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Continuity of Care: Charting Progress for Babies in Child Care Research-Based Rationale

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Recommendation #3

Support continuous relationships between providers and caregivers and the children they care for, from when they enter child care to age three: Provide information and supports for providers and caregivers to develop nurturing, responsive, and continuous relationships with children from when they enter child care to age three.

"The irreducible core of the environment during early development is people. Relationships matter." – Ross Thompson, "Development in the First Years of Life," The Future of Children[1]

What does the research say about babies and toddlers and continuity of care?

The most important relationships usually begin in the family, when an infant forms an attachment relationship with the person who is primarily responsible for the infant's care.

If the baby's needs are met, the infant forms a secure attachment—or "base"—that creates a foundation for healthy development in early childhood and beyond.[2] When early relationships are nurturing, individualized, responsive, and predictable, they increase the odds of desirable outcomes—

building healthy brain architecture that provides a strong foundation for learning, behavior, and health.[3] Young children with a weak early foundation have an increased risk for problems later, when they will need to build on those basic capabilities established in the early years to develop more complex skills.[4]

Providers and caregivers who regularly care for very young children can have a positive impact on child development by forming continuous, strong attachments with children.

Young children need a secure base from which to explore in their non-parental care settings. Research has found that infants with secure attachment relationships with their care providers are more likely to play, explore, and interact with adults in their child care setting.[5] When very young children transition from room to room according to pre-determined developmental stages or ages, they can experience high levels of distress.[6] A study of children aged six- to thirty-months in child care centers found that when the children experienced fewer changes in those who cared for them in a day and longer stretches with their primary caretaker, they were less likely to exhibit behavior problems in child care.[7] Higher numbers of changes in center or family child care providers in the earliest years has been linked to less outgoing and more aggressive behaviors among children at ages four and five.[8]

A "continuity of care" approach can enhance the relationship between caregivers and young children in center-based child care programs by keeping young children within the same setting and with the same team of providers for an extended period, usually for the first three years of their lives. One evaluation of a program using this approach found that attachment grows over time. The longer infants and toddlers were with the same provider, the more likely they were to form a secure attachment to that provider; 91 percent of infants and toddlers who had been with their provider for more than one year had a secure attachment relationship.[9]

Providers and caregivers who regularly care for very young children can also have a positive impact on child development by supporting attachment and helping families.

A secure attachment relationship between infants and their child care providers can complement the relationship between parents and young children and facilitate early learning and social development.[10] Children in both child care centers and family child care homes have been found to benefit when their providers are sensitive and responsive.[11] Other family members, friends, and neighbors who provide regular care for babies and toddlers can also play a critical role in helping support the stability of the family if they are supportive of the parents.[12] Further, unlike professional child care providers, these family, friend, and neighbor caregivers are likely to be part of a baby's life well beyond the early years.

How can state child care licensing, subsidy, and quality enhancement policies ensure continuity of care for babies and toddlers?

Researchers have found that the number of child care providers that support the idea of continuity of care for babies and toddlers is greater than the number that have been able to implement it.[13] An analysis across a small number of centers in Louisiana found that directors had concerns about space limitations, staff turnover, and making the model work from a business perspective, but that directors were more likely to identify the attitudes and abilities of the providers in the classroom as barriers to implementing continuity of care from birth to age three.[14]

State policymakers can take steps to provide information and training, create supportive licensing rules, and support implementation of continuity of care strategies. The continuity of care approach is a central recommendation of the **Program for Infant/Toddler Care (PITC)**, a nationally recognized training model for child care providers.[15] It is also being piloted in **Educare** centers in five states using two models, one in which the same children are together birth through age three in similar age groups, another in which mixed-age groups of infants and toddlers are cared for together while they are between birth and age three.[16] A critical feature to moving toward this recommendation on continuity of care is providing state funds to help child care providers learn and implement these approaches. States can use their Quality Rating and Improvement Systems (QRIS) and child care subsidy systems as vehicles for providers to meet and maintain continuity of care standards. Further, states can provide accessible information to caregivers and parents about the critical nature of early relationships.

To move toward this recommendation, states may use multiple policy levers, starting from different points. Potential state policies include:

Licensing

- Require that centers and family child care homes assign a primary child care provider responsible for each infant and toddler, through state licensing requirements.
- Require that centers implement continuity of care strategies to allow children to remain with their primary caregiver(s) from entry into child care to age three, through state licensing requirements.
- Remove any barriers in state licensing requirements to centers operating rooms with mixed-age groups in order to implement continuity of care strategies for children birth to age three. Apply the provider-to-child ratio applicable to the youngest child in the group.

Subsidy

- Raise child care subsidy payments to centers and family child care homes that implement continuity of care strategies with low-income infants and toddlers in their care.

Quality Enhancement

- Train providers on methods to promote continuity of care by keeping children with the same providers and in the same group from birth to age three, to the maximum extent possible.
- Ensure that the standards, design, and incentives of state Quality Rating and Improvement Systems (QRIS) specifically address and encourage use of primary caregiving and continuity of care techniques with infants and toddlers.
- Develop and disseminate information and resources appropriate for family, friend, and neighbor caregivers and parents about the importance of consistent early relationships for babies and toddlers.

What are some other recommendations that affect continuity of care for babies and toddlers?

- States can underscore the importance of continuous, primary caregiving relationships in what the state sets as the standards for a core body of knowledge that infant and toddler providers should have (see Recommendation #1: Establish what providers and caregivers should know to care for babies and toddlers).
- States can increase access to systems of professional development for providers and supports for caregivers to learn more about infant and toddler development and needs for continuity of care (see Recommendation #2: Ensure that providers and caregivers for babies and toddlers have access to education, training, and support).
- Continuity of care practices can be supported by broader state initiatives to improve the quality and reduce turnover of the child care workforce. Reducing turnover of providers is critical; a study of three California communities at three points in time found average annual turnover rates of 30 percent for all child care center staff, and over half the centers with turnover in the last year had not been successful in replacing all the staff they had lost.[17] The same study found that child care staff wages compared unfavorably with those of K-12 public school teachers, were not keeping pace with inflation, and were identified by teaching staff as needing improvement in order to reduce turnover. State quality enhancement policies and workforce policies, such as wage and benefits programs for child care providers and scholarship programs, can influence turnover and thus continuity of care (see Recommendation #4: Promote competitive compensation and benefits for infant and toddler providers).

- Effective implementation of continuity of care and primary caregiving in group settings is reinforced by better provider-to-child ratios and small group sizes (see **Recommendation #6: Ensure that babies and toddlers in centers are in small groups with sufficient numbers of providers** and **Recommendation #7: Ensure babies and toddlers in family child care are in small groups with sufficient numbers of providers**).

- State subsidy policies can influence the access that low-income families have to high-quality providers and the length of time that families have financial support to pay for child care. For example, state subsidy policies determine reimbursement rates for infant/toddler care, which in turn influence whether high-quality programs participate in the subsidy system, and how much those programs can pay to attract and maintain qualified, experienced child care providers to work with babies and toddlers. State policies also determine how long families may qualify for a subsidy, which can determine whether parents are able to stay with the same provider over time (see **Recommendation #14: Promote stable, quality care through subsidy policy**).

Online tools and resources for state policymakers:

Information on child development:

- The Web site of the **National Scientific Council on the Developing Child** contains several publications on various aspects of child development, in the form of working papers, articles, and science briefs. Two recommended publications from the Council are:

    - **A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children**, and

    - **The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do**.

- The seminal book, **Neurons to Neighborhoods: The Science of Early Childhood Development**, examines findings from neurobiology, behavioral sciences, and social sciences on the critical nature of development during ages 0-3 and presents recommendations on how society, policy, and practice can better support infants' and toddlers' healthy development.

- **ZERO TO THREE** focuses specifically on infants and toddlers and has a variety of resources on its Web site, organized broadly for professionals, parents, and policymakers, on topics such as **child development**.

Information on implementation of the continuity of care approach in policy initiatives:

- The **Program for Infant/Toddler Care (PITC)** is a training curriculum for infant and toddler providers based on the importance of early relationships. The **California Department of Education** has **implemented** the PITC model across the state.

- The **Educare model** is being implemented in cities across the country.

- Indiana has required a continuity of care approach in state licensing rules, and released **guidelines** to help ensure that child care inspection staff members have a tool for determining compliance with regulations.

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[1] Ross A. Thompson, **"**Development in the First Years of Life**,"** *The Future of Children* 11, no. 1 (2001): 21-34, **http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=79324.**

[2] Ross A. Thompson, "Early Attachment and Later Development," in *Handbook of Attachment: Theory, Research, and Clinical Applications*, ed. Jude Cassidy and Phillip R. Shaver, 1999, 265-286.

[3] *The Science of Early Childhood Development*, National Scientific Council on the Developing Child, 2007, **http://www.developingchild.net/pubs/persp/pdf/Science_Early_Childhood_Development.pdf**.

[4] *The Science of Early Childhood Development*.

[5] Helen Raikes, "A Secure Base for Babies: Applying Attachment Theory Concepts to the Infant Care Setting," *Young Children* 51, no. 5 (1996): 59-67.

[6] Debby Cryer, Laura Wagner-Moore, Margaret Burchinal, Noreen Yazejian, Sarah Hurwitz, and Mark Wolery, "Effects of Transitions to New Child Care Classes on Infant/Toddler Distress and Behavior," *Early Childhood Research Quarterly* 20, no. 1 (2005): 37-56.

[7] J. Clasien de Schipper, Marinus H. Van Ijzendoorn, and Louis W.C. Tavecchio, "Stability in Center Day Care: Relations with Children's Well-being and Problem Behavior in Day Care," *Social Development* 13, no. 4 (2004): 531-550.

[8] Carollee Howes and C.E. Hamilton, "Children's Relationships with Caregivers: Mothers and Child Care Teachers," *Child Development* 63, no. 4 (1992): 859-866.

[9] Helen Raikes, "Relationship Duration in Infant Care: Time with a High-Ability Teacher and Infant-Teacher Attachment," *Early Childhood Research Quarterly* 8, no. 3 (1993): 309-325. In comparison, 67 percent of infants and toddlers who had been with their caregiver for 9-12 months had secure attachments, and 50 percent of infants and toddlers who had been with their caregiver for 5-8 months had secure attachments.

[10] Carollee Howes, "Attachment Relationships in the Context of Multiple Caregivers," in *Handbook of Attachment: Theory, Research, and Clinical Applications*, ed. Jude Cassidy and Phillip R. Shaver, 1999, 671-687.

[11] Alison Clarke-Stewart, Deborah Lowe Vandell, Margaret Burchinal, Marion O'Brien, and Kathleen McCartney, "Do Regulable Features of Child Care Homes Affect Children's Development?" *Early Childhood Research Quarterly* 17, no. 1 (2002): 52-86; Susanna Loeb, Bruce Fuller, Sharon Lynn Kagan, and Bidemi Carrol, "Child Care in Poor Communities: Early Learning Effects of Type, Quality and Stability," *Child Development* 75, no. 1 (2004): 47-65.

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[13] Debby Cryer, Sarah Hurwitz, and Mark Wolery, "Continuity of Care for Infants and Toddlers in Center-Based Child Care: Report on a Survey of Center Practices," *Early Childhood Research Quarterly* 15, no. 4 (2000): 497-514.

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[15] Program for Infant/Toddler Care, "PITC's Six Program Policies," **http://www.pitc.org/pub/pitc_docs/138?x-r=disp**.

[16] Personal communication with Mary Jane Chainski, Director, Bounce Learning Network.

[17] Marcy Whitebook, Laura Sakai, Emily Gerber, and Carollee Howes, *Then & Now: Changes in Child Care Staffing, 1994-2000, Technical Report*, Center for the Child Care Workforce, 2001, **http://www.ccw.org/pubs/Then&Nowfull.pdf**.