Elements of Choice. What went into parent's choice of in-home or relative care and the kinds of information that could have facilitated that choice were also pursued. For 73% of the parents this was the first time they had used in-home or relative care; however, 50% of them had used other types of child care, such as unpaid babysitting, family day care homes, or day care centers in the past. For these parents, the choice this time was made on the basis of safety, love, and convenience.

Eighty-five% did not consider another type of child care in making their decision to use in-home or relative care this time. Almost all the respondents heard about the in-home and relative care option from the welfare office/Pathways program; 65% did not receive information about any other type of child care at the time they found out about in-home and relative care. However, when they were asked if there was information that would have been helpful in making the decision that was not available at the time, 70% said "no."

Sixty percent of the respondents think that they will leave their children in this type of care during the time they are eligible for DHS funding. Those who are thinking of moving their children into another type of care are contemplating that choice because their child is reaching the age (usually at four years old) where they believe that some kind of preschool experience would be beneficial. Again, however, when parents were asked if there was information that would be helpful *now* in making child care choices, they said "no" (62%).

Among families, choice is a two-sided phenomenon. In addition to parents *selecting* relative care, the relatives also had to agree to *provide* it. The reasons for the decision undoubtedly include many elements. One that came through very clearly with grandparents was the fear of care provided outside the family system. Stories of abuse and neglect in child care centers that have aired on television or been featured in newspapers have apparently made deep impressions. Among the older providers of care, the grandmothers and great-grandmothers, the reflection was to a changing world "You can't trust anybody anymore" or "There are lot more crazy people than there used to be." More commonly, however, the comments

pertained directly to stories the providers had read or seen on TV. Some of the comments that were made to us are quoted below.

> "The only people you can trust are your own family."
>
> "I keep an eye on them at all times; I heard they don't do that at a center."
>
> "I have a fear of day care. I know what I've read and I know what I've heard and there's no way I would let my grandchildren go to one of those."
>
> "They don't teach them right from wrong at a Center. What do they care?"
>
> "We've been hearing so much talk about these day care centers. Do they check on how many people watch at one time?"

The word vendors used most frequently was "safe." When children leave their homes to go to a center, they are no longer safe but exposed to indifference and lack of supervision. Worse, children who are in centers are not protected from abuse, particularly sexual abuse, which appeared to a subliminal note to the words "safe" and "unsafe." Statistics that show that children are more likely to be abused by relatives than by the staff of child care centers were greeted with disbelief and anger, when they were quoted to parents or relative caregivers. Ironically, in the area of physical safety, we observed sufficient hazards to state that children are not always safe in their own homes or those of relatives. Compared to the safety standards that must be met by regulated care providers, the children in this population are not as well-protected.

Conclusions from the Vendor Study

Overall, the researchers summarized the Vendor Study interviews process by saying that they met "nice people doing the best they can." There were, however, a few situations in which the researchers were uncomfortable, based on their observations of the surroundings or vendor interactions with children. Since this occurred in no more than five of 50 interviews, it might be said to be a negligible occurrence. However, since all the respondents knew that they were being reported on to DHS and since all interviews were pre-scheduled, even ten percent seems an important occurrence. And, of course, no occurrence of a situation in which children seem physically or emotionally at-risk can be dismissed as unimportant. Several

researchers reported feeling "great discomfort" with some of the situations they observed. However, it should be pointed out that there was no hard evidence observed or reported to justify any stronger statement.

There was also some evidence, self-reported, in four of the eleven in-home provider interviews that this care is not always carried out according to the regulations. The four vendors, apparently unaware that they were out of compliance, reported that they sometimes cared for the child in their own home, based on their convenience and/or that of the parent. These four cases amount to 36% of the cases and is therefore not an insignificant indication that the regulations concerning in-home care are unclear to vendors.

Generally, it should be concluded that the participants in in-home and relative care are happy with it. This includes the vendors, the parents, and apparently the children themselves. Safety, convenience, and love are the important ingredients in child care to this population and they believe that they are providing or receiving the care that assures that these needs are met. In a sense, it might be said that the findings confirm the popular wisdom that children are best off with their families and to contradict the professional wisdom of the child care community that tends to be suspicious of relative and in-home care. The majority of children are well-fed (which was obviously important to many respondents), clean and well-dressed, and comfortable with family members (usually grandparents) who say that they love to take care of them.

Themes of safety, love, and convenience reflect the concerns of vendors and parents. But we cannot ignore in this discussion that while children receive the quality of care that satisfies their relatives and parents, they may not be receiving care that optimally meets their developmental needs.

Our observational data is hardly conclusive. However, there were troublesome indicators among those data. For example, we did not see any books for children in 58% of the homes we visited. Also, among the toys that we saw, about 75% were non-educational in that they were not manipulable nor did they appear to require higher order thinking skills. (The degree to which a toy is "educational" is arguable at best–we offer our opinions here only as judgments, based on experience). Finally, the television was an omnipresent factor in interviews; it appeared that in some

homes it is simply always on, whether anyone is watching it or not. The effect, at least as we perceived it, is to reduce other verbal communication in the house, which is not conducive to the acquisition of the verbal skills needed by at-risk children.

Some tentative conclusions about choice of child care emerged from the parent interviews. First, parents seem to want to use in-home and relative care for the same reasons that vendors want to provide it although parents tend to emphasize convenience while vendors stress safety. However, the question emerges, do parents know enough about other kinds of care available to make an informed choice? In other words, if they knew about factors other than safety, love and convenience, would these factors also become important in the decision-making process? The data tell us that for 73% of parents, this was the first experience with in-home and relative care and for 50%, it was the first experience with any kind of child care. Yet 85% did not consider any other kind of care and 65% did not receive information on any other kind of care at the time they made the decision. These data must be balanced against the fact that only 30% felt that they needed more information when they made the choice. The simple answer to this of course might be that "they don't know what they're missing" in terms of new or alternative options for care.

Overall, the vendor study has left us with a picture of a viable system for child care in Rhode Island. However, as in most studies, it raised questions as well as answered them. Some of these questions appear below.

- In Rhode Island, criminal records and CANTS checks are estimated to reject 10% of all in-home and relative care provider applicants. What role do these checks play in the benign overall picture of in-home and relative care, i.e is the system successful in weeding out the "bad apples" at the outset?

- How important is money in making the overall system viable for relatives? Is it being underestimated as a factor by providers, as the researchers suspected, because (for example), vendors don't want to be perceived as looking after their own grandchildren because of the payment. ("That's my people.")

- Virtually all the in-home providers were termed "friends" by the parents of children. However, we did not ask if they became friends after they began to provide care or were friends before. Is it true, as we suspect but cannot prove, that many parents found their in-home providers from the larger kith-ship system in which they live and formalized existing relationships by turning unpaid babysitting into paid babysitting? If true, is this a phenomenon peculiar to Rhode Island and is it the reason that in-home and relative care tended to look so much alike in this study?

The answers to these and other salient questions must await research efforts devoted to in-home and relative care in other states and localities. Our data, taken as a whole, suggest that such studies might focus on ways to strengthen and support a system that is thriving beyond the expectations of many professionals in the child care community and beyond.

INFORMATION SYSTEM ENHANCEMENTS

Introduction

This section contains our recommendations and observations concerning the current and future uses of information systems related to the in-home and relative care program, administered by the Office of Child Care of the Department of Human Services. This report provides a brief outline of the current system, describes some of the potential uses of information pertinent to the Office of Child Care, and presents recommendations for the future. One caveat is in order–an internal systems analysis is currently being conducted, and this report is necessarily independent of that analysis.

Uses of Information

The major applications of information may be classified as administrative and policy oriented. The following are ways that information can be utilized by the Office of Child Care, both locally and within an overall DHS/DCF child care context.

- Management & Administration. The most obvious uses of information systems is in the traditional Management Information System (MIS) model. This refers to the day to day administration of the Office. As such, its focus is internal. Personnel reports, case load management, preparing annual budget requests, periodic and cumulative expenditures are typical of the information in this category. This is the kind of information that is useful in the day to day administration of an organization.

- Policy Analysis/Setting. There are two distinct levels of policy information. One refers to overall global departmental policy issues; the other, to programmatic policy, which is the implementation of departmental policy. Information resources can profitably be brought to bear on issues of both types. Vendor surveys and analyses, rate setting, program planning and evaluation are examples in this area.

The Current System

The primary computer resource available to the Office of Child Care is a centrally administered, multi-user, mainframe based system. Staff prepare written requests for data processing services, which are submitted to the central organization. Printed output, if any, is available within a few days.

Providers of in-home and relative child care first enter the system when a qualified parent initiates a request for Child Care (Form CSS-1) and the accompanying Parent/Provider Agreement (Form CSS-2, or CSS-3). The information in these forms is checked for parent and child eligibility. The vendor must clear a criminal records check and a check for previous child abuse incidents via the Child Abuse and Neglect Tracking System (CANTS). It appears that no data on the status of prior applications are maintained in the system. Therefore, no record is kept of applicants who have been rejected.

Once accepted, vendors can receive payment based on the monthly Attendance Reports (Form CSS-6, or CSS-6R) they submit to the Office for Child Care. Information from the forms (names of children cared for and hours of care provided by week) is entered into the system where it is used to print payment checks for the vendors. The system performs what is essentially a vendor payroll function, with some internal administrative use of information from the various forms, and little if any analytic use. In addition to this payment function, a variety of reports detailing the information contained in the forms can be produced on an ad-hoc basis via requests to the central system staff.

When it comes to sharing data with other organizations that have responsibilities in the child care system, the present system is best described as cumbersome and manual. This point was highlighted during the Vendor Study phase of the project. In order to contact some vendors we needed to contact a parent of the child for whom care was being provided. This required a number of phone calls among researchers, DHS staff and staff at other state agencies. The process was relatively inefficient, time consuming, and failed to provide all of the desired information.

There are two significant conclusions to be drawn from this description. First, the CSS-6 and CSS-6R have become the major means of communication between the

vendors and the Office of Child Care. Second, the Office of Child Care is not the custodian of all of the information relevant to its function. The Department of Children, Youth and Families, the criminal justice system, and other organizations within DHS have responsibility for various other aspects of a system ("THE SYSTEM") with which both vendors and vendors' clients must interact–a system which they tend to see as monolithic.

Towards a Child Care Information System

The child care world and the computer world share at least one desire–people want "seamless systems". In the child care world this implies, in part, a single, integrated, coherent system, dedicated to the administration of child care. In the computer world, it means an apparently integrated, single, coherent system dedicated to the task of making the system easier to use. In short, a "user friendly" system.

In neither case does it matter if the system is one organization (software program), or many, as long as they function cooperatively and smoothly, together. What matters is that clients (external users) and staff (internal users) see a single, "user friendly" system.

This would be the ideal–a seamless computer system that allows access to any and all data relevant to child care in the state. This implies some level of inter-departmental collaboration, not only in system design, but in considering issues of confidentiality and information security (access to confidential data).

Recommendations

The following is a set of brief recommendations that address the mechanics of system improvement. They are stated and intended as action steps.

- Make more extensive use of the information already collected. There are a lot of useful data already collected on the various CSS forms. For example, the data could be used to construct an accurate, current vendor profile. This in turn could inform any number of programmatic and policy decisions.

- In any system that is developed, request/define two or three extra fields. This will allow the collection of data on an ad hoc, temporary basis, without requiring major intervention by data processing personnel. Time brings new focus; there will always be new pieces of information to insert in extra fields.

- Provide desktop capability for appropriate personnel. Ideally, this means personal computers with file transfer, analysis, and reporting capability. At a minimum, it means terminals accessing the central mainframe. This would make data more accessible to the people who need it when they need it.

- Provide some means of interdepartmental data sharing. The lack of ready accessibility caused delays in contacting parents for both the Vendor Survey and the Parent Telephone Survey. Again, personal computers are the preferred means to accomplish this. A small local area network (LAN), shared by all organizations with child care responsibilities would be one means of providing this access. Failing that, mainframe data terminals accessing a common or shared set of data would give some of the same capability. While this would be a major undertaking, data sharing is the cornerstone of "seamless systems", both human and computer. A well designed, integrated, computer system can help in planning, and in allocating scarce resources so that services to both tax-payers and clients are better optimized.

- Earlier we stated that the Attendance Report (Forms CSS-6 and 6R) has become the major means of communication between the Office for Child Care and the vendors. Capitalize on this by adding a few fields to them. For example:

    - A check-off box to indicate that the vendor needs a new supply of forms

    - Vendor change of address/phone number information

    - Information requests from the Office for Child Care, perhaps tied to the extra fields defined for the data base

- Retain all information related to prior vendor applications. Of particular concern would be information related to those who were refused authorization. Remember with data sharing and a seamless system, this information might also be useful to other organizations.

- If this has not already been done, establish and support an *inter-* and *intra*-departmental information systems steering committee.

OPTIONS AND RECOMMENDATIONS

Introduction

This section presents the fruits of the study in terms of options for change and improvement in the Rhode Island system. Some of these recommendations may be applicable beyond the state borders; others are state-specific and even DHS-specific. Some recommendations stem from the national survey and the policy review, but the views on which they are founded grow primarily out of the Vendor Study and the many implications of its findings. There are two parts to this section of the report. One is a general discussion of how Rhode Island can build on the strengths of its current system. The other is a set of recommendations for action that DHS may use to carry out the strengthening process.

We believe that strengthening the system consists of linking its components more closely together and giving it more internal cohesion. The first can best be accomplished by fostering collaborations among insiders (organizations) and outsiders (vendors) to fully utilize available resources. The second consists of gap-filling, bringing in new resources and ideas as necessary.

Collaboration

Fostering Interorganizational Collaboration. Rhode Island has a strong history of collaborative effort on behalf of children and families. The important work of the Permanent Commission on Child Care with its broadly based representation provides a fine example of a system that has worked to improve the lives of children and families needing child care. Outside of government, advocacy and other groups work together to affect the system as well. The Public Policy Coalition for Rhode Island's Children and the Handicapped Children's Early Education and Demonstration Project at Rhode Island College are two of just seventy-two collaborative efforts throughout the nation that Sharon L. Kagan featured in her recently published book, United We Stand, Collaboration for Child Care and Early Education Services.

As the "lead agency" for child care, the Department of Human Services takes on the responsibility for providing the leadership necessary to bring the broad early care

and education constituencies together to act in a collaborative fashion. If all the children in child care are to be well served, meeting the needs of regulated and unregulated providers will require such a collaborative approach. The definition of collaboration we have used is taken from Kagan (1987) and defined as "organizational and interorganizational structures where resources, power, and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently" (p. 3).

Building a Collaboration with Families. The Vendor Study points the way to establishing a new and stronger system within the in-home and relative care program. A viable system is likely to have much in common with family support programs rather than resembling the professional family day care model. In fact, the vendors made it clear that support for them will only be successful if it takes an approach that builds on the family system that is already in place. To strengthen this system, the state would do well to develop resources for relative care providers based on a family resource and support model. Such a model (embodied in Head Start, for example) makes a commitment to empowerment and partnership with parents.

Making such a model effective requires a shift in thinking from what Bernice Weissbourd, founder and president of both Family Focus and the Family Resource Coalition calls the "parent education" approach. Rather than view parents as empty vessels, passive beneficiaries of all the wisdom parent educators can pour in, effective programs take a non-deficit approach. In a review of the research, Powell (1991) identified five critical factors in successful family resource and support programs:

- They are "family friendly" and recognize the developmental stages of parenthood;

- They provide an opportunity for parents to engage in supportive exchanges with other parents;

- They maximize opportunities for informal exchanges with parents;

- They appreciate individual differences in parent circumstances and values;

- They view parents as allies.

More specific recommendations on this topic appear later in this section.

Gap-Filling

To the extent that the previous discussion was one of building on strengths, this section addresses the issue of remedying weaknesses. The first step is to identify the weaknesses that exist in the system. The matrix on the next page is drawn from notes provided by Gwen Morgan and depicts a working model of a dynamic child care system. The large white space in the middle of the graph visually points to a gap in the system of in-home and relative care in the areas of training and monitoring. To address this gap, in the midst of tough economic times, will be difficult but we see two tools that may make the task possible.

While it is not possible to monitor the vendors personally, Morgan suggests that it is possible to define what is meant by "care" in a way that establishes reasonable expectations for the service that is purchased from all caregivers. An example (immunization) is included in the more specific recommendations later in this section. Another tool for gap-filling is the information that appears in the second table on which lists sources of federal funds that might be tapped if DHS chooses to become involved in support and "training" activities. A list of resources appears in Appendix B.

Specific Recommendations

The remaining pages in this chapter contain specific, action-oriented recommendations for consideration by DHS. They are based on building collaborations with families, setting standards for care through definition, and gap-filling. Each of the five "mega-recommendations" contains a set of subsidiary recommendations for implementing it.

WORKING MODEL OF A DYNAMIC CHILD CARE SYSTEM	*PARENT*	*RELATIVE/KITH*	*IN-HOME / FAMILY DAY CARE MODELED ON RELATIVE/PARENT*	*REGULATED FAMILY DAY CARE*	*PROFESSIONAL FAMILY AND CENTER BASED CARE*
Based on notes provided by Gwen Morgan	***Cares for own child; legal obligation to provide care; failure to provide care is neglect; obligation includes food, shelter, medical attention, education to station in life, etc.: all other carers are delegatees; also has an irrational attachment to child, high affect, treasures child.***	***Care modeled on parental care. Includes high affect and irrational attachment.***	***Home providers, usually caring for children of just one family, may discuss with parent the location: your house or mine, hours,etc.; mostly modeled on relative or "babysitter."***	***Provider of care is holding service out to the general public, not caring only for child for whom there is a special relationship, and not an employee of parent.***	***Regulated provider has taken the opportunity to receive training, has joined a professional association, has been in the field for 2 or more years, and views self as a professional.***
Subsidy	None	See regulated family day care	Inf/toddlers, up to $73./week Preschoolers, up to $49./week School-agers, $24./week	Inf/toddlers, up to $79./week Preschoolers, up to $53./week School-agers, $26./week	FDC (as at left), Centers - Inf/toddlers, up to $96./week Preschoolers, up to $66./week
Department administering subsidy	None	R. I. Department of Human Services	R.I. Department of Human Services	R.I. Department of Human Services	R.I. Department of Human Services
Approach to training	Family resource and support and/or parent education programs as available			Specific family day care training	Specific training for work with children, more advanced; generic child development; CDA training; High Scope; etc.
Sources of training $	Possibilities include Head Start, DOE, child welfare and protection, special education/early intervention, maternal and child health, etc.			Becoming available thru CCDBG, CCFP provides free training, CDA scholarships if income eligible	As at left, Head Start has staff training $
Does any program or agency visit?	Possibilities include visiting nurse, Head Start home visitor, case manager/social worker, early intervention spec., etc.			DCYF, Health, Building Insp., Fire Marshall and other as req. by local law; may include visits to child by specialists	As at left, but inspection visits more frequent for centers than homes
Child or adult purpose?	Child, adult or both			Both, focuses on all aspects of service provision as well as child's needs	As at left
Legal relationship parent/caregiver	Legal, married if spouse	Family member	Parent is employer of caregiver	Parent is a consumer of the service	Parent is consumer of the service, also has overtones of consultant relationship

Selected Federal Early Childhood Legislation (Adapted from charts in Julie Sugarman, Building Early Childhood Systems, CWLA, 1991)

Program	*Program Purposes and Services*	*Eligible children and families*	*Federal Administering Agency*	*Estimated Funding Levels, '91*
AFDC Family Support Child Care (sec. 402g)	Guarantees child care for AFDC families who are working or participating in training and education programs. Continues for up to twelve months after leaving AFDC.	Children under age 13 in families receiving AFDC or having left AFDC within last twelve months.	Department of Health and Human Services, ACYF	
Child Care for Low Income, Non-AFDC Families (sec. 402i)	Assists in providing child care to working families or those receiving education and training who might otherwise need AFDC.	Children under age 13 in families not receiving AFDC who need care in order to enable a parent to work.	as above	300 M
Child Care and Development Block Grant (CCDBG)	Funds aimed at financing child care, improving its quality, child development and before and after school care.	Children under age 13 whose family income does not exceed 75% of the state median income for families of similar size.	as above	731 M
Individuals with Disabilities Education Act (IDEA)	To assist local education agencies in providing special education and related services to handicapped children ages three to five.	1) Handicapped children ages 3 to 5 2) Handicapped infants and toddlers and their families	Department of Education, Office of Special Education	339.9 M (P'S) 117.1 M (I/T)
Even Start	Finances family-centered education projects to help parents become full partners in the education of their children, assist children in reaching their full potential as learners, and provide literacy training for their parents.	Familes with children ages 1 to 7 eligible for participation in an adult education program; and living in Chapter I, Part A, of ECIA designated areas.	Department of Education, Bureau of Elementary and Secondary Education	49.8 M
Head Start	Overall goal is bringing about greater degree of social competence in children of low income families. Provides comprehensive education, health, and social services and parent involvement.	Children between 3 and compulsory school age, at least 90% of whom must be low income according to OMB's poverty guidelines and at least 10% of whom must be handicapped.	Department of Health and Human Services, ACYF	1,951.9 M
Parent and Child Centers	Centers are designed to enhance the development of low income children who are less than three years of age and strengthen family unit by increasing parent's child development skills/knowledge.	Low income families with children under three and pregnant women.		30 M
Dependent Care and Development Grants	1) 40% to assist in establishing, but not operating, resource and referral programs 2) 60% to aid in establishing, but not operating, school age child care programs.	1) R & R covers children up to 17. 2) SACC covers ages 5 through 13	Department of Health and Human Services, ACYF	13.2 M
Maternal and Child Health Block Grant	Puposes include assuring mothers and children (esp. low income) have access to quality maternal and child health services.	see box at left	as above	593.2 M

Recommendation # 1: Develop "user friendly" resource materials to assist parents, in-home providers and relative care providers.

Materials on making child care choices should be prepared and distributed in advance of the decision making process to all Pathways clients and other parents seeking child care assistance. The materials should be designed to be user friendly, highly accessible, and to address basic needs. Hints for their preparation appear below.

- Literacy issues.

  As many Pathways participants are enrolled in classes to improve their English proficiency, materials should be written at a level that matches their needs. Brochures should be made available in, at minimum, English and Spanish.

- Distribution points.

  Mail materials to parents who seek information from the department and the Options for Working Parents program by phone, hand them out directly to parents at meetings with Pathways case managers and day care social workers, and distribute them through day care centers, family day care homes and family/community service agencies.

- Length, format.

  Simple, easily reproduced, uncopywrited, one page brochures would enable the department to revise material periodically without the expense of recreating a lengthy document whenever information changes.

Information targeted to relative care providers/parents should address the practical issues faced by families taking care of other family members and include a list of state and local resources/services available free or at low cost.

- Payment.

  Include information about the vendor payment system, address issues associated with co-payment responsibilities, and include phone numbers for dealing with various problems. Humanize the brochure by including a picture of one of the payroll staff on the phone with a vendor. Utilize question/answer format to address typical problems -

  Q: Why hasn't my payment arrived?
  A: Be sure to mail your forms by the date . . .

- Relationships. "When your mother is also your child care provider."

  Provide tips on helpful topics for parents and providers to discuss and agree upon. Use issues identified by parents and providers such as provision of food, feeding issues, bedtimes, managing the kids when personal issues come up, dealing with emergencies, approaches to discipline, paperwork responsibilities, arranging for alternative care due to sickness, authorized/unauthorized visitors, etc. Utilize actual parent and vendor quotes ("Kids are my life." "We differ on when to introduce solid foods.") and pictures.

  Consider including a contract to be signed by both the provider and the parent, identifying responsibilities and spelling out program requirements.

- Health/Nutrition/Safety.

  Seek corporate donations to supply all providers with safety kits that include such items as safety plugs, a choke gauge, etc.

  In conjunction with staff from the Rhode Island Department of Health and/or Rhode Island Cooperative Extension develop handouts on the importance of immunization (include a schedule), lead paint poisoning, basic first aid, car seat usage, Heimlich maneuver, poisonous plants, choking hazards, toy, home and playground safety, fire prevention, etc. Take the generation gap into consideration in preparing materials.

Grandparents may be less well informed or out of touch with safety issues if they have not recently had young children underfoot on a regular basis. The Rhode Island Department of Transportation, the Junior League, and other service organizations may be able to offer assistance.

- Changing care situations. "Considering Head Start, day care or nursery school?"

  Aim the material at parents of two year olds and address the specific needs of Pathways and low income parents for subsidized care. Describe the various early care and education programs and outline the benefits and limitations of each as well as cost factors and available subsidies (e.g., Head Start is offered free to qualifying families, but may only be available part day.) Include information about the paperwork necessary to make change (e.g., notify your case manager, fill out form #101, etc.) and a specific section for parents of special needs children.

- Developmental milestones, guiding behavior, and appropriate expectations.

  Seek guidance from the National Association for the Education of Young Children's Rhode Island affiliate about producing brochures outlining developmental milestones of children at various ages. Material should include tips on guiding behavior, on determining age appropriate expectations, and on fun and simple activities to do at home.

- Becoming certified as a family day care home provider.

  Seek guidance from the Division of Community Services at the Rhode Island Department for Children, Youth and Families. Outline the basic certification requirements and list the potential benefits (e.g. Child Care Food Program) and any available resources. List DCYF contacts, include quotes from current family day care home providers, and openly address fears and misconceptions about regulation.

  Seek corporate sponsorship for equipment essential to certification (smoke detectors, boiler switches, etc.).

- Income taxes and tax credits.

  Address provider questions: To claim or not to claim?

  Also aim a brochure at parents in an effort to assist them in determining eligibility for the Earned Income Tax Credit (EITC) for low-income working families with a child under age 19, Child and Dependent Care Credits and other tax assistance programs. (Seek technical assistance from the U.S. Treasury Department, the National Women's Law Center and pro bono advice from R.I. tax attorneys.)

  (The department may also wish to consider the degree to which the EITC increases a parent's ability to pay for child care when determining eligibility guidelines for state child care subsidy.)

- A newsletter with every check.

  Send a one page newsletter to parents and providers addressing issues identified above and other topics of interest. Identify free and low cost outings with children and relevant public television series such as "Childhood" currently running on PBS. Address typical/seasonal health issues, provide lists of children's books available at local public libraries and include a Q & A/advice from a grandmother column. Provide tips on toys that can be made out of ordinary household objects, suggest appropriate activities for children of varying ages (focus on children under three and school age children), etc.

  Seek private, public and interdepartmental contributions and sponsorship.

- Establish two-way telephone communication.

  Parents and providers report frustration at being unable to reach the department with questions by phone due to busy signals and the inability to leave a message. DHS should consider installing an answering machine

that enables callers to leave a message or alternatively provides a message for callers when no one is available to answer the phone (e.g. "You have reached the payroll office. The best time to call is between . . . and . . . " or "Checks will be mailed out on the tenth.").

Recommendation # 2: Provide case managers and child care counselors with tools and resources to assist AFDC and low income families in becoming wise consumers of child care services.

- Assist case managers in identifying "Red Flags" that place children at risk due to established, biological and environmental risk factors.

The department should discuss, in collaboration with early intervention (e.g., R.I. Birth to Three Project) and other specialists, the practicality, feasibility, and potential benefit of developing a list of "red flags" that could be used to signal case managers/social workers to recommend that identified parents receive more intensive counseling about child care programs that may offer necessary support services and/or be referred to resources for more information to assist in the decision making process.

The degree to which the choice of child care inhibits or supports the potential identification of children with or at risk for developmental delays and subsequent provision of services should be examined as well. It would also assist Pathways case managers in complying with FSA regulations requiring states take into account "the appropriateness of the care to the age and special needs of the child" (Federal Register, Vol. 54, No. 97, Oct. 13, 1989).

For example, consider prenatal/perinatal risk factors such as chromosomal/genetic abnormalities, maternal nutrition, adolescent pregnancy, maternal education and whether a combination of multiple risk factors can, at this point in time, recommend one child care choice over another. The practicality of any instrument will greatly depend on the ease of it's administration, for DHS officials report that personnel cuts have left Pathways and child care case managers greatly overburdened.

- Maximize "teachable moments."

Develop a fifteen to twenty minute video on child care choices for use in waiting rooms at Pathways and welfare offices. Represent varied family types and cultural/ethnic groups. Briefly describe all the types of care that parents may choose from to meet their child care needs. Show actual footage of center based, home based, and relative care and utilize parent narrators in describing personal experiences and decision making processes. Picture DHS personnel processing forms and conducting interviews with parents.

Schedule appointments with parents twenty minutes early to allow time for viewing the videotape prior to talking with a case manager or day care social worker about child care choices. Make brochures available in the waiting room as well.

Take advantage of underutilized wall space in Pathways waiting rooms to create picture displays of a wide variety of child care settings in an effort to inform parents visually and dispel unwarranted fears of day care. Request the volunteer help of child development and/or photography students from the Community College of Rhode Island, the University of Rhode Island, Rhode Island School of Design, Roger Williams College, to produce graphic displays and take photographs. Make brochures available in the waiting rooms.

Seek donations from corporate sponsors.

- Create "One Stop Shopping" with Options for Working Parents.

Arrange to have representatives of Options for Working Parents available at Pathways offices on a regular basis to assist parents with child care choices.

Conduct periodically scheduled workshops on choosing child care at Pathways offices and other convenient locations. Invite Pathways

participants to assist in informing others about child care choices and to discuss their satisfaction with their particular care arrangements. Invite relative, center and family based caregivers to discuss the benefits and drawbacks from their respective points of view.

Recommendation #3: Continue to Take Steps to Improve the Quality of the Regulated System

While continued efforts to improve the quality of the regulated system will most directly benefit those children and families utilizing licensed centers and certified homes, these efforts will also supply indirect benefits to in-home and relative care providers as well. A surprising forty-five percent of all the in-home and relative care providers with whom we spoke have considered becoming certified family day care home providers. In addition, strengthening families is an important goal of high quality early care and education programs. As such, early care and education programs may also benefit from the incorporation of aspects of healthy family support systems into future program designs.

- Encourage Options for Working Parents and Rhode Island Department for Children, Youth and Families to develop training and technical assistance materials regarding the certification of family day care providers and child care center licensing. Technical assistance workshops should be developed and offered periodically in communities throughout the state. Materials should be produced in, at minimum, English and Spanish and workshops conducted in Spanish when appropriate. Unregulated caregivers in the Rhode Island Department of Human Services vendor system should be invited to attend.

- Support the further development of community based family day care home provider networks, administered by community centers, family support and resource centers, and/or center based child care programs. Network staff should demonstrate experience in the provision of child care services, be bilingual as necessary, and have resources sufficient to allow for provider recruitment. Supply funds/resources that assist potential providers in overcoming simple barriers to becoming certified (e.g. smoke

detectors, installation of boiler switches). Relative and in-home care providers should be notified about networks that are in their community. Support the development of a network of Hispanic providers.

- Examine ways of increasing the availability of transportation to and from child care, particularly for low income families. Consider transportation models in place for elderly day care including pooled transportation (may be impractical for infants) to day care centers, family day care homes, and relative care providers and develop resources for assisting programs in the actual purchase of vehicles.

- Earmark further increases in the rate of reimbursement to improving caregiver wage scales and benefits as part of an effort to reduce the turnover rates that have significant negative impacts on program quality.

- Urge child advocacy organizations to continue to assist parents in becoming informed and outspoken advocates for quality child care services. Parents and children are the prime beneficiaries of improved program stability and quality. However, low income and AFDC parents bear a particularly heavy burden, may be more likely to take what they can get and thus find it difficult to advocate on behalf of better services both directly at their child's program and within the public arena. Head Start's survival, even during tough economic times, is due in large part to the advocacy of its strong, vocal, and well organized parent organization.

- Provide funds to enable the Rhode Island Early Childhood Training and Resource Center to become a reality. This and other recommendations listed below will undoubtedly require the skills of a training program coordinator. Utilize the Center's survey of staff training needs to target training and resources to early care and education program staff. Training and resources should be developed that:

1. Increase knowledge/sensitivity to the particular stresses faced by low income and single parent families;

2. Support interdisciplinary collaboration;

3. Support collaborative efforts between and among early care and education program types and support systems; and

4. Increase sensitivity to ethnic, racial, and cultural diversity.

- Encourage the Permanent Commission on Child Care to resubmit its higher education loan deferment bill to the General Assembly in its upcoming session.

- Encourage center accreditation available through the National Academy of Early Childhood Programs. Seek funds that allow both non-profit and independent child care programs serving low income children to seek the accreditation and enable them to carry out quality improvements essential to successfully completing the process. Seek to match public dollars with contributions from the private sector.

- Expand and develop alternative models for Child Development Associate (CDA) Training. Explore means to enable the existing competency-based CDA training program at the Community College of Rhode Island, that largely serves Head Start staff, to include representation from family day care providers and center-based infant-toddler and preschool program staff. Develop alternative models for CDA training and investigate the availability of funding through the Job Training Partnership Act, Workforce 2000, and other such work/employment programs.

Recommendation #4: Develop Resources for Relative Care Providers based on a Family Resource and Support Model

Relative and in-home care providers are not a natural extension of the family day As such, efforts to regulate and train may serve only to move them into the market system where their real needs are less likely to be met and their strengths may go unnoticed. As family resource and support programs continue to grow and expand over the next decade, it will become important to define "family" broadly enough to

include relative caregivers. One task will be to envision and subsequently develop a family support system in which it is possible to move toward a goal where no care provider operates in total isolation, but receives the community support and resources necessary for successful child rearing. Ultimately, we may test and even sacrifice family strengths if we make no effort to assist when help is needed.

- Seek funding to develop models of intergenerational family resource and support programs that meet the needs of multiple generations and are based on family resource and support principles. Use the relative care connection as a means of making contact with families.

- Invite participants from variety of disciplines and service programs types to present/participate in an annual family resource and support conference aimed at developing collaborative efforts and addressing ways to maximize the intergenerational strengths of families while meeting the individual needs of children, parents and grandparents. Include DHS case managers and social workers along with professionals from various disciplines in the planning process. Conferees could be encouraged to display materials and provide information to others about the kinds of services they supply. Ample opportunity should be planned for one-on-one dialogue.

- Invite in-home and relative care providers to locally based "get togethers" with a facilitator who assists attendees in developing an agenda for future meetings. Design the program with the goal in mind that leadership will emerge from among the participants and supply resources and support as necessary to sustain the group.

- Encourage interested in-home and relative care providers to become certified family day care home providers. Link unregulated providers with family day care home providers or networks in their area and supply technical assistance and resources as necessary.

- If the department already plans and conducts family support activities for Pathways participants , also invite relative care providers to participate.

Recommendation #5: Improve basic protections and define standards of care rather than license or certify relative care providers.

- Provide greater protection from potential abuse or neglect. Continue to require CANTS and criminal records checks of relative care providers and add the requirement of fingerprinting for in-home providers. Family communication systems coupled with criminal record checks offer reasonable evidence and minimize the risk that a relative care provider has an out of state history of child abuse. In-home providers, however, do not always enter the relationship with families as friends over time. As such, extending the requirement of fingerprinting to include these providers offers better protection than checks alone. Research team members felt that the requirement was unlikely to be met with any resistance from in-home providers. One provider offered fingerprinting as a suggestion for improving the system. She had been fingerprinted for other jobs and felt that "children are vulnerable . . . the BCI check (alone) is nothing." She did point out, however, that Providence police charge $14.00 for fingerprinting and that travel to the state police barracks in Scituate (where fingerprinting is done at no cost to providers) was difficult to arrange for city dwellers with no car.

- Include basic health provisions as a standard for providing care. Require proof of immunization for the provision of child care by in-home and relative care providers. Given the statistics on the low rates of immunization for children under the age of two in Rhode Island, the need exists for an intensified effort to both locate unvaccinated children and to provide free and easily obtainable vaccinations. While the reasons for ensuring that all children are fully immunized are indisputable, a main obstacle in achieving this goal is the difficulty in locating unvaccinated children before they enter the school system. As a consequence, young children are contracting serious infectious diseases, a tragedy that can be avoided by the simple act of immunization. According to figures compiled by the Rhode Island Department of Health, only fifty-three percent of low-income children are fully vaccinated at age two. Since low-income children in regulated early care and education settings are required to show proof of

immunization, it may be safe to assume that it is children in unregulated care who are at greater risk of not being vaccinated This strategy has been implemented in the state of New Mexico, which has a very strong link between its Department of Health and Department of Human Services. Parents must show proof of immunization before care is authorized by the Department.

- Provide parents with information about the Department of Health's new program that periodically provides the opportunity for free vaccinations at local clinics. If immunization is to be required, it is crucial that parents not only be informed as to what this process entails, but also have ample opportunities to comply with the new regulations. Since there is a strong likelihood that many of these children do not have regular access to a doctor or full health insurance coverage, an extended effort must be made to keep the process of immunization as simple and efficient as possible. Having free immunization clinics around the state will help address the issue of access. One possible way to increase awareness of these clinics is to include relevant information with the provider's check. As this method does not ensure that parents will receive the necessary information, details on the immunization process must be conveyed at the point at which the parent applies for child care subsidization.

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APPENDIX A

IN-HOME AND RELATIVE CHILD CARE
VENDOR STUDY REPORTING FORM

COVER SHEET *

VENDOR:
NAME _____

ADDRESS _____

_____

_____

PHONE NUMBER _____

PARENT:
NAME _____

ADDRESS _____

_____

_____

PHONE NUMBER _____

LOCATION OF INTERVIEW:
PROVIDER HOME _____ PARENT HOME _____ OTHER _____

NAME(S) OF INTERVIEWERS _____

DATE OF INTERVIEW _____

TYPE OF CARE (IN-HOME OR RELATIVE) _____

OTHER PERTINENT INFORMATION
(e.g., ease/difficulty of access; level of cooperation; other concerns):

* Confirm all FACE SHEET information at beginning of interview.

INTERVIEW AND RESPONSES

INTRODUCTION

We are doing a study of the In-Home and Relative Child Care Program. No one has studied the program before -- to see how it works, to ask people about its advantages or disadvantages.

You were randomly selected from providers in Rhode Island. We did the sampling ourselves. The state does not know whom we chose, and everything you say will be confidential. Our report to the state will be based on what providers in general have said to us and not about what you said in particular. We appreciate your cooperation in meeting with us.

BACKGROUND

I'd first like to ask you some questions about yourself.

1) How long have you been taking care of children? I mean taking care of children in general, not just as part of this program? (This includes time spent raising their own children).

   Number of years _____
   (If less than one year, put fraction of year).

2) Do you have children of your own?

   Yes _____ No _____

   IF YES: How many? _____

   What are their ages? _____

3) Would you mind if I ask your age? (If they mind or it is uncomfortable to ask, estimate age and put next to (E))

Age of provider _____ or (E) _____

Sex of provider Female _____ Male _____

4) How much formal schooling have you completed?

Completed Grade _____ High School Graduate _____ GED _____

Some college or post-sec. _____ College Graduate _____

Other _____

5) **IF APPLICABLE:** Other than raising your own child(ren), have you had any experience in caring for children?

Yes _____ No _____

IF YES, EXPLAIN: at home, for friends, in daycare center, etc.)

6) Have you ever received any special training in child care or parenting, (such as STEP, special classes or workshops)?

Yes _____ No _____

IF YES, EXPLAIN:

7) What is your relationship to the parent for whom the Dept. of Human Services is providing the funding for childcare?

	Child (a)	Child (b)	Child (c)
Mother	_____	_____	_____
Father	_____	_____	_____
Sister	_____	_____	_____
Aunt	_____	_____	_____
Friend	_____	_____	_____
Spouse/Mate	_____	_____	_____
Child's Father	_____	_____	_____
Other (**EXPLAIN**)	_____	_____	_____

8) How long have you been caring for:

Child (a) _____

Child (b) _____

Child (c) _____

9) Where is the child's parent while you care for the child?

Child (a) _____

Child (b) _____

Child (c) _____

10) What language do you <u>usually</u> speak in your home?

English _____ Spanish _____ Portuguese _____ French _____

Other _____ (Identify) _____

11) What language do you usually use in talking with the child(ren)?

	Child (a)	Child (b)	Child (c)
English	_____	_____	_____
Spanish	_____	_____	_____
Portuguese	_____	_____	_____
French	_____	_____	_____
Other (Identify)	_____	_____	_____

12) What is the native language of the child? (Ask separately for Child (a), Child (b), and Child (c).

	Child (a)	Child (b)	Child (c)
English	_____	_____	_____
Spanish	_____	_____	_____
Portuguese	_____	_____	_____
French	_____	_____	_____
Other (Identify)	_____	_____	_____

13) What is the total number of children that you currently care for under this program?

Number of children _____

How old are the children?

Child (a) _____

Child (b) _____

Child (c) _____

14) How many <u>hours a day</u> are they in your care? (Include the hours that you take care of children with DHS payment and without DHS payment).

	with DHS payment	without DHS payment
Child (a)	_____	_____
Child (b)	_____	_____
Child (c)	_____	_____

15) How many <u>days per week</u> are they in your care? (Include the days per week with DHS payment, and without DHS payment.)

	with DHS payment	without DHS Payment
Child (a)	_____	_____
Child (b)	_____	_____
Child (c)	_____	_____

15a) Would you be able to manage financially if you were not paid for providing child care?

IF NO: a) **Would you do child care without pay and take an additional job?**

b) Would you have to stop providing child care and get other work?

16) Do you think you will continue to provide child care for any of these children after this program (funding availability) is over? Specify for Child (a), (b), (c).

	Child (a)	Child (b)	Child (c)
Yes	_____	_____	_____
No	_____	_____	_____
Don't know	_____	_____	_____

17) Do you care for other children? (This refers to paid or unpaid babysitting).

Yes _____ No _____

IF YES: How old are they?

a. _____ b. _____ c. _____

18) **IF APPLICABLE:** What is the greatest number of children that you ever care for at one time, including DHS-funded children and others (including your own)?

Number of children _____

19) Are other adults likely to be here when you are caring for children?

Yes _____ No _____

IF YES: Who are they?

Do they assist with child care for the child(ren)?

Yes _____ No _____

PARENT AND PROVIDER

20) How often are you, the child, and the parent together? (Ask separately for child (a), child (b), and child (c)

	Child (a)	Child (b)	Child (c)
Most of the time	_____	_____	_____
Some of the time	_____	_____	_____
Rarely	_____	_____	_____
Daily	_____	_____	_____
Other	_____	_____	_____

21) When you are together with the child's parent, do you ever talk about how the child should be raised or how the child should be taken care of? (Ask separately about child (a), child (b) and child (c).

	Child (a)	Child (b)	Child (c)
Yes	_____	_____	_____
No	_____	_____	_____

IF YES: To what extent do you agree (or disagree) about child rearing?

	Child (a)	Child (b)	Child (c)
We:			
Mostly agree	_____	_____	_____
Sometimes agree	_____	_____	_____
Sometimes disagree	_____	_____	_____
Mostly disagree	_____	_____	_____
Other (**EXPLAIN**)	_____	_____	_____

DAILY ACTIVITIES

22) **IF NOT IN-HOME CARE,** how do the child(ren) get here? How do they get home? (Ask separately for child (a), (b), and (c)

	Child (a)	Child (b)	Child (c)
Parent drops off	_____	_____	_____
Parent picks up	_____	_____	_____
Parent brings child on pub. trans.	_____	_____	_____
Provider picks up	_____	_____	_____
Provider drops off	_____	_____	_____
Other (**EXPLAIN**)	_____	_____	_____

23) What meals do you provide for the child(ren), and what do you typically serve for each? (Ask separately for Child (a), Child (b), and Child (c).

	Child (a)	Child (b)	Child (c)
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Supper	_____	_____	_____
Snacks	_____	_____	_____

24) What are the usual things that the children do while they are in your care? **(Check all that apply)**

Do you go on outings with them? _____
Do you play games? _____
Do you watch TV? _____
Do you listen to music? _____
Do you read stories? _____
Do they play outdoors? _____
Do they watch movies on the VCR? _____
Other (**EXPLAIN**) _____

25) What are the most positive aspects of providing child care through this program? (**Check all that apply**)

Having the children with someone they know _____
Not having to take the children out of the home _____
The money _____
Other (**EXPLAIN**) _____

26) What's been hard for you about providing child care?

For Example:

Not enough space _____
Not enough toys or things to do _____
The child cries, acts up, misbehaves __ ___
Other (**EXPLAIN**) _____

IF NOT MENTIONED: There must be times when the child acts up. What do you do when they act up? (**Probe for discipline approach.**)

27) When a problem comes up in taking care of the child, where do you get help or information? (Examples are eating and sleeping habits, health, toilet training, etc.). (**Check all that apply.**)

Friend _____
Neighbor _____
Other family member _____
Doctor _____
Hospital _____
Other (**EXPLAIN**) _____

PARTICIPATION IN THIS PROGRAM

28) How did you find out about the In-Home and Relative Child Care program?

From the parent of a child I am caring for _____

From a Social Worker at the Welfare Office _____

From a Friend who is doing childcare in this program _____

Other (**EXPLAIN**) _____

29) How long have you been providing child care under this program?

Length of time _____

IF APPLICABLE: On average, how long does a parent need you to provide child care?

30) How long do you think you will continue to provide child care through this program?

Indefinitely (as long as needed) _____

A few more months (Estimate the number) _____

I don't know _____

Other (**EXPLAIN**) _____

RESOURCES/SUPPORT

31) Is there any information or assistance that would be helpful to you (or other people) in providing In-Home and Relative Child Care?

Yes _____ No _____

IF YES: What kinds of help would you want? Are there special topics or issues you would like to get help with?

Health _____
Nutrition _____
Discipline _____
Other (**EXPLAIN**) _____

32) If there were meetings or get togethers outside the home to provide programs and assistance for child care providers, would you **BE ABLE** to come?

Yes _____

IF YES: Is this something that you would **BE INTERESTED** in doing?

Where would feel most comfortable going for such meetings?

Church _____
School _____
Welfare Office _____
Neighborhood Community Center _____
Other? (**EXPLAIN**) _____

No _____

IF NO: Why not (e.g., transportation problems, scheduling etc.).

THE STATE PROGRAM

I also have some questions about the experience you have had with the state's program of In-Home and Relative Child Care.

33) Have there been any special problems dealing with the state?

Yes _____ No _____

IF YES: EXPLAIN.

34) Have the staff been helpful (e.g., with paperwork, payments, other)?

Yes _____ Somewhat _____ No _____

EXPLAIN.

35) Are there some things that the state could do better?

Yes _____ No _____

IF YES: EXPLAIN.

36) Have you thought about becoming a Family Day Care Home Provider?

Yes _____ No _____

IF YES: EXPLAIN.

37) Do you have any other comments about the program or about our study?

IN-HOME AND RELATIVE CHILD CARE OBSERVATIONS

CHECK THE FOLLOWING ON THE BASIS OF YOUR OBSERVATIONS:

Safety:

1) Any evidence of

Peeling paint _____
Exposed plugs (no caps in plugs) _____
Open windows on upper floors _____
Dangerous objects within a child's reach _____
Other safety problems? (**EXPLAIN**) _____

2) What is the comfort range

Too hot _____ Too cold _____ Too stuffy _____ Satisfactory _____

3) What is the general cleanliness or tidiness of the setting?

Good _____ Fair _____ Poor _____

Environment:

4) Any evidence of

Books _____ Paper _____ Crayons/Pencils _____

Educational toys _____ Other toys present _____

Child's drawings or other things child has made _____

TV _____ VCR _____ Cable box _____

Outdoor play area _____

Interactions with the Child(ren) Observed

5) What is the general appearance of the child(ren)?

Clean, well-cared-for _____ Unkempt _____
Other (**EXPLAIN**) _____

6) How does the child(ren) appear?

Happy _____ Generally passive _____ Afraid _____
Other (**EXPLAIN**) _____

7) Is the reinforcement to child(ren) generally:

Positive _____
Negative _____
More positive than negative _____
More negative than positive _____

8) If children were disciplined in your presence, how were they disciplined (any physical discipline?)? **EXPLAIN:**

ANY OTHER OBSERVATIONS THAT WERE NOTEWORTHY?

IN-HOME AND RELATIVE CHILD CARE
CLIENT TELEPHONE SURVEY

COVER SHEET *

CLIENT:

Name _____

Telephone Number _____

Children:

Name	Age
_____	____
_____	____
_____	____

Name of Vendor _____

Interviewer Name_____

INTRODUCTION

As you probably know, we are doing a study of the In-Home and Relative Care Program. We have talked to (the vendor) about his/her experiences in providing care through the DHS in-home and relative care program. Now, we would like to ask you a few questions about your experiences with the system. Your answers will be confidential and, if there are any specific questions that you do not want to answer, we will understand that too.

(**Note:** You do not need to read all the probes but try to code respondents' answers in the categories if possible).

---

* All COVER SHEET information comes from the FACE SHEET.

DECISIONMAKING

1. Is this the first time you have used in-home or relative care for your children.

   Yes _____ No _____

   IF NO, EXPLAIN PREVIOUS EXPERIENCE.

2. In the past, have you used other types of childcare?
   Yes_____ No_____

   IF YES: Was it

   Unpaid babysitting_____
   Family daycare home provider_____
   Daycare center_____
   Other_____

   IF YES, What were the positive and negative aspects of the kind of care you used?

   Positive

   Good experience for child_____
   Convenience____
   Cost_____
   Other_____(Specify)

   Negative

   Cost_____
   Inconvenience_____
   Transportation_____
   Feel you're taking advantage of relative_____
   Other_____

3. (**This time**), why did you decide to use in-home or relative care for your child(ren)?

Safety____
Convenience_____
Didn't know other options_____
Other_____

4. (**This time**), did you consider other types of care?

Yes _____ No _____

IF YES, what were they?

Licensed Daycare Home_____
Daycare Center_____
Preschool Center_____
Other _____ (Specify)

5. Where did you first hear about in-home and relative care?

Pathways Program_____
Another client_____
Other_____ (specify)

6. Did you find out about other types of care at the same time?

Yes _____ No _____

IF YES, What other kinds did you find out about?

Licensed Daycare Homes_____
Daycare Centers_____
Preschool Center_____
Other_____

NEED FOR CARE

7. Why do you need childcare currently?

   Going to school_____
   Involved in job training_____
   Working_____
   Other_____ (Specify)

8. How long do you expect to need childcare?

   Length of time _____

9. During the time that you are eligible for childcare under this program, do you think that you will leave your children in in-home or relative care or that you will move your child(ren) into some other kind of care?

   Move _____Stay _____

   IF MOVE, what kind of childcare and why?

10. In addition to the care provided under the in-home and relative care program, do you have other childcare currently?

    Yes _____ No _____

    IF YES, who else takes care of the child(ren)?

SATISFACTION

11. What are the most positive aspects of having this type of childcare for you, for your child(ren)?

For Parent:

good experience for child_____
safety_____
convenience_____
other_____ (Specify)

For Child:

being with someone they know_____
remaining in own home_____
other_____ (Specify)

12. What are the negative aspects of this type of childcare for you, for your child(ren)? (EXPLAIN)

For Parent:

none_____
transportation_____
inconvenience_____
feel you're taking advantage of relative_____
other_____ (Specify)

For Child:

none_____
away from friends_____
not enough toys/activities/play_____
think they're too old to have sitter_____
other (Specify)

IF THE CLIENT USES RELATIVE CARE, does this type of care cause any strain on the family, (such as disagreements over childrearing or discipline)?

Yes _____ No _____

IF YES, EXPLAIN.

RESOURCES/SUPPORT

13. Do you think it would be helpful to offer training in childcare for vendors in the in-home and relative care program?

Yes _____ No _____

IF YES, in what areas or why?

health_____
discipline_____
child rearing_____
nutrition_____
constructive play activities_____
other_____

IF NO, why not?

14. Looking back to the time that you selected the type of childcare you would use, is there any information that would have been helpful that was not available to you?

Yes _____ No _____

IF YES, EXPLAIN.

15. Is there any type of information about childcare options that would be helpful to you now?

Yes _____ No _____ Don't Know_____

IF YES, EXPLAIN.

THE STATE PROGRAM

16. Have there been any special problems dealing with the state?

Yes _____ No _____

IF YES, EXPLAIN.

17. Was the paperwork that you had to do when you began using in-home or relative care difficult to complete?

Yes_____ No_____

IF YES, EXPLAIN.

18. Have the DHS staff been helpful (e.g., with paperwork, other)?

Yes _____ No _____

IF YES, EXPLAIN.

19. Are there some things that the state could do better?

Yes _____ No _____

IF YES, EXPLAIN.

20. Do you have any other comments about the program or our study?

Introduce yourself and the study and explain that one task of the study is to obtain information about in-home and relative care and the system regulating such care in other states. See if the respondent has 20 minutes or so for an interview now or if you need to schedule one. Then ask the following questions. Note: You will be asking for copies of several documents. At the end of the interview, tell the respondent that you will be sending him/her a reminder of which documents he/she is going to send.

LOG INFORMATION

STATE

Name of respondent

Title

Phone

Address

Date of Interview

Reschedule Information or note

General Overview

1. Does your state subsidize any child care provided either by relatives or in the child's home by non-relatives?

   (Note: If the state does not use the terminology "in-home and relative care," make sure that you have a very clear understanding of the population to which the respondent is referring! You may have to modify the questions accordingly.

2. Does your state distinguish between family day care and in-home and relative care?

   How are these two terms defined in your state? (Probe for number of children allowed in each, at what point care must be licensed/registered, etc. Get documents). Is in-home and relative care considered a form of unregulated child care? Are there any other situations in which child care is legally exempt from regulation?

3. How is the term "relative" defined in your state?

   Who is included as a relative? (Get document)

   Has this definition been, or will it be, affected by the Child Care and Development Block Grant or the At-Risk Child Care Program? (Get a definition in writing).

4. Has the Child Care Development Block Grant affected your approach to in-home and relative care in other ways?

   Do you expect to see an increase in the number of parents opting for in-home or relative care?

5. Does your state use a "certificate" system, contracts, or both to purchase in-home and relative care?

   Who receives the reimbursement--the parent or the vendor?

   How are these terms (contract, certificate, voucher) defined in your state? (Get a verbal definition and also ask for a copy of whatever document has the definition writing. Find out what the document is called for your reminder card).

General Overview (Continued)

6. Under what state department is the responsibility for administering and monitoring in-home and relative care?

   Are there any other departments that are involved in this type of child care? (Probe for monitoring, administering, handling of funds, policy decisions, etc.).

   Is major responsibility at the state, county, or local level?

7. About how many children in the state are in subsidized child care?

   Of these, about how many are in-home and relative care? (These can be gross numbers as of any date the respondent specifies).

   (**Note**: If the respondent does not know this information, find out whether the state documents these statistics at all).

8. About how many total vendors are there?

   How many in-home and relative care vendors?

9. Is it possible for you to provide a breakdown of funding sources used for in-home and relative care?

   For example, about what percent of children in in-home and relative care are funded by:

   Federal sources:

   Title IVA Child Care for JOBS
   Title IVA Transitional Child Care
   Title IVA At-Risk Child Care
   Child Care and Development Block Grant
   Title XX Social Services Grant
   Other (specify):

   State sources: (**Note**: These will differ from state to state.)

Reimbursement Issues

10. What are the reimbursement rates for in-home and relative care?

    Infant
    Toddlers
    Preschoolers
    School-agers
    Special needs
    Other

11. How does this rate compare with:

    Day Care Centers?
    Family day care homes?

    (Obtain a copy of the document that contains rates and qualifications for rates).

12. Is implementation of the Child Care and Development Block Grant or At-Risk Child Care Program expected to affect these rates?

    What forms do vendors complete to obtain payment? (Ask for a copy of the form(s)).

    Are there any procedures within the agency/department to verify information on the application form by relatives and in-home vendors?

    How well do they work?

Monitoring System

14. What are the qualifications for in-home and relative care vendors?

    Are there any checks done, for example, on their criminal record when they enter the system?

    (Ask for a copy of the application completed by clients and/or vendors to enter the system).

15. What monitoring is done by the state (or county) of:

    Health and safety standards?
    Honesty in claiming reimbursements?
    Other monitoring?

    (Probe for any monitoring forms or documents and ask for a copy).

    Do you have any recommendations about monitoring this type of care?

    Have your requirements for relatives and in-home vendors changed in the last few years? **(If so, how? For what reason?).**

    Do you expect any changes in the near future?
    (**Note**: The respondent may have already answered this in response to #3 and #4 so probe for other reasons for change).

16. Do vendors participate in any child nutrition program?

    If so, how does this work?

17. Has any effort been made to train, inform, or educate vendors who provide in-home and relative care about child development guidance or any other topics?

    (Probe for any pilot or small scale project, or materials that have been developed and get the name of a contact person and/or any documentation that is available. Whenever possible, find out the names of the materials for your reminder card. If commercially prepared materials are used, find out the names of the chief resources used).

Monitoring System (Continued)

18. If you were designing information/education materials or programs for in-home and relative care providers, what do you think the key topics should be?

    Why?

19. What do you think is the strongest element of the system in your state?

    (We are interested in documenting a few "best practices" for inclusion in the report).

20. What do you see as the major problems with in-home and relative care in your state?

    (Probe for problems with regulations, reimbursement, monitoring practices, other).

21. What roles do computers fill in you overall system?

    No role, we are not computerized.

    Administrative (vendor registration, reimbursement, statistical reporting, etc.)

    Monitoring (quality control, screening vendors, compliance issues, etc.)

    Management, policy, and planning.

    How would you characterize the use of computers in your department, in terms of usefulness to your department?, to others in the state?, or others?

22. Who would be the best person from whom we could get more detailed computer system information?

23. In addition to (whatever names the respondent has provided), is there any one else that we should talk to get a complete picture of in-home and relative care in your state?

    (Find out why the respondent thinks this person is important).

APPENDIX B

RESOURCE LIST

Ablex Publishing Corporation
355 Chestnut Street
Norwood, N.J. 07648

Publishes the Early Childhood Research Quarterly sponsored by the National Association for the Education of Young Children in cooperation with the ERIC Clearinghouse on Elementary and Early Childhood Education. Many other publications (see bibliography).

American Academy of Pediatrics
Division of Publications
141 Northwest Point Blvd
PO Box 927
Elk Grove Village, Il 60009-0927
(800) 433-9016
FAX (708) 228-1281

Professional publications, life support programs, audiovisual material, educational programs, journals, research and more. Titles include "Day Care: Finding the Best Child Care for Your Family" (pamphlet), Health in Day Care: A Manual for Health Professionals (book), and Kid Safe (videotape). The Academy was also responsible, in conjunction with the American Public Health Association, for developing a set of national health and safety standards for child care.

The Center for Career Development in Early Care and Education
Wheelock College
200 The Riverway
Boston, MA 02215
(617) 734-5200
FAX (617) 566-7363

Funded by the Carnegie Corporation, the Rockefeller Brothers Fund and the Ford Foundation. Gwen Morgan is the Center's Project Director. The initial project will be a "State of the States" report, the first national study of training and career development in early care and education. Information currently available includes "Project Spotlights" describing innovative training projects and outreach programs and brief reports of progress to date.

Child Care plus +
Educational Home Model Outreach Project
Rural Institute
52 N. Corbin Hall
University of Montana
Missoula, MT 59812

Publishes a newsletter focused on integration of special needs children in child care settings.

Children's Defense Fund
122 C Street, N.W.
Washington, D.C. 20001
(202) 628-8787
FAX (202) 783-7324

Publishes monthly newsletter and annual reports on the status of a broad range of state and federal initiatives affecting children and families. Technical assistance available from CDF staffers. Many other publications (see bibliography).

City of Boulder
Children's Services Division
Department of Housing and Human Services
Boulder, CO 80306
(303) 441-3180

Children's Services provides information, resources and referral, training, etc. Services are developed for parents, child care professionals, employers, agencies, and organizations. Publishes a clever brochure titled "The Best Thing Since Sliced Bread" to interest unregulated providers in the Child Care Food Program.

Council on Interracial Books for Children
1841 Broadway
New York, N.Y. 10023
(212) 757-5339

Catalog for resources to counter racism, sexism and other forms of bias in school and society. A listing of filmstrips, lesson plans, curricula, books, pamphlets and The Bulletin, which regularly reviews children's books, texts and other materials. Works to assist parents, teachers, librarians, community leaders and others in providing a bias-free environment for all children.

Department of Health and Rehabilitative Services
Alachua County Coordinated Child Care
Alachua County, Florida

Send for the Family Day Care Home Enhancement Project material, an early intervention program whose primary goal is a comprehensive language stimulation model aimed at the period of most rapid growth (0-3).

Family Resource Coalition
200 S. Michigan Avenue
Suite 1520
Chicago, IL 60604
(312) 341-0900
FAX (312) 341-9361

The Coalition represents some 2500 community-based family resource programs and thousands of people who work with programs and parents throughout the United States and Canada. The Coalition represents it's constituency on a national level, building awareness about family

resource programs and advocating for policies that will build program resources at the community level. They are the national focal point for information about family resource programs and each year the Coalition undertakes training and consulting projects for a variety of clients. Various publication titles include the basics of building family supportive programs, special resources which focus on parents and special reports on the latest information available in the family resource field.

First Steps-Parents As Teachers
121 N. 5th
Canon City, CO 81212
(303) 269-1523

First Steps offers a program of support and information for parents going through the many changes in the first three years of their child's life. Support is offered in group meetings, play groups, work shops, a newsletter and a telephone service "Warm Line". Although First Steps is based in Colorado it follows the nationally recognized Parents As Teachers program based in St. Louis, Missouri.

Ford Foundation
Office of Communications
320 East 43rd Street
New York, New York 10017

Send for complete list of publications, generally available at no cost. The foundation has funded a series of occasional papers through it's "Project on Social Welfare and the American Future" (e.g. David Weikart's Quality Preschool Programs: A Long Term Social Investment).

Greater Minneapolis's Day Care Association
1628 Elliot Avenue South
Minneapolis, MN 55404
(612) 341-1177

Video - Best For My Baby: Low-Income Parents and the Struggle to do the Right Thing. What is "best" and "how can I give it" is the subject of this 30 minute video. In the words and stories of low-income Black, White, Hispanic and Indian parents, the best care, guidance, and learning experiences are explored for children under age three.

The High/Scope Press
600 North River Street
Ypsilanti, Michigan 48198-2898
(313) 485-2000
FAX (313) 485-0704

Catolog of various materials on preschool curriculum, preschool programs and day care, movement & dance, public policy and research and material for and about parents. High Scope publishes research reports and materials related to the Perry Preschool Program.

Johnson & Johnson
Consumer Products, Inc.
P.O. Box 71687
(800) 526-3967

Aids for health and early education and care specialists in monitoring the latest scientific advances in pediatrics. Their publications include *The Pediatric Round Table Series*, consisting of fourteen publications which offers a full spectrum of current research data with titles that include "Group Care For Young Children" and "Child Health Care Communications". Other publications include entertaining videos that foster parent-child relationships, booklets, posters, and pamphlets.

Jossey-Bass Inc., Publishers
350 Sansome Street
San Francisco, CA 94104

Series of sourcebooks published four times a year which provide up-to-date information on the newest topics in developmental psychology. Each volume serves as an introduction to the issues, methods, and finding of its research field." Titles include Child Care and Maternal Employment: A Social Ecology Approach and Economic Stress: Effects on Family Life and Child Development.

Kiwanis International Headquarters
3636 Woodview Terrace
Indianapolis, Indiana 46268
(317) 875-8755

Kiwanis International has made a three-year commitment to develop projects that address the needs of children, prenatal through age five. The service program is called Young Children: Priority One. Contact the Kiwanis District Chairman of Rhode Island.

National Association for the Education of Young Children
1834 Connecticut Avenue, N.W.
Washington, D.C. 20009-5786
(800) 424-2460
(202) 232-8777
FAX (202) 328-1846

Early childhood resource catalog containing extensive listings of various books, posters, kits, brochures and videos. Titles include books and information on accreditation criteria, procedures and guides, activities for school-age children, curriculum guides for preschool/kindergarten and young children, nutrition education and food preparation, what is developmentally appropriate in programs, discipline, the early childhood profession, and information for parents about their children. Other titles include information about infants and toddlers, language arts, multicultural education, the physical environment, play, programs and schools, building quality child care, compensation and affordability, teachers and about caregivers. Early childhood resource catalog listing various books, posters, kits, brochures and videos.

National Association for Regulatory Administration
c/o Ms. Grace B. Nied, Treasurer
4159 Steck #108
Austin, TX 78759

A national professional association dedicated to the protection of the health, safety and well-being of children and vulnerable adults in day or residential human care facilities through licensing and other forms of regulation. Publishes a newsletter and position statements on child care licensing.

National Black Child Development Institute
1463 Rhode Island Avenue, N.W.
Washington, D.C. 20005
(202) 387-1281

NBCDI was founded in 1970 and is dedicated to improving the quality of life for Black children and families. NBCDI focuses primarily on issues and services that fall within four major areas: health, child welfare, education, and child care/early childhood education. Publications include books, reports, posters, resource guides and much more.

National Commission on Children
1111 Eighteenth Street, NW, Suite 810
Washington, D.C. 20036

Send for the Commission's final report, "Beyond Rhetoric". Established by Public Law 100-203, the commission's purpose is "to serve as a forum on behalf of the children of the nation".

National Committee for Prevention of Child Abuse
332- S. Michigan Ave., Suite 1600
Chicago, IL 60604-4357
(313) 663-3520

NCPCA catalog includes listings of material for child abuse prevention, information for children and for parents, special subjects, i.e., child abuse and the law, child care and the family, etc., public awareness materials and Spanish translations of listed materials.

National League of Cities Institute
1301 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-1763

The products, activities, and services of the National League of Cities (NLC) are designed to help mayors, council members, and other municipal officials take action on behalf of at-risk children and their families. NCL serves as an advocate for its members in Washington, they offer training, technical assistance and information to municipalities to help them improve the quality of local government and they undertake research and analysis on topics and issues of importance to the nation's cities and towns.

National Safe Kids Campaign
111 Michigan Avenue, NW
Washington, DC 20010-2970
(202) 939-4993

The National Safe Kids Campaign is a nationwide, comprehensive childhood injury prevention campaign. Materials are offered to help increase awareness of the seriousness of childhood injury and they provide programs that can be implemented in any community to create a safer environment for children.

National Women's Law Center
1616 P Street, NW Suite 100
Washington, D.C. 20036

Contact re: Child Care Tax Credits Outreach Campaign. Publishes resources to assist individuals and organizations in understanding the provisions of child care tax credits and various pieces of federal child care legislation.

Parent Action
P.O. Box 1719
Washington, D.C. 20013
(202) 835-2016

Parent Action is a national membership organization dedicated to speaking out for what parents need to do their job. Advocacy, collaboration and production of publications intended to mobilize parents to work together.

Pro Ed
8700 Shoal Creek Boulevard
Austin, Texas 78758-6897

Send for their catolog which lists tests, materials, books and journals on reading, speech and language, learning disabilities, special and remedial education, early childhood and rehabilitation. Journal titles include *Intervention in School and Clinic, The Journal of Special Education, Topics in Early Childhood Special Education* and many more.

The Program for Infant Toddler Caregivers
California Department of Education
Bureau of Publications, Sales Unit
P. O. Box 271
Sacramento, CA 95802-0271
(916) 323-1342

Training modules include Social Emotion Growth and Socialization, Group Care, Learning and Development, Culture, Family and Providers. Other resource materials available as well.

The Rockefeller Foundation
Equal Opportunity Program
1133 Avenue of the Americas
New York, New York 10036

The Into the Working World series provides reports on Rockefeller Foundation projects undertaken to identify practical routes to move families out of poverty and toward full participation in American life. Summary reports, technical papers and videotapes available.

Rutgers University
New Jersey Network for Family Life Education
Center for Community Education
School of Social Work
Building 4087 Kilmer Campus
New Brunswick, New Jersey 08903
(908) 932-7929

A non-profit agency which distributes free copies of the newsletter, Family Life Matters, giving readers clear, accurate and balanced information concerning health issues, adolescent sexuality, etc.

Superintendent of Documents
Government Printing Office
Washington, D.C. 20402

Various documents, pamphlets, publications, and reports. Publishers of Children Today a prize-winning magazine published bi-monthly by the Office of Human Development Services, U.S. Department of Health and Human Services. It is written by and for those whose daily jobs and interests are focused on children, youth and families.

Teachers College Press
Teachers College, Columbia University
New York, N.Y. 10027
(800) 445-6638
FAX (802) 878-1102

Publishes early childhood materials related to curriculum/ teaching, play, child development, multicultural education, child care/ supervision and parenting, policy and history, assessment instruments, etc.

U.S. Department of Education
Office of Educational Research and Improvement
Washington, D.C. 20208-5570
(800) 424-1616
FAX (202) 275-0019

Office of Education Research and Improvement (OERI) offers new information, publications, data sets and important events in a OERI Bulletin.