Family day care educators’ knowledge, confidence and skills in promoting children’s social and emotional wellbeing: Baseline data from Thrive

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THIS PAPER PRESENTS BASELINE data from Thrive, a capacity-building program for family day care educators. Educators completed a self-report survey assessing knowledge and confidence in promoting children’s social and emotional wellbeing. An in-home observation was used to assess care quality. Twenty-four educators responded to the survey (40 per cent response rate). They had an average of nine years’ experience and 82 per cent held childcare qualifications. Educators reported knowledge of, on average, three early signs of social and emotional problems in children, three risk factors and two protective factors. Using a scale from 0–10, mean educator confidence levels ranged from an average of 6.69 to 7.25. Quality of care ratings were moderate. Although educators had a good understanding of children’s social and emotional wellbeing, the study identified opportunities for significant changes in the quality of the educators’ interactions with children in their care and their professional development.

Introduction

Family day care (FDC), a scheme in which registered educators provide formal paid care in their own homes for other people’s children under the management of a local coordination scheme, is an important form of child care in Australia and internationally (Davis et al., 2012). Since 2009, all Australian early childhood educators, including FDC educators, have been required to practise according to principles established by a national curriculum framework and national quality standards. Belonging, being and becoming: The Early Years Learning Framework for Australia (EYLF) (DEEWR, 2009) is part of the recently introduced National Quality Framework (Commonwealth of Australia, 2008) and National Quality Standard (Commonwealth Government, 2010) for the education and care of children. The EYLF includes an explicit focus on children’s social and emotional wellbeing: stating, for example that ‘when children feel safe, secure and supported they grow in confidence to explore and learn’ (DEEWR, 2009, p. 20). This increased focus on supporting children’s social and emotional wellbeing, and the fact that FDC educators are often faced with challenging family and child contexts (Williamson, Davis, Priest & Harrison, 2011), requires that educators receive further support for their knowledge, confidence and skills in the area of childhood mental health. In the absence of any existing professional development programs specifically designed for FDC, Thrive is a new program, developed in partnership with FDC educators, to build their capacity to promote children’s social and emotional wellbeing (Davis, Williamson et al., 2011).

To date, only three Australian studies and no international studies have examined childcare educators’ knowledge of, and confidence in, addressing children’s mental health problems. In 2005, baseline data from ‘A Healthy Start’ program indicated that educators across various
childcare settings had limited mental health literacy, particularly with reference to child conduct disorder and maternal postnatal depression (Farrell & Travers, 2005). Combined results from centre-based educators, FDC educators and occasional care educators showed that at baseline 25 per cent, 45 per cent and 25 per cent of educators could name one, two and three risk factors respectively for child mental health problems. In terms of protective factors, 40 per cent could not name any protective factors, 40 per cent could name one protective factor and 17 per cent could correctly name two protective factors. Confidence in discussing conduct disorder with parents was also low: only 13 per cent reported they were 'very confident', 40 per cent 'fairly confident' and the remaining 45 per cent had 'little to no confidence'. Subsequently, our research team conducted a qualitative study to explore FDC educators' child mental health literacy (Davis, Priest et al., 2011). All participants but one had completed qualifications in child care. The results demonstrated that educators had difficulty identifying the causes and early signs of mental health problems for children. Strategies used to promote children's mental health were related to educators' individual knowledge and skills. Being able to identify mental health-promoting policies within the FDC scheme and being able to connect families with community health services were highlighted as challenges. Common barriers to mental health promotion included a lack of financial resources, knowledge about child mental health, and a fear of discussing mental health concerns with parents. Educators reported that they would like further training in child mental health and how to communicate with parents. Building on this and further qualitative research with FDC educators (Davis, Young, Corr & Cook, 2013), a new program was developed to support the promotion of children's social and emotional wellbeing (Thrive).

The Thrive program, the first program to be developed specifically for FDC, aims to: increase FDC educators' knowledge, confidence and skills in promoting children's social and emotional wellbeing; increase co-ordinators' and fieldworkers' knowledge and confidence in promoting children's social and emotional wellbeing; and build the capacity of the FDC organisation as a whole to promote children's social and emotional wellbeing (as measured by workforce development, resource allocation and leadership) (Davis, Williamson et al., 2011). Although there is significant overlap between the constructs of social and emotional wellbeing, development and mental health, Thrive uses social and emotional wellbeing as preferable terminology for early childhood and early childcare settings based on consultations with the sector. The Thrive intervention components include workshops on child social and emotional wellbeing (topics include development, promoting resilience, infant and child mental health problems and partnering with parents); connecting educators through sharing information on ways to promote children's social and emotional wellbeing; focused discussion on social and emotional wellbeing during coordinator visits; and provision of other Australian resources that have recently been developed in the area of child mental health, including those developed by the KidsMatter Early Childhood team (KidsMatter, 2012) and the Response Ability team (Response Ability, 2012).

Thrive was conducted within one FDC scheme to trial and evaluate its appropriateness, acceptability, cost and effectiveness, using a randomised control trial (see Method). Four FDC fieldworkers along with the 24 consenting educators they support were randomly assigned to either an intervention or a control group.

The design and implementation of the intervention program is underpinned by the Diffusion of Innovation theoretical framework, which states that individuals and groups move from acquiring knowledge about an 'innovation' (e.g. a new idea), to finding the new information persuasive, deciding to adopt or reject the innovation, implementing the innovation, and last to evaluating whether the adoption of the evaluation was worthwhile (Rogers, 1995). It is a theory of how innovations diffuse through social systems, such as FDC schemes. Increasing the knowledge and confidence of childcare educators in child social and emotional wellbeing is therefore essential to the system adopting an innovation. In other areas of health-related behaviour, such as healthy eating and the use of tobacco and alcohol, knowledge about an issue has not always resulted in behaviour change, and so this dimension is being monitored within the study to examine its influence in this context.

This paper presents baseline data from the Thrive randomised control trial, which is the first quantitative examination of FDC educators' knowledge, skills and confidence in promoting children's social and emotional wellbeing. It also presents descriptive data on educators' knowledge, confidence and skills in supporting children's social and emotional wellbeing.

Method

Study design

Ethical approval for the trial was obtained from The University of Melbourne Human Research Ethics Committee (HREC 1136446). The trial is registered with the Australian and New Zealand Clinical Trials Registry (343312) and full details of the aims and design of the trial are given in the previously published protocol (Davis, Williamson et al., 2011). This study uses a wait-list control cluster randomised controlled trial design. In this study design, participants are randomly assigned to either
control or intervention group. The control group ‘waits’ to receive the intervention, receiving it after the intervention group has received the intervention. The intervention program is being conducted within one FDC scheme based in a geographically large low socioeconomic area of Melbourne. A low socioeconomic area was selected because the prevalence of child mental health problems is higher in less advantaged areas (Sawyer et al., 2000). Baseline data collection consisted of a survey and an in-home observation of care quality. Follow-up data collection will occur at one month, six months and 12 months post intervention commencement. The effectiveness of the intervention program will be determined by assessing change in educators’ and fieldworkers’ knowledge of and confidence in children’s social and emotional wellbeing and skills in terms of interactions with children. Process data will assist with understanding exposures, implementation and factors affecting outcomes. Baseline data reported in this paper draw solely on data collected prior to randomisation.

Participants and recruitment
A cover letter, plain language statement and consent form describing the Thrive intervention and evaluation was mailed to all scheme educators. An administrative assistant from the FDC scheme telephoned educators to determine if they were interested in participating in the study. If so, the researchers telephoned the educators to discuss the study and organise a time for the baseline data collection. Of the 60 educators contracted to the scheme, 40 agreed to be contacted by researchers. Six educators could not be reached and did not respond to phone messages left by administrators. The remaining educators reported being too busy (n = 12), one educator was uncomfortable with the observations planned as part of data collection and another was leaving FDC at the end of the year. Researchers contacted the 40 consenting educators to describe the study and invite their participation and 24 agreed to participate in the yearlong trial (40 per cent of the scheme). Again, being ‘too busy’ was the main reason for declining participation. Reasons cited were studying for declining participation. Reasons cited were studying, working part-time, becoming an FDC educator; hours attending professional development annually; qualifications; number of years working in family day care; and number and characteristics of children in care. Additional measures included knowledge about children’s social and emotional wellbeing, confidence in promoting children’s social and emotional wellbeing, and skills in promoting children’s social and emotional wellbeing.

Survey and in-home observations
The baseline survey collected demographics information including: educator age; preferred language; reason for becoming an FDC educator; hours attending professional development annually; qualifications; number of years working in family day care; and number and characteristics of children in care. Additional measures included knowledge about children’s social and emotional wellbeing, confidence in promoting children’s social and emotional wellbeing, and skills in promoting children’s social and emotional wellbeing.

Knowledge about children’s social and emotional wellbeing
New items were developed based on Farrell and Travers (2005) study on conduct disorder and postnatal depression. The items included ‘How would you rate your knowledge about children’s social and emotional wellbeing?’ and ‘How would you rate your knowledge of who to contact and what to do if you are worried about the social and emotional wellbeing of a child in your care?’ (Scale 0–10 with 0 = almost no knowledge, 10 = very knowledgeable). In addition, the extent of agreement with several statements about children’s social and emotional wellbeing was rated. Also included were open-ended questions about risk and protective factors for good/poor social and emotional wellbeing; early signs of social and emotional problems for young children and school-aged children; and strategies to promote children’s social and emotional wellbeing.

Confidence in promoting children’s social and emotional wellbeing
New items were developed to measure this construct based on the approach used by Farrell and Travers (2005). Four self-report questions included: ‘How confident are you in your ability to promote children’s social and emotional wellbeing?’, ‘How confident are you in your ability to identify children’s social and emotional problems?’, ‘How confident are you in talking with parents about promoting children’s social and emotional wellbeing?’ and ‘How confident are you in talking with parents about potential problems with their children’s social and emotional wellbeing?’ (Scale 0–10 with 0 = not confident, 10 = very confident).

Quality of care
Skills in promoting children’s social and emotional wellbeing were assessed through observation methods focusing on the quality of the interactions between educators and children, as well as the quality of the environment related to children’s social and emotional wellbeing. Quality of the FDC environment was assessed by a trained researcher using the Family Child Care Environment Rating Scale Revised Edition (FCCERS-R), a companion tool of the Early Childhood Environment Rating Scale used in long day care settings. Quality of interactions was assessed using the Caregiver Interaction Scale (CIS) (Arnett, 1989; Harms, Cryer & Clifford, 2007).

The FCCERS-R has 38 items forming seven subscales. In this study, three subscales (24 items) were used that focused on interactions and environments expected to influence child social and emotional wellbeing: listening and talking (helping children use and understand language, using books); activities (fine motor, art, music and movement, blocks, dramatic play, math/numbers, sand and water play, nature/science); promoting acceptance of diversity, use of TV, video and computer, active physical
play); and interactions (supervision of play and learning, provider-child interaction, discipline, interactions among children). Each item is scored on a criterion-based scale ranging from one (inadequate) through three (minimal), five (good) to seven (excellent). A score of four indicates an acceptable level of care, where, nevertheless there is room for improvement. The FCCERS-R has high inter-observer reliability (0.83–0.90) and moderate to high internal consistency for the subscales (0.70–0.93).

The CIS has 26 items divided into four subscales (Positive, Harsh punitive, Detached and Permissive) that measure sensitivity, harshness, detachment and permissiveness of caregivers in the childhood care/education environment. Items are scored from one (not at all true) to four (very much true). It has a moderate to high inter-observer reliability (0.75–0.97) and high internal subscale consistency (0.81–0.91) (Arnett, 1989).

Before undertaking in-home observations and as part of training, research assistants (n = 4) watched short videos of FDC interactions and scored them. Scores were then compared after each clip and the group (including lead researchers) reached a consensus based on FCCERS-R guidelines by discussing reasons behind decision making. By the end of training, research assistants had consistent scoring approaches. As the CIS guidelines are less explicit, the group reached consensus on scoring based on their interpretation of the CIS scoring information.

Procedure

Researchers telephoned the participants and booked in a time for an in-home visit. Questionnaires were mailed out and collected by the researcher when they conducted the in-home observation visit. Observations were conducted over a two-hour period. Four researchers conducted the observations. Statistical analyses were conducted using SPSS 20. Analyses consisted of descriptive statistics and correlations. A significance level of 0.05 was used.

Results

Demographics

Twenty-four educators responded to the survey (40 per cent response rate). The majority of participants were born in Australia (66.6 per cent), with a mean age of 44 years (SD = 9.44, range 27–66 years). Although only one educator reported speaking a language other than English at home, six educators were born in countries where English is not the main language spoken. Forty-five per cent of educators had completed a Diploma or Associate Diploma in Children's Services and 37 per cent had completed a Certificate III in Children's Services (see Table 1). The proportion of the sample that held a Diploma was above the national average: the most recent data indicate that 16 per cent of educators have a Diploma or Advanced Diploma and 36 per cent of educators have a Certificate III or IV qualifications (Productivity Commission, 2011).

Table 1. Educator educational achievements

<table>
<thead>
<tr>
<th>Educational achievements</th>
<th>n</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of post-secondary school qualifications completed (n = 24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None or not completed</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>Certificate</td>
<td>9</td>
<td>37.5</td>
</tr>
<tr>
<td>Diploma or Associate Diploma</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td>Bachelor Degree (including honours)</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td>Area of post-secondary school qualification (n = 23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood education</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Child care</td>
<td>12</td>
<td>52.2</td>
</tr>
<tr>
<td>Primary or secondary education</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nursing</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Special education</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Another field</td>
<td>8</td>
<td>23.2</td>
</tr>
<tr>
<td>Currently studying for a qualification in child care or early childhood education (n = 24)</td>
<td>8</td>
<td>33.3</td>
</tr>
<tr>
<td>Area of current course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood education</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Child care</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Primary or secondary education</td>
<td>1</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Educators reported working 45 hours per week on average (SD = 14.14, range 24–96 hours), which is longer than a standard 38 hour ‘full-time’ week. They had been working in child care nine years (M = 9.13 years, SD = 8.87, range 0–36 years) and in FDC for most of that time (M = 8.69, SD = 6.90, range 0–28 years). The average time per week spent in professional development in the past year (excluding studying for a qualification) was 3.63 hours (SD = 1.35, range 1–6 hours).

Educators cared for different numbers of children in their service. Most cared for fewer than 10 children per week (n = 14, 60.8 per cent), however 39.4 per cent (n = 9) had more than 11 children each week. There were nine educators with children attending services from non-English speaking backgrounds (from one to over four children) and five educators with children who had a diagnosed disability or developmental delay. No educators reported children from an Aboriginal or Torres Strait Islander background in their care.
Reasons for working in FDC

Educators’ plans to continue working in FDC varied widely. Five educators (20.8 per cent) reported planning to stay for a further one to two years, nine indicated (37.5 per cent) three to five years, four were planning to stay (16.7 per cent) for a further six to 10 years and six educators (25 per cent) anticipating remaining for over 10 years. Educators’ motivations for commencing FDC work are presented in Table 2. The primary motivation was the enjoyment of working with children (91.7 per cent). This was followed by reasons that enabled women to work independently at home. Many educators (66.7 per cent) reported planning the enjoyment of working with children (91.7 per cent). This was followed by reasons that enabled women to work independently at home. Many educators (66.7 per cent) started FDC to be available for their own children, but only five (20.8 per cent) currently included their own children in their FDC service.

<table>
<thead>
<tr>
<th>Reason*</th>
<th>n</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy working with children</td>
<td>22</td>
<td>91.7</td>
</tr>
<tr>
<td>It suited me to work from home as I had my own child/children at home</td>
<td>16</td>
<td>66.7</td>
</tr>
<tr>
<td>I like the idea of working from home</td>
<td>14</td>
<td>58.3</td>
</tr>
<tr>
<td>It lets me decide my hours of work</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td>I wanted to work with children in a non-centre-based environment</td>
<td>10</td>
<td>41.7</td>
</tr>
<tr>
<td>I wanted to run my own business</td>
<td>5</td>
<td>20.8</td>
</tr>
<tr>
<td>I wanted to work from home while completing other study</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>It suited my career development plan</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2</td>
<td>8.3</td>
</tr>
</tbody>
</table>

*Multiple responses were permitted

Knowledge of children’s social and emotional wellbeing

In terms of perceived knowledge about children’s social and emotional wellbeing, educators reported having a moderate level of knowledge (M = 7.13, SD = 1.36, ratings on a scale from 0–10). In terms of knowledge about what to do if worried about the social and emotional wellbeing of a child in their care, educators reported an average rating of M = 7.71 (SD = 1.53), on a scale from 0–10.

Educators were able to report, on average, between three to four early signs of social and emotional problems in young children and primary school-aged children, three to four risk factors, and two to three protective factors (presented in Table 3). Commonly reported signs of problems in young children included internalising (anxiety, depression) and/or externalising behaviours (aggression, oppositional defiance); withdrawing from normal social behaviour; and regressed behaviour. For primary school-aged children, the most frequently reported early signs of social and emotional problems were internalising and/or externalising of behaviours, anti-social behaviour and disconnection from others. Key risk factors for poor child wellbeing identified by educators included: stress/problems in the family home or care environment (n = 12, 50 per cent); negative parenting (n = 10, 42 per cent); and the death or separation of a family member (n = 10, 42 per cent). Identified protective factors against developing social and emotional problems included: providing a safe and caring environment (n = 8, 33 per cent); providing guidance and teaching resilience (life skills) and independence (n = 6, 25 per cent); and early recognition and intervention (n = 5, 21 per cent).

Educators mentioned an average of four strategies to promote child social and emotional wellbeing, the most common being: allowing time for children to express themselves and their feelings within the context of the family day care program (n = 9, 39 per cent), praising the child’s efforts (verbally and through displaying their work) (n = 9, 39 per cent) and the provision of group activities to promote different values and interactions (n = 9, 39 per cent).

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of named early signs of social emotional problems in a young child n = 24</td>
<td>1–7</td>
<td>3.38</td>
<td>1.44</td>
</tr>
<tr>
<td>Number of named early signs of social emotional problems in primary school children n = 22</td>
<td>0–7</td>
<td>3.45</td>
<td>1.6</td>
</tr>
<tr>
<td>Number of named risk factors for social or emotional problems n = 24</td>
<td>1–8</td>
<td>3.25</td>
<td>1.59</td>
</tr>
<tr>
<td>Number of named protective factors for good social and emotional wellbeing n = 24</td>
<td>1–5</td>
<td>2.71</td>
<td>1.2</td>
</tr>
<tr>
<td>Number of named strategies to promote social and emotional wellbeing n = 23</td>
<td>1–8</td>
<td>4.00</td>
<td>1.71</td>
</tr>
</tbody>
</table>

Educators’ responses to statements about children’s social and emotional wellbeing were in keeping with current understandings of best practice in childhood mental health (see Table 4). All educators agreed that they were in a position to help children manage their feelings. None of the educators endorsed statements that: ‘parents are the only ones who can influence children’s social and emotional wellbeing’; ‘children’s social and emotional wellbeing is not as important as their physical health’; ‘social and emotional problems don’t exist for young children’ (one exception); and ‘children don’t need help to manage their feelings’.
Table 4. Educators' responses to statements about children's mental health

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educators can help children learn to identify and manage their own feelings</td>
<td>10(46)</td>
<td>12(54)</td>
<td>13(56)</td>
<td>4(17)</td>
<td>10(44)</td>
</tr>
<tr>
<td>Parents are the only ones who can influence children's social and emotional wellbeing</td>
<td>3(13)</td>
<td>7(31)</td>
<td>8(35)</td>
<td>4(17)</td>
<td>1(4)</td>
</tr>
<tr>
<td>Children grow out of social and emotional problems</td>
<td>14(64)</td>
<td>7(32)</td>
<td>1(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and emotional problems don't exist for young children</td>
<td>15(65)</td>
<td>7(30)</td>
<td>1(5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children don't need help to manage their feelings</td>
<td>11(48)</td>
<td>9(39)</td>
<td>3(13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a parent has a mental illness, their child will have a mental health problem too</td>
<td>17(74)</td>
<td>6(26)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Bolded answers are those that reflect current empirical understandings of best practice (Costello, Egger & Angold, 2005).

Quality of care

Observed ratings of quality on the FCCERS-R ranged from M = 3.40 (Activities), M = 3.75 (Listening and Talking) to M = 4.40 (Interaction), all between the minimal and good ratings. Using the Caregiver Interaction Scale (CIS), which ranges from 0–4; subscale results were as follows: Positive interactions M = 2.81 (SD = 0.42); Harsh/Punitive M = 1.23 (SD = 0.28); Detached M = 1.30 (SD = 0.50); and Permissive M = 1.61 (SD = 0.72). While a higher score on positive interactions means higher quality of care, lower scores for harsh/punitive, detached and permissive subscales are linked to higher quality care.

Inter-relationships among knowledge, confidence and quality of care

We used correlation analyses to examine the associations between educators’ self-rated knowledge and confidence, and our observed ratings of the quality of the interactions between educators and children, and the quality of the environment related to children's social and emotional wellbeing. Results are presented in Table 6. Perceived knowledge was moderately correlated with all of the confidence items (rs = 0.46–0.72) and a significant relationship was found between the number of named protective factors and confidence about talking with parents about promoting children’s social and emotional wellbeing, although this was in an unexpected direction (r = –0.50). No relationship existed between the number of named early signs of problems or risk factors and ratings of confidence. A significant association was found between the CIS sub-scale ‘permissiveness’ and named early signs of social and emotional problems in primary school-aged children (r = 0.47).
None of the correlations between the quality of care measures (CIS/FCCERS-R) and confidence items were significant. Observed CIS ‘positive’ (r = 0.53) and CIS ‘detachment’ (r = −0.55) were significantly correlated with the FCCERS-R ‘interaction’ subscale.

**Discussion**

This is the first study internationally that provides quantitative data specifically on FDC educators’ knowledge and confidence in promoting children’s social and emotional wellbeing. FDC educators reported moderate levels of perceived knowledge and confidence, and received moderate ratings on the observed quality of care measures. The findings are more positive than those reported in our previous qualitative study with FDC educators which demonstrated that educators had difficulty identifying causes and early signs of social and emotional problems (Davis, Priest et al., 2011), perhaps reflective of the increasing emphasis on children’s social and emotional wellbeing within the sector in recent years. Major learnings from this study include that while educators are able to recognise and recall a few early signs of problems and suggest strategies to promote social and emotional wellbeing, they face challenges in identifying more complex issues and implementing effective strategies. Further research could explore strategies to enhance educators’ ability to address social and emotional problems in children.
promote children's social and emotional wellbeing, there is potential to strengthen the quality of care related to the promotion of children's social and emotional wellbeing. The findings are useful to understand educators' strengths and challenges and directions for future support, training and research.

**Perceived knowledge**

Educators perceived themselves to be moderately knowledgeable and typically believed that they could influence children’s social and emotional wellbeing; that children needed help to recognise and regulate emotions; and that children could have social and emotional problems. Educators were able to report several early signs of, and to name risk and protective factors for, childhood mental health, demonstrating a higher level of knowledge than in an earlier study of educators generally (Farrell & Travers, 2005). This is perhaps not surprising given the recent changes in the childcare sector aimed at improving quality of care, and the high proportion of qualified educators who were involved in this study. One notable omission from the list of ways that educators promote children’s social and emotional wellbeing was through secure attachment or close relationships. Attachment is widely recognised as important to the mental health of children (Harrison & Ungerer, 1997; Sims, 2009). This suggests a need for educators to be given more information, training and support relating to attachment. Although educators relate to children every day, it would be useful for them to understand the attachment construct, the importance of relationships and what they can do to further strengthen their own and parents’ relationships with children.

The FDC educators’ opinions varied about whether children grow out of mental health problems. Whereas 56 per cent of the educators sampled were unsure or agreed with the statement ‘children grow out of mental health problems’, the evidence is that most children with mental disorders do not grow out of them (Costello et al., 2005; McLaughlin et al., 2010; RAND Labor and Population, 2010). If educators have this mistaken belief, they may be less likely to intervene appropriately or to seek advice to assist the child and the parent.

**Confidence**

The educators reported moderate levels of confidence in promoting children's social and emotional wellbeing. There may be a need to increase educators’ skills and resources to improve their confidence in communicating with parents. Educators may avoid communicating with parents about children's social and emotional wellbeing because of a desire to maintain positive relationships with parents and ensure the child stays in their care. Previous studies note the complexity of educator–parent relationships (Butler & Modaff, 2008) and show that poor parent–educator relationships are related to job stress (Curbow, Spratt, Ungaretti, McDonnell & Breckler, 2000). Curbow et al. (2000) found that parents may blame educators for their child’s bad behaviour, which may be another reason why FDC educators avoid raising the
child's social and emotional problems. Unfortunately, failure to discuss the child’s wellbeing or potential mental health difficulties means that parents are not fully informed about their child’s life in child care. This may result in lost opportunities for early intervention to enhance child wellbeing.

**Quality of care**

Both the Caregiver Interaction Scale (CIS) scores and FCCERS-R scores indicate room for improvement in how educators interact with children in their care. CIS scores painted, on the whole, a more positive picture than FCCERS-R scores. CIS scores generally indicated that positive interactions were frequent, harsh/punitive or detached interactions were very uncommon and that permissive interactions were infrequent. FCCERS-R scores for Listening and Talking, Interactions between educator and child/ren and Activities in this study indicated that quality in these areas was rated as above minimal (3), but below good (5), presenting opportunities for improvement. Although there are no Australian norms for the FCCERS-R, it would be useful to explore the use of FCCERS-R in an Australian context, as it has the potential as a quality improvement tool. The need for quality improvement in FDC is also supported by Tayler, Ishimine, Cloney, Cleveland and Thorpe (2013) who reported lower quality scores in FDC homes in the E4Kids study using subscales of the ECERS-R, a similar measure to the FCCERS-R.

**Correlations among knowledge, confidence and skills**

This study demonstrated that educators’ perceived knowledge was moderately correlated with their perceived confidence; therefore future studies may not need to assess both variables. It is surprising that only one knowledge variable and no confidence variables were significantly related to the quality of care measures, however the knowledge and confidence items were more focused on background information about social and emotional wellbeing (i.e. preventing problems and promoting wellbeing) whereas the quality of care measures were focused on interactions and activities. This study highlights the importance of capturing both self-report and observational data.

**Limitations**

The results need to be interpreted with caution because of the small sample size, and the higher proportion of Diploma-qualified participants. Recruiting educators to this study was extremely challenging, despite having developed the Thrive program with them, perhaps reflective of the number of changes they are currently facing in their sector and the amount of time that educators are spending in completing training.

**Conclusion**

The results suggest that FDC educators in this study had a good understanding of children’s social and emotional wellbeing. The results also suggest opportunities for changes in the quality and assertiveness of the educators’ interactions with children in care and their parents, to benefit the immediate and longer-term wellbeing of the children. An important area that needs further exploration from this study is attachment—specifically, the need to better inform FDC educators about attachment and provide training and support for the ways in which they can promote secure attachment relationships to the children in their care. Finally, the measurement tool used in this study is a useful instrument for assessing FDC educators’ knowledge, confidence and skills in promoting children’s wellbeing. As such, it could be used internally by schemes to guide and evaluate professional development.

**References**


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