

A COMPARISON OF TWO TRAINING MODELS
FOR THE ENHANCEMENT OF QUALITY OF CARE
FOR FAMILY CHILD CARE PROVIDERS

by

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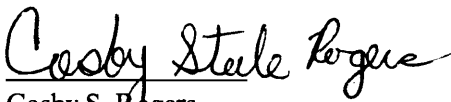
Family and Child Development

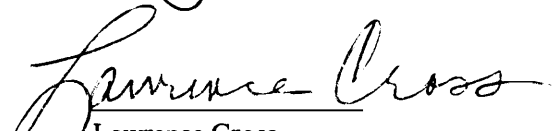
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A COMPARISON OF TWO TRAINING MODELS
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(ABSTRACT)

Thirty-six family child care providers were divided into matched pairs, then randomly assigned to two treatment groups; catalyst and self-study. The purpose was to investigate how training affects quality of child care and to determine what provider characteristics interact with self-paced learning methods to change quality of care.

The Family Day Care Rating Scale (Harms & Clifford, 1989) was used to rate quality of care. Three pretest and three posttest ratings were collected for each provider before and after a three-month treatment period. Ratings were collected from trained validators, from the providers as a self-rating, and from parents with children in care. An additional score was collected from providers regarding their perception of training method using a ten-item rating scale.

There was a 38% attrition rate in the original sample resulting in a final sample size

of 22. Results from this study suggest that at least two key criteria affect quality of care in family child care; (a) provider training in child-related areas and, (b) provider affiliation with family day care organizations. Providers not previously affiliated with a family day care association had a greater initial margin for improving their quality ($F=9.21$ $p<.007$) than affiliated providers.

All providers improved their quality of care scores during the three month period. When asked to evaluate the training, all providers perceived their assigned training method as flexible and convenient. Providers in the catalyst training group rated two items significantly higher than self-study; the value of new information ($F=11.30$ $p<.003$), and the degree of personal growth experienced ($F=9.28$, $p<.007$).

Parents differed from both validators and providers in their evaluation of the provider's child care environment. This suggests that parents are not fully aware of either the components of quality child care or the daily operations in the home of their own family child care provider.

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CHAPTER ONE

Introduction

The provision of child day care has become an important issue across the nation, primarily because of changes in the American society centering on the entry of increasing numbers of women into the workforce. More than 70% of women age 25-34 are in the labor force compared to 35% in 1950. The "traditional" American family with father working and mother at home caring for the children now makes up fewer than ten percent of all American families (U.S Dept. of Labor, 1988). With more women in the workforce, fewer family members are available to care for children.

Accompanying the expanding number of working parents is an increased need for quality child care. Child day care may be obtained in a variety of forms. Licensed, unlicensed and certified family child care homes, licensed and unlicensed church centers, private and public preschools, and military regulated operations are all among the options. Ten million children nationally are cared for outside the home and most are in unlicensed family child care (Nika, 1989).

Within all of the day care delivery types are employed persons ranging in educational qualifications from no training in child development or early childhood education to caregivers with post secondary educational experiences. The expanding

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need for high quality child care has led educators to examine training needs of child care practitioners.

There is evidence that provider training is a major component of quality in child care environments (Bredekamp, 1987). Current child care and education literature contains a recognition that training seems to help providers help children grow and learn and to support good relations with families (Modigliani, 1991). To be effective, caregivers should understand the needs and interests of children and prepare the environment to enable the child to explore and learn through discovery (Modigliani, Reiff & Jones, 1987).

For many reasons, the responsiveness of child care providers to training has been unpredictable and erratic. To plan programs that will encourage providers to seek training, an understanding of the educational and training components is required. Training components include both **what** the providers are taught and **how** they are taught.

This researcher investigated two training methods designed for family child care providers. The quality of provider care environments will provide the central focus of the review and research which follows.

CHAPTER TWO

Review of Literature

Mothers are entering the labor force in record numbers with reports of more than 70% of women aged 25-34 working. Nationally, there are nearly two million children under the age of four spending their days in a day care facility and about 10 million U.S. children being cared for by a family child care provider. Good child care programs are a must for the near future as more mothers enter the workforce (Nika, 1989). Family child care providers offer a home environment for a small group of children. This care is given in the provider's home. The caregiver may be either trained or untrained in child care and development. Some are licensed. Some are not.

Harms and Clifford (1989) found that when parents of children under three need child care outside their homes, they are more likely to choose the care of a family child care provider as opposed to care in a center. The United States Department of Labor (1988) reports that the choice of most parents when selecting child care is that of family child care.

In the United States, it is estimated that 94% of the family child care providers are

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operating without a license (Nika, 1989) and are often referred to as an "underground" network. They operate in fear of regulation and seem to avoid contacts where they may have to reveal their professional identity to either regulatory or taxation agencies. For these and other reasons, publicly offered training sessions for child care providers may be considered undesirable or not needed by family child care providers.

A Virginia legislative report (Virginia Senate Document # 3, 1990) printed as a result of a Joint Legislative Audit and Review Commission (JLARC) study on the regulation and provision of child day care in Virginia, concluded that "provider training can improve the quality of child care by helping ensure **the safety** of children in care. Training opportunities, especially for unregulated (unlicensed) family day care providers could be greatly expanded (pp 128)."

Through the JLARC review, it was estimated that there are 337,000 children under 13 years of age in some type of care in Virginia. Of these, 80% of Virginia's children are in unregulated care, mostly in family child care homes. Of the remaining 20% of children in state regulated care, 44% are cared for in family child care homes. According to the report, Virginia currently has no means of regulating family child care homes which care for less than six unrelated children (Virginia Senate Document #3,

1990).

Specific provider training and education in early childhood development are often used as indicators of caregiver competence and ultimately quality of care. These variables, along with professional affiliation are reviewed as part of this research. Two treatments, a self-study training program and a catalyst training program, were used with family child care providers. The quality of the provider's environment was assessed by parents, validators and providers themselves using the Family Day Care Rating Scale.

Quality

Definitions of quality of child care commonly include descriptions of the provider, the environment, the curriculum and the relationship between parent and provider. The National Association for the Education for Young Children (NAEYC) has described characteristics of quality child care. Practitioners find it the most applicable to date. The major components in assuring quality care are; (a) the teacher/caregiver is trained in an area specifically related to child development/ early childhood education; (b) the group size is limited and sufficient numbers of adults are provided for individualized

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and age appropriate care and education for children in the program; (c) the continuity and stability of teachers is assured, particularly for the very young child and; (d) there is a strong relationship maintained between parents and teachers (Caldwell, 1983).

According to the NAEYC, the quality of caregivers is the "most important determinant of the quality of an early childhood program" (Bredekamp, 1987). Understanding the developmental needs of children enables the caregiver to prepare an environment which enables children to discover and learn through exploration.

The goal in evaluating the quality of child care, as stated by Harms and Clifford (1989), is to foster total development rather than provide custodial care. The provider is expected to provide a safe, supportive, stimulating environment for a group of children with varying needs and to communicate with parents about their child's growth and development.

An instrument called the Family Day Care Rating Scale (Harms & Clifford, 1989) measures quality in family child care homes. The scale provides a comprehensive evaluation for family child care. The items in this scale are based on and draw from the theoretical base of the 13 Child Development Association competency areas. The Family Day Care Rating Scale is composed of 32 items covering six categories: Space

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and Furnishings, Basic Care, Language and Reasoning, Learning Activities, Social Development, and Adult Needs. Jones and Meisels (1987) documented improvements in family child care home environments as a result of training using the Family Day Care Rating Scale (FDCRS).

Cited among the components in most definitions of quality are the characteristics of the provider and provider training. Training has been noted to make a difference in child care practice (Tittnich, 1986; Snow & Creech, 1986; Vander Ven, 1986) and seems to undergird all definitions of quality which time and again indicate that child care provider training is related to quality child care (Modigliani, Reiff, & Jones, 1987).

Other Variables Which Affect Quality

The link between caregiver training, education, years of experience and quality of care has been investigated. The findings are mixed.

Experience.

Caregivers with more years of experience have been found to engage in less social interaction and cognitive stimulation with infants and toddlers (Roupp, Travers, Glantz, & Coelen, 1979). Conversely, Howes (1983) found that experienced caregivers

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were more responsive to children's bids for attention and less likely to express negative affect and restrict toddler activity.

Phillips (1987) and Howes (1983) noted a need to closely examine the relationship between experience and competence of the caregiver. Experience with children and experience working with other child care practitioners who have been trained in appropriate practices play an important role in developing provider capabilities. Providers in one study indicated that "liking children" and "experience with own and other children" are considered more important than academic or special training in child development leading the researcher to conclude that informal learning experiences in the home may be more valuable than structured classes (Atkinson, 1990).

Education.

The National Day Care Study (Roupp et al., 1979), indicated that child-related education as opposed to total years of education contributes to quality child care. Some studies have shown that caregivers with specialized training in child development use more appropriate interactions with preschool children (Howes, 1983; McCartney, Scarr, Phillips, Grajeck, & Schwartz, 1982; Snider & Fu, 1990; Vandell & Powers, 1983).

Due to these mixed findings and to lend additional insight into family child care

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providers' quality of care, experience in family child care, and specialized training in child-related areas were controlled as potential important variables in this study.

Professional affiliation.

Individuals involved in professional occupations are expected to achieve some level of specialized training. The dictionary definition of a profession is an occupation or vocation requiring advanced study or advanced training in a specialized field (Morris, 1975). Consequently linking specialized education to professional development is a logical connection. Professionalization of family child care was virtually nonexistent ten years ago, however, the benefits can be realized by children and parents alike. Additionally, professionalism enables providers to find ongoing training, support, and it aids the provider in viewing family child care as a career choice, which promises stability and continuity for children (LaFarge, 1990).

Both The National Academy of Early Childhood Programs Accreditation criteria and the Harms/Clifford Family Day Care Rating Scale assess regular provider participation in continuing education programs and personal affiliation. Both criteria are cited as improving skills in working with young children.

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In many communities, providers are starting to exhibit behaviors considered to be a move towards a more respected and professional image. In defining professionalism, Spodek, Saracho, and Peters (1988) offer these definitions. A professional is a person operating with a "high degree of skill and competence... and a high degree of training (pp. 6-7)." For the early childhood profession, Spodek et al. (1988) suggested a model of craftsmanship. Although a craft is defined as a skill or ability (Morris, 1975), they indicate that craftsmanship is an "individual, expressive, practical and idiosyncratic process best taught through modeling, rather than through academics" (Saracho, Spodek, & Peters, 1988, pp. 7). Organized professional associations offer opportunities for professional modeling.

Katz (1988) listed eight criteria for an occupation to be classified as a profession. These include prolonged training in a specialized area, a required cognitive focus, knowledge mastery, completion at an accredited institution, a common core of knowledge, and a continuing education program. Family child care providers are increasingly becoming concerned about their professional image and are seeking the support of professional associations to find continuing education and training opportunities.

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Gass and Smith (1989) indicated that members in family day care associations may characteristically operate differently and be more motivated towards training and professional behaviors than providers not affiliated with professional organizations. Providers' comments suggested that training raises their expectations of being treated as professionals and on an equal basis with parents. Further, providers who are members in family day care associations are more likely to engage in forms of professional behavior such as having written agreements with parents, taking vacations, charging parents who picked up children late, and listing with a resource and referral service.

Since professionalism is linked through the expected educational attainment in the given specialized field; and child-related education in turn relates to quality of care, professional affiliation was chosen as a variable for this study.

Parental Involvement.

Another essential component in quality child care programs is parent involvement. The National Association for the Education of Young Children (NAEYC) emphasizes the importance of involving parents with a rationale statement which reads, "Young children are integrally connected to their families. Programs cannot adequately meet

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the needs of children unless they recognize the importance of the child's family and develop strategies to work effectively with families" (Bredekamp, 1984. pp. 15).

The National Academy of Early Childhood Programs includes the need for healthy staff-parent interaction since parents are the principle influence in children's lives. Aspects of communication, orientation, visitation, progress conferences and information/sharing systems are included in the accrediting process which recognizes early childhood program quality.

The selection of child care and the promotion of quality child care is the responsibility of parents. However, the JLARC review (Virginia Senate Document #3, 1990) emphasized that there is a need to educate parents regarding those factors which constitute quality care. Parents surveyed by Atkinson (1990) stated that they selected family child care because they wanted personal relationships in a small group and family atmosphere. The quality of child care and qualifications of the provider were also considered important. However, parents believed that "liking children" and "experience with own and other children" were considered more important than academic or special training in child development.

Parent involvement is an essential factor in quality child care programs. To review

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the effects that continuing education and training have on a parent's evaluation of child care quality, parental assessments of their family child care provider's quality is also included as a control variable along with experience, affiliation, and training in child care and development.

Training

Increasingly the need for well trained caregivers has become the focus of public concern for quality child care. In the National Day Care Study, along with group size, specialized caregiver training emerged as the most formidable predictor of positive classroom dynamics and child outcomes. In that same study, Roupp, Travers, Glantz, and Coelen (1979, p.3) reported that "caregivers with education/training relevant to young children deliver better care with somewhat superior effects for children." Training individuals in the developmental needs of young children is essential for the provision of quality child care environments. The results of the National Day Care Study indicated that providers' overall years of education are positively related to the amount of social interaction and cognitive/language stimulation in toddler groups and to lower ratings of child apathy and potential danger in infant groups.

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Because family child care providers are typically self-employed, there currently are no required qualifications, except those which parents individually may seek. Ritter and Welch (1988) described the family child care provider as an "unknown clientele unreachable through traditional programs and somewhat unmotivated to seek further education." Many caregivers respond to opportunities for training with negative interest saying training is not necessary since they have been mothers and grandmothers. Katz (1988) points out that mothering and child care caregiving require different skills; for example, mothers' interactions with children are more emotional than teachers'. Caregivers trained in child development are more likely to plan care based on developmental expectations of appropriate behaviors. Training helps child care personnel justify and explain the choice of activities to parents. Trained caregivers are more likely to be aware of the issues involved in fostering secure attachment relationships in the children in their care.

A feasibility study for the Virginia Department of Social Services noted that a statewide training curriculum would achieve consistent caregiving techniques, raise provider competence and ability, increase opportunity for quality care, and enhance providers' self-esteem (Virginia Senate Document 17, 1989). According to the Joint

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Legislative Audit and Review Commission study (Virginia Senate Document #3, 1990), many providers in Virginia have been trained in first aid or cardiopulmonary resuscitation (CPR) and many providers in their sample had some child-related training either in high school, college, or through a workshop sponsored by a private or governmental agency.

Research indicates that training makes a difference in the amount and quality of interaction of caregivers and children. For family child care providers, the issue is one of determining how to best help providers by presenting child development information using a teaching method to meet their needs.

Adult Learning Processes

Before planning or implementing a training program, one should become familiar with teaching and learning processes. In assessing the most appropriate method to teach child care information to adult audiences, an overview of learning processes assists in determining how to present the information in such a way that it will be stimulating, personally motivating, and provide a basis for skill building to enhance quality child care.

Modigliani (1991) infers that adults go through developmental learning stages which

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include awareness, exploration, inquiry and utilization. Research evidence on learning styles suggests there is a considerable range of learning style preferences and that adults do not all learn in the same way. Multiple factors interact with teaching and learning and present some limitations to planning research to measure improved performance (Apps, 1988).

Thies-Sprinthall and Sprinthall (1987) in a review of adult training research, comparing types of training, noted that adults remain largely unchanged following most conventional educational experiences. In-service education may result in the acquisition of a few skills, but nothing that would support significant long-term growth. Similarly, short term workshops and retreats have no noticeable long-term effects on adult stage-growth.

A criticism of traditional teaching methods is that a uniform approach is used with students regardless of their individual needs and characteristics. Catering to individual needs is crucial, particularly for adults who bring to the learning situation more clearly defined personal goals, better ideas about what constitutes useful subject matter, and a desire to learn about things they define as useful and applicable. The concept of "individualized learning" has been used for many years and developed out of the

dissatisfaction with traditional methods (Knapper & Copley, 1985).

Malcolm Knowles (1984), has compared a pedagogical model of learning to an andragogical model. The andragogical model is a **process** model in contrast to a content model. Instead of a teacher planning the body of content in advance and presenting this in some sort of sequence, the andragogical teacher prepares a set of procedures to involve the learner in creating a mechanism for mutual planning. Comparisons, according to Knowles, support the notion that an andragogical approach increases learner self-directiveness; lends to the immediacy of application, is mutually respectful; informal and collaborative; and lends itself to self-diagnosis. The content is sequenced in terms of readiness and experiential learning is the focus.

Many adults recall the routine of school and still carry the notion that learning only occurs only under the supervision of an authority figure; that success or failure is external; that learning is passive; and that the speed of learning is specified by others (Knapper & Copley, 1985). Planners of adult learning programs should be particularly cognizant of perceptions adult learners maintain in order to plan for effective teaching methods to optimize learning.

Barriers to Training Family Child Care Providers

Snow and Creech (1986) outlined advantages and disadvantages of several training methods for child care providers. Among these, they explore workshops, materials, media packages, and on-site visits. When training is conducted on the job site, in a day care setting, a modeling training method has proven most effective. The advantages for this face-to-face model include the fact that training can be designed to meet specific needs, no participant travel is necessary, time off the job for caregivers is minimized, feedback to trainers and trainees is immediate, and accessibility of the target group is maximized. The disadvantages include the fact that it is expensive due to the high trainer/trainee ratio, it is inefficient in reaching the masses and extensive travel for training staff may be necessary.

In researching family child care providers, Aguirre (1987) surveyed providers and found that they had little or no training or experience beyond personal parenting experiences, but they wanted to have more educational opportunities. Aguirre's research also revealed certain barriers to training, including lack of time, loss of income while coming to class, and the difficulty associated with finding alternative arrangements for children while attending class.

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In evaluations from training groups participating in the Virginia Rural Child Care Project, providers asked for more support, follow-up to training, and the use of a consultant in their homes to advise them on child care practices (Virginia Senate Document # 12, 1990). Providers also reported that barriers such as transportation, time, and family responsibilities limit provider attendance in training workshops. Kilmer (1979), discovered still other barriers to training including initial resistance to group meetings, need for assistance with transportation, child care relief, and the perception that training is a private matter not requiring interference by outsiders. In another study (Ritter & Welch, 1988), caregivers made it clear that weekends were reserved for their own families, household chores and preparing for child care. Training programs scheduled during this time were less likely to be attended.

Provider Training Methods

Various methods have been tried in an attempt to reach family child care providers with information about young children. Ritter and Welch (1988) made informal home visits to providers. During these visits, they observed an eagerness by providers to share ideas on child care, share tips on dealing with parents, and ideas on running a household as well as a business. The researchers gained an appreciation for the sense

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of isolation, day-to-day problems and the providers' desire for professional development and job recognition. At the completion of the home visit program, 72% of the caregivers reporting adoption of one or more recommended practices. Researchers felt as if the strength of the program was including providers in planning the program objectives and content.

The North Carolina Department for Human Resources (1985) concluded that a suitable learning environment can be created through teleconferencing as well as through the traditional face-to-face training methods. This was determined by assessments of amount of learning and attitudes towards training. There was no relationship between knowledge acquisition and various training methods. However, from the caregiver's perspective, the knowledge gain was greatest when using the traditional (classroom) approach.

To meet the demands of the limited time for training of family child care providers, Aguirre and Marshall (1988) evaluated the success of the a structured home-study course offered by the Texas Extension Service. Home-study, accommodates learners at home and provides some structure with flexibility. Results indicated that the home-study course was successful in increasing the knowledge of participants and in changing

their reported behavior. Favorable evaluations were elicited.

Atkinson (1990) interviewed 32 family child care providers to evaluate the importance of provider qualifications, quality in child care, and training. It was found that provider training programs based on informal learning experiences in the home may be seen as more valuable than structured classes. It was also suggested that providers may find information more immediately available through telephone hot-lines, newsletters, and educational videotapes.

Self-study.

Similar to the home-study model is self-study or independent study. Beggs and Buffie (1971) note that independent study emphasizes the individual's role in learning. It is a way to personalize learning, make use of human and material resources, and strive for self-improvement.

A modification to the self-study approach is self-validation. It is a process used by the National Academy of Early Childhood Programs in accrediting programs. Undertaking a self-study through accreditation implies a "voluntary commitment to self-evaluation and self-improvement (Bredekamp, 1984)." Self-study serves as the central element which provides the opportunity for parents and staff to examine

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operations of a program, identify strengths and weaknesses, and voluntarily commit to self-improvement. Following a self-study, validators are assigned to verify information from the self-study. Validators then meet with the center director to discuss the results of the validation. This provides for an opportunity for additional input or explanation.

The National Association for Family Day Care (NAFDC) provides professional recognition for providers delivering exceptional care through a similar accreditation process. This process includes six hours of observation by a NAFDC validator. Parents complete evaluations and providers complete a self-evaluation (Sibley & Shim, 1989).

Mentoring.

Another method of learning which is often referenced with differing descriptive terms, is mentoring. Often referred to as consultants, catalysts, visitors and advisors, mentoring has been documented as an effective and supportive training option in business and educational settings.

Successful mentoring programs in business and government include the IRS "coaches" program; the Federal Executive Program, referred to as "senior advisors;" Jewel Companies, in which mentors are called "sponsors;" the Department of

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Agriculture; the California Women in Government, and the Association for Counselor Education and Supervision, which all identify their participants as "mentors" (Phillips-Jones, 1983). Since family child care providers reportedly have little time to invest in attendance at training sessions and have requested more support, a home-based mentoring adaptation would appear to be a method worth exploring for this audience.

Kilmer (1979) implemented an adaptation of a mentoring model. Kilmer referred to the mentors who trained day care providers as catalysts. The catalyst facilitated learning by assisting providers in seeking and evaluating new information. A balance was maintained between an appreciation for the provider's current accomplishments and the introduction of new or different ideas for working with children and families. Home visitation by catalysts was the primary method of contact. A formal written agreement concerning areas of future training was signed by the provider and the catalyst. Training visits totalled approximately 12 hours with optional continuance in a second sequence of sessions.

Of the catalyst trained providers, 75% indicated a change in behavior as a direct result of the training. Additionally, 90% of the providers said they would recommend the training to their friends because it was valuable and enjoyable, providing helpful

results (Kilmer, 1979).

Similar to mentoring, Almy (1988) outlines the necessity of administrative staff to provide on the job training to inexperienced individuals. In support of this model, staff must have access to early childhood education specialists to conduct training. Almy suggests that this individual should think concretely (like children), and think formally in theory and practice in order to teach adults.

Wildman, Niles, Magliaro, and McLaughlin (1987) use mentoring in their research with beginning public school teachers. The mentor roles include prevention, monitoring and emergency assistance. The mentor-novice partnership prevents unnecessary prolonged anxiety and an informational overload. The mentoring process begins with persons trained through experience or formal classes to develop protege' relationships which will be supportive and facilitate growth.

Basic mentoring behaviors outlined by Anderson and Shannon (1988) include modeling, informing, confirming, disconfirming, prescribing, and questioning. Additional support is realized by student participation in activities assigned to them such as assisting with lesson plans, demonstrating, observing and providing feedback.

In a review of mentoring studies, Thies-Sprinthall and Sprinthall (1987) found

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evidence to support developmental growth and improvement in the quality of supervision for beginning teachers using a two part training program; one for mentors and one for mentor-trainers. The initial training for mentors creates a major opportunity for teacher revitalization.

Alleman, Cochran, Doverspike, and Newman (1984) recommended developing a mentor training program which includes the following components: (a) benefits of a mentoring relationship; (b) the dynamic nature of the relationship, it's phases and stages; (c) ways to increase the protege's competence; (d) ways to increase the protege's self-esteem; (e) ways to help the protege get ahead; (f) anticipating and forestalling problems; (g) adapting mentoring practices to a particular setting and gaining organization-wide support; (h) integration and synthesis. The researchers further suggest that mentors could act as support networks with each other as they put mentoring practices into action.

Various techniques have been used to develop a supportive relationship within mentoring models. Time, is an important component. Accurate timing is essential in sensing the protege's stage of development. Relationship lengths in the above cited studies vary. Kilmer's catalysts provided 12 contact hours; Niles et al. provide mentors,

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conveniently, for a school term; the Child Care Partnership program in Texas schedules 36 contact hours with providers, and the Family Day Care Training Model (Jones & Meisels, 1987), used a bi-weekly five month interval. Justification for time is not generally given, although Daloz (1987) emphasizes the importance of timing and knowing when the protege is ready for termination.

Considering a broad definition borrowed from Daloz (1987), one measures individual growth should be measured by the extent it causes an individual to desire continued growth. Current programs offered by educators to family child care providers may not be stimulating individuals to continue with their personal growth and professional development. This stimulation is necessary to increase willing participation in educational programs which in turn, raises the quality of child care environments.

With a concern for improving the quality of child care and the need to offer training for difficult to reach clientele, this study compared two training models. Family child care providers were assigned to one of two treatment groups; a self-study treatment group and a catalyst treatment group.

Both models afforded family child care providers the opportunity to learn at home, alleviating the barriers of giving up caregiving income to attend training and the need

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to leave the family in the evening hours to attend training. For purposes of this study, the two training models are referred to as the self-study treatment and the catalyst treatment.

Change in the quality of family child care was the central focus of the study. In addition to testing two training methods to meet the needs of family child care providers, provider characteristics were controlled. These characteristics included experience in family child care, affiliation with a professional family child care association, and the extent of previous training in child-related areas.

CHAPTER THREE

Methods

Two methods of child care training were tested in this study. The provider-catalyst model involved weekly one-on-one contact sessions between the catalyst and the provider for a three-month period. The second training method was a self-study process which involved one initial contact by the validator with no instructional or supportive follow-up.

The following section describes participants in the sample, the instruments used, and summarizes the treatments and procedures. A description of the methods of data collection and the analysis used to test each hypothesis are detailed.

The Provider Sample

Recruitment of a pool of family child care providers was not an easy process. Extension Agents in 10 counties in northern Virginia were asked to identify family child care providers who had five or fewer years of experience, providers who were licensed, and those who were unlicensed; and providers who were affiliated with family child care

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associations, and those who were not. Providers were also recruited through newsletters, word-of-mouth, newspaper articles, radio announcements, and referrals. A sample letter and news release were provided to Extension Agents (see Appendix A.

Extension Agents contacted and discussed the training project with more providers than would agree to participate. A skeptical attitude of potential regulation and interference was expressed by the providers, particularly by those who were unlicensed. Even with a home visitation model, time to invest in training was given as a reason for non-participation.

All 36 recruited providers were subsequently asked to become a part of the study. There was a three month time lapse between the time providers were recruited and the time the actual study began. At the beginning of the study, the matched pairs sample totaled 36 (18 pairs) providers from the ten counties.

Procedures

Training for data collection

Prior to data collection, twenty people (10 validators and 10 catalysts) attended a six-hour training program to prepare for the study. Validators were identified to collect

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quality of care scores. Catalysts were the trainers involved in one-to-one home visits individualizing provider training. Training for validators and catalysts included information on developmentally appropriate practices, adult learning, the concept of mentoring, and use of the Family Day Care Rating Scale (FDCRS).

Catalysts and validators were expected to be knowledgeable of child care and child development. They were given a short test to assess this knowledge with items selected from the Family Day Care Rating Scale. A copy of the instrument used to assess child care knowledge is included in Appendix B. Better than 80% accuracy was obtained by the group. Individuals who scored below 80% were asked to retake the test at the end of the training. Following the test retake by three individuals, the group mean was 93%.

To establish interrater reliability, the validators viewed a videotape of three family child care providers and used the FDCRS to rate their practices. Since there was only one observation per cell, the ANOVA interaction term was used for the error term. The hypothesis being tested was essentially that the mean rating for validator one was equal to the mean rating for validator two...and the same for all other validators. The outcome should approach zero to assume no interaction is occurring. The F ratio used

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to test the hypothesis $M_{\text{validator 1}} = M_{\text{validator 2}} \dots M_{\text{validator 10}}$ was $F = MS_{\text{validator}} / MS_{\text{interaction}}$.

An interrater reliability of .078 was obtained indicating little interaction and variability between validator ratings of the providers.

Pretreatment measures

Upon completion of the preparatory training, validators contacted their assigned providers to schedule a time to visit the providers' homes to complete the FDCRS pretest. Throughout the study, validators were blind to the assigned treatment. All ten validators collected pretest and posttest ratings from at least one provider. The maximum number of providers for which each validator was responsible was four.

Following the validator's visit, the providers assigned to the self-study group, received a packet of Extension publications from Extension Agents about child care and development and a listing of available resources which could be ordered through the Extension Office or from local community colleges (Appendix C).

Participants in both treatment groups supplied the researcher with the names and addresses of parents of the children in their care. Parents were asked to rate the child care environment at the beginning of the treatment program and at the end.

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Catalysts worked weekly with providers assigned to the catalyst treatment group. Each contact averaged one hour. Their task was to individualize training and target those areas which needed improvement as assessed by the validator's ratings. Contacts varied from provider to provider depending upon the rapport with the catalyst, the areas which needed improving, provider resources, and personal style.

During the initial visits, the provider and catalyst agreed upon what focus areas to include during the treatment time. Most visits were informal with the catalyst modeling appropriate practices with the children in care or discussing options in caregiving practices. Some visits involved reviewing specific materials or leaving videotapes or books for loan. The researcher consulted with catalysts on unique provider situations i.e. activity ideas to build self-esteem, handling provider favoritism, space arrangement, or managing care with a limited income and no toys or materials.

Instruments

Demographics

All providers in the sample were asked to complete a brief questionnaire to obtain information about current child care practices, training needs, personal characteristics such as educational level, past child care experience, geographic location, and licensure

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status (see Appendix D). Providers were matched as closely as possible by these characteristics before they were assigned to treatment groups.

Quality Assessment.

Quality of care ratings were collected for all providers by trained validators using the Harms/Clifford Family Day Care Rating Scale (FDCRS). This comprehensive scale is based on the 13 competency areas identified by the Child Development Association. Thirty-two items covering the following six categories are used: Space and Furnishings, Basic Care, Language and Reasoning, Learning Activities, Social Development and Adult Needs. Information for obtaining the scale is provided in Appendix E.

Each item is rated on a 7-point scale ranging from inadequate to excellent. The inadequate and minimal ratings focus on the basic provision of materials and health and safety precautions, while the good and excellent ratings require positive interaction, planning and personalized care as well as suitable materials. The items cover the needs of children ranging in age from infancy through kindergarten.

Perceptions of the training model.

At the end of the three month training period, providers in both treatment groups

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were asked to complete an evaluation of the training program (see Appendix F). The evaluation was designed to assess the level of support, quality of relationships and personal feelings about the training in regard to its suitability as a learning method for family child care providers. A score ranging from ten to fifty was obtained after summing a 1 to 5 rating scale across the ten items.

Parental Input.

One of the major components in determining quality is the positive interaction between provider and parent, and the consistency and continuity of care between home and day care. Involvement of parents for this model was limited to the voluntary completion of a questionnaire pertaining to provider quality of care for their children (see Appendix G). The instrument was constructed using the same 13 assessment areas as the Family Day Care Rating Scale. In an attempt to simplify the Harms and Clifford scale, the researcher offered the parents a four-point scale using the anchor points from the seven point scale of inadequate, minimal, good and excellent. This questionnaire, along with a letter was mailed to parents with a self-addressed stamped envelope at the beginning of the study and at the end of the treatment.

Design Summary and Hypotheses

Basically three ratings were collected prior to the treatment. Validators rated all providers using the Family Day Care Rating Scale. Parents rated their own providers using the a four-point scale with the same areas as the Family Day Care Rating Scale. And providers rated themselves using the Family Day Care Rating Scale. Parents, providers, and validators also provided posttest ratings using the same instruments.

The quality of care rating as measured by the Family Day Care Rating Scale was the dependent variable. The independent treatment variables were treatment groups (catalyst and the self-study). Provider characteristics such as education, professional affiliation, and experience had been collected and controlled through matched pairing of providers prior to random assignment to treatment groups.

The following hypotheses were tested:

1. There will be a difference between the experimental (catalyst) and the control (self-study) treatments from the pretest to the posttest quality of care ratings (time) as manifested by the interaction of treatment group by time.
2. Quality of care ratings will differ when providers are classified according to educational attainment, previous training in child care and development, and experience

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in family child care.

3. There will be a difference in perception of benefit of training when family child care providers are classified according to level of education and professional affiliation.

CHAPTER 4

Results

The major purpose of this study was to investigate the change in quality of care ratings for family child care providers assigned to two treatment groups: catalyst and self-study. An additional purpose was to determine the differences between provider perceptions of the treatment models and the association between their perception, the educational level of the provider, and the providers' affiliation with a professional family child care organization.

Three pretest quality of care ratings and three posttest quality of care ratings were collected for each provider using the Family Day Care Rating Scale (FDCRS). Ratings were collected before and after a three-month treatment period by a trained validator; by the provider as a self-rating; and from parents with children in care. An additional score was collected from providers regarding their perception of the treatment using a ten-item rating scale designed by the researcher.

Descriptive Data

Thirty-six providers were grouped into 18 matched pairs prior to their assignment to a treatment group. As closely as possible, the characteristics of licensure, affiliation, education, past training in child care/ development, and experience in family child care were considered when matching. The original plan was to include only those providers with less than five years of experience. Since recruitment was somewhat difficult, a decision was made to include nine additional providers who had more than five years of experience. This change resulted in a range from less than one year to 20 years of family child care experience.

Affiliation was another provider characteristic of interest. There are 14 family day care associations in Virginia and two organized groups in the geographic area from which the sample was drawn. Of the providers in the original sample, 41% (9) of the providers in the sample were members of at least one of these organizations.

Attrition

During the course of the study, fourteen providers (38%) dropped out. Unfortunately, this is characteristic of child care providers. The annual turnover rate in child care nationally is 42% (Whitebrook, Howes, & Phillips, 1989). To summarize

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reasons for withdrawal, three were not caring for any children by the time the study began; two quit being family day care providers, to seek more lucrative work; three moved; and two asked to be dropped due to a heavy child care work schedule. One provider was dropped since a validator was overloaded (assigned more than four providers). The Department of Social Services enforced confidentiality policies in another county which affected two more providers. And finally, the Persian Gulf War was in progress during the treatment time so one provider was lost due to a need to care for children of family members stationed in Saudi Arabia. The final sample size was 22 with 14 in the catalyst treatment group and eight in the self-study/control group.

In reviewing characteristics of the providers who dropped out of the study, there were a few noteworthy trends. More providers assigned to self-study (9) than assigned to the catalyst group (5) dropped out. This may be due to the fact that those in self-study were required to seek new information without the support of a catalyst. The self-study providers received no direct attention or feedback following the visit from the validator.

More unlicensed (9) than licensed providers (5) dropped out. Perhaps the step of officially becoming licensed relates to one's interest or motivation to take part in

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formalized programs. And more non-members (10) than members (4) of Family Day Care Associations dropped out of the study. Non-members may be uncomfortable with interactions in that they have not previously sought the type of support which was offered.

Ten of the 14 providers who dropped out had no previous child care or child development training. The lack of training in child development prior to becoming a child care provider may be a factor contributing to the high turnover rate noted in the field. Table 1 shows the characteristics of providers in the final sample by treatment group and notes characteristics of the providers who left the study.

Insert Table 1 about here

Quality of Care

Six quality of care ratings were collected for each provider using the Family Day Care Rating Scale. Parents, trained validators and providers themselves, rated the child care environment before treatment and following treatment.

Table 1

Provider Characteristics in the Final Sample and Those Who Left the Study Within Treatment Groups

		Providers in final sample N=22											
		Licensed as family child care provider		High school graduate		Previous training in child care and development		Years of experience in family child care		Affiliated with family child care association			
Treatment		Yes	No	Yes	No	Yes	No	1-5	6-10	11-15	16-20	Yes	No
Catalyst	N=14	5	9	11	3	10	4	10	2	1	1	4	10
Self-study	N=8	4	4	8	-	5	3	5	-	2	1	5	3
Total		9	13	19	3	15	7	15	2	3	2	9	13
		Provider Characteristics of Those Who Left the Study N=14											
		Yes	No	Yes	No	Yes	No	1-5	6-10	11-15	16-20	Yes	No
Catalyst		1	4	4	1	1	4	5	-	-	-	3	2
Self-study		4	5	7	2	4	5	7	1	1	-	1	8
Total		5	9	11	3	5	9	12	1	1	0	4	10

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On a 7-point scale, the greatest range in ratings were those of the validators. Validator pretest ratings for the 22 providers ranged from 1.60 to 6.15 while their posttests ranged from 1.97 to 6.73. Providers pretest self-ratings ranged from 3.06 to 6.77 and posttest self-ratings ranged from 3.83 to 6.83.

Parents using the services of a provider within the sample were mailed a questionnaire with the same items as reflected on the FDCRS. These ratings were requested from parents on a simpler 4-point scale then made equivalent to an expanded 7-point scale at the time of analysis by multiplying the average parent rating by 1.75. Since providers care for more than one family's children, multiple parent questionnaires were averaged together to arrive at one parent rating for each provider. At least one parent evaluation was returned for each provider. Parent ratings reflected the highest evaluation of care with pretest ratings ranging from 4.65 to 7.00 and posttest ratings ranging from 4.57 to 7.00.

Test of the Treatment Effect

Hypothesis 1 was: **there will be a difference between the experimental (catalyst) and the control (self-study) treatment groups from the pretest to posttest quality**

of care ratings (time) as manifested by the interaction of treatment group by time. The validator's pretest and posttest ratings using the Family Day Care Rating Scale served as the dependent variable when testing hypothesis 1. There was initial concern that due to attrition there may have been a problem in maintaining equivalent treatment groups. Therefore, a *t*-test was conducted using the validator ratings of the catalyst and self-study groups at the time of the pretest to determine if the treatment groups were equivalent. As shown in Table 2, the mean for the self-study group ($M=4.4$) was higher than the catalyst group ($M=3.8$). The difference was not statistically significant. Thus it was concluded that the two groups were equivalent prior to treatment.

Insert Table 2 about here

Additional *t*-tests were run with provider and parent pretest ratings. These means, also depicted in Table 2, did not reveal any statistically significant differences between the two groups. Parent ratings did not vary greatly for either group from the time of the first rating to the time of second parent rating. Providers in both treatment groups, however, rated their quality of care higher on the posttest.

Training for Quality

To determine if any of the five variables used to match the groups were significant, further *t*-test comparisons were made with each matching variable serving as the independent variable and posttest quality of care ratings serving as the dependent variable.

No significant differences were found between those who were licensed and those who were not; those with a high school education or less and those with college degrees; those with previous child-related training and those with no training; those with less than five years and experience and those with more than five years of experience.

There was a significant difference between those who were and those who were not professionally affiliated ($t=3.98$, $p<.01$),

Table 2

Pretest and Posttest Quality of Care Means and Standard

Deviations for Treatment Groups Reflected in Parent.

Provider and Validator Ratings

Ratings						
	Validators		Parents		Providers	
	Pre	Post	Pre	Post	Pre	Post
Treatment	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Catalyst N=14	3.8 (1.3)	4.9 (1.3)	6.1 (.52)	6.2 (.52)	5.0 (.97)	6.0 (.65)
Self-study N=8	4.4 (1.4)	4.9 (1.1)	5.7 (.87)	5.7 (.55)	4.6 (.91)	5.2 (1.2)

Repeated Measures Analysis of Variance for Treatment.

A 2 X 2 X 2 (Treatment groups X Affiliation status X Time [pre and posttest]) repeated measures analysis of variance was computed using the validators' ratings as a dependent variable. The means and standard deviations by group and affiliation are shown in Table 3. Table 4 summarizes the results of the analysis of variance.

Insert Tables 3 & 4 about here

A significant main effect was found for affiliation ($F=4.57, p<.05$) and for the time (pre to post) factor ($F=11.60, p<.003$). The main effect for treatment was not significant. The results indicate that the significant main effect for affiliation was due to the increase in quality ratings found for the non-affiliated providers. As shown previously in Table 3, quality ratings increased from pretest to posttest. Although the catalyst group evidenced a greater increase than the self-study group in quality ratings, the difference was not statistically significant. Non-affiliated providers had lower pretest ratings than affiliated providers, but they displayed greater gains regardless of the type of training.

Table 3

Means and Standard Deviations for Members and Non-members in Family Day Care Associations at Pretest and Posttest by Treatment Group

Treatment	Ratings			
	Affiliated		Non-affiliated	
	Pre M (SD)	Post M (SD)	Pre M (SD)	Post M (SD)
Catalyst	5.2 (1.0)	5.2 (.91)	3.2 (.87)	4.7 (1.4)
Self-study	4.9 (1.1)	5.1 (1.3)	3.6 (1.7)	4.5 (.77)

Table 4

Summary of Repeated Measures Analysis of Variance UsingValidators Pre and Post Ratings Within Treatment Groups and Affiliation Levels

Source	Sums of Squares	df	Mean Square	F	Significance
Affiliation	11.07	1	11.07	4.57	.047*
Treatment	.00	1	.00	.00	.971
Affiliation X Treatment	.23	1	.23	.09	.761
Residual	43.65	18	2.42		
Time	4.08	1	.35	11.60	.003**
Affiliation X Time	3.24	1	3.24	9.21	.007**
Treatment X Time	.10	1	.10	.28	.604
Affiliation X Treatment X Time	.22	1	.22	.62	.442
Residual	6.33	18	.35		
Total	68.92	43	18.61		

Training for Quality

The only interaction which reached statistical significance was Time X Affiliation. For affiliated providers the group mean of 5.1 ($SD=1.0$) did not change from pre to posttest whereas the mean ratings for non-affiliated providers increased from 3.3 ($SD=1.0$) to 4.7 ($SD=1.3$).

Test of Relationships Between Variables

Hypothesis 2: **Quality of care ratings will differ when providers are classified according to educational attainment, experience in family child care, previous training in child-related areas.** Correlations between these variables and parent, provider, and validator ratings were computed. Posttest ratings were used in these analyses.

Training.

Previous training in child-related areas was related to educational attainment ($r=.46$, $p<.05$) indicating that providers with child care and development training also had more years of education. Child care and development training was also significantly related to high posttest quality of care validator ratings ($r=.52$, $p<.01$). Training had negative but non-significant relationships to years of experience, parent ratings, and provider

ratings. Years of experience and number of years of education were not significantly related to any of the other variables.

Inter-relationships among quality ratings.

Validator ratings had a negative, non-significant relationship with parent ratings, but a positive, significant ($r=.56$, $p<.01$) relationship with provider self-ratings. The correlation between parent and provider ratings was not significant. All correlations are shown in Table 5.

Insert Table 5 about here

Table 5

Inter-Correlations Between Dependent Posttest Ratings and Independent Variables

	Training	Experience	Education	Validator	Parent
Experience	-.29	-			
Education	.46**	-.33	-		
Validator	.52**	-.05	.22	-	
Parent	-.12	.23	-.22	-.23	-
Provider	-.06	.25	-.17	.56*	.08

* p < .05

** p < .01

Training for Quality

Response to Final Perceptual Evaluation

To respond to Hypotheses 3: **There will be a difference in perception of benefit of training when providers are classified according to level of education and professional affiliation**, providers were asked to complete a scale which included 10 items to be rated on a continuum of 1 to 5. A rating of 1 (not valuable to me) was the lowest item score. A maximum score of 50 was possible. The ten perceptual items on the evaluation included: level of resource support, method of learning, value of experience, value of new information, feelings about the process, personal growth, convenience of the method, flexibility of the method, new skills or insights to help you as a person, new skills or insights to help you as a provider.

There was an 87% return rate for the final evaluations. Overall, ratings were positive for both treatment groups with a range in total scores of 33-50. The results from this summary indicate particularly high ratings for the flexibility of both programs and convenience of the learning methods. With the exception of one rating of 2 (not well suited to my needs) by a provider assigned to the self-study group, all remaining ratings were 3-5.

A oneway analysis of variance between treatment groups and each item of the

perceptual scale was conducted. The means are reported in Table 6.

Insert Table 6 about here

Table 6

Means and Standard Deviations for Perceptual Variables by Treatment Group (N=18)

	Catalyst		Self Study	
	Means	Standard Deviation	Means	Standard Deviation
Method of resource support	4.1	.79	4.0	.76
Method of learning	4.1	1.2	3.5	.93
Value of Experience	4.3	.65	4.1	.99
Value of new information*	4.4	.51	3.6	.52
Feelings about the process	4.5	.69	4.1	.99
Personal growth*	4.8	.45	3.9	.83
Convenience of method	4.6	.51	4.5	.76
Flexibility of method	4.3	.65	4.5	.53
New skills as a person	4.3	.45	4.1	.99
New skills as a provider	4.3	.78	4.1	.83
Total	43.1	5.8	40.7	6.5

* p < .01

Training for Quality

ANOVA results indicated a significant main effect between the treatment and personal growth ($F=9.28, p<.007$) and between treatment and the provider rating of the value of new information ($F=11.30, p<.004$). Table 7 reports the results of the ANOVA for value of new information and Table 8 indicates the results of the ANOVA for personal growth.

Insert Tables 7 & 8 about here

Additional t -tests were conducted for each perceptual dependent variable and both educational level and affiliation independent variables. There were no significant differences.

Table 7

Summary of Analysis of Variance Between Value of New Information and Treatment Groups

Source	Sums of Squares	Degrees of Freedom	Mean Square	F	Significance
Between Groups	3.00	1	3.00	11.30	.003
Within Groups	4.79	18	.266		
Total	7.80	19			

Table 8

Summary of Analysis of Variance Between Provider Personal Growth and Treatment Groups

Source	Sums of Squares	Degrees of Freedom	Mean Square	F	Significance
Between Groups	3.68	1	3.68	9.28	.007
Within Groups	7.12	18	.396		
Total	10.80	19			

CHAPTER 5

Discussion

Three research questions examined in this study; (a) there will be a difference between the experimental (catalyst) and the control (self-study) treatments from the pretest to the posttest quality of care ratings (time) as manifested by the interaction of treatment group by time; (b) quality of care ratings will differ when providers are classified according to educational attainment, previous training in child care and development, and experience in family child care; (c) there will be a difference in perception of benefit of training when family child care providers are classified according to level of education and professional affiliation.

The hypotheses were based on past research regarding barriers to training family child care providers and the expectation that self-paced methods with and without support would differ for providers depending on their previous training in child care and development, their educational level, and their professional affiliation. Determination of which provider characteristics impact quality was undertaken.

Findings were contrary to the central hypotheses i.e. that specific and

individualized training would result in significant differences between the treatment groups. The results of the study do reinforce the notion that child-related training improves quality of care in family child care settings, but the catalyst method was not superior. The two methods used were self-paced, self-evaluative methods of training which improved quality of care ratings for all providers.

Additionally, it was found that an additional key to quality care is provider affiliation with a family day care organization. Results from this study indicate that training contributed to quality of child care primarily for family child care providers who were not previously affiliated with a family day care organization.

Attrition

Although family child care provider retention and willingness to participate in formal training was not under investigation in this study, it became an important variable. In previous work with providers, Kilmer (1979, p.16) indicated, there may be an "initial resistance" for child care providers to participate in group meetings. In this study, initial contact and the resistance to training was evident during the recruitment process. Ritter and Welch (1988, p.5) stated that providers are "somewhat unmotivated to seek further education." This perceived opposition to

training may be a reasonable assumption, however, lack of training opportunities during the past decade may also explain why providers with more than five years of experience have had less previous training. In this study, one might consider that those providers interested enough to commit to a three-month training program may have been disappointed with the assignment to the self-study group since 50% of those assigned to the self-study withdrew compared to 25% of the catalyst group.

Losing 38% of the providers from the sample stimulated the researcher to review their reasons for withdrawal from the study. Most of the providers who dropped out of the study also left the occupation of family child care. This in turn caused interruption in care for children and families. Stability and reliability of care was rated by family child care providers in another research study as one of the most important characteristics of their care and the one aspect which most met parents' needs (Atkinson, 1990).

Reasons given by providers leaving the profession are often too varied to fit into single-response categories and many include multiple factors. Nelson (1990) indicated the median tenure of a family child care providers is three years and that turnover is a complex process in which feelings and attitudes about the occupation

emerge.

In addition to examining their reasons for withdrawal from the study, examining other characteristics of providers who were unable to complete the program might provide the key in future recruitment and retention of family child care providers. For example, in this study, those providers new to the profession dropped out more frequently than providers with over five years of experience in family child care. And having previous training in child-related areas proved important in retaining providers in the study since providers without past child care and development training dropped out at twice the rate of those with previous training. New providers may be unaware of the time, effort, and relatively poor compensation involved in a caregiving profession. Coping with these factors alone may distress new providers and create retention problems.

A supportive network to inform new providers about how to cope with work stress and provide outlets for training and networking, may be one way to reassure new providers and to offer initial support. This support could be created through family day care provider organizations. As noted in the retention of affiliated providers, there may be a tendency of the affiliated providers to thrive on a

supportive training model as exemplified in the catalyst program.

Based on the attrition during the three-month treatment period in this study, further examination of the retention of family child care providers should be conducted. Further study should focus on family child care provider retention nationally and compare reasons for leaving the profession with provider motivation to receive training, initial support within the community, enhancement of professional skills, affiliation with support networks, and quality of child care.

Training and Educational Attainment

Training enhances quality of care in family child care settings. Bredekamp (1987), Jones & Meisels (1988) and the National Day Care Study (Roupp et al., 1979) described the importance of training for individuals working directly with young children. In this study, previous training in child care and development correlated significantly with level of education ($r=.46$) indicating that those providers with higher educational attainment also had enrolled in more child-related training programs and were less likely to terminate their work in family child care.

But more importantly child-related training correlated significantly ($r=.52$) with the posttest quality of care score recorded by validators. Those providers who had

an understanding of children's needs were able to incorporate new practices into their family child care environment more readily than those without a basis of child-related knowledge.

Affiliation

An important finding from this study which can easily be applied to the family child care field is the effect a professional organization plays in the provision of quality child care. Through professional networks providers can not only break the reported isolation from other adults but model practices of other providers. The benefit of affiliation was evidenced by the retention of the affiliated providers with the training study and on the marked difference in pretest scores between affiliated and non-affiliated providers. In this sample, non-affiliated providers benefited from training more significantly than those who were already affiliated with family day care organizations. Trainers should give careful consideration to offering supportive training and encouraging professional affiliation with other adults in caregiving.

Training for Quality

Bookman (1979) found that involvement in family child care associations tends to improve quality of care. Providers in the Bookman study noted that connection with support networks encouraged providers to "view themselves as professional, providing a vital service to the community (p. 21)." Providers indicated that associations break the isolation. They also indicated that the interest generated through the associations in quality child care is effective in getting the message about quality to providers and parents.

Although affiliation to raise quality is supported, affiliation combined with training also may have some bearing on the expressed desire to raise the image of family child care providers through enhanced quality in family care settings. Family child care providers, perhaps, should become more informed regarding definitions of professional status which generally include specific training in a specialized area and a plan for continuing education.

Parent Perceptions

When parents select child care, their criteria for judging quality are often based on their personal feelings towards the caregiving situation. Parents using centers

and those using family child care differ in their criteria for selecting good child care (Pence and Goelman, 1987).

In this study, parents, providers, and validators were given the opportunity to evaluate the quality of child care. Validator and provider scores correlated significantly ($r=.56$) suggesting that there is a relationship between how providers and validators were viewing the caregiving situation. However, parent scores, did not significantly correlate with either the provider scores or the validator scores. This may be due to the fact that validators spent 1-2 hours in the providers' homes, while parents spend only a short portion of each day dropping off and picking up children.

Parents rely on their intuitive judgement concerning the suitability of care for their children (Wattenberg, 1980). Nelson (1990) determined that parents select family child care because they think they will be able to maintain control over the style and content of care.

In this study, overall parent ratings exceeded both validator and provider self-ratings but parent ratings from pretest to posttest did not change a great deal, as

noted previously in Table 2. Parents may not have a full understanding of the potential in quality of care and may assume the quality of their care is exemplary based on a snapshot of the day. When completing the rating scale, many parents left the curriculum-related section of the questionnaire blank or commented that they did "not want structured learning, that is why we chose family day care instead of center care." These comments echo those in Nelson's (1990) studies with remarks such as, "I'm not looking for an academic setting (p. 69)." Not answering this section may indicate the lack of understanding by parents about quality care. Nelson concluded that relationships between parents and caregivers are marked by "mutual misunderstanding (p. 48)."

These parental perspectives advance the recommendation by the 1990 Virginia Joint Legislative Audit and Review team (Virginia Senate Document #3, 1990), which emphasized the need to educate parents regarding the factors which constitute quality care. The National Association for the Education for Young Children has recently initiated a campaign for increased parental involvement in advocating for quality care and increased parental understanding of quality child care (Willer,

1990). Parental evaluation of the quality of their own child care may require additional study to examine how parental involvement and awareness of quality of care may affect provider-parent interaction and subsequent motivation of providers to enroll in training or change practices.

Method of Training

Providers were assigned to either a self-study or catalyst training group. Although individual quality ratings for providers improved; there were no significant differences in quality of care ratings relative to the training method. The changes in quality may have been made as a direct result of the self-evaluative process alone. The provider was in control in both of these models which, according to Knowles (1984), leads to immediate application, self-diagnosis and self-direction.

Both of these methods proved to be effective techniques in overcoming training barriers for family child care providers as noted previously from the literature. Both models were evaluated by providers as convenient and flexible. Providers were not obliged to lose income while attending training, and since all training took place in

their homes, transportation was not a problem. One provider assigned to the self-study group, remarked, "I didn't want to be a part of the study at first, but once I saw what was involved, it was ok and I learned alot on my own. I read everything (packet with 8 Extension publications and a resource list)."

Providers completed a ten-item rating scale following the three-month treatment period. They were asked to rate the level of resource support, the method of learning, the value of the experience, the value of the new information, their feelings about the training process, their feelings towards their own personal growth, the convenience of the training method, the flexibility of the training method, new skills or insights gained to help them as individuals, and the new skills or insights gained to help them as providers.

The catalyst group means exceeded self-study group means for all perceptual items with the exception of flexibility. Self-study with a self-evaluative component is increasingly emerging as a flexible and valuable learning method in child care and development to improve quality. This method is widely used and acclaimed as beneficial by NAEYC and NAFDC as an important component of the accreditation process. Both national organizations indicate that many providers of child care

suspend their accreditation process following the self-study. At this point changes are made in an effort to improve programs prior to initiating a validation visit. Self-evaluation allows providers to review the breadth of the child care field and begin to consider the whole environment, the total child and their interaction with the children and parents.

Significant differences were found in the means between the two training groups for two items on the final perceptual evaluation. First, the catalyst ratings for the "value of the new information" ($F=9.28$ $p<.007$) was significantly higher. The combination of support and cooperative planning for those involved in the catalyst training model proved meaningful in conveying valuable information. Secondly, provider ratings of their "feelings towards their own personal growth" ($F=11.30$ $p<.004$) signify that there was personal value found in the training process. These results support the relevance of using a catalyst model of training to enhance personal growth of providers and convey information. This personal growth factor may be the motivation to move providers into a higher developmental stage of learning and professional behavior.

The catalyst training program was based on a mentoring approach. Growth is

a key factor in the mentoring literature. Daloz (1987) indicates that individual growth should be measured by the extent to which it causes an individual to desire continued growth. On an open-ended question, all of the providers involved in the study indicated that they were interested in more training programs. However, a stronger and more active indication that further growth is desired has been demonstrated through providers' actions. As a result of their involvement in this study, providers in two different counties have already formed new family day care provider associations. Five of the 6 providers from these two counties had been assigned to the catalyst treatment group. Four of the 6 providers had been engaged in previous child-related training. These qualitative results combine provider affiliation, desire for additional training, and pursuit of a support system, with a desire to continue their growth process and personally enhance their of quality of care.

The formation of family day care organizations was reported by Extension Agents from those counties within a month after the posttest. This finding should lead future researchers to explore subsequent connections between training and affiliation. One plausible question is: does training create a desire for additional

support and affiliation, or does affiliation create opportunities and desire to seek advanced training?

At the conclusion of the training program, catalysts were asked to complete a final evaluation (Appendix H) and comment on the training process. The results from this evaluation are found in Appendix I. In thanks and recognition for their achievements, all providers, validators and catalysts were mailed a certificate of completion. A sample certificate is located in Appendix J. Correspondence about the project with Extension Agents is included in Appendix K.

Summary

In summary no differences were found between the two training methods relative to quality of child care. This study did reinforce the fact that training in child care and development improves quality of care. Additionally, it was found that family child care providers who were not previously affiliated with a family day care organization improved in their quality through these training programs more significantly than those who were members of such organizations.

Family child care providers, however, are a diverse audience with special training needs. Just as developmental levels are evident in young children, this research supports the notion that various adult developmental levels may be apparent based on personal characteristics of providers. Educational level, affiliation tendencies, past training in the vocation, licensure, and other variables may determine how these developmental levels present themselves. The primary findings from this study, that affiliation and training enhance quality of child care, implies a need to apply the concepts of individualizing and developmentally appropriate training to adult learners. Faced with diversity, the necessity to provide supportive self-evaluative individualized educational programs emerges.

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Training materials, information about procedures, or inquiries may be directed to Karen DeBord, Department of Family and Child Development, Virginia Polytechnic Institute and State University, Blacksburg, Virginia 24061-0416.

Appendices

Appendix A : Provider recruitment letter, article

Appendix B : Assessment of quality of child care knowledge

Appendix C : Resource list

Appendix D : Provider information sheet and written agreement to participate in study

Appendix E : Family Day Care Rating Scale

Appendix F : Perceptual evaluation

Appendix G : Parent letter and questionnaire

Appendix H : Final catalyst evaluation

Appendix I : Results of final catalyst evaluation

Appendix J : Sample of certificate

Appendix K : Correspondence

Appendix A

Provider Recruitment Letter and Article

Recruitment Letter

Dear Child Care Provider,

Child care providers are valuable people in the lives of many parents and children. To study the training needs of day care providers, we are recruiting family day care providers. Since we know that it is difficult for family day care providers to get out of the house for training programs, the program will be offered in your own home.

There will be two methods of training to be offered. One will involve a person who has received training in child development who will be assigned to come into your home and discuss child care and development at least bi-weekly for three months. Together, you and the trainer will develop your own learning program based on your needs and interests.

The catalyst will bring you free resources in child care and development. All of the home visits or phone contacts will be planned to meet your caregiving schedule in your home. No outside travel is necessary unless it is convenient with you.

The second model is self-study which will be more self-paced. A resource list will be given to you. It will be up to you to request resources and record your use of them. The model is to determine the worth of self-study in enhancing quality in family day care environments. An evaluator will come to your home to observe and ask a few questions about your caregiving practices. You will be given a questionnaire with a listing of factors which constitute quality care for children. You will be asked to rate yourself and your child care environment. The evaluator will then discuss the questionnaire with you to be assured you have an understanding of it.

After three months, the evaluator will make an appointment to come into your home and observe again. In the meantime, you are welcome to seek assistance or

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attend training sessions, ask for resources or read on your own.

Since this is a pilot program, there is no cost and you will be awarded with a certificate of completion from Virginia Tech for display in your home following the three month training program. Providers interested in participating will be assigned to a training model to begin in the Fall.

In return for this valuable training, you will be asked to allow an evaluator to make an appointment to come observe in your home before the training begins and following the training. Additionally, you will be asked to complete two brief questionnaires and provide addresses of parents you serve so they can complete a questionnaire. No provider names will be requested on these. All information is confidential.

We really need interested persons to participate. Your contribution will be valuable enough providers across the state will be interested in a similar training program.

Please complete the information sheet enclosed and return to _____ . Because we need a balanced cross section of providers, we need people with a range of experience and education. After the sample is selected, you will be notified when a catalyst has been assigned to you.

Many thanks for your interest!

Recruitment Article
CATALYST

Child care providers are valuable people in the lives of many parents and children. To study the needs of day care providers, we are recruiting providers to participate in two pilot training programs. We need your help!!

What is involved?

- Free resources in child care and development
- A home visitor with child development knowledge will work with you to develop an individualized learning plan
- All training will be planned to meet your schedule in you home
- No outside travel is necessary unless it is convenient with you. If necessary, relief child care will be arranged.

Why would I want to be involved?

- There is no cost
- The pilot study will benefit all providers
- To learn new ideas about child care with training in tune to your schedule
- You will receive a certificate of completion
- With increased training, parents may find your services more valuable
- You will learn the components of quality child care

Length

One training program will involve a total of 24 hour minimum of learning. This is about 1-2 hours per week in your home or by phone. The second model is self-study which will be more self-paced. A resource list will be given to you. It will be up to you to request resources and record your use of them.

What will I have to do?

- Complete two brief questionnaires
- Plan for your own learning
- Provide addresses of parents you serve so they can complete a questionnaire. No provider names will be requested on these.
- All information is confidential
- Allow a home visitor to come in and assist you if you are selected for the catalyst program
- Allow someone to come into your home to complete a pre-checksheet of information and a post checksheet of information

How to become involved:

1. Call the county facilitator _____ at _____ by _____.
2. Someone will contact you.

Many thanks for your valuable assistance!!

Recruitment Article
SELF-STUDY

Dear Child Care Provider,
Child care providers are valuable people in the lives of many parents and children. To study the needs of day care providers, we are recruiting providers to participate in a training model. We need your help!!

What is involved?

- Free resources in child care and development at your request
- All training will be planned to meet your schedule in you home
- No outside travel is necessary unless it is convenient with you.

Why would I want to be involved?

- There is no cost
- The pilot study will benefit all providers
- To learn new ideas about child care with training in tune to your schedule
- You will receive a certificate of completion
- With increased training, parents may find your services more valuable
- You will learn about the components of quality child care

Length

It is up to you. The program allows you the flexibility to work at your leisure. If you need resources or assistance with a particular area of child care, you may contact the project coordinator for assistance. It is all up to you.

What will I have to do?

- Complete two brief questionnaires
- Plan for your own learning with the trainer
- Provide addresses of parents you serve so they can complete a questionnaire. No provider names will be requested on these.
- All information is confidential
- Allow a child care validator to visit your home

How to become involved:

1. Call the county facilitator _____ at _____ by _____.
2. Someone will contact you.

Many thanks for you valuable assistance!!

Appendix B

Assessment of Quality Child Care Knowledge

Select the **B E S T** response which would indicate the highest level of expectation of a family child care provider.

EXAMPLE:

- A. In supervising children's play, a caregiver should
- a. provide no supervision unless problems occur
 - b. look for chances to extend learning
 - c. attend mainly to safety and proper use of materials
 - d. allow children to play outdoors if there are household chores which must be attended to

1. In preparing an environment for child care, there should be:
- a. some children's artwork displayed
 - b. child sized furniture and child sized play furnishings (play kitchen, easel)
 - c. some store-bought or adult-made pictures put up for children to view (ABC's numbers)
 - d. plenty of cribs in which to place children during the day for safe play.
2. Play space should
- a. offer few opportunities to play alone
 - b. allow alone time but provider should interact about every 10 minutes
 - c. include materials for each age group and promote independent use by children
 - d. be safe

3. The basic care of children should include
 - a. morning greetings of children as frequently as possible
 - b. encouragement of self-help with individual needs of children in mind
 - c. naps
 - d. punishment for toileting accidents

4. Personally, the caregiver should
 - a. provide at least one hand towel for every 3 children
 - b. assure each child has a change of clothes
 - c. have children wash hands before and after meals
 - d. encourage good health habits and practices such as eating healthy foods and not smoking in front of the children

5. In helping children understand language,
 - a. the caregiver should use clear instructions and describe events throughout the day
 - b. no assistance should be given to identify pictures when reading
 - c. provide no more than 6 children's books for toddlers
 - d. providers should focus on using yes/no questions for children two and over

6. To help children learn concepts,
 - a. teach school skills to young children whether they are interested or not
 - b. encourage children to reason and sequence events
 - c. do **not** make eye contact when the child is speaking
 - d. incorporate coloring sheets

7. In planning learning activities,
 - a. using TV is okay if only the caregiver watches
 - b. use fairly loud background music during other activities
 - c. provide art materials at least every month
 - d. provide space and time for music and movement daily

8. Learning materials should include
 - a. some sand and water play at least in the summer
 - b. TV for background noise and distraction
 - c. well organized dramatic play materials for independent use
 - d. some blocks of at least square and rectangular shapes

9. Scheduling should incorporate
 - a. caregiver use of variety of routines as part of learning experience
 - b. time to handle basic routines or eating, nap, toileting
 - c. very little routine use for young ages
 - d. no time between routines to dilly dally

10. Physical contact between child and caregiver should be
 - a. limited with little display of affection
 - b. kind, respectful and incorporate praise
 - c. used mainly for control of children
 - d. used with favorite children and not for misbehavers

11. Incorporating discipline into a child care program should
 - a. remember that control of the child is of utmost importance
 - b. use follow through for both rewards and punishment
 - c. allow children freedom from rules at young ages
 - d. help children find positive solutions to problems through discussion

12. Providing a culturally aware environment,
 - a. takes planning to incorporate multicultural and multiracial, nonsexist materials
 - b. is not necessary for preschoolers
 - c. boys and girls should be limited to only traditional roles or choices in play activities
 - d. include people of all races, ages and cultures in pictures and books

13. Caregiver/parent relationships should include
 - a. no set policies for parents (payment, hours, parent responsibilities)
 - b. the opportunity for parents to share skills and interests in the child care home and provide for daily reports of each child's activities
 - c. welcome opportunities for parents to visit and observe
 - d. reports of the child's activities at least once a week

14. In order for providers to balance personal and professional responsibilities,
 - a. caregiver should continue with household duties just as before children were cared for in the home
 - b. substitute care should be provided as a backup
 - c. child care responsibilities should not interfere with family responsibilities
 - d. caregiver should use household jobs as learning activities when possible and coordinate caregiving with family responsibilities

15. To take advantage of opportunities to grow as a professional in the caregiving field, a provider should
 - a. limit involvement in professional development
 - b. participate in professional development programs and activities at least 4 times a year
 - c. read childrearing books or magazines
 - d. enroll in at least one home study course or workshop once a year

Appendix C

Family Day Care Providers

Resource List

This list is divided into categories as defined by the Harms/Clifford **Family Day Care Rating Scale**. You are welcome to borrow the materials to review in your home.

Ownership key:

* Available through the Virginia Cooperative Extension Service

Call your county/city Extension Office

KBD - Extension Specialist DeBord

VV - Extension Specialist Vincell

** Available through the Community College System

Send requests to: John Tyler Community College, Library Circulation Dept. Chester, VA 23831 Phone: 804-796-4068.)

These may be borrowed for one month. Request titles by mail by using title, number and description (audio, written, video).

Include your name, SSN, home and work address with phone numbers.

Resource Format Key:

W= written resource

V= video

S= slide set

A= audio tape

F= 16mm film

Child Care in General:

V * - Child Care: A Family Day Home Care Provider Program (Texas Extension Service) - four self-study units with manual and video tape (KBD)

W * - Home Day Care and You - Toys and Things Press, 12 unit notebook reprinted with permission by the Virginia Department of Social Services (KBD, VV)

W * - Good Times with Child Care - notebook developed by the Colorado Extension Service with age/stage information and activities.

W * - Starting a Home Day Care Business - Coleman, Extension manual (VV)

W * - Miseducation: Preschoolers at Risk, D. Elkind (book) (KBD)

W * - The Hurried Child, D. Elkind, (book) (KBD)

W * - Quality Child Care: A Position Statement - Southern Association for Children Under Six brochure (KBD)

V * - What is Quality Child Care - lecture tape. Not varied enough for group viewing. Okay for self-instruction (KBD).

V * - Mr. Rogers Talks with Parents and Teachers - live lecture on how caregiving impacts children's learning (KBD).

W * - Quality Child Care: A Common Goal 350--37

W * - Accrediting Criteria and Procedures of the National Academy of Early Childhood Programs, Bredekamp (KBD)

W * - Child Development Association National Credentialing Program for Family

Day Care Providers

W ** - Virginia Day Care Skills Training Guide (0073)

W ** - Patience pays off - (0080L)

W ** - The Business of Listening

S * - How the Average Child Behaves: 1-5

W ** - Generic licensing procedures (0081C)

S ** - Make room for children (family day care) (0147A)

A ** - Child care provider training materials (0169C)

V * - Family Day Care Through a Different Lens (KBD)

V * - A variety of thirty-minute selections from T. Berry Brazleton: Birth to 3 years series (KBD)

Planning Space, Furnishings, Business Management

W * - Planning Environments for Young Children: Physical Space, Kritchevsky, Prescott and Walling (KBD)

W * - Good Schools for Young Children, Leeper, Dales, Skipper, Witherspoon (KBD)

W * - Day Care Evans, Shub, Weinstein (KBD)

W * - Starting a Home Day Care Business, Coleman -Extension manual (VV)

W ** - Classroom spaces and places: Room arrangement (0120A)

W ** - Movement exploration for young children (0121)

S,W * - Come out and Play (constructing outdoor play areas)

F * - Water Play for Young Children

Basic Care

S * - Safe-Toy Environments

W * - Opening Your Door to Children: How to Start a Family Day Care Program, also available through NAEYC catalog, Modigliani, Reiff and Jones (KBD)

A * - CARE tapes from the USDA Food Program (KBD)

W * - School-Age Child Care: An Action Manual, Baden, Genser, Lerne and Seligson (KBD)

V,W,* - Child Care: A family day home provider program (Texas Extension Service) Units on child development and guidance, nutrition, health and safety, business and management (KBD)

W * - Food for the Preschooler, 6 lessons

W ** - First Aid Handbook for Childhood Emergencies (0065C)

W ** - Infectious diseases in Child Day Care (0065E)

W * - Feeding your Preschool Child (348-599 through 607)

W * - Common Cold Checklist (348-646)

W ** - Better baby care: Family Day Care Providers (0066A)

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W ** - Child Care Food Cycle Program Cycle Menus (0069A)

W ** - Day Care in Your Home (0086)

W ** - Manual for Day Care Providers (0065D)

W ** - Nuts and Bolts (managing preschool classes) (0106D)

V ** - Building Children's Self Esteem (0156C)

V ** - Developmentally Appropriate Practice (0155A)

V ** - Appropriate guidance: Discipline and Day Care (0160A)

(Many other nutritional publications available by topic through the Extension Service)

Language and Reasoning

W * - Discipline 350-077

W * - General Principles of Communication 350-077

W * - Listening as a part of Communication - 350-079

W * - Discipline for Young Children - self- study, 6 units with certificate of completion

W ** - Play: Mental, social physical and emotional benefits (0118)

W ** - Play in the lives of children (0118B)

V * - Footsteps Series (VV)

S ** - Everyday Problems with Young Children (0150)

S ** - How an Average Child Behaves (0151)

S ** - Toddlers: Biting, Tantrums, Sharing (0151B)

V ** - Culture and the Education of Children (0162)

V ** - Language Development (0162R)

V ** - Child Language (0166D)

V * - Discipline: A Discussion with Jimmy Hymes (KBD)

Learning Activities

W * - Good Times with Child Care -notebook developed by the Colorado Extension Service with age/stage information and activities (KBD)

W * - Developmentally appropriate practice in early childhood programs serving children birth through age 8, Bredekamp

W * - How Children Learn

V * - How Children Learn: A Discussion with Constance Kamii (19 min.) (KBD)

W * - Home Day Care and You (KBD, VV)

W * - All about child care - trainers and trainees manuals (KBD)

W ** - Activities for School Age Child Care (0083B)

W ** - Hello World (art and movement) (0106C)

S * - Toys and Activities for Preschool Children

W ** - The Daily Routine: Small Group Time (0106H)

W ** - Learning Different Shapes (0109)

W ** - Games and Activities for school children (0116)

V * - Developmentally Appropriate Practice: Curriculum - the role of the teacher
(KBD)

(local libraries will have many selections with activities too)

Social Development

W * - Social and Emotional Development 350-072

W * - Cognitive Development 350-073

W * - Children the Challenge, Dreikurs (KBD)

W * - How Children Learn

W * - The Working Mother: No nonsense parenting guide Chubet (KBD)

W * - Helping Parents Teach Young Children 350-710

W * - Infants and Parents Communicating 350-828

W * - The Child's Self-Concept: OK or Not Ok - 350-661

W * - Developmental Needs of Adolescence 350-070

W ** - Teaching toys (0119A)

W ** - Music for ones and twos (0121A)

W ** - Creative movement for the development of children (0121H)

S ** - Human development: the first 2 1/2 years (0143A)

S ** - Human development 2 1/2 to 6 years (0143B)

S ** - The Eight Stages of Human Life : Prenatal-12 (0143D)

S ** - Mondays and Fridays: Separation anxiety (0147F)

S * - The Black Child

F * - Learning is Observing

V ** - Play (0162N)

V ** - Early childhood: Growth and development (0162O)

A ** - Family Involvement in early childhood education (0173)

A ** - Rhythmically moving (0183-0183H)

W * Various titles listed in HEER : Fun at Home, Quiet Book Pattern, Children's Art, Crayon Activities, Modeling Clay, Recipes, Finger Painting, Music and Rhythm, Movin' Hap Palmer tape, Learning in the Home

(many other selections are available through the community college system, Extension, other community agencies and through your local library)

Special Needs

S * - Children with Handicaps: Families Who Care (5 slide sets)

W * - Good Times with Child Care -notebook developed by the Colorado Extension Service with age/stage information and activities. Includes a section on special children.

Personal Needs:

W * Stress Connection 350-001,350-002

W * Steps to Professional Growth Leadership Development through Family Day Care Associations, notebook on organizing provider groups

The following audiocassettes are presentations from a National Conference. They were taped with an audiences present, but many are quite good and have innovative ideas. All of the titles which follow are available through Extension Specialist, Karen DeBord.

A * - Let's Associate

A * - The Provider Connection

A * - Insurance: Pitfalls and Benefits

A * - Recruitment and Retention: Nurturing the Provider Today and Tomorrow

A * - The Market for Family Day Care: Myths and Realities

A * - Promoting a Good Relationship Between CCR & R and Family Day Care

A * - Roles, Rules and Responsibilities: How Providers Can Work Together

A * - Child Care: A Community Issue

Appendix D

Family Day Care Provider Information

Name _____

Mailing Address _____

Phone number () _____

Current Practices:

1. Circle one:

- a. I am a licensed family day care provider
- b. I am an unlicensed family day care provider

2. List the ages of the children other than your own you currently in your care:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. If you have preschoolers of your own, list their ages _____

4. How many years have you been providing care for children other than your own

in your home? _____

5. Circle other positions you have held in early childhood programs Circle as many as apply.

- a. public school teacher
- b. teacher in child care center
- c. aid in a child care center
- d. aid in a family day care home
- e. camp counselor
- f. church school teacher
- g. other _____ (name)

6. How many total years experience would you estimate you have had working with children? _____.

6. Circle the highest grade you have completed.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+

7. What kind of training have you had in child care or child development? Circle all that apply.

- a. Non-credit child care classes offered through a community agency
- b. Credit classes in child care offered through a 4-year college
- c. Associate degree in child care/development
- d. Bachelor degree in child care /development
- e. post graduate education in child care/development
- f. Child Development Association certification (CDA)
- g. no training in child care
- h. Other _____

8. Are you a member of a Family Day Care Association?

- a. yes
- b. no

9. Are you a member of any other child centered associations?

- a. yes
- b. no

If Yes, list the name of the association and the number of years you have been a member:

Name _____ Years as a member _____

Name _____ Years as a member _____

10. Do you want, or see a need for you, to have additional child care training?

- a. yes
- b. no

Appendix E

Family Day Care Rating Scale

The Family Day Care Rating Scale is available for under \$10.00 (1991 prices)
from Teachers College Press, New York

Appendix F

Provider Perceptual Evaluation

To be completed by ALL providers involved in the training program.

Since the recent training program was part of a pilot programs, we need your input about the value you received from the experience.

Rate the following factors based on your recent family child care training experience. Circle one number per item.

1= not really valuable to me

2= not well suited to my needs

3= OK as compared to other training I have received

4= very suited to my needs

5= positive experience for me

- | | - | | | | + |
|---|---|---|---|---|---|
| 1. Level of resource support | 1 | 2 | 3 | 4 | 5 |
| 2. This method of learning | 1 | 2 | 3 | 4 | 5 |
| 3. Value of the learning experience | 1 | 2 | 3 | 4 | 5 |
| 4. Value of new information | 1 | 2 | 3 | 4 | 5 |
| 5. Your feelings about the process | 1 | 2 | 3 | 4 | 5 |
| 6. Feelings towards personal growth | 1 | 2 | 3 | 4 | 5 |
| 7. The convenience of this method of learning | 1 | 2 | 3 | 4 | 5 |
| 8. Flexibility of program | 1 | 2 | 3 | 4 | 5 |

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9. New skills or insights to help you as a person 1 2 3 4 5

10. New skills or insights to help you as a provider of child care 1 2 3 4 5

Please circle Y for YES or N for NO.

Would you recommend this training method to a friend? Y N

Are you interested in having further training? Y N

Are you interested in having alternative training in child care? Y N

Do you feel you could now serve as a trainer for a new child care provider? Y N

Did the training method seem a personal threat to you since it took place in your home? Y N

What other aspects should be included in the training program?

What aspects were unnecessary to have been included in this training program?

What changes have you made as a direct result of this training program?

List the three most valuable things you gained through this experience.

- 1.
- 2.
- 3.

Appendix G

Parent Letter and Questionnaire

Dear Parents,

Your child care provider is involved in a training program for family day care providers. We are interested in the valuable information which parents can provide about the care their children currently are receiving. Parent involvement is important in providing quality care for children and your input is very important to the success of the program.

Please complete the enclosed form. Since the information will be used for study purposes only, a number has been assigned to enable us to look at the results of the training program for the provider groups. The information on this form is confidential, but very important in planning future program to enhance the quality of child care for families. After three months, you will again be asked to complete an evaluation. **It is very important we receive both evaluations.**

A stamped addressed envelope has been provided for your ease in returning this form. Please feel free to write additional comments on the form or to contact me if you have questions about the training project. Please return the form by _____.

Sincerely yours,

Karen DeBord
Project facilitator

Study number _____

Parental Assessment

How long has your child been in the care of your current child care provider?

- a. less than 6 months
- b. six months to one year
- c. one to two years
- d. three to four years
- e. more than four years

List the ages of your children which are cared for by your child care provider: _____

Please rate the following aspects of the family child care environment by **circling** the most representative answer: Please answer **ALL of the items**.

- 1=inadequate
- 2=minimal
- 3=good
- 4=excellent, child centered

Environment

Adequacy furnishings/supplies

inadequate
minimal
good
excellent, child centered

Indoor space arrangement

1 2 3 4

Space for active play

1 2 3 4

Space for children to have alone time

1 2 3 4

Basic Care

Arriving and leaving routine 1 2 3 4

Meal and snack routines 1 2 3 4

Satisfaction with nap, rest routine 1 2 3 4

Diapering, toileting routines/areas 1 2 3 4

Provider's attention to personal
cleanliness and grooming 1 2 3 4

Attention to child's health needs and
emergency information 1 2 3 4

Attention to providing safe environment 1 2 3 4

Language

Caregiver's informal use of language 1 2 3 4

Helping children understand language 1 2 3 4

Helping children reason 1 2 3 4

Learning Activities

Appropriateness of learning
and play activities 1 2 3 4

Eye-hand coordination activities 1 2 3 4

Art activities 1 2 3 4

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Music and movement activities	1 2 3 4
Sand and water activities	1 2 3 4
Dramatic play activities	1 2 3 4
Block play	1 2 3 4
Use of TV	1 2 3 4
Schedule of daily activities	1 2 3 4
Supervision of play indoors and outdoors	1 2 3 4
Social Development	
Caregivers attention, tone, contact	1 2 3 4
Discipline techniques used	1 2 3 4
Attention to cultural diversity	1 2 3 4
Relationship with parents	1 2 3 4
Balance of personal household chores & caregiving responsibilities	1 2 3 4
Caregiver's involvement towards personal growth and knowledge of child care	1 2 3 4
Special Needs	
Caregiver's attention to special needs of children (diet, handicap)	1 2 3 4

Appendix H

Final Catalyst Evaluation

To be completed each person serving as a catalyst.

Rate the following factors based on your training experience.
Circle one number per item.

1= Poor 2= Unsatisfactory 3= Satisfactory 4= Very good 5= Excellent

- | | |
|---|-----------|
| 1. Level of training and resource support | 1 2 3 4 5 |
| 2. Overall quality of the relationship with providers | 1 2 3 4 5 |
| 3. Value of the original learning plan | 1 2 3 4 5 |
| 4. Value of information shared with provider | 1 2 3 4 5 |
| 5. Your feelings about the training process | 1 2 3 4 5 |
| 6. The mentoring method of learning for family child care providers | 1 2 3 4 5 |
| 7. Your personal satisfaction as a trainer with this method of learning | 1 2 3 4 5 |
| 8. The level of involvement with the provider | 1 2 3 4 5 |
| 9. New skills or insights to help you as a person | 1 2 3 4 5 |

10. Your feelings towards the level of learning which occurred 1 2 3 4 5

Please circle response.

11. Would you say that more learning occurred about child care or about the provider as a person?

12. Would you recommend this child care provider training method to others?

13. What other aspects should be included in the training program?

14. What aspects were unnecessary to have been included in this training program?

15. What changes have **you** made as a direct result of this training program?

16. Are you interested in offering similar training?

17. List the three most valuable aspects of this experience.

1.

2.

3.

Appendix I

Evaluative Responses from Catalysts

Extension Agents who served as catalysts completed a 10 item final evaluation primarily focusing on their involvement in the training program. Nine of the ten catalysts returned evaluation forms. Each item was to be rated with a 1 for poor, progressing to a 5 for excellent.

Overall ratings for items related to the value and personal satisfaction with the catalyst method of training averaged 3.7. The highest rated item was the overall relationship developed with individual providers averaging 4.0.

Qualitative remarks were summarized and most Agents agreed that a great deal of learning occurred about child care during the experimental time. Time intensity was noted as a concern. Agents suggested using volunteer trainers and to provide more detailed initial training about child development to the catalysts to raise their comfort level. Six of the 9 respondents are interested in pursuing the catalyst method of training further.

The most valuable aspect of the training from the catalysts point of view was the personal reward achieved through the provider-catalyst contact and observing

Training for Quality

positive changes occur in the child care environment as a direct result of the contact.

The catalysts reported learning more about child care environments and child development as a result of being involved in the training process.

Appendix J

Sample of Certificate of Completion

(Awarded to all providers, catalysts and validators involved in the study)



Award of Completion



This is to certify that

*has served as a validator of quality care of
Family Day Care Providers in a training program
sponsored by Virginia Cooperative Extension*

Project Catalyst

*Karen DeBord
Extension Specialist
Child Development*

Appendix K

Correspondence

VIRGINIA COOPERATIVE EXTENSION SERVICE

VIRGINIA
TECH

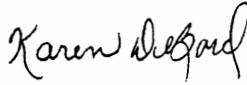
VIRGINIA
STATE

Extension Home Economics
217 Smyth Hall
Virginia Tech
Blacksburg, VA 24061-0417
(703) 231-5686

June 20, 1990

To: Extension Home Economists in Select Counties

From: Karen DeBord
Extension Specialist
Child Development



Re: Pilot Family Day Care Training Program

As promised, enclosed are copies of materials you will need to begin recruitment of a pool of providers for the pilot family day care training program.

1. Family Day Care Provider Information forms
2. Sample provider recruitment letter
3. Sample provider recruitment article
4. Permission form for use after the sample is identified (after training in August)
5. Two short articles on family day care and recruitment

I have reserved the classroom in the Northern District Extension Office. We will meet on August 17 beginning at 9:30 am. Hopefully we will be through by 3:00 that day. At least two persons from each unit should attend the training session; a validator and a catalyst. If you have decided to recruit both of these people, then they should attend along with you. **All involved agents should attend whether you are in a validating or catalyst role or not, since all communication will occur through the Extension offices.** If there are more than two people attending the training session that day, just let me know for a lunch and handout count.

Thank-you for your enthusiasm. I am looking forward to an exciting project!!

c. Bob Tudor



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An equal opportunity affirmative action employer



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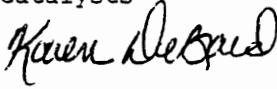
VIRGINIA
TECH

VIRGINIA
STATE

September 17, 1990

To: All Family Day Care Pilot Training Counties
Validators and Catalysts

From: Karen DeBord



Re: Let's begin!!

I have identified the family day care providers for our sample. A list is enclosed. Validators may begin by contacting providers and completing the Family Day Care Rating Scale AND obtaining a list of parent addresses for me.

The validators who are circulating the tape should not begin until the sample of providers have been scored and the scores sent to me!!

I will send a list of providers listing their training type (self-study or catalyst group) next week to Agents who are not validators.

Be sure to:

1. Get permission forms signed by each provider (enclosed).
2. Break up the resource packet for catalyst providers so as not to be overwhelming.
3. Call me if you are at all unsure about any part of the process. Many of you have already called my attention to important details.
4. Let me know your training program starting date.

You are a wonderful and dedicated group!! Many, many thanks and good luck!!

mailed attachments

validator instructions
provider permission forms
provider phone number list

c. Janet Sawyers

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Validators

Before you visit the assigned providers to complete the Family Day Care Rating Scale, place a friendly phone call to tell them that this first step in the pilot project is to have you visit their home and complete a checksheet about their day care setting. You will also have them and the parents of the children who they keep to complete the scale.

1. Obtain the addresses of the parents of the children whom they keep and mail those with the providers' name **immediately** to:
Karen DeBord
Family and Child Development Dept.
Wallace Annex
Virginia Tech,
Blacksburg, Virginia 24061-0416.
2. Set up a time to visit them for a few hours to observe. Tell them you will not get in their way, only observe. This is not meant to be a stressful situation!!
3. Tell them that in order to have them complete the scale, you will mail (or deliver) the checksheet and workbook. Then you will pick it up when you visit their home. That way they can rate themselves in advance and have the book to be sure they are rating themselves accurately. You are welcome to copy the pages as an option to giving them the book.
4. Mail or deliver the rating scale and score sheet to the provider with a letter of explanation.
5. Visit the home. Have an opening conversation. Greet the children and satisfy their curiosity by showing them what you have brought and that you just want to watch them play today.
6. Following your evaluation, ask the provider if they have any questions about using the rating scale. Try not to use example evident in the providers home when clarifying items. Collect the provider's score sheet, the green book and your score sheet. Allow the catalyst to copy the score sheets if she wants to at this point. This is what the catalyst will use to build the instructional plan for the provider. Mail all of the provider score sheets to Karen DeBord at the above address as soon as they are complete!!
7. When the CATALYST notifies you that the treatment time is complete, again schedule a visit to the provider's home. Mail or deliver the score sheet and scale and set up a time to visit each provider.
8. Mail all post evaluations from the validator and the provider to Karen DeBord at the above address as soon as they are complete!!

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Sample Letter

Personalize as appropriate

Date

Dear Provider (Substitute name),

I am looking forward to visiting you and the children on _____ (date). Before that time, please take some time to complete the Family Day Care Rating Scale. There is a score sheet and a book which explains each category. This is a scale which is cumulative, meaning that everything in the lower items must be met before a higher score is given. For example * for a score of three, everything must be met before a rating of 3 is given and everything in 3 and 4 and 5 must be met before you can get a score of 5 on any item.

Go ahead and complete the scale and I will answer any questions when I visit when we can go over the scale together.

Thank-you for your participation in this important pilot child care project.

Sincerely,

Your Name

* May wish to copy a page from the FDCRS and direct their attention to what is meant by cumulative for one item

Training for Quality

To: Extension Home Economists involved in the FDC Pilot Project

From: Karen DeBord

Now that the time is approaching to meet with providers selected for the pilot training program, several of you have been concerned about WHAT TO DO with the providers. I just want to help you remember the main points of this training program. I hope this will help you as you begin to meet the providers in the catalyst group.

1. This is not a traditional teaching method. You may be accustomed to planning a lesson and then being knowledgeable enough to answer all related questions and be the "expert" on the topic. The reason I am hoping that Extension Agents will do so well in this new method is that Agents are usually by nature very resourceful and creative problem solvers.
2. This new method will be a challenge to you. Not only will the provider learn new things, but maybe you will have some "Ah-ha" experiences along the way.
3. The first few meetings will be get acquainted time. Keep business to a minimum. Get to know the kids, sit on the floor, assure the provider through your actions that you understand her non-attentiveness to you and her attentiveness to the children from time to time. Discuss the best times for you to visit with her. Try to fit into her schedule as much as possible. Model acceptable practices by talking to children on eye level, being friendly and positive.
4. Explain to the provider that you will be using the validators comments to build a suggested program of learning especially for her. You will then go over it with her and see if it sounds ok. That might happen the next visit or the next after that. Only you will be able to read the body language and determine how fast or slow to proceed. Some providers may be ready to jump right in. Others may need more time just getting to know you first.
5. When the validator completes the FDCRS, copy the rating sheets you need for the catalyst group and send the originals all to me. Then use the score sheet to go through each area with the green manual and look at each item. Look at the score and determine what was not present in the environment. For example, Paula had some minor problems with broken furniture. Being the resourceful agent that you are, perhaps you could pull the old publication about repairing furniture, refer to it and together creatively and inexpensively decide what to do about the broken chair.

OR

Paula did not get on the child's eye level to speak to them. Through modeling, perhaps she would remember to do it more, OR since Carol said "no field trips," look around her immediate

Training for Quality

surroundings and suggest some field trip opportunities within walking distance for all to enjoy. For instance, could one of the workers across the street show the children some tools for 5 minutes or is there a field with flowers and leaves that the children could tape a reverse band of masking tape in their wrist and collect wild flowers, etc. to take back home and examine or paste to a paper plate?

Helping the provider expand their thinking is all part of it.

6. Refer to the resource recommendations list for Paula and develop a plan for your providers which you would like to accomplish. Then summarize it on a sheet for the provider. Use that as an initial planning guide.

7. The yellow handout I gave you but did not go over called Refreshing Your Memory on Adult Learners, has some ideas which will be helpful especially in the beginning. Read through that for some ideas for ice breakers.

8. When you think I should have received the score sheet on the provider in the mail, and you want some help discussing it, give me a call and we can talk through some ideas. I WANT YOU TO USE ME AS A RESOURCE. You are not expected to be a child care/development expert. Your resourcefulness will carry you through this new method of teaching.

9. Sometimes as a resource in the community, we are used to giving all of the answers. THIS time, on some occasions, just let the provider TALK and you listen and ask open-ended questions. Allow her to just talk while you supportively listen and reflect. Ask her "Why do you think that happened" or "Do you think there was a reason for Sam's unusual behavior" or "What could I do to help you find a way to deal with that?"

I know you will do a great job. It is just so out of character to teach in such an open-ended way. But one of the main objectives of this project is to test a new method of learning. With TIME at a premium, we need to continually look at the way we deliver information.

One Agent asked if you might all get together to talk about what is/is not working and share ideas after about a month. That would be fine and great. I would be happy to come on a convenient date to informally discuss things.

Also we can get together to talk about the whole process sometime in January maybe (if there is ANY travel money left by then!!) and discuss applying this model in the Extension system. I am thinking of a CARE MASTER program, such that some of these people who were in the catalyst group may give something back to the program by playing a supportive role to a new provider, through home visits (at night) and over the phone. At one time, I was thinking of using this concept with paid staff like EFNEP

Training for Quality

technicians. With such low funds right now, that isn't an alternative. But as we move along, you may have other ideas about how other units could use pieces and parts of this project.

Although it is not required, you may wish to keep a log on each provider or a notebook on the project with ideas that occur along the way.

Thank-you again for your hard work!!

VIRGINIA COOPERATIVE EXTENSION SERVICE

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October 22, 1990

To: All catalysts and validators

From: Karen DeBord *Karen DeBord*
Extension Specialist
Child Development

Re: For all you do

For all you are doing, have done and will do--I'd like to give each one of you a winning lottery ticket - but my crystal ball is out. Or, I could give you each \$5000, but unfortunately I didn't get my raise (- not that it would have helped!).

So, instead I'd like to give you a resource you might be able to use. Do something nice for yourself and select a book from the following list. If you can decide by October 20, I'll order the title you have selected and send it to you when it arrives.

It's just a token, but please know I'm appreciative for your hard work!!

Select two titles. One for first choice and one as a back-up depending on availability.

NAEYC

1. Art: Basic for Young Children
2. The American Family: Myth and Reality
3. Caring: Supporting Children's Growth - positive ways to deal with challenges of growing up including divorce, abuse, death
4. Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8
5. Feeling Strong, Feeling Free: Movement Exploration for Young Children
6. A Guide to Discipline
7. Helping Children Develop Through Play: A Practical Guide for Parents, Caregivers and Teachers
8. Helping Children Understand Peace, War and Nuclear Threat
9. How to Generate Values in Young Children: Integrity, Honesty, Individuality, Self-confidence, and Wisdom
10. The Infants We Care For
11. Let's Play Outdoors
12. More than Graham Crackers: Nutrition Education and Food Preparation with Young Children
13. Number in Preschool Education and Kindergarten: Educational Implications of Piaget's Theory

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14. Opening Your Door to Children: How to Start a Family Day Care Program
15. Parent Involvement in Early Childhood Programs
16. Places and Spaces for Preschool and Primary (outdoor structures)
17. Play: The Child Strives towards Self-realization
18. Separation
19. Setting up for Infant Care: Guidelines for Centers and Family Day Care Homes
20. The Significance of a Young Child's Motor Development
21. Woodworking with Young Children
22. Understanding the Multicultural Experience in Early Childhood Education
23. Teacher-Parent Relationships

Gryphon House (Children's literature):

24. Feelings - for age 3-6
25. Dr. Martin Luther King Story - for age 4-8
26. Something on my Mind - for age 4-8 (earnest, heartfelt feelings and moods of Black children earnestly expressed)
27. Caps for Sale - for age 4-7 (fun to act out!)
28. Sometimes I'm Afraid - for age 3-7
29. William's Doll - for age 4-8
30. Sometimes a Family has to Split up - for age 2-6
31. My Day Care Book - for age 2-5 (displays a multicultural classroom)
32. I Use a Wheelchair - for age 3-6
33. The Velveteen Rabbit - for age 4-8
34. Goodnight Moon - for age 2-5 (for before nap/bedtime)
35. No Bath Tonight - for age 4-8 (game played between grandmother and child to lure into bath)
36. Look Around - for age 2-6 (book of shapes)

Toys and Things Press

37. Take a Bite of Music, It's Yummy - combining music and nutrition
38. Kids and Play - activities and games for age 0-12.
39. Eye Winker, Tom Tinker, Chin Chopper - fingerplays, folksongs
40. With a Hop, Skip and a Jump - movement activities
41. Talking with Your Child About Sex
42. Parents Book of Toilet Teaching
43. It's My Body - story on resisting uncomfortable touch
44. Sometimes I'm Jealous - handling the arrival of a new baby
45. I Can't Wait - book to help children problem solve, choices, options

Name _____

First Choice(#) _____ Back-up Choice(#) _____

Mail to: Karen DeBord, FCD Department, Wallace Annex, Virginia Tech Blacksburg, Virginia 24061-0416

VIRGINIA COOPERATIVE EXTENSION SERVICE

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January 18, 1991

To: Extension Agents involved in the pilot family day care study
Greene, Fauquier, Shenandoah, Madison, Caroline,
Rappahannock, Spotsylvania, Clarke, Frederick, Loudon

From: Karen DeBord *Karen DeBord*
Extension Agent

Re: Nearing the end

Whew!! I guess you never realized what you were volunteering for when I asked who was interested in being involved in a pilot study. I have discussed progress of providers with several of you and am pleased to hear success stories and want to hear not so successful stories as well.

There are a few wrap-up tasks and reminders. Please read these carefully and respond as necessary.

1. Please notify me of your projected end date so I can send out the post parent evaluation forms.
2. Please duplicate the final perceptual evaluation form enclosed with this letter and send it to ALL of the providers for whom you are responsible. This will give us a different kind of feedback which will be valuable as we attempt to tell other units about the program. They can return them to you or directly to me. Se the bottom of page two. Return one per provider to me by March 15.
3. Work with your validator to assure all POST test scores are sent to me no later than March 15 UNLESS YOU CALL ME and we have agreed on an exception.
4. Have providers complete a POST self assessment using the Family Day Care Rating Scale.
5. I have enclosed certificates for all catalyts, validators and providers. Thanks to Bobby Swain in Extension Computing Resources, these look rather nice, I think!! Please consider an appropriate means of awarding the providers for their involvement in the project and extend my appreciation through assuring they receive this certificate in a timely manner.
6. Talk among yourselves and determine if there is a time when I could visit with you as a group to share and make recommendations about implementing such a program statewide.

Training for Quality

I realize the time intensity involved in this project and commend you on how you have included this project in with your other Extension work. I have made recommendations for technician-type staff to be employed to deliver training to family day care providers, but there is a (great) chance this would not be funded. There are other ways in the meantime we could discuss for implementing a mentoring type of system with the providers we have just trained.

If one of you could let me know if there is a meeting we could tag on to or a convenient time, I can check my schedule.

7. Return the resources which are out on loan as soon as providers have used them.

8. Complete the form called Final Catalyst Evaluation for immediate input and jot down any additional notes or thoughts (while they are fresh on your mind) for use to share in discussing and debriefing in our coming meeting!!

9. For those of you who sent the order form back, I purchased you a resource. I will be forwarding these through the Extension UPS system within the next two weeks. I am waiting for a few more to arrive to me first.

Thank-you, thank-you, thank-you, Thank-you, thank-you, thank-you!!

enclosures

c. John Huddleston
Deloris Ellis
Jay Mancini

Vita

Karen Brown DeBord received her Bachelor of Science degree in 1976 from Virginia Polytechnic Institute and State University in Management, Housing and Family Development. After working for three years as an Extension Agent in Wythe County, Virginia, she took educational leave to attend Virginia Commonwealth University in Richmond, Virginia where she completed a Master of Education degree with a specialization in Mental Retardation. Karen returned to Virginia Cooperative Extension and served as an Extension Home Economist and Four-H Youth Agent for three more years before transferring to Blacksburg to become a State Extension Specialist.

At the beginning of her doctoral coursework, she continued to be employed with Extension as a Program Development Specialist with Virginia Tech's Continuing Education Program. After three years in this position, she joined the faculty in the Department of Family and Child Development as an Extension Specialist for Child Development.

Karen Brown DeBord