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Child care quality in the Netherlands: From quality assessment to intervention

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CHAPTER 1

General Introduction



Foto: Joods Historisch Museum

CHAPTER 1

1.1 Background of this thesis

The quality of care provided in Dutch child care centers has been repeatedly measured since 1995 up until now. In 1995 Van IJzendoorn, Tavecchio, Stams, Verhoeven, and Reiling (1998) were the first to assess child care quality in The Netherlands using the Infant/Toddler Environment Rating Scale (ITERS; Harms, Cryer, & Clifford, 1990) and Early Childhood Environment Rating Scale (ECERS; Harms & Clifford, 1980). Results from this study showed that quality of care, on average, was relatively high in international perspective ($M = 4.8$, $SD = 0.61$ on a 7-point scale), with none of the groups scoring in the inadequate quality category and 40% of the groups scoring in the high quality category. The second assessment of child care quality in Dutch centers, using the same ITERS and ECERS, was carried out in 2001 by Gevers Deynoot-Schaub and Riksen-Walraven (2005). Compared to the 1995 measurement, quality of care was significantly lower in 2001 ($M = 4.3$, $SD = 0.74$). The effect size for the difference between 1995 and 2001 was $d = 0.76$, corresponding to a large effect according to Cohen (1988). In 2001, inadequate care (score < 3 on a 7-point scale) was observed in 6% of the groups, and only 18% of the groups scored in the high quality category.

Shortly after this second quality assessment in 2001, a study by the Early Child Care Research Network from the National Institute of Child Health and Human Development was published (NICHD ECCRN, 2002). In the comprehensive longitudinal research project conducted by the NICHD ECCRN, children have been followed from infancy up until the 9th Grade (14-15 years old). In 1991, over a thousand children were enrolled in this large-scale longitudinal study, that was explicitly set up to examine the effects of nonparental child care on children's development and functioning (see e.g., Belsky, 2006). Researchers have collected extensive information about the quantity, quality, and type of child care the children have received from birth onwards, as well as about their temperament and socio-emotional and cognitive development and about characteristics of the children's family and other aspects of the context. The NICHD ECCRN has reported both positive and negative impacts of early child care on young children's development. The NICHD ECCRN publication in 2002 demonstrated that high quality of care was positively related to children's cognitive and language development. But it also showed that children who attended child care for more than 30 hours per week, on average, scored higher on behavioral problems at age 4.5 (as rated by their professional caregivers) than children who attended child care for less than 10 hours per week (NICHD ECCRN, 2002). In combination with the decreasing quality scores from the 2001 Dutch quality assessment, the latter negative effect of child care found in the US caused vehement public debates in The Netherlands. A crucial question was whether the findings of the NICHD study were generalizable to the Dutch context at that time, given that the Dutch child care context is considerably different from the US context in a number of respects (see 1.2. below; Tavecchio, 2002; Van IJzendoorn, 2004).

To answer this pressing question, the Dutch Government granted a 12-year subsidy to the Netherlands Consortium for Research in Child Care (Nederlands Consortium Kinderopvang Onderzoek, NCKO) to study the quality of care as provided in child care centers in The Netherlands. The NCKO was established in 2002 by the University of Amsterdam, Radboud University Nijmegen, and Leiden University. The general aim of the NCKO research program was twofold: to assess *and* to improve the quality of center-based child care for 0- to 4-year-olds in The Netherlands (see 1.3 below for a description of the complete NCKO research program). This thesis describes four empirical studies that have been conducted as part of the NCKO research project.

1.2 Child care context in The Netherlands

The number of children attending formal child care in The Netherlands has increased substantially, mainly as a result of the increasing number of mothers with young children who continue to work after bearing a child. Recently, however, the number of children attending child care has been decreasing, which is probably due to the present economic downturn. Today, more than 70% of women with young children are employed, although the majority work part-time, contrary to fathers who generally work fulltime (Merens, Hartgers, & Van den Brakel, 2012). Fifty-six percent of the 0- to 4-year-old children in The Netherlands attend formal child care (30% center care, 26% family day care), with an average of 19 hours per week (OECD, 2014). Higher educated parents choose center care or family day care more often (59%) than middle (36%) and lower educated (25%) parents, who generally choose informal forms of nonparental care (Merens et al., 2012). Child care centers are open to children from 3 months of age (when paid maternity leave ends) up to 4 years, when kindergarten starts.

Dutch child care centers typically distinguish three types of groups with different age compositions: infant groups (0- to 2-year-olds), preschool groups (2- to 4-year-olds), and mixed age groups (0- to 4-year-olds). The mixed-age groups, with the wide age range, are predominant in The Netherlands, while such groups are relatively unknown in other countries. The vast majority of (nearly all female) caregivers have received a 3-year vocational training in general 'social-pedagogic' work, which is not specifically focused on caring for very young children in a child care setting, but rather prepares them for working with a broad variety of age groups in different domains of care (Gevers Deynoot-Schaub & Riksen-Walraven, 2005; Vermeer et al., 2008). Recently, in 2011, caregiver education has changed from social-pedagogic work (SPW) to pedagogic work (PW), which now educates students to work with children from 0 to 12 years old in child care or children up to age 18 in child welfare. This change in caregiver education was implemented after the first two studies of this thesis (Chapter 2 and 3) had been conducted. In other words, this change in education does not apply to studies 1 and 2. During data col-

lection of studies 3 and 4 (Chapter 4 and 5), caregivers were educated in the new system, although the vast majority of caregivers in the sample of these studies had followed the ‘old’ social-pedagogic course. Both in Dutch caregiver education and in everyday child care practice, the focus typically lies on *care* rather than on *education*, which is also reflected by the fact that most time of the program for young children in child care centers consists of free play and little attention is given to structured developmental activities (Oberhuemer, Schreyer, & Neuman, 2010; OECD, 2006).

In 2005, the introduction of the Child Care Act was a significant policy change that altered the child care funding system and may have affected quality of care afterwards (Donner, 2004). Funding changed from a supply-side system with financial support for providers, to a market-driven system with financial support for parents. Possible implications of this change in the funding system for the quality of child care will be discussed in study 2 (Chapter 3) of this thesis.

This brief description of Dutch child care makes clear that child care in The Netherlands has unique characteristics, which makes it difficult to generalize the findings of the NICHD ECCRN study to the Dutch context. Therefore, it is important to carefully adapt the definition of child care quality and quality assessment instruments to the Dutch situation.

1.3 The NCKO research project

Between 2002 and 2014, the NCKO project addressed the following main issues: 1) the development and validation of a measurement instrument to assess child care quality in the Dutch child care context, 2) the development of a simplified version of this measurement instrument to be used by professionals in child care centers to rate the quality of care in their own centers, 3) national quality assessments in representative samples of child care centers, and 4) the development and evaluation of an intervention program to improve the quality of child care as reflected in the NCKO quality instruments.

The NCKO instrument to assess child care quality

The NCKO started with the development and validation of a measurement instrument of child care quality that is attuned to the Dutch child care context. Point of departure was a theoretical model of child care quality that defined quality from the child’s perspective: high quality child care was defined as care that contributes to the child’s wellbeing and development. The model (Riksen-Walraven, 2004; see Figure 1) distinguishes the two types of quality that are generally used in child care research, namely process quality and structural quality. Process quality (right hand panel of Figure 1) is defined as the quality of children’s everyday experiences in their interactions with the caregivers and with other children and materials in the

care group (see also Lamb, 1998; Vandell & Wolfe, 2000). The caregivers play a pivotal role in determining the quality of children’s experiences, because, next to their very important direct interactions with the children, they also play an important role in determining the quality of the children’s interactions with their peers and with materials in the center (reflected by the bold arrows in the figure).

Structural quality (left hand panel of Figure 1) is generally defined as the more distal characteristics of the child care environment that do not influence the child directly, but indirectly by affecting the process quality and thereby the children’s everyday experiences. Next to the three ‘classical’ structural quality characteristics, i.e., caregiver education, group size, and caregiver-child ratio (Vandell & Wolfe, 2002), other structural quality characteristics (depicted in the figure) are space, program structure, caregiver work experience, and age composition of the group.

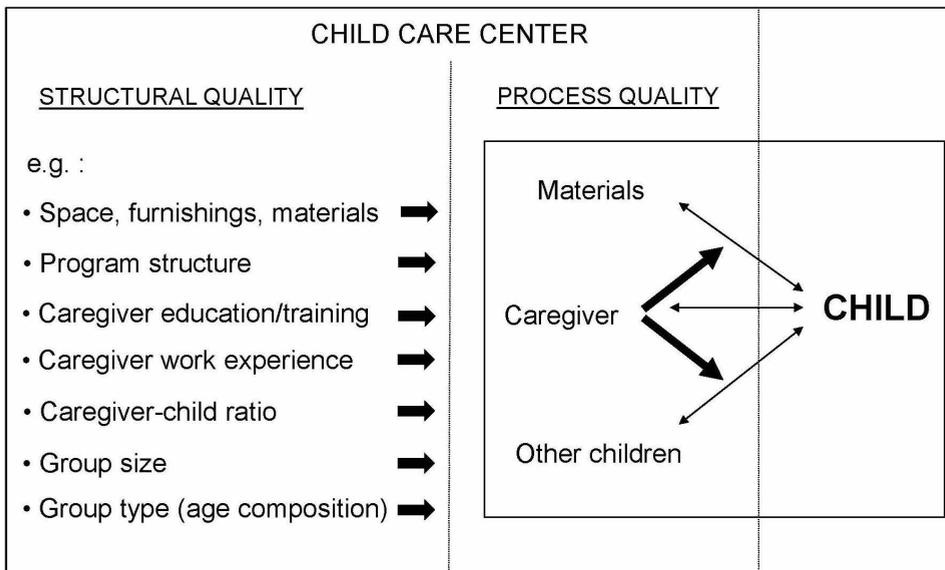


Figure 1 NCKO Quality Model (Riksen-Walraven, 2004)

In the NCKO project, we focused on developing a measure to reliably and validly assess *process* quality in Dutch child care centers, with special attention to the key aspect of process quality, namely the quality of caregiver-child interactions. The NCKO quality model distinguishes six key caregiver interactive skills that are assumed to contribute to 0- to 4-year old children’s wellbeing and development, and that should therefore be included in a process quality measure: sensitive responsiveness, respect for autonomy, structuring and limit setting, verbal communication, developmental stimulation, and fostering positive peer interactions (Riksen-Walraven, 2004).

We first searched for available instruments that could be used to assess process quality, including the six caregiver interactive skills, in the Dutch context. The most

widely used instruments designed to assess process quality are the Infant/Toddler Environment Rating Scale-Revised (ITERS-R; Harms, Cryer, & Clifford, 2003) and Early Childhood Environment Rating Scale-Revised (ECERS-R; Harms, Clifford, & Cryer, 1998), which provide a comprehensive and global picture of the quality of the child care environment (Perlman, Zellman, & Le, 2004; Sakai, Whitebook, Wishard, & Howes, 2003). Two previous Dutch quality assessments in 1995 (Van IJzendoorn, et al., 1998) and 2001 (Gevers Deynoot-Schaub & Riksen-Walraven, 2005) used the ITERS/ECERS, because the widespread use of these instruments allowed international comparison. Given that the ITERS-R/ ECERS-R provide a broad picture of child care quality and that they allow international comparisons as well as a comparison with previous Dutch quality assessments, the NCKO decided to hold on to the ITERS-R/ECERS-R as a global measure of child care quality.

Because the six key caregiver interactive skills could not be assessed adequately with the ITERS-R/ECERS-R, nor with any other available instrument, the NCKO also developed a new measure that specifically focuses on the six caregiver interactive skills and that can be applied in combination with the ITERS-R/ECERS-R. The development and validation of this measure, the Caregiver Interaction Profile (CIP) scales, is reported in study 1 (Chapter 2) of this thesis.

The NCKO Quality Monitor

Based on the NCKO instrument (including the ITERS-R/ECERS-R and the CIP scales) described in the former section, the NCKO Quality Monitor was developed (Gevers Deynoot-Schaub, Fukkink, Riksen-Walraven, De Kruijff, Helmerhorst, & Tavecchio, 2009). The Monitor is a self-evaluation tool for professionals in child care centers/organizations to get an impression of the child care quality provided in their own centers. Just like the NCKO measurement instrument described above, the Monitor includes a global quality part (based on the ITERS-R/ECERS-R) and a part that specifically focuses on the six caregiver interactive skills (based on the CIP scales).

The part of the Monitor focusing on the caregiver interactive skills includes simplified scales to rate the six interactive skills on a 3-point scale format (high, medium, low) instead of the original 7-point format of the CIP scales. The simplified format allows professionals in the child care field to self-rate quality of caregiver-child interactions.

The global quality part of the Monitor comprises a checklist that is based on the ITERS-R/ECERS-R subscales space and furnishings, activities, language, and program structure, which allows evaluation of the global quality of the child care environment. The checklist includes 26 items on a dichotomous scale with positive anchors (i.e., indicator should be present) and negative anchors (i.e., indicator should not be present). This set-up provides professionals with direct insight in stronger and weaker aspects of the child care environment in a specific child care group, and therefore also with information as to which points need improvement.

CHAPTER 1

The checklist for the global quality of the child care environment was used as a self-evaluation tool for center directors in study 4 (Chapter 5) of this thesis, which describes the evaluation of a consultancy program for center directors to improve global child care quality.

National quality assessments

Using the measurement instrument described above, the NCKO has carried out national quality assessments in 2005, 2008, and 2012 to examine the quality of child care in representative samples of child care centers in The Netherlands. The 2005 quality assessment was performed on request of the Dutch Ministry of Social Affairs and Employment to assess the quality of care just before the introduction of the Child Care Act. This study, which only used the ITERS-R/ECERS-R because the CIP scales were not yet available, has been reported in Vermeer et al. (2008). The second assessment was carried out in 2008, three years after the introduction of the Child Care Act in 2005. This was the first assessment where the newly developed CIP scales were applied together with the ITERS-R/ECERS-R in a nationally representative sample. This study is described in study 2 (Chapter 3) of this thesis. The third and most recent quality measurement was carried out in 2012 (see Fukkink, Gevers Deynoot-Schaub, Helmerhorst, Bollen, & Riksen-Walraven, 2013).

An intervention program to improve child care quality

The fourth and final issue addressed in the NCKO project was to develop and evaluate an intervention program to improve the quality of child care. This part of the NCKO research project constitutes the main topic of the present thesis; the data for the intervention study were collected during the PhD project for the present thesis. The intervention program was aimed at improving the process quality of care as assessed with both components of the NCKO instrument, namely global quality of the child care environment (as measured with the ITERS-R/ECERS-R) and caregiver-child interactions (as measured with the CIP scales). Table 1 provides an overview of the complete intervention program and the design of the effect study. As shown in the table, the intervention program consisted of two parts that ran simultaneously in each care group. One part of the intervention was a 5-week video feedback training for the caregivers to strengthen their interactive skills with the children as defined in the CIP scales (left hand panel of the table). The other part was a consultancy program for the center directors, comprising three consultations in total, to enhance the global quality of the child care environment as assessed with the ITERS-R/ECERS-R (right hand panel of the table). The development and evaluation of the two parallel components of the intervention program is reported in two separate studies in this thesis, namely study 3 in Chapter 4 (CIP training) and study 4 in Chapter 5 (consultancy program).

Table 1 Overview of the complete intervention program and the design of the effect study

Week		
1	PRETEST Measures: CIP scales & ITERS-R/ECERS-R	
	<i>Start intervention program</i>	
	CIP training Directed at: Caregivers Aim: Improve caregiver interactive skills as defined in CIP scales	Consultancy Directed at: Center directors Aim: Improve quality of the child care environment as defined in ITERS-R/ECERS-R
2		1) Consultation 1
3	1) Video feedback session 1	<i>Self-assessment by center director with NCKO Quality Monitor</i>
4	2) Video feedback session 2	2) Consultation 2
5	3) Video feedback session 3	
6	4) Video feedback session 4	
7	5) Video feedback session 5	3) Consultation 3 by telephone
9	POSTTEST Measures: CIP scales & ITERS-R/ECERS-R	
22	FOLLOW-UP Measures: CIP scales & ITERS-R/ECERS-R	

1.4 Thesis outline

After this introductory chapter, the thesis describes four empirical studies. *Chapter 2* reports on the development and validation of the CIP scales. *Chapter 3* describes the 2008 national quality assessment, in which the CIP scales were used for the first time in a nationally representative sample of child care centers. Chapters 4 and 5 report the development and evaluation of the intervention program (outlined in Table 1) to improve child care quality. *Chapter 4* reports on the effects of the CIP training for caregivers, and *Chapter 5* describes the effects of the consultancy program directed at center directors. Finally, *Chapter 6* presents a summary of the results of the four studies followed by the main conclusion and a general discussion.

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