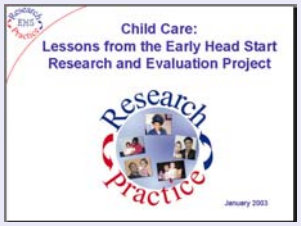
Early Head Start Research and Evaluation Project

TALKING POINTS:
"CHILD CARE"

SLIDE 1:
Lessons from the Early Head Start Research and Evaluation Project



[*Notes to the presenter: you may want to add a few slides from the Overall Findings PowerPoint presentation to provide background on the Early Head Start program or the Early Head Start Research and Evaluation Project*.]

These slides include findings from the Early Head Start Research and Evaluation Project that pertain to child care use and quality in Early Head Start communities.

ADDITIONAL INFORMATION

Findings in this presentation are drawn from the Early Head Start Child Care Policy Report, *The Role of Early Head Start Programs in Addressing the Child Care Needs of Low-Income Families with Infants and Toddlers: Influences on Child Care Use and Quality* (ACF, 2002c). This study is embedded in the larger Early Head Start Research and Evaluation Project that followed 3001 children and families from the time families were recruited for the program (and the research) until they were 36 months of age. The overall findings may be accessed through the web site on the last slide in this presentation. See *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start* (ACF, 2002a) for overall impact study results.

SLIDE 2:
Why Study Child Care in Early Head Start?

Child care receives this special focus because even before Early Head Start began, the Advisory Committee on Services for Families with Infants and Toddlers knew that many Early Head Start children would require child care.

The Committee thought this would be true whether the program offered center-based, home-based, or a combination of services.

The Committee went further to recommend that the program be responsible for the quality of care that all children were receiving.

If care was not provided on site, the Committee directed programs to help families find quality care. This would be challenging because the supply of quality care for infants and toddlers in communities was known to be low. Thus, many programs would need to form partnerships with child care providers in their communities to ensure the care that families chose became good quality.

This goal was supported by the Head Start Program Performance Standards that provide direct guidance for quality in child care settings.

The findings reported here are drawn from a longer report, *The Role of Early Head Start in Addressing the Child Care Needs of Low-Income Families with Infants and Toddlers: Influences of Child Care Use and Quality (ACF, 2002c).*

ADDITIONAL INFORMATION

The provision that services for families with infants and toddlers would receive a specified portion of the Head Start budget began with the Head Start Reauthorization of 1994. This law also mandated a committee of experts to establish the framework for the new program.

The Advisory Committee on Services for Families with Infants and Toddlers was appointed by the Secretary of Health and Human Services in 1994. It included child development, program, and research experts from across the U.S. The Advisory Committee made many recommendations to ensure that Early Head Start children receive quality child care.

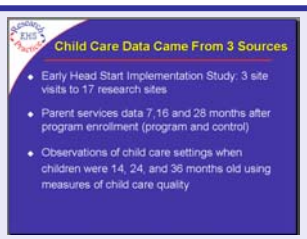
The Head Start Program Performance Standards were revised and became official in 1998.

A number of studies have documented a shortage of good quality infant-toddler center-based care in the U.S. The four-state Cost, Quality and Child Outcomes in Child Care Centers Study (Cost and Quality Study Team, 1995) reported that fewer than 10% of infant center-based settings were of good quality. Lower quality child care has been found to relate to lower levels of child functioning (Burchinal, Roberts, Nabors and Bryant, 1996) and this has been especially true for low-income children.

DISCUSSION QUESTIONS:

- What do the Performance Standards say about child care quality?
- How adequate is the supply of good quality care for infants and toddlers in your community/state/region? What are the strengths in infant-toddler care in your community/state/region?
- Do Early Head Start programs in your area provide on-site child care or partner with community child care providers? What are the pros and cons of these two approaches?

SLIDE 3:
The Early Head Start Studies of Child Care



The Early Head Start child care studies drew upon data from several sources.

First, the 17 Early Head Start research programs were visited in three rounds of site visits to learn about their implementation of Early Head Start services, including child care.

Second, as part of overall data collection about services, extensive data about use of child care were collected from parents in the research sample.

Third, you have heard that the children and families were assessed when children were 14, 24, and 36 months of age. As part of this child and family assessment, families who used 10 hours of child care or more were asked if the study could contact their primary child care provider. These providers were then observed using well-known child care quality observation scales.

The quality of care received by children in both program and control groups was observed. Quality was observed in all types of settings; however, the researchers were more successful in completing observations in center-based care than in family child care settings.

Most of what we report today is from *descriptive* data of Early Head Start children and families, but in some cases we report about impacts of the study by using data from the program and control groups. Because the main study was an experimental design study, it is possible to study differences between the program and control groups, and when differences are found, it is possible to attribute them to Early Head Start.

ADDITIONAL INFORMATION

Observations used included the Infant-Toddler Environment Rating Scale (ITERS; Harms, Cryer, and Clifford, 1990), the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R; Harms, Clifford, and Cryer, 1998), and the Family Day Care Rating Scale (FDCRS; Harms and Clifford, 1989) in family child care. In all settings, the Arnett Caregiver Interaction Scale (Arnett, 1989) was used as an additional measure, and a new measure that examined the language environments of children in child care was used. This measure is called the Child-Caregiver Observation Scale (C-COS; Boller, Sprachman, and the Early Head Start Research Consortium, 1998). It was developed by drawing upon the Observational Record of the Caregiving Environment (ORCE; NICHD Early Childhood Research Network, 1997) and the Adult Involvement Scale (Howes and Smith, 1995). Children were observed in child care settings for a minimum of two hours per observation. All observers were required to meet strict reliability standards to ensure uniform data collection methods across the sites.

All scales except for the C-COS have been used in many child care studies. They do not correspond perfectly to the Performance Standards, but programs scoring highly on these measures would be expected to meet most of the Performance Standards for quality and vice versa.

The research design was not perfect because child care was dynamic in communities. For example, some control group children attended community child care centers that may have become Early Head Start partners. This was unavoidable.

The response rates for the observations varied by the age point at which they were conducted, the type of arrangement (center or family child care), and whether the child was in the program or the control group. At 24 months of age, for example, response rates were 78% and 63% for program and control groups, respectively, in center care and 39% and 28%,respectively, for program and control groups in eligible family child care arrangements. Family child care included both licensed and legally exempt care or informal care. These rates are comparable to those found in other studies of child care quality. The lower response rates for family child care limited answering some research questions across types of care.

The final implementation study report, *Pathways to Quality* (ACF, 2002b), provides greater detail about child care from the program point of view.

DISCUSSION QUESTIONS:

- What do you know about assessment of child care quality in your area? Are you familiar with the measures used in this study? What other measures of child care quality are you familiar with? What dimensions of quality tell you the most about the experiences your children are receiving?
- Why do you think the researchers were more successful in assessing quality in centers than in family child care homes, which included informal care? Do you have similar experiences? What are implications for monitoring quality in settings used by Early Head Start children?

SLIDE 4:
The Policy Context During the Early Head Start Evaluation Period

During the Early Head Start study of child care, there were other things happening in the country that influenced child care use.

The Personal Responsibility and Work Opportunity Reconciliation Act, better known as welfare reform, was passed and began about the same time that the Early Head Start research programs began enrolling families. Also, throughout the period of the evaluation, the American economy was strong.

Both welfare reform and the strong economy increased the families' needs for child care.

Many Early Head Start programs changed their program designs during the early years of implementation. Many, even most, of the changes were driven by families' increasing needs for child care.

ADDITIONAL INFORMATION

DISCUSSION QUESTIONS:

- How did welfare reform affect the need for child care in your area?
- How has the economy affected the need for child care in your area, in the 1990s and currently?
- How has the economy affected the subsidy program in your state?
- How do these changes affect the Early Head Start programs?
- Have you observed that Early Head Start programs make major program changes based on changing needs of families for child care?

SLIDE 5:
Programs Took Alternative Approaches to Providing Child Care

Center-based programs (those providing the center-based option to all families) provided on-site child care in centers (4 of the 17 research sites). For the most part, center-based programs did not offer center care during nonstandard hours so families generally relied on less formal forms of care during those hours, if they had a need.

Home-based programs (those providing weekly home visits and group socializations) did not offer on-site child care but, as we will see, many families needed child care. Home-based programs may have contracted with community providers for center-based or family child care. Many families found their own arrangements, especially in the beginning of the evaluation period.

Mixed-approach programs (those offering home-based and center-based services in various combinations) used a combination of options. Some had centers on site and others contracted with community providers for child care. These contracts were more often with center providers than with the home providers. Some families found their own arrangements, as well.

ADDITIONAL INFORMATION

Three of the center-based programs in the evaluation sample offered full time on-site child care during standard working hours. The fourth received expansion funds midway through the evaluation period that allowed them to expand from part day to full day services.

DISCUSSION QUESTIONS:

- How do the Early Head Start programs in your area meet families' child care needs?
- What portion of Early Head Start children are in child care that meets (or attempts to meet) the Performance Standards? Is this on-site center care, a partnership with a community center, another arrangement, or a combination of options?
- What do you think are the pros and cons of various ways of meeting child care needs of families (on-site care, formal relationships with community providers, or informal relationships with community providers)?
- What trends influence the decisions programs make about which types of options to select?

SLIDE 6: Programs Took Many Steps to Enhance Child Care Quality and Quantity

The implementation study found there was tremendous activity in Early Head Start programs related to child care.

Altogether, Early Head Start programs implemented many innovative activities to enhance child care quality and availability both on site and with community partners (ACF, 2002b; Love, Raikes, Paulsell and Kisker, in press). Just a few of the many activities that occurred around child care were as follows:

- **Many programs became accredited** through the National Association for the Education of Young Children (NAEYC) accreditation system.
- **Partnerships between Early Head Start programs and community child care providers increased.** When the evaluation began, few of the relationships were formalized with contracts but by the end of the evaluation, there were more partnerships and more with formal contractual relationships.
- **Programs made many staffing, training, and building changes to meet the Performance Standards.** Programs took steps to ensure that staff had CDA or higher educational qualifications. Buildings were remodeled; in many cases, walls came down to create smaller classrooms to accommodate smaller group sizes specified by the Performance Standards.
- **Programs initiated methods to monitor quality both for on-site child care and for care in community settings.** Programs assessed individual classrooms and helped teachers take steps to improve quality.
- **They visited Early Head Start children in community centers**. When providers did not form partnerships, home visitors made resources available to the provider and child through visits at the child care site.
- **And they provided training for child care staff—both on site and for community providers.** Early Head Start programs offered considerable training to their own staff, but many programs also opened this training to child care partners and other providers in their communities.
- **Many new community collaborations were formed**. Councils, committees and groups formed to study the availability of child care within the community, and to address community-wide child care issues.
- **Many programs found new resources**. Many program directors found additional resources to meet the child care needs of their families, and many formed successful relationships with state subsidy managers. In some cases, states funneled quality enhancement or gaming funds to Early Head Start programs to partner with child care providers, and in other states, subsidies provided direct tuition.

ADDITIONAL INFORMATION

The Early Head Start implementation study reports provide full documentation of the steps programs took to influence child care quality. See the following reports:

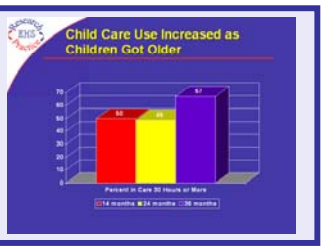
- ACF (2002b) *Pathways to Quality and Full Implementation in Early Head Start* and
- ACYF (1999 and 2000), *Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs, Volumes I, II,* and *III.*

These reports are available on the web site listed at the end of this document.

DISCUSSION QUESTIONS:

- What steps have the Early Head Start programs in your area taken to enhance child care availability and quality?
- What have you learned about the differences between partnerships with and without a formal contract?
- Which of the mechanisms seem to best leverage quality in your opinion?
- What are changes that have taken place in state-Early Head Start relationships? Do the Early Head Start programs in your area have relationships with state subsidy personnel? Do state Head Start Collaboration Coordinators communicate with state child care subsidy personnel?
- How integrated is Early Head Start with the overall child care community in your area and state?

SLIDE 7:
Child Care Use Increased as Children Got Older



Many Early Head Start families used child care.

Data from the study showed that child care use increased as children got older. Across all program approaches, around half of all children were in full-time child care (30 hours or more) at ages 14 and 24 months. By the time they reached 36 months, three-fourths were in full-time child care.

Child care use followed different patterns in programs with different program approaches.

In **center-based programs**, as would be expected, child care use was greatest; most (two-thirds) of the children were in 30 hours of care or more when children were 14 and 24 months of age. By the time they were 3 years old, three-fourths of the children were in care for that amount of time. Because these figures do not reach 100%, it is clear that some children were receiving center-based child development services on less than a full-time basis.

Families in **home-based programs** used considerably less child care. Only 37% of the families used full-time child care when children were 14 months of age, but by the time they reached age 3, 51% were in full-time child care (30 hours a week or more).

For **mixed-approach programs**, when children were 14 and 24 months of age, half of the children were in full-time child care, a figure that increased to two-thirds by the time the children reached age 3.

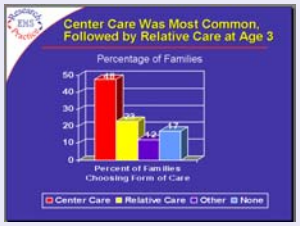
ADDITIONAL INFORMATION

Child care needs often determined the dominant service delivery model that programs selected, whether center-based, home-based or a mixed-approach. The Early Head Start Research and Evaluation project found that many programs originally funded as home-based tended to change to mixed-approach by the end of the study. In the beginning of the study, four of the programs were center-based, seven were home-based, and six were mixed-approach. By the time of the final site visit, four were center-based, two were home-based, and 11 were mixed-approach.

DISCUSSION QUESTIONS:

- How do patterns of child care use in the national study compare with child care use in your area? If there is a difference, what do you think accounts for the difference?
- Do families in your area tend to use more child care as children grow older?

SLIDE 8:
Center Care Was Most Common, Followed by Relative Care



What types of care did families use as their primary form of child care?

Across all program approaches and all three time points, center-based care was the most common form of child care used. By age 3, 48% of the children were in center-based care as their primary arrangement.

Child care provided by relatives was second most common, used at age 3 by 23% of the children. Interestingly, even in center-based programs, 14% of families reported that relatives were the primary child care provider.

Another 12% of children used care by another provider, and 17% were not in child care at age 3.

ADDITIONAL INFORMATION

The study defined primary care as the regular arrangement that the child was in 10 hours or more per week.

When children were 36 months of age, 68% of the parents with children in center-based programs reported that center-based care was their primary form of child care. Perhaps more surprisingly, 14% of the families in center-based programs reported that a relative was the primary child care provider, providing even more care than received at the center. Among the parents in center-based programs, 3% used other care and the remaining 15% did not name a provider they used for 10 hours a week or more.

When children in home-based programs were 36 months of age, about a third were in community center-based care. A quarter of the children were in the care of relatives for 10 hours a week or more. Another 15% were in other forms of care, while the remaining 22% did not identify a provider they used more than 10 hours a week.

In mixed-approach programs, when children were 36 months of age, almost half were in center-based care as their primary form of care while a quarter were in relative care. Another 13% were in the care of nonrelatives in homes, and the remaining 13% were not in any arrangement more than 10 hours a week.

Preferences for and patterns of child care use seem to have a cultural component. Child care use patterns varied by race/ethnicity of parents. Although child care use was high for all groups, more African American families used child care and used more center-based care, including Early Head Start centers, than was true for other groups. Across all program approaches, Hispanic families were most likely to increase center-based care as a result of participating in Early Head Start (the program group was highest relative to the control group). African American children were most likely to be in child care at a year of age; Hispanic children were least likely to begin child care during the first year of life, while White children were in between.

DISCUSSION QUESTIONS:

- How do the patterns of child care use in the Early Head Start program you know compare to use patterns reported here?
- What are cultural influences on child care in your area? Do they resemble patterns reported here?

SLIDE 9:
Several Other Trends Were Discovered

A substantial portion of children received care in their primary child care arrangement during nonstandard hours (not during 8-5 workdays). For example, at 24 months of age, the primary child care arrangement for 34% of the children included evening hours; and for 21% it was during weekend hours. For 16%, primary care was provided overnight.

Most Early Head Start children used only one regular child care arrangement for their Early Head Start child. **Fifteen percent used more than one regular concurrent arrangement.** Families enrolled in center-based programs were most likely to use multiple concurrent arrangements. Thirty percent of center-based families used multiple concurrent arrangements.

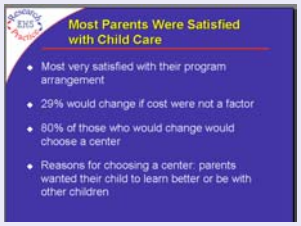
Despite the relatively high levels of use, the study found that many children seemed to be moving in and out of child care; so for some, child care use may have been inconsistent or unstable.

ADDITIONAL INFORMATION

DISCUSSION QUESTIONS:

- What is your experience of children using more than one arrangement or of needing care during nonstandard as well as standard hours?
- Have you observed that children may be moving in and out of child care? What causes this instability?
- What are the implications of these trends for children? For families? Are some trends or policies supportive of families but not children or vice versa? Who should have priority?

SLIDE 10:
Most Parents Were Satisfied with Child Care



How satisfied were parents with their child care?

At 28 months after program enrollment 95% of parents were satisfied with their primary child care arrangement, and nearly three-quarters were very satisfied. This is consistent with what has been found in other studies.

Despite parents' high levels of satisfaction, 29% said they would prefer to change child care arrangements if cost were not a factor. This rate of preference for change is similar to what has been reported in other child care studies.

Parents in home-based programs were most likely to prefer different arrangements (32%) compared to 26% of parents in mixed-approach programs and 28% of parents in center-based programs.

Of the families who said they would like to change child care arrangements, 80% preferred a center arrangement.

Of those who wanted center care, the main reasons were that parents thought centers would help their children learn better and they wanted their child to be with other children. Of those who wanted relative care, safety and convenience were the primary reasons.

ADDITIONAL INFORMATION

Parents were asked if they were very satisfied, satisfied, somewhat satisfied, not satisfied, or not at all satisfied with their child care arrangements and with specific aspects of the child care, e.g., safety, amount of attention the child received, how much the child was learning, and how good the provider was with children. They were also asked if they would prefer to change arrangements if cost were not a factor. Among those who would prefer to change, parents were asked what form of child care they would prefer and about their reasons for wanting to change. These questions were asked of all parents during the Parent Services Interviews conducted 7, 16, and 28 months after program enrollment.

At these high levels of satisfaction, parents were slightly more satisfied with safety and the attention their child was receiving than with how much their child was learning, with 97%, 97%, and 93% reporting satisfaction in these areas across the three time periods, respectively. A lower proportion of parents in home-based programs were very satisfied with these aspects of their child care arrangements compared to center-based and mixed-approach programs. For example, more center-based parents were very satisfied (74%) compared to 68% of mixed-approach and 65% of parents in home-based programs.

Although most parents who would change preferred center-based care, smaller percentages preferred a relative provider (8%), nonrelative providers such as friends and neighbors (5%), or other (6%), at 28 months after enrollment. Preferences for center-based care increased over time—from 67% at 7 months after enrollment to 73% at 16 months after enrollment to 80% at 28 months after enrollment.

DISCUSSION QUESTIONS:

- How satisfied are Early Head Start parents you know with their child care arrangements?
- How closely do you think satisfaction levels correspond with those reported here?
- What beliefs do parents in your area have about the merits of different forms of care for their children?

SLIDE 11:
Quality Was Good in Early Head Start Centers, Lower in Community Centers, Lowest in Family Child Care Homes

Early Head Start was charged with the task of ensuring good quality child care. What was the level of quality of child care that Early Head Start children experienced? Because ensuring quality in child care environments was a goal of the program, the study completed a quality assessment for all children in child care 10 hours a week or more when they were 14, 24, and 36 months of age. The investigators used well-known measures of child care quality: the Infant-Toddler Environment Rating Scale (ITERS) in infant centers; the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R) in centers when children were 3; and the Family Day Care Rating Scale (FDCRS) for family child care homes. We will look at quality in three settings.

Looking first at Early Head Start on-site centers (red bars): Early Head Start centers averaged above 5 at each measurement period—good quality. Scores of 5 and above on the measures used—the ITERS and the ECERS-R—are generally considered "good" quality. These findings affirm the importance of the Performance Standards for providing a base for quality.

Second, community centers (yellow bars). Average quality in community centers attended by Early Head Start children was lower than in the Early Head Start centers but appears to have improved over time (yellow bars). Some of the community centers were in partnerships with Early Head Start programs but some represented care families found on their own. Partnerships increased over the course of the study. By age 3, community centers and Early Head Start quality were fairly comparable.

Quality in community family child care improved but was lower than in center-based care. See purple bars.

ADDITIONAL INFORMATION

Quality scores for Early Head Start centers on the ITERS were 5.0 at 14 months, 5.2 at 24 months. When children were 36 months, it was necessary to use the preschool center-based assessment, the ECERS-R, and the score on that instrument was 5.1 on average.

Quality scores for community centers that Early Head Start children attended were 3.8 at 14 months (ITERS), 4.5 at 24 months (ITERS), and 4.9 (ECERS-R) at 36 months. These ratings included centers that were in partnership arrangements with Early Head Start programs and those that families selected on their own. The number and success of partnerships increased over the period of the study, as reported in the Early Head Start implementation study (ACF, 2002a).

Quality scores for family child care that Early Head Start children used were 3.4 at 14 months and 3.9 when children were 24 and 36 months of age. It was more difficult to gain the cooperation of family child care providers than center-based providers and so the findings for family child care should be interpreted with caution. Other studies have also reported greater difficulty in completing observations in family child care. Methodological studies generally report that providers who complete observations tend to be better educated and complete more training than those who do not. ITERS, ECERS-R, and FDCRS rating scales were developed at the University of North Carolina and have been used throughout the world as measures of child care quality. Scores on these measures have been found to significantly associate with child development outcomes, particularly for low-income children. In 2002 a revised ITERS scale was published.

Analyses of the ITERS and ECERS-R scale scores show variation in the levels of quality across the dimensions rated. At both 14 and 24 months, centers were rated highest or second highest on the ITERS Interactions scale. At both ages, Learning Activities received one of the lowest ratings. The ECERS-R scales differ somewhat from those of the ITERS but the same general pattern was found. On the FDCRS across all three ages, highest ratings were found in the area of Adult Needs, Social Development, and Language and Reasoning; lowest ratings were in Furnishings and Basic Needs.

DISCUSSION QUESTIONS:

- How does the overall quality observed in the national study compare with child care quality in your area?
- How has the quality of infant toddler center care and family care been affected as a result of Early Head Start program partnerships?
- The study found that, relatively speaking, learning activities needed improvement in centers. What are relative strengths in the centers (and homes) in your area?

SLIDE 12:
Child-Adult Ratios In Early Head Start Centers Bettered the Performance Standards

The next slide shows that ratios of children to adults observed were low (favorable) and exceeded the requirements of the Performance Standards in Early Head Start programs (on the left) and were near to the Performance Standards for the most part in community centers (on the right). The standards require no more than four infants and toddlers in care up to age 3 for each adult.

At **14 months**, observed ratios averaged one adult to fewer than three children in Early Head Start centers, and one adult to four children in community centers.

At **24 months**, ratios were observed at one adult for three children and slightly over one to four in community centers. Remember these community centers included both partner and nonpartner care.

At **36 months**, ratios were slightly over one adult for four children in Early Head Start centers and one adult for every six children in community centers. Some children had transitioned to preschool settings by the time their 36-month observations were completed and different ratio requirements would apply.

Ratios were observed at the same time quality ratings were completed.

ADDITIONAL INFORMATION

In child care centers used by Early Head Start children, child-adult ratios averaged 2.9 children per adult at 14 months, 3.5 to 1 at 24 months, and 5.5 children per adult at 36 months.

Many of the children had transitioned into preschool settings at the time of their 36-month observation. Therefore, they would be subject to the Performance Standards for 3-year-olds, which allow 13 to 15 children for two adults.

The Profile of Child Care Settings found an average child-teacher ratio between 6:1 and 7:1 at 36 months in a nationally representative sample of centers (Kisker, Hofferth, Phillips and Farquhar, 1991).

Other ratings of quality included in the study were the Arnett Caregiver Interaction Scale and the C-COS. Findings from these assessments were consistent with others reported here.

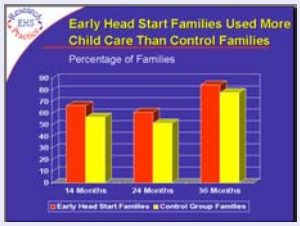
Early Head Start centers had higher scores on the Arnett Caregiver Interaction Scale than community centers, but only the difference at 14 months was significant.

The C-COS measured (1) any caregiver talk to the child; (2) caregiver responding to the child; (3) caregiver initiating talk with the child; and (4) incidents of the child's negative behavior. Differences between Early Head Start and community centers following the general pattern showed in these ratings also but were less pronounced than for other quality measures. Children in Early Head Start centers experienced more talk from the caregiver at 36 months than Early Head Start children in community centers. The C-COS also showed that caregiver talk to children was lower in centers at 36 months than in family child care homes (but not at 24 months). The researchers found that children experienced less caregiver talk of all kinds at 36 months than 24 months in centers, possibly due to increased child-teacher ratios. Incidents of negative behaviors were infrequent and not different across settings.

DISCUSSION QUESTIONS:

- How do children's experiences change when child-adult ratios are low (are more favorable)?
- Do you think it is true that teachers talk to children less when child-adult ratios increase?

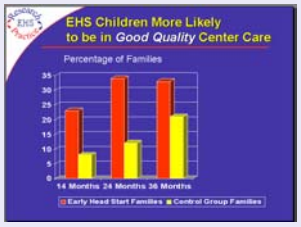
SLIDE 13:
Early Head Start Families Used More Child Care Than Control Families



The Advisory Committee on Services for Families with Infants and Toddlers charged Early Head Start programs to increase children's chances for receiving child care that would support their development. Did this happen?

First the study asked whether Early Head Start children participated in more child care overall than the control group. This analysis drew on the experimental design. In this slide we see that Early Head Start children did receive significantly more child care of any type than children in the control group at every age the study examined. This happened for a number of reasons—programs helped parents find employment and stay in school and they helped them find child care when they needed it.

SLIDE 14:
Early Head Start Children Were More Likely to be in Good Quality Center Care



Second, being in Early Head Start substantially increased the percentage of children who experienced good quality center care. Studies have shown that quality, center-based care can be a protective factor for low-income children.

The next finding also came from the experimental design. Across all forms of center-based care (Early Head Start and community centers in the eight [at 14 and 24 months] or nine [at 36 months] of our sites where there was sufficient sample) Early Head Start children were three times more likely to be in good quality center-based child care than were control group children when they were 14 and 24 months old (and nearly twice as likely to be in good quality care at 36 months). Because of difficulty gaining cooperation in observing family child care homes, especially in the control group, the study was not able to examine whether Early Head Start children were also more likely to be in quality family child care.

ADDITIONAL INFORMATION

This information is especially important because it was obtained using the experimental design. It was obtained by comparing the percentage of Early Head Start children who were in good-quality center-based care with the percentage of control group children who were in good-quality center-based care. These comparisons were made in a sample of center-based and mixed-approach sites that had sufficient sample. The number of children studied at 14 months was 1045, at 24 months it was 979, and at 36 months it was 1094. Numbers in the program and control groups were comparable.

The study also found that Early Head Start children used significantly less primary care during nonstandard hours; 47% of the control group vs. 35% of the program group received care during evenings. Additionally, 28% of the control group vs. 21% of the control group used primary care on weekends.

DISCUSSION QUESTIONS:

- Do you think Early Head Start is shifting the odds that children will have quality center care in your area?
- What are the long-term implications of this finding in your area?

SLIDE 15:
Quality Mattered for Early Head Start Children's Development

Does child care quality matter to Early Head Start children's development? As has been found in other studies (Burchinal, Roberts, Nabors, and Bryant, 1996), child care quality was positively associated with children's developmental outcomes.

Center-based child care quality was positively related to children's cognitive and language development. Higher quality for Early Head Start children in center care meant higher cognitive development scores when they were 2 and better language development when they were 3. Quality was not associated with aggressive behavior problems overall.

Spending more time in center-based child care related to higher levels of cognitive development at 2 and 3 years of age and with better language development at age 3. Overall, time in center-based child care was not related to behavior problems. Early Head Start data showed that when children spent more time in center-based child care, they did not display increased behavior problems, unless child-adult ratios were large (unfavorable).

ADDITIONAL INFORMATION

Regression analyses were conducted that controlled for key child and parent demographic variables. Selection bias may have been minimized because all families were Early Head Start families and many received guidance from the program in selecting child care.

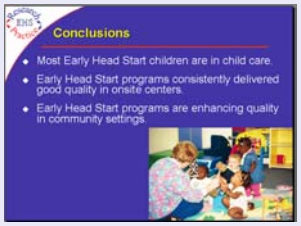
Other studies have reported similar findings. The National Research Council's recent review concluded that more positive structural quality features (higher caregiver qualifications; more favorable child-adult ratios and smaller group sizes lead to enhanced child development (Shonkoff and Phillips, 2000). Others have reported associations between quality and cognitive development (Burchinal et al., 1996).

At least one study reported increased aggressive behaviors associated with child care participation (NICHD Early Child Care Research Network, in press).

DISCUSSION QUESTIONS:

- What is different in children's experience in good quality child care as compared to lesser high quality care?
- How does good quality child care contribute to the development of Early Head Start children?
- Why would poor quality child care potentially harm the development of Early Head Start children? Would this be any more the case for low-income children than for any children?

SLIDE 16:
Conclusions



The majority of Early Head Start children are in child care—of these, a majority is in center care but a number are in relative care.

Early Head Start dramatically increased the chances of children—especially children 2 years of age and younger—receiving good quality, center care.

Early Head Start on-site care was good quality care, on average—demonstrating the value of the Performance Standards as a base for quality.

Quality in community child care center settings that Early Head Start children used went up over time and as children got older. Quality in family child care remains a concern.

Early Head Start program-community child care partnerships offer a promising mechanism for the future.

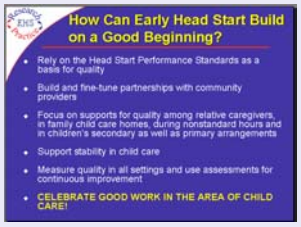
Both quality and quantity in child care centers were found to support the development of Early Head Start children.

ADDITIONAL INFORMATION

DISCUSSION QUESTIONS:

- What do you think are the most important findings from the research on child care?
- What has been the most important finding from research or other means of gathering information in your area?

SLIDE 17:
How Can Early Head Start Build on a Good Beginning?



The research suggests ways that Early Head Start can build on this good beginning.

1. Rely on the Performance Standards as a basis for quality.

2. Build and fine-tune partnerships with community providers.

3. Focus on supports for quality among relative caregivers, in family child care homes, during nonstandard hours and in children's secondary as well as primary arrangements.

4. Minimize children's frequent entries into and exits out of child care.

5. Measure quality in all settings and use assessments for continuous improvement.

Celebrate a good beginning in the area of Early Head Start and child care!

ADDITIONAL INFORMATION

Several dissemination committee members said that child care community partnerships present some unique challenges. On one hand, they say, directors and Early Head Start staff must hold their partners to the Performance Standards, and on the other hand they know they are building a long-term relationship that can suffer if it is too compliance-oriented. Thus, the relationships need to be nurtured over the long term. The Early Head Start program must be motivator, monitor, and friend. Some would claim the Early Head Start program should end the relationship if the child care provider does not comply, but to do so defeats the purpose of enhancing community child care and the provider may have the best child care in the community. Thus, the consultants say, it is important that monitors and trainers understand the narrow road Early Head Start needs to walk and provide support accordingly.

When the researchers asked about child care use at a specific point in time (such as around the child's third birthday), the percentage in care appeared smaller than when they asked the parent about their child being in care over the past six months. These differences suggest that some children may be experiencing frequent entries into and exits from child care. This would not be unexpected if reliance on government subsidies were necessary to pay for the child care. If the parent were temporarily unemployed, the family would lose subsidy eligibility. Covering the "gaps" in payments presents a large challenge for programs. As loss of child care payments is difficult to anticipate, it is difficult to budget for it. Child care facilities are often not able to cover the layoff period either. Withdrawing the child from service presents problems associated with instability for children. The problem is likely to require creative blending of funds from several sources and reexamination of policies by all parties involved. In states in which child care administrators have invested in Early Head Start as a mechanism for enhancing community child care quality, it may be possible to experiment with different procedures designed to enhance stability in quality settings.

DISCUSSION QUESTIONS:

- How can partnerships be built and fine-tuned in your area? What supports are needed from regional offices and trainers? How can the relationships between child care community partners and Early Head Start be built so they are win-win relationships?
- How have programs partnered or enhanced care with relatives, providers in secondary arrangements, and family child care homes in your area?
- What is a reasonable approach to interrupted needs for child care?
- How have programs resolved problems related to temporary loss of child care subsidy payments in your area? What are the possibilities for engaging subsidy administrators in a dialogue to enhance stability in quality settings?
- What is there to celebrate about the progress that has been made in a few short years in Early Head Start child care in your area?

SLIDE 18:
For More Information

For more information log onto the following web site:

http://www.acf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

ADDITIONAL INFORMATION

Findings in this report are based on reports completed by the Early Head Start Research and Evaluation Project available at www.acf.hhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html.

The Early Head Start Information Kit: Research to Practice--Child Care and other papers in this series are available from www.headstartinfo.org or www.ehsnrc.org.

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