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LITERATURE REVIEW

Demographics of Family, Friend, and Neighbor Child Care in the United States

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The Reviews of Research series synthesizes research on selected topics in child care and early education. For each topic, Reviews of Research provides an in-depth Literature Review, a summary Research Brief, and a companion Table of Methods and Findings from the literature reviewed. Each of these are available on the *Research Connections* web site: www.researchconnections.org.

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What We Know

Family, friend, and neighbor (FFN) child care (also referred to as informal care, home-based care, kith and kin care, kin care, relative care, legally unlicensed, and license-exempt care) is growingly recognized as home-based care – in the caregiver's or child's home – provided by caregivers who are relatives, friends, neighbors, or babysitters/nannies. While FFN care is typically unlicensed or subject to minimal – if any – regulation, the distinction between FFN care and licensed family child care (FCC) can sometimes be blurred since variation in state or county regulations may mean that care that is regulated in one state may not be regulated in another.

Research on FFN care is still in early phases. While studies have not consistently defined FFN caregivers, a growing number of national, state, and multi-site studies indicate the following about the demographics of families that use FFN care and provide this type of care:

- FFN care is the most common form of non-parental care in the U.S., with estimates of the proportion of children with employed parents using this care ranging from one-third to over one-half (33-53 percent for children under 5, and 48-59 percent for school-age children).
- Patterns of FFN use differ by children's age. Infants and toddlers – regardless of family income or structure – are most likely to be cared for by FFN caregivers as their only non-parental source of care, while preschoolers are more likely to use multiple care arrangements that include relative care. School age children also spend a considerable amount of time in FFN care, with 6-9 year olds spending more time in relative care than 10-12 year olds, who are increasingly likely to be in self-care.
- Patterns of FFN use also differ by family characteristics. There are no clear patterns of FFN use by ethnicity; families across all socioeconomic groups rely on FFN care, although families with low-incomes are most likely to use this care; generally, families' decision to use FFN is influenced by a combination of factors including family structure (marital status), parents' work status, and parents' work schedule.
- FFN caregivers tend to share several characteristics. They are most commonly relatives and most often grandmothers; FFN caregivers are usually located in close geographic proximity to the children for whom they care (in both urban and rural settings); FFN caregivers are often of the same ethnic background as the children they care for; and FFN caregivers often have similar incomes to the families of the children they care for.
- FFN caregivers of children receiving child care subsidies are more likely to provide care for more hours (essentially full-time), across standard and non-standard hours; they are more likely to express interest in licensure; and non-relative caregivers are more likely than relative caregivers who receive child care subsidies to view providing child care as a way to generate income.

Introduction

Currently, more than 60 percent of children in the United States under the age of 5 are in some type of non-parental child care on a regular basis (Johnson, 2005) and care by family, friends, or neighbors (FFN) is the most common form of non-parental child care in the nation (Maher & Joesch, 2005; Sonenstein, Gates, Schmidt, & Bolshun, 2002; Snyder, Adelman & Dore, 2005). Nearly half of all children (under the age of 6) spend time in family, friend, and neighbor care (Boushey & Wright, 2004), and nearly a quarter of school-age children are cared for by FFN caregivers (Capizzano, Tout, & Adams, 2000; Snyder & Adelman, 2004).

Recognizing the widespread use of FFN care, a number of national and state initiatives have invested public funds to support the use and strengthening of family, friend, and neighbor care. For instance, since 1988 parents can use federal child care subsidies (through the Child Care and Development Fund) to pay for care by a FFN caregiver, and currently nearly a quarter of all children who receive federal child care subsidies use FFN care (U.S. Child Care Bureau, 2006). Additionally, more than 25 percent of states now fund initiatives specifically aimed at family, friend, and neighbor child care (Porter & Rivera, 2005).

Policymakers are also interested in FFN care due to the national focus on children's readiness to enter kindergarten and the creation of state-funded public preschool programs, which have prompted policymakers, researchers, and parents to question how various early childhood settings affect child outcomes and prepare children for school. Much of the child care research to date has explored licensed child care settings (such as child care centers and family child care homes). Given that FFN caregivers are generally exempt from state regulation (depending on the state) and therefore not required to meet defined program standards, a growing body of literature explores who these caregivers are and the type of care they provide.

This review examines the literature on the demographics of family, friend, and neighbor care. (A separate review is being prepared by the authors for *Research Connections* on the quality of FFN care.) Specifically, it answers the following questions:

- What proportion of employed parents use FFN care?
- Do patterns of FFN use vary by the child's age?
- Do patterns of FFN use vary by family characteristics, such as income level, ethnicity, and parent work schedule?
- What are the characteristics of FFN caregivers?

Exploring these questions is complicated since, to date, researchers and policymakers have not consistently defined FFN care. For instance, some researchers have focused on caregivers providing child care for relatives but have not included those caring for the children of friends or neighbors. Additionally, some researchers have studied home-based care but have not specified the caregiver's relation to the child, and have included both regulated and non-regulated homes in their samples. (Sampling complications are further discussed below). Despite these limitations, a review of the current literature on demographics of FFN care begins to pull together information to inform future research on family, friend, and neighbor care as well as guide policies and programs (such as support groups, home visitation, etc.) to serve these caregivers.

Further understanding of the characteristics of family, friend, and neighbor care also provides important context for examining the quality of FFN care. A number of studies on family, friend, and neighbor care (several included in this review) also explore the quality found in this type of care, mostly in comparison to the quality found in other child care settings. (See *Research Connections'* review *Quality in Family, Friend, and Neighbor Child Care Settings* <www.researchconnections.org/location/14340>.)

What is Family, Friend and Neighbor Child Care?

Family, friend, and neighbor care (also referred to as informal care, home-based care, kith and kin care, kin care, relative care, legally unlicensed, and license-exempt care) is one of several types of non-parental child care. Child care types are typically categorized according to setting (center-based or home-based), regulatory status, and the provider-child relationship (see Morgan, Elliott, Beaudette, & Azer, 2001). Other types of non-parental care include center-based (licensed and licensed-exempt) care and home-based, licensed family child care.

In this review we define family, friend, and neighbor care as home-based care – in the caregiver's or child's home – provided by caregivers who are relatives, friends, neighbors, or babysitters/nannies who are unlicensed or subject to minimal – if any – regulation. While this definition reflects a growing consensus in the field, researchers and policymakers have yet to settle on a consistent term and definition to describe the unregulated, home-based sector of child care in which so many children spend their time.

Across the literature, FFN caregivers have been categorized differently in various research and administrative datasets. For instance, in some studies researchers have classified child care by a non-relative that is paid for and provided in the non-relative's home as family child care rather than FFN care, even if the non-relative is not licensed (Brandon, 2005). Other studies group all home-based providers regardless of licensing status (Mulligan, Brimhall, West, & Chapman, 2005). Despite these inconsistencies the demographic findings of these studies are described below to pull together the information currently available.

These inconsistencies are also not surprising, given that family, friend, and neighbor caregivers can be difficult to distinguish from family child care providers since states and counties vary widely in which home-based providers are required to be regulated. That is, care regulated in one jurisdiction may not be regulated in another (Brown- Lyons, Robertson, & Layzer, 2001; Morgan, et al, 2001; Whitebook, Phillips, Bellm, Crowell, Almaraz, & Yong Jo, 2004). In one state, for example, a home-based provider may need a license to care for one unrelated child; in another she/he may not need a license until she/he cares for four. Even within jurisdictions, the implications – for providers, parents, and children – of regulated and unregulated categories of home care are unclear (Porter & Kearns, 2005).

Despite these complexities in regulatory status, family, friend, and neighbor care is distinct from other types of child care in several ways. It encompasses a greater variation in caregivers and caregiving situations than licensed settings. For example, caregivers may care for only related children – possibly including their own, a mix of related and unrelated children, or only unrelated children. They may provide care in their home or the child's home. They may be paid for the care they provide or not. There also may be a variety of reasons caregivers choose to provide care. As understanding of the FFN caregiver population and the families and children they serve progresses, greater consensus on definitions and terms across the research, program, and policy sectors will be essential.

Background Research on Family, Friend, and Neighbor Care

Research on FFN child care is still in an early phase. Prior to 2003, studies were limited, with generally small and non-representative samples (with the exception of Brandon, et al, 2002; Kontos, Galinsky, & Howes, 1995; and Sonenstein, et al, 2002). Questions focused most heavily on the demographics of families using FFN care and FFN caregivers themselves (Brown-Lyons, et al, 2001; Susman-Stillman, 2003). Themes emerging from those early reports reflect an interest in describing FFN caregivers, including their level of education and training and their interest in pursuing education, support and/or licensure. There was also interest in understanding the use of FFN caregiving by low-income families.

In general, these early studies were instructive in guiding a post-2003 phase of research, when questions about demographics and use were asked in a

wider variety of studies, and when questions about the quality of FFN care began to be posed. Since 2003, findings have accumulated more rapidly and present a more detailed picture of patterns of FFN caregiving, FFN users, and FFN caregivers. These findings are detailed below.

Criteria for Selection of Studies for Review

In combing the literature for relevant research, the authors considered a wide range of sources, including peer-reviewed journals; published reports from government agencies and well-known research organizations; presentations at respected research conferences; and recently completed unpublished studies. Twenty-five studies are included in this review, all which were judged methodologically sound (met minimum standards of scientific inquiry and are based on representative samples[1]) and draw evidence-based conclusions, using what is currently understood as best theory and practice.[2] Recently completed studies that have not yet been published were included based on the use of questions or methods that broke new methodological ground or yielded new information.

A table on the methods and findings of the studies focusing on demographics accompanies this review. The table summarizes groups studied and questions asked in these reports, as well as methods, data, and findings (see the *Demographics of Family, Friend, and Neighbor Care in the United States–Table of Demographics Methods and Findings* at <www.researchconnections.org/location/14339>.)

Description of Studies

The descriptive literature to date on the demographics of family, friend, and neighbor care can be broken into four categories: (1) studies based on large-scale, national surveys; (2) multi-site studies; (3) state studies and (4) smaller-scale studies. (See Table 1: Methodology of studies reviewed for a full listing.)

Demographic information on family, friend, and neighbor care was collected through surveys, interviews, and administrative data. The large-scale national surveys listed above collected basic demographic information such as primary child care arrangements used, and variations of arrangements used by the child's age or family income status. Since child care arrangements are a subset of these questionnaires, they do not offer in-depth information about FFN caregiving, such as the type of relative providing care or hours of care provided, but they provide nationally representative information on use of unlicensed or relative care.

The state surveys were designed to focus more specifically on child care arrangements and family, friend, and neighbor care, thus they are more likely than the national surveys to answer questions about the type of relative providing care, the hours of care provided, and payment received. The multi-site studies and smaller-scale studies also collected demographic information through interviews and focus groups.[3]

There are several issues in summarizing the information collected from these studies. As noted above the studies each define FFN care differently either separating relative and non-relative care or grouping all home-based caregivers together regardless of regulatory status. Secondly, some studies focused on certain subgroups of providers and families using child care. For instance, one national study (the *National Study of Child Care for Low Income Families*) examined low-income families using child care, some multi-site studies focused on families receiving cash assistance (such as the *Three City Study* and *Growing Up in Poverty*), and one state study (in Illinois) examined caregivers within the subsidy system. Comparability across studies is therefore limited, but themes across this young literature are summarized below.

Table 1: Methodology of Studies Reviewed

Types of Studies	Methodology/ Datasets	Studies Reviewed
National survey studies	National Survey of America's Families (NSAF)	Capizzano & Adams, 2000; Capizzano, Tout & Adams, 2002; Snyder & Adelman, 2004; Snyder, Adelman & Dore, 2005; and Sonenstein, Gates, Schmidt, & Bolshun, 2002
	National Study of Households and Families (NSHF)	Guzman, 1999
	National Household Education Survey (NHES)	Mulligan, Brimhall, West, & Chapman, 2005
	Survey of Income and Program Participation (SIPP)	Boushey & Wright, 2004; and Brandon, 2002
Multi-site qualitative studies	Parent and/or provider interviews; provider questionnaire (in the NICHD study).	Coley, Li-Grining, & Chase-Lansdale, 2001; Fuller, Chang, Suzuki, & Kagan, 2001; Fuller, Kagan, Loeb, & Chang, 2004; Layzer & Goodson, 2006; Loeb, Fuller, Kagan, and Carrol, 2004; NICHD, 1996; Vandell, McCartney, Owen, Booth, & Clarke-Stewart, 2003
State survey studies	Illinois – linked surveys of parents and their license-exempt providers participating in the state subsidy system. Longitudinal analysis of statewide subsidy administrative data.	Anderson, Ramsburg, & Scott, 2005
	Washington – telephone survey of families and FFN caregivers	Brandon, Maher, Joesch, & Doyle, 2002
	Minnesota – telephone survey with randomly selected households across the state	Chase, 2005; and Chase, Arnold, & Schauben, 2006b
Smaller-scale qualitative studies	Focus groups and/or interviews with parents and/or caregivers	Drake, Unti, Greenspoon, & Fawcett, 2004; Maxwell, 2005; Porter, 1998; Reschke & Walker, 2005; Todd, Robinson, & McGraw, 2005

Emerging Themes

The literature reveals several themes about the demographics of the families of children in FFN care as well as of family, friend, and neighbor caregivers.[4]

FFN care is the most common form of non-parental care in the United States

Both national and state-based studies consistently show high use of family, friend, and neighbor care. Estimates across studies of the proportion of all children with employed parents using FFN care range from one-third to over one-half, with estimates for regular use of FFN child care as high as 33-53 percent for these children under age 5 and 48-59 percent for 6-12 year olds (Boushey & Wright, 2004; Maher & Joesch, 2005; Sonenstein, Gates, Schmidt, & Bolshun, 2002; Snyder & Adelman, 2004; Snyder, Adelman & Dore, 2005). Care is also most often provided by relatives (ranging from 17 percent to one third, varying across age groups and across studies). Parents are therefore relying very heavily on FFN caregivers, particularly relatives, to care for their children while they work.

Not only is FFN care common, but children are also likely to have this as their only child care arrangement, particularly if they are very young children (under age 3) or cared for by a relative (Layzer & Goodson, 2006; Sonenstein, et al, 2002; Snyder & Adelman, 2004*)*. A national survey found that among all children under age 13 with employed parents, only about 7 percent have multiple arrangements that include relative care (Snyder & Adelman, 2004) however, research suggests that these percentages vary with the age of the child. One multi-site study found that for 90 percent of the children in home-based child care, this was their single full-time child care arrangement (Layzer & Goodson, 2006). Other research focused on families using FFN care also suggests that multiple arrangements may be more likely among some populations using FFN child care than others (such as low-income families; see Knox, London, Scott & Blank, 2003).

Patterns of FFN Use Differ by Children's Age

Infants and Toddlers

Infants and toddlers, regardless of family income or structure, are predominantly cared for by family, friends, and neighbors. One state study in Minnesota, for example, found that 78 percent of children under the age of 3 were in FFN care (Chase, 2005). Children under age 3 are also most likely to use relative care as their only non-parental source of care (Maher & Joesch, 2005; Snyder & Adelman, 2004). Among children of employed parents in relative care, infants and toddlers are as likely as preschool-age children to be in full-time (35 plus hours per week) relative care (Snyder & Adelman, 2004). Moreover, infants and toddlers living below the poverty line are more likely to use relative care than non-relative or center care (Mulligan, et al, 2005).

Preschoolers

Preschoolers are more likely to use center-based care than infants and toddlers, and the use of multiple care arrangements that include a combination of formal and informal care, is more common for 3 and 4 year-olds with employed parents than any other age group (estimates range from 13 to about 40 percent) (Capizzano & Adams, 2000; Maher & Joesch, 2005; Snyder & Adelman, 2004). At the same time, approximately one-fifth of 3 and 4 year-olds use relative care as their single arrangement (Mulligan, et al, 2005).

School-Age Children

Relative care is also one of the most common forms of care for school-age children (6-12 year-olds) with approximately 20 percent in relative care. Given that school-age children are in school during the day, they spend shorter periods of time in relative care than do younger children, but significant amounts of time nonetheless. Roughly two-thirds to three-fourths of school-age children in relative care are in care 15 hours per week or less (Capizzano, Tout, & Adams, 2000; Snyder & Adelman, 2004), while about 40 percent of younger children in relative care spend 35

or more hours per week in relative care (Snyder & Adelman, 2004). Early elementary age children tend to spend more time in relative care than 10-12 year-olds, perhaps because older children are more likely to spend time in self-care (Chase, et al, 2005).

Patterns of FFN Use Differ by Characteristics of the Families Who Use FFN Child Care

Ethnicity

Families of all ethnicities use FFN child care, but some research suggests that use of family, friend, and neighbor care may be higher among certain ethnic groups, and may be commonly used by immigrant families in the United States, because they want their children to be cared for by someone who shares their culture, language, and values (Porter, 2005). The research findings are mixed, however, on whether certain ethnic groups may use FFN care more frequently. Some national and multi-site studies found FFN care use to be the highest among Latino and Black families (Capizzano, Tout & Adams, 2000; Kids Count, 2006; Layzer & Goodson, 2006; Snyder & Adelman, 2004), but other national surveys did not reach this finding. For instance, the National Household Education Survey (NHES) found Black families with children under 6 were as likely to select relative and center-based care (Mulligan, et al, 2005), and the Survey of Income and Program Participation (SIPP) did not find that FFN use varied by ethnic group (Boushey & Wright, 2004). Other analyses of the SIPP data show that immigrant families were more likely to rely on relative care than were non-immigrants (U.S.-born) (Brandon, 2002).

Beyond cultural preferences, greater use of FFN care by certain ethnic groups may also be tied to income level or to access issues such as cost or needing care during nights and weekends. For example, one study found that Blacks are as likely to report a preference for center-based care as for relative care, but yet are more likely to use relative care (Brandon, 2002), while other studies show Black mothers receiving welfare (and therefore have access to subsidies) tend to use center care (Loeb, Fuller, Kagan & Carroll, 2004; Mulligan, et al, 2005). Further research on the interactions between ethnicity, income, and type of care is necessary. More qualitative data to help understand parent's selection of care will be particularly useful.

Income

While families across all socioeconomic groups rely upon FFN care, families with low incomes may be more likely to rely upon FFN care than licensed care (Anderson, et al, 2005; Chase, et al, 2006 a, b; Coley, Li-Grining, & Chase-Lansdale, 2001; Layzer & Goodson, 2006). Estimates from multi-site and state studies of the proportion of low-income families who receive subsidies that use FFN care range from about one third to over one half (Layzer & Goodson, 2006, Anderson, et al, 2005), and national studies show that families with incomes in the top 20 percent are least likely to use FFN care (Boushey & Wright, 2004; Mulligan, et al, 2005). Data from the Child Care and Development Fund also indicates that about one-quarter of subsidized low-income families use this form of care (U.S. Child Care Bureau, 2006). Low-income families may be more likely to use FFN care because of the low-cost or no cost for this arrangement, or because these families may need flexible arrangements for shift work and non-standard hours, which FFN caregivers can provide, or because of the limited availability of licensed care within their community.

The research is somewhat mixed however, as one national study found no differences in the use of relative and center-based care by families with children living below the poverty line and decreased likelihood of using relative care in families living at or above the poverty threshold (Mulligan, et al, 2005), suggesting that there may be factors beyond cost, flexibility, and/or access when low-income families select their child care arrangements. Some research has suggested that those accessing subsidies are more likely to use center-based care perhaps because subsidy agencies refer more to centers (Burstein, Layzer, and Cahill, 2007).

Parental Work Status and Family Structure

Other factors such as family structure (parents' marital status) and parents' work status (full-time or part-time employment) – can also affect parents'

decision to use FFN care. Several large-scale surveys have examined these factors in various combinations. According to analysis of the National Survey of America's Families (NSAF) data, employed single-mothers with children under age 13, regardless of full-or-part-time work status, relied more on relative care as their single, full-time care arrangement or on a combination of relative and other care arrangements than did two-parent working families (Snyder & Adelman, 2004). Further, analysis of a subset of the NSAF data found that 6-12 year olds with full-time, employed parents – both single and married – used FFN care at similarly high rates (Capizzano, Tout & Adams, 2000). Taken together, these findings suggest that families with single parents and full-time working parents are more likely to use FFN care. While Brandon and colleagues also found that children in FFN care were more likely to have single parents and employed mothers, they observed that this was also true for children cared for in centers and family child care settings (Brandon, et al, 2002).

Other research also suggests that mothers who are married or have partners may be less likely to use FFN care than single parents. Moreover, unlike single mothers, the work status of married mothers may be indicative of the type of care they choose. Data from the National Survey of Families and Households (NSFH) suggest that married/partnered mothers who work part-time are more likely to use husband/partner care and those working full time are more likely to use center care. In one study, mothers' employment status and family structure did not tend to predict use of grandparents, other relatives, or informal non-relative caregivers (Guzman, 1999). Similarly, in the NICHD Study of Early Child Care – parents in two-parent working families with very young children were more likely to share child care responsibilities and limit non-parental care (Han, 2004). Data from the SIPP suggest that mothers who worked more than 40 hours per week were less likely to choose FFN as their primary arrangement and most likely to use formal care (Boushey & Wright, 2004). More research is needed to clarify the impact of work status and other family variables on FFN care use.

Timing of Parent Work Hours

One widespread belief is that FFN child care offers parents the flexibility that licensed settings cannot provide. Parents in focus groups and interviews, including statewide samples, report that they choose FFN care because it provides the flexibility they need, namely care during non-standard hours (Anderson, et al, 2005; Brandon, et al, 2002; Chase, et al, 2006a; Coley, Chase-Lansdale, & Li-Grining, 2001; Drake, Unti, Greenspoon, & Fawcett, 2004; Maxwell, 2005). Results from a number of large-scale samples vary on the link between FFN care use and parent non-traditional work hours, with some studies finding no differences in the rate of relative care use by parent work schedule (Guzman, 1999; Snyder and Adelman, 2004) while a study of low-income families using home-based care found that mothers tended to work non-standard hours. (Layzer & Goodson, 2006). This discrepancy requires further study.

Children with Special Needs

Data on children with special needs in FFN settings comes mainly from state-specific studies. In two states, approximately 16-20 percent of FFN caregivers report caring for a child with special needs (Brandon, et al, 2002; Chase, et al, 2005). In those studies, special needs are broadly defined as special physical, emotional, behavioral or developmental needs.

Parents of children with disabilities and other special needs may tend to choose FFN care because they have difficulty finding regulated care for their children (Brown-Lyons, et al., 2001; Chase et al, 2005). However, some studies find greater percentages of children with special needs cared for in licensed settings (Layzer & Goodson, 2006), while others find no significant differences in the likelihood of parents using FFN or center care for children with or without special needs (Brandon, et al, 2002). While centers may indicate ability to provide care to children with disabilities and other special needs, they often have few available slots. As with other parents using FFN care, parents of children with special needs may not be aware of center options or not confident that their children will receive appropriate care in a center

(Fuller et al, 2001; Browns-Lyons, 2001). State policies are an important consideration, as some (such as in Massachusetts) may promote licensed settings for children with special needs. Further research is needed to examine the number of children with special needs cared for in FFN settings, the extent to which their needs are being met in FFN settings, and the kinds of supports provided to their FFN caregivers.

What are the Characteristics of FFN Providers?

Below we discuss themes about FFN providers, including how likely FFN caregivers are to be related to the children they care for, the ethnicity of FFN caregivers, where care tends to take place, caregivers' income and employment, and whether they receive payment for the care they provide.[5]

FFN Caregivers Are Usually Relatives, Most Often Grandmothers

Relatives, most often grandmothers, are the most common FFN caregivers, although the proportions of relative and non-relative caregivers vary across studies (Boushey & Wright, 2004; Brandon, 2002; Guzman, 1999; Layzer & Goodson, 2006; Vandell, McCartney, Owen, Booth & Clarke-Stewart, 2003). More is known about relative than non-relative caregivers, perhaps due in part to the fact that relatives are most likely to provide FFN care. It is difficult to gauge accurately the distribution of relative and non-relative FFN caregivers because large-scale studies differ in their categorization of FFN caregivers and generally lack the ability to clarify which relative or friend provides the care. There are virtually no survey data available that describe non-grandparent relative caregivers.

Relative caregivers are more likely than other providers to provide care for all weeks of the year. Studies vary on the number of hours per week relatives provide care, with some finding that they provide full-time care (Snyder & Adelman, 2004) and others finding that they provide fewer hours of care (Layzer & Goodson, 2006.) In another study, relative caregivers receiving subsidy payments provided care for longer hours than relatives who did not (Chase, et al, 2006b).

Some research has explored patterns of grandparent caregiving. Rates of grandparent care use vary across studies, with studies looking at samples of various sizes, different time periods of care, and full and part-time care. In one multi-site longitudinal study, roughly 14 percent of children consistently received care from grandparents over a three-year period, and 35 percent received care from grandparents during at least one three-month period (Vandell, et al, 2003). In a national study, 28 percent of preschool-aged children with employed mothers were cared for by grandparents either full-time or part-time (Guzman, 1999).

Patterns of grandparent care are differentially related to factors including co-residence, maternal work status, maternal work hours, and ethnicity. Co-residence predicts use of grandparent care – consistent full-time care, consistent part-time care, or sporadic care (Guzman, 1999; Vandell, et al, 2003). Data from the NICHD SECC show that full-time grandparent care over a period of at least one year is most likely under conditions of co-residence, full-time parent employment, and non-white ethnicity; while consistent part-time care is most likely under conditions of co-residence and maternal employment during non-standard hours across all ethnic groups. Sporadic grandparent care is most likely under conditions of co-residence, maternal employment during non-standard hours, and younger mothers (Vandell, et al, 2003).

Analyses from the NSFH (Guzman, 1999) also show that grandparents are more likely to provide care when they live nearby or in the household, when they have a good relationship with the child's mother, and when the grandchildren are their biological grandchildren. Two curious findings emerged from these analyses – that grandparents are less likely to care for children under the age of 3, and that grandparents who provide care are less likely to be in good health. As infants and toddlers are most likely to be in FFN care, and grandparents are the most common caregivers, this finding is hard to reconcile with others. More research is also needed to understand the health and well-being of grandparent care providers and the implications for children and families.

The Location of FFN Care

Two questions arise regarding the location of FFN care: rates of use by geographic area and by specific location of care (the provider's or child's home). State and smaller-scale studies offer some indication that FFN care is used widely in both urban and rural areas, some of which are economically depressed or have fewer centers available (Anderson, et al, 2005; Chase et al, 2006a; Todd, et al, 2005).

Not surprisingly, FFN care is most likely when the caregiver is located in geographic proximity to the children for whom they care (Guzman, 1999; Maxwell, 2005; Reschke & Walker, 2006; Vandell, et al, 2003). The bulk of FFN caregiving, by both relatives and non-relatives, takes place in the provider's home. Children under age 3 and ages 3 through 5 are significantly more likely to be cared for in a relative's home than their own home (or a combination of a relative's home and their home) than school-age children. However, Hispanic children under age 6 who receive care from relatives are more likely to receive care in their own home (Mulligan, et al, 2005). While co-residing with a relative caregiver strengthens the likelihood that a child will be cared for by the relative (e.g., Anderson, et al, 2005), the majority of children who are cared for by relatives do not live with them (Snyder & Adelman, 2004).

Ethnicity

As FFN use is common across all ethnic groups, there is great ethnic variation in FFN providers. Often (69 percent of the time) there is an ethnic match between FFN providers and children, even when caregivers are not family members (Layzer & Goodson, 2006). Having an ethnic match is viewed by some parents and providers as an advantage of FFN child care, as it can aid in the transmission of cultural knowledge, values, and practices (Anderson, et al, 2005; Drake, et al, 2004; Guzman, 1999).

Income and Employment

FFN providers often match the income brackets of the families of the children for whom they care. While some FFN caregivers are in low-income brackets (Layzer & Goodson, 2006) not all are. In Washington State, only 20 percent of FFN providers fall into low or moderate income categories (Brandon, et al, 2002), and in Minnesota, half of FFN providers have household incomes above $40,000 (Chase, et al, 2006). Studies of lower-income and subsidy populations find that FFN caregivers and parents have similar incomes. Not surprisingly, providers caring for children receiving subsidies tend to have lower incomes than those caring for children who do not receive subsidies. In Illinois, almost half of FFN providers caring for children receiving subsidies had participated in means-tested social programs in the last five years (Anderson, et al, 2005). In Minnesota, FFN providers caring for children receiving subsidies owned homes at lower rates, and double the number had incomes below $30,000.

In addition to providing care, some FFN providers work outside the home, while others do not (Brandon, et al, 2003; Chase, et al, 2005). In Minnesota, FFN providers who care for children receiving subsidies are less likely to have a job in addition to providing child care and are more likely to generate income from providing child care than other FFN providers (Chase, et al, 2006b). Further research is needed to understand the patterns of additional employment and the economic stability and resources of FFN providers. FFN providers' income and employment indicate the potential resources they can invest in their caregiving, and those data can be used to help target supports to subgroups of FFN providers.

Payment

The extent to which FFN providers, particularly relatives, charge for care is related to their motivations for providing care. Relative providers often provide care to help out the family and not to generate significant income (Porter, 1998; Reschke & Walker, 2006). Other research indicates that they perceive their caregiving as a support for their families, following the notion that caring for their family is what is expected of them and the right thing to do (Bromer, 2006). As a result, relatives tend to charge little or nothing (Brandon, et al, 2002; Chase, et al, 2005; 2006a; Mulligan, et al, 2005), or accept the level of subsidy

payment with no co-payment from the child's parent. Non-relative providers are more likely to charge for care, as they are more likely to provide care to earn money and/or receive alternative forms of payment. For instance, some families report that they provide concrete help to their provider, such as transportation, food, or housecleaning in exchange for child care (Anderson, et al, 2005; Chase, et al, 2005).

Characteristics of FFN Care and FFN Caregivers Linked to Subsidy Receipt

A limited number of state studies offer some insights into the links between subsidy use, the type of care families choose, and characteristics of FFN caregivers who receive subsidy payments (Anderson et al, 2005; Chase et al, 2006b). Nationally, subsidy use is increasing (Tout & Zaslow, 2006), although periods of subsidy receipt are often short and interrupted (Anderson, et al, 2005). The use of subsidy dollars appears to affect some parents' choice of care as well as some features of the care provided. As noted above, there is some indication that parents using Child Care and Development Fund (CCDF) dollars choose center-based care more frequently than other forms of care. It is unclear, however, the extent to which this is due to: self-selection where parents who preferred center-based care applied for subsidies; parents' greater likelihood of learning about subsidies from a center director; or to encountering fewer barriers to the use of subsidies for center care. (Burstein, Layzer, and Cahill, 2007*)*.

Nonetheless, a notable percentage of parents receiving subsidies choose FFN care. Nationally, nearly a quarter of families receiving subsidies use FFN care (U.S. Child Care Bureau, 2006). This percentage is even higher in some states. In both Illinois and Minnesota, at least half the families receiving subsidies chose FFN care as their primary care arrangement (Anderson, et al, 2005; Chase, et al, 2006b). The parents receiving subsidies and choosing FFN care in Illinois indicated they are satisfied with their care (Anderson, et al, 2005). Interestingly, findings from other studies indicate that families using subsidies to pay for child care increase their use of relative care after they leave the welfare system (Robins, 2003; Snyder & Adelman, 2004). Subsidy money may aid in the quality and stability of FFN caregiving arrangements since it offers caregivers income and/or is used to help buy children basic provisions such as food, clothing, and books (Anderson, et al, 2005).

The impact of the CCDF program on FFN caregivers and the care they provide is another emerging area of study. The very limited amount of data currently available suggest that there are some similarities between subsidized and non-subsidized FFN care (such as reasons for providing care for relatives and providing care during non-standard hours), but also some important differences. For example, providers caring for children receiving subsidies are likely to do so for more hours (essentially full time), across standard and non-standard hours, and are more likely to indicate an interest in learning about licensure (Anderson, et al, 2005; Chase, et al, 2006b; Todd, et al, 2005). There are also differences between subsidized relative and non-relative FFN providers. Non-relatives are more likely than relatives to view providing child care as a way to generate income (Chase et al, 2006b). To an extent, when supported by subsidies, FFN care – especially by non-relatives – may share some features of licensed home-based care. Further research is warranted on the impact of CCDF on the use of FFN care, on FFN providers, and on features of FFN care.

Methodological Issues

As the literature describing FFN providers is growing, there are some important methodological issues of which to be aware.

Inconsistent Definitions of FFN Care

As discussed throughout this review, the lack of a consistent definition of family, friend, and neighbor caregivers has implications for future research, practice, and policymaking. Comparisons across data sets are difficult, and conclusions are limited by inconsistencies in how FFN providers are categorized. As a result, it is often impossible to identify caregivers as relatives or non-relatives, or identify the type of

relative, neighbor, friend, or acquaintance. For example, analyses describing characteristics of different relative providers, or patterns of use by type of provider, cannot be conducted consistently with current data. Without those kinds of data, the efforts of practitioners to provide support to FFN providers may be less effective, and the diminished ability of policymakers to understand the similarities and differences among different groups of FFN caregivers may hamper effective policymaking.

Sampling

In addition to inconsistent definitions, sampling with FFN caregivers is a tremendous challenge. Recruiting a representative sample of FFN caregivers for research can be difficult since, by definition, they tend to be an invisible, informal, and diverse population, making them hard to reach (Whitebook, et al, 2004). Conducting outreach to FFN providers is time-consuming and expensive, and few researchers are able to muster the necessary resources (see Layzer & Goodson, 2006 for a further description of the difficulties encountered in sampling). The heterogeneity of the FFN population necessitates a range of strategies to engage them in research, but there is currently no data to indicate which strategies are the most effective in engaging the FFN population for research purposes.

As a result of these difficulties, samples of convenience may be common (Brown-Lyons, et al, 2001), or select populations are studied (such as FFN caregivers who receive subsidy payments), and generalizability is therefore limited. While there are legitimate reasons to restrict sampling to the CCDF population, it is also the case that CCDF providers are easier to locate and track. Analyses of administrative data are limited to CCDF providers or to providers who opt to be part of the administrative system; they may differ from providers who do not. The reality is that with FFN populations, as compared to licensed caregiving populations, obtaining samples where the results can be generalized to all FFN caregivers is harder to achieve.

Issues Not Adequately Addressed by the Current Set of Studies

Continued research on the use and features of FFN care is critical, particularly in light of its prevalence and the growing efforts to develop effective programs and policies to enhance FFN caregiving. However, the ability to synthesize information across studies is hampered by the lack of a consistent definition of FFN caregivers. Whether that definition should acknowledge regulatory and licensing status may be open for debate (Brandon, 2005).

Many important and useful questions are open for study, particularly clarifying patterns of use by ethnicity, parental work status and family structure, as well as focusing on similarities and differences in providers who do and do not receive subsidies. More information is needed about relative caregivers, specifically grandparents, but also the other relatives and friends who play an important caregiving role in children's lives. In addition, while there are some longitudinal data from national surveys and some from administrative data, further research is needed to examine patterns over time, particularly in concert with programs and policies.

Conclusion

While there are still many unanswered questions about the population of family, friend, and neighbor caregivers, families who use FFN care, and factors affecting patterns of use, the growing number of studies converge on several themes: FFN caregiving is commonly used by all kinds of families; patterns of use vary by children's age with FFN care being most common among infants and toddlers; families across all socioeconomic levels use FFN care but low-income families are most likely to use this care; families' decisions to use FFN care are influenced by a combination of factors including family structure (marital status), parental work status, and parent's work schedule; FFN caregivers tend to share several characteristics – they are usually relatives (most often grandmothers), they typically live close to the child's home, and they tend to share the same ethnic background and income

level as the families of the children they care for; and finally, there are notable state variations in FFN care populations, in part reflecting state-specific policies. The continued evolution of this literature, building on this early generation of work, will be of great importance as researchers, program developers, advocates and policymakers work to meet the needs of these caregivers who are integral to the lives of families and children in our communities.

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Endnotes

1. As noted above, subgroups of FFN caregivers were often sampled and are therefore representative of those subgroups but cannot be generalized to all FFN caregivers. Distinctions of these subgroups are made throughout the report.

2. The companion review *Quality of Child Care in Family, Friend, and Neighbor Settings* includes several of these studies which address the quality, as well as the demographics of FFN care, plus studies that focus exclusively on quality in FFN child care. See www.researchconnections.org/location/14340.

3. Many of these studies also involved observational quality assessments. See the literature review *Quality in Family, Friend, and Neighbor Child Care* for a listing and explanation of quality measures used in the FFN child care studies.

4. See Appendix 1 for the studies that correspond to each theme.

5. For information related to provider's education and training see the companion review *Quality in Family, Friend, and Neighbor Care*.

Appendix 1: Topics Addressed by Reviewed Studies on Demographics of FFN Care

Themes	Studies Reviewed
FFN care is the most common form of non-parental care in the United States	Boushey & Wright, 2004; Capizzano & Adams, 2002; Layzer & Goodson, 2003; Maher & Joesch, 2005; Knox, et al, 2003; Sonenstein, Gates, Schmidt, & Bolshun, 2002; Snyder & Adelman, 2004; Snyder, Adelman & Dore, 2005
Patterns of FFN Use Differ by Children's Age	Anderson, et al, 2005; Capizzano & Adams, 2002; Chase, et al, 2005; Maher & Joesch, 2005; Mulligan, et al, 2005; Snyder & Adelman, 2004
Patterns of FFN Use Differ by Characteristics of the Families Who Use It	
Ethnicity	Boushey & Wright, 2004; Brandon, P., 2002; Brandon, et al, 2002; Capizzano, Tout & Adams, 2000; Chase et al, 2005; Layzer & Goodson, 2006; Loeb, et al, 2004; Mulligan, et al, 2005; Snyder & Adelman, 2004
Income	Anderson, et al, 2005; Coley, et al, 2001; Boushey & Wright, 2004; Chase, et al, 2006a, b; Layzer & Goodson, 2006; Mulligan, et al, 2005
Parental work status and family structure	Boushey & Wright, 2004; Capizzano, Tout & Adams, 2000; Guzman, 1999
Timing of parental work hours	Anderson, et al, 2005; Brandon, et al, 2002; Chase, et al, 2006; Coley, et al, 2001; Drake, et al, 2004; Guzman, 1999; Layzer & Goodson, 2006; Maxwell, 2005; Snyder & Adelman, 2004
Children with special needs	Brandon, et al, 2002; Chase, et al, 2005; Layzer& Goodson, 2006
Patterns of FFN Provision Differ by Characteristics of FFN Providers	
Relative caregivers	Boushey & Wright, 2004; Brandon, 2002; Chase, et al, 2005 b; Guzman, 1999; Layzer & Goodson, 2006; Snyder & Adelman, 2004; Vandell, et al, 2003
Location of FFN care	Anderson, et al, 2005; Chase, et al, 2006a; Guzman, 1999; Maxwell, 2005; Mulligan, et al, 2005; Reschke & Walker, 2006; Vandell, et al, 2003; Snyder & Adelman, 2004; Todd, et al, 2005
Ethnicity	Anderson, et al, 2005; Drake, et al, 2004; Guzman, 1999; Layzer & Goodson, 2006
Income and employment	Anderson, et al, 2005; Brandon, et al, 2003; Chase, et al, 2005; Layzer & Goodson, 2006;
Payment	Anderson, et al, 2005; Brandon, et al, 2002; Chase, et al, 2006a; Mulligan, et al, 2005 ; Porter, 1998; Reschke & Walker, 2006 ; Todd, et al, 2005
Characteristics of FFN Care and FFN Caregivers linked to subsidy receipt	Anderson, et al, 2005; Chase, et al, 2006 a, b; Todd, et al, 2005