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Comparative Analysis of State Policy-Making in Child Welfare:

Utilizing Theory to Explain Policy Choices

Mary Elizabeth Collins, AM, PhD

Boston University School of Social Work

Abstract: Kingdon's three streams of agenda-setting identified in *Agendas, Alternatives and Public Policies*, as well as Schneider and Ingram's social construction framework, set out in the *American Political Science Review*, are used to compare four US states' policy responses following fatalities of children in care. Results suggest that tension between the social construction of children as vulnerable dependents and their troubled families as deviants affects policymakers' responses and may interfere with systemic policy learning within and across jurisdictions.

Key words: child welfare policy; child fatalities; agenda-setting; social construction; comparative analysis; comparative case studies; policy process

Introduction

Child deaths while in state care bring extensive attention, accusations, and calls for action. Despite attention to the system of care, however, it is not clear to what extent these tragedies lead to policy changes that improve a public response. Understanding what, if any, impact these events have on effective policy change would contribute critical knowledge to this practice field and potentially impact the lives and well-being of vulnerable children. To further this understanding, the current study conducted a comparative analysis of US states' responses to child tragedy. Two theoretical frameworks were used: Kingdon's multiple streams theory (1984) and Schneider and Ingram's (1993) social construction of populations typology.

This analysis leads to both theoretical extensions and practical applications. For example, the analysis suggests Kingdon's framework may be differentially applied to target populations and adds important nuance regarding the impact of focusing events (e.g., child tragedies), identification of potential solutions (e.g., administrative response), and actions of political stakeholders (e.g., governors, advocates, unions). The analysis also offers insight regarding the transferability of approaches. In terms of practical application, the elimination of child tragedies in care would be an unambiguously positive outcome. Aside from the clear humane result, elimination of these incidents would avoid political problems for agencies and governmental leadership and lessen opportunities for reactive actions that can cause further damage. Thus, analysis of the impact of tragedy on state policymaking offers substantial opportunities for vital transferable learning (that is, policy learning that can be shared and adopted across jurisdictions). The ability of policymakers to consciously absorb the lessons from experience in their own and other settings may increase take-up of effective approaches.

The ongoing development of child welfare policy is often conceptualized as a "pendulum swing" in which attention fluctuates between efforts to help families with supportive and preventive services and a child protective stance in which the child is the unit of concern and protecting child safety, potentially through removal from the family, receives primary focus (McGowan, 2014). There is general professional consensus of the need to move further towards developing a family orientation because a family-based orientation is both more humane and effective in the long run (Duffy, Collins, & Kim, 2016). Yet, high profile cases of child maltreatment, and particularly child deaths while under the supervision of the system, can push public attention toward emphasis on child protection.

Cross-national analyses have examined child welfare policies through a comparative lens (Katz and Hetherington 2006). In the US, child welfare is a domain for fruitful comparative analysis at the sub-national level because numerous systems operate under common federal guidelines but with some independent policymaking capacity. US federal laws govern states' operation of child welfare systems by setting standards, issuing guidance, and providing funding. For example, in an effort to promote enhanced accountability for state child welfare systems, the federal Child and Family Services Review (CFSR) process assesses states' conformity with federal requirements (Mitchell, Thomas and Parker 2014). Thus, within the federal structure, states operate child welfare systems fairly independently and this offers opportunity for comparative analysis and consequent transferable learning.

Theoretical Frameworks

Kingdon's multiple streams framework (1984) addresses three processes—the problem, policy, and politics streams—through which issues advance to the public policy agenda. The "problem" stream focuses on which types of conditions may be recognized as problems requiring attention of policymakers. Factors influencing problem definition include the extent to which the problem offends social values and the extent to which the condition identifies existing deficits through comparisons to other countries, other states, or an agreed-upon norm. Focusing events, data indicators and constituency feedback are important to framing a problem. The "policy" stream identifies characteristics of policies that enhance their likelihood of being selected for adoption, including technical feasibility, congruence with the values of community members, and the accurate anticipation of future constraints. Using Kingdon's metaphor, policy solutions float around in the policy soup, waiting to be coupled with defined problems. Key factors in the "politics" stream include elections, the political mood, and the influence of interest groups.

Although numerous scholars have applied Kingdon's framework to various policy domains (Pierce et al. 2014, Béland and Howlett 2016), it has seen limited application in child welfare (Collins and Clay 2009 is an exception). While widely used, the framework has been critiqued for having such fluidity that it lacks explicit hypotheses (Sabatier, 2007) and for its limited predictive capabilities (Zahariadis, 1999). It is well-suited to the current analysis, however, in part because of the critical role of focusing events and framing in child welfare policymaking. As defined by Birkland (2011, p.180) focusing events are "sudden, relatively rare, events that spark intense media and public attention because of their sheer magnitude, or sometimes because of the harm they reveal." The dramatic nature of these events causes the

public and policymakers to pay attention and, thus, provides opportunities for interest groups to advance their aims.

Schneider and Ingram (1993) have brought attention to the social construction of populations as an important variable in policy processes. The construction of populations influences the framing of problems and thereby affects the likelihood of a problem achieving agenda status and policy action. The dimensions identified by Schneider and Ingram are the perceived power of the target group and their basic construction as either positive or negative. Using these dimensions, they identified four groups: the “advantaged” (positively constructed; strong power), “contenders” (negatively constructed; strong power), “dependents” (positively constructed; weak power), and “deviants” (negatively constructed; weak power).

Young children in child welfare systems are dependents in this typology, with a generally positive social construction but little political power. Their age and victim status reinforce their dependency, particularly when they are in foster care. Their positive construction may be contested, however, when their caregivers are portrayed as deviants. Parental and family behaviors related to abuse, crime, addiction, and other challenges may lead to judgments regarding the “worthiness” of families. Additionally, experiences in foster care carry stigma and a sense of being harmed by the system experience which may signal to the public that these children are potential future deviants.

Integrating the two frameworks aids examination of how particular focusing events involving dependents and deviants (tragedies in state care) activate policy responses through the three streams of problems, policies, and politics. The resulting insights create potential for more efficacious transferable learning from one state jurisdiction to another.

Method

The comparative case method strengthens the potential for uncovering key findings, thereby contributing to potentially transferable knowledge, "[C]omparison [also] allows learning from the innovations or experience of others. Thus, comparative analyses may also help in answering pragmatic 'what to do?' questions" (Denters and Mossberger 2006, p.553).

This study applied the comparative case method to original research conducted in Massachusetts and information from three previously published cases focused on New Jersey, Florida, and Colorado (Gainsborough 2010). The case study method is particularly appropriate to this research because of the complexity of the phenomenon and the critical importance of context in understanding responses to child tragedy.

The case is defined as a state public child welfare agency's policy-making response to child tragedies in care within a limited period of time. Gainsborough's (2010) study involved three cases (states) selected because each faced a significant child welfare tragedy during the time period of her study (1999-2003). The states she selected also differed in geographical location and had varied institutional and political settings. The case of Massachusetts was selected because several, widely reported child tragedies occurred between 2013 and 2016 that, similar to Gainsborough, triggered public attention and action by stakeholders. Public attention is necessary for purposes of this study because of its importance for agenda-setting.

A detailed description of the Massachusetts case is compared with the previous cases. Several data sources were utilized in the Massachusetts case: five reports[1], numerous media

[1] The five reports are identified in the References.

accounts (primarily from the *Boston Globe*), documents related to a class action lawsuit, and state budget and legislative bills. Kingdon's problem, policies, and politics categories structured Massachusetts data analysis and were applied retrospectively to Gainsborough's (2010) findings from Colorado, Florida, and New Jersey. Within each of the three analytic domains, data were further analyzed to develop additional concepts. In this way, similarities and differences across cases are identified and theory-based explanations are derived.

The Massachusetts Case

Although this analysis begins with the tragedy of Jeremiah Oliver in 2013, there were previous child fatalities and near-fatalities of children in the care of the Department of Children and Families (DCF)—the Massachusetts state agency responsible for child protection. In 2005, Haleigh Poutre arrived at the emergency room severely beaten which resulted in permanent disability. Widespread media coverage led to public calls for accountability. In July 2008, new legislation, *An Act Protecting Children in the Care of the Commonwealth*, created the Office of the Child Advocate to monitor state agencies that provide services to children. In 2010, the advocacy group Children's Rights, Inc. filed a class-action lawsuit, *Connor v Patrick*, on behalf of children in DCF custody, alleging serious violations of the children's rights.

Problem

Table 1 presents basic data about the circumstances of five child tragedies in Massachusetts, along with indicative statements from key stakeholders.

Table 1: Child Incidents in Care, Massachusetts 2013–2016

	Circumstances	Statements
Jeremiah Oliver (2013)	4-year-old went missing while being monitored by DCF. Officials did not realize he was missing until later. Body found off of interstate. Investigation found that assigned social worker skipped mandatory visits. Mother was charged.	*DCF Commissioner*: "We are deeply saddened by the tragic loss of Jeremiah Oliver. The Department is grateful for the dedication of the District Attorney and law enforcement partners leading this investigation and will continue to assist in any way we can."
Jack Loiselle (July 2015)	7-year-old boy beaten and starved by his father, fell into a coma. Significant weight loss, bruises and burns. Was being monitored by 16 DCF workers, 8 behavioral health counselors, medical providers, and school personnel. Over 100 contacts with the family in ten months. Father charged with nearly killing son.	*Governor Baker*: "I'm not going to stand here and say there are no systemic issues here. I'm going to stand here and say we are in the process of dealing with an agency that has many systemic problems, and we're going to fix them."
Ava Conway-Coxon (August 2015)	2-year-old died in foster care. Cause undetermined: indications of heat stroke, bruises suggesting a struggle to get out of car seat. Boyfriend of foster mother alleged drug addict with criminal record. Received earlier report alleging boyfriend was living in the home, violating DCF policy, and had hit another foster child. Criminal background should have triggered increased oversight but did not.	*Governor Baker*: "Understanding that caseloads are still too high, and staff is forced to operate under difficult circumstances, the failure to recognize and report certain issues within this foster home and parent is unacceptable." *SEIU Local 509 rep*: "Whether systemic challenges or individual action, any factor that plays a role in a tragedy must be fully investigated and addressed ….we will continue to work with law enforcement and the Administration to ensure appropriate action is taken."
Bella Bond (September 2015)	Unidentified child's body found. National search for identity took three months. Mother and boyfriend charged. Complaints to DCF in 2012 and 2013 were investigated. State social worker used old reports, which prevented proper evaluation. Case closed September 2013. Mother had previous rights to a child terminated for maltreatment.	*Governor Baker*: "We need to go as fast as we can to fix the managerial oversight, supervision, infrastructure, guidance, and direction that we provide to social workers at DCF, and then hold them accountable. But you can't hold them accountable if you don't give them any guidance, you don't have a rulebook, and you don't have any supervisory policies."

Kenai Whyte (2016)	Died from traumatic injuries 2 days after being rushed to hospital. Step-mother charged. Open case with DCF, multiple complaints. DCF worker had recently spoken with a caretaker, who reported no issues.	*DCF spokesperson*: "The Department of Children and Families is working in collaboration with law enforcement during their ongoing investigation, and is additionally conducting an internal investigation of this case."

These cases all involve young children with parents frequently troubled by drug use, mental illness, and/or homelessness. Two of the cases (Oliver and Bond) involved the parent and/or the parent's boyfriend killing the child. Selected statements, drawn from media accounts, provide information about how the problem was publicly framed. In all cases, the perpetrators (parents, foster parents, or caregivers) received condemnation in the press. DCF workers were criticized (for example, for not following record-keeping protocols). But most of the attention was given to the systemic nature of the problems plaguing the agency: caseload size, management oversight, and "outdated" (but undefined) policies. Statements from DCF personnel were limited, expressing concern for children and an intent to investigate.

Published reports related to these cases, most of which were produced by knowledgeable child welfare professionals, contributed to systemic framing. These included a governor-commissioned review of the Oliver case by the Child Welfare League of America (2014)—perhaps the foremost national organization in child welfare—which presented recommendations consistent with standards of child welfare practice to move the agency toward better practice. At legislative request, The Office of the Child Advocate conducted a management review (2015) of DCF and identified ways in which the Department's infrastructure had been "so weakened over many years" that it was unable to provide needed case oversight to insure good decision-making (p.8). Less typical was a report produced by the

Pioneer Institute—a conservative-leaning think tank that seeks solutions “based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government”—which suggested that “DCF is dysfunctional”, cited mission “confusion”, noted the need to overhaul the practice model, and advocated use of new technologies (Blackbourn and Sullivan 2015, p.5).

The class action lawsuit, *Connor v Patrick*, filed in 2010, was also important in establishing a systemic frame. While Massachusetts successfully defended DCF’s practices on behalf of children in care, the allegations brought attention to the agency through media coverage of the court proceedings, which began in 2013 and continued through appeal in 2014. The lower court’s opinion indicated substantial concern with agency performance and noted evidence that Massachusetts was below national standards in child maltreatment. The judge’s opinion stated that “the flaws noted herein are more about budgetary shortfalls than management myopia. We are all complicit in this financial failure” (Young, 2013). The appellate judge agreed, writing “Improvements in the system must come through the normal state political processes” (Lynch 2015).

There was a nearly complete absence of reference to empirical scholarly research or program evaluation in the course of problem framing and policy development. Data and evaluation evidence from within DCF were particularly lacking. The management review by the Office of the Child Advocate (2015) noted a lack of quality assurance mechanisms at DCF as a problem. The limited data that were utilized were provided primarily by sources external to DCF. Widely noted was a series of reports by the New England Center for Investigative Reporting (McKim 2015) indicating that 110 Massachusetts children died between 2009 and

2013 in circumstances suggesting maltreatment; a third had been under care of DCF. Those reports also suggested there may be many other deaths that are not identified either because their abuse was not known to the state or because of "the state's missteps and failures . . . long concealed by confidentiality laws and secrecy" (p.30).

Policies

Responses to the problem frames by relevant officials took two distinctive forms: "early actions" and "policies". Early actions typically involved suspensions or firings of workers and calls for investigations. Other early actions took the form of immediate administrative actions such as order to change casework practice, additional hiring, enhanced training, ending differential response, and budget increases.

Several initial policy responses were targeted toward the specific actions identified to be direct contributors to the tragedy. For example, following the loss of Jeremiah Oliver, poor access to information was identified as a problem and mobile devices were provided to workers. After Ava Conway-Coxon died in a foster home and it was discovered that there had been frequent 911 calls from this home, Governor Baker suggested that 911 call information should be part of the review process for foster parents. Details of the Jack Loiselle tragedy identified too much conflicting information as part of the problem, which led to a proposed solution requiring supervisory review of such cases.

One major change, instituted very quickly in response to the Bella Bond case, was the elimination of the policy known as differential response, alternative response, or dual-track. Differential response allows for more than one method of initial response to reports of child

maltreatment. Based on the assessment of family circumstances, cases are determined to be either "high-risk," and thus require an investigation, or "low" or "moderate" risk, in which an alternative response, such as voluntary engagement in services, is deemed appropriate. Over the past two decades, more than two-thirds of the states have implemented or begun planning for differential response (Child Welfare Information Gateway 2014). Among several reasons for this trend were the concern that typical child welfare responses are overly intrusive and harmful to family life and the recognition that engaging (rather than investigating) families produces greater parental cooperation, leading to more effective protection of children.

Some of the child deaths identified by McKim (2015) had been assigned to the "low risk" track, which led some to argue that differential response procedures were complicit in these deaths. Hence, differential response as a policy came under intense fire. Although the research evidence on differential response has been mixed (Child Welfare Information Gateway 2014), the policy discussion made no effort to engage with or interpret that evidence. Massachusetts had not conducted an independent evaluation of its differential, dual-track system, and so had no clear evidence on which to act. Moreover, a simplistic understanding of the dual-track system dominated the public discussion. Although supervision of the family and connecting the family to resources and supports are critical components of a successful differential response system, there was no discussion of whether adequate services were being provided to families. In a rare expression of support for differential response, Scharfenberg (2015) quotes one child welfare expert who indicated that the policy was not implemented well and suggested it should be improved rather than eliminated. Identifying the policy itself as an important variable in these tragedies led to an easily coupled solution—eliminate the policy.

Ending differential response was tied to other immediate policy changes, as well. These included overhauling the intake policy so that all screened-in reports of abuse and neglect receive the same treatment, conducting criminal and sexual offender checks for all people in the household, reviewing 911 call history for foster homes, and enhancing supervisory review of cases. More complex policies were to be implemented later in the year. These focused on family assessment and action planning, an in-home case practice policy to ensure regular visits to the child, and a case-closing policy which lays out the process and criteria for closing a case.

In his 2017 budget proposal, Governor Baker included $30.5 million in new funding for DCF—a 5.1 percent increase—primarily for additional case workers, administration and oversight (Massachusetts Budget and Policy Center 2016). Other aspects of the proposal included a 3.2 percent increase for additional domestic violence and substance abuse specialists. Increased funding for foster care and adoption as well as group care recognized the "dramatic recent increases in the removal of children to out-of-home placements", "relative scarcity of foster families", and the "anticipated growth in the number of children sent to live in group foster care"; whereas a $1.5 million increase for family support services was judged by watchdogs "not sufficient to provide all the services families might need to help them stay together safely and prevent child neglect" (Massachusetts Budget and Policy Center 2016).

In summary, although the proposed increases were welcome for a system that is considered under-funded, critics point out that the DCF budget has been cut every year since 2005 (Chan 2014) and these increases were not enough. The overall Massachusetts budget continues to be strained (Massachusetts Budget and Policy Center 2016), and other areas of human services that are integral to the well-being of families were also under-funded.

Politics

Widespread media coverage clearly contributed to a political mood that something must be done. People looked to the new governor----Charlie Baker----for action following the 2014 gubernatorial election in which issues of child welfare played a larger role than usual. Despite some criticism of Baker's commitment to children that arose during the campaign (McNamara 2014), Governor Baker maintained a high favorability rating throughout the child-welfare crisis and its aftermath.

Compared with the governor, the Commissioner and the Secretary of Health and Human Services had little visibility beyond their presence at multiple press conferences. More visible was the union (Service Employees International Union (SEIU) Local 509) representing human service workers and educators throughout Massachusetts. In September 2015, when Governor Baker announced reforms "jointly" with SEIU, the SEIU chapter president stated, "This is an unprecedented collaboration between frontline child protection workers and agency administrators. Working together, we will succeed in doing what has been necessary for so long – making deep, systemic changes." The SEIU website reported that "the Administration has joined us" in addressing the caseload crisis and misguided policies, with (1) significant investments to hire front-line social workers; (2) retention of experienced, talented staff; and, (3) returning to "commonsense" child protection policies.

The Massachusetts' Office of the Child Advocate was also a visible player. Governor Baker specifically ordered the Office to examine the involvement of child welfare, all executive agencies, police, and any other service providers with Bella Bond's family to see if important

steps were missed and to learn if similar tragedies might be prevented. A comprehensive report was issued that contributed to a review and revision of case closing policies. Additionally, the Office produced a review of management at DCF mandated by the legislature. In this report, the Child Advocate noted some progress related to hiring more workers and additional funding, but identified a number of areas that required additional attention.

One group of stakeholders with limited visibility were the private providers of child welfare services. Previous research in Massachusetts has identified private agencies as a powerful interest group that can act in their own self-interest by framing a problem as residing within DCF (Collins and Clay 2009). These providers who receive a substantial amount of budget funding from contracts with DCF largely remained silent.

Social construction of the population

Maltreated children are clearly 'dependents' in Schneider and Ingram's typology. They lack power but are generally viewed favorably. To the extent that children are linked to their parents, however, public support is much less clear. In reality, a child's wellbeing cannot be divorced from the parents'. This murkiness related to the social construction of the population affects both the framing of the problem and policy solutions (for example, favoring child removal rather than family support). The politics, also, lean toward child protection when families are viewed as deviants. Furthermore, robust support of child welfare systems from policymakers, particularly in the form of budget appropriations, wanes in absence of a crisis.

Comparative Analysis

The agenda setting process in the Massachusetts case was sufficiently similar to that of other states to draw useful comparisons. Similarities include the role of focusing events, framing, media coverage, and political context. This case also highlights points of difference with important implications for further theory development and transferable learning. Table 2 compares data drawn from Gainsborough's earlier study (2010) with this article's original Massachusetts case analysis, and the analysis below draws connections across the problem, policy, and politics streams.

Not all child tragedies become focusing events. Each case is unique, yet certain identifiable features contribute to the likelihood that a case will capture policymakers' attention. These include characteristics of the death, the child, the parent or caretaker, and agency involvement. Cases in which there is mystery, such as a missing child, can capture public attention long before the actual facts are known. This was notable in the Florida case and in the Massachusetts (Bella Bond) case. By the time the child's death comes to light, public interest is already high, and the political mood is set; the case cannot escape under the radar.

Table 2: Comparison of Problem, Policy, and Politics Streams

	New Jersey	Florida	Colorado	Massachusetts
Problem Framing	Agency failures: poor decision-making, lack of accountability, poor coordination with agencies; need for re-organization	Variable: isolated tragedy (DHS), government agency (governor), systemic (child advocates)	Systemic: multiple tragedies; decentralized, privatized system	Systemic: multiple tragedies; outdated policies; caseload size
Politics				
Electoral politics	No	Explicit	No	Minor
Class Actions	Settlement of lawsuit was major factor to spur reform in multiple areas	No	No	No settlement; finding in favor of DCF although criticism by judge
Interest Groups	Union provided consistent voice for systemic framing; advocacy group provided institutional memory about previous reforms.	Private Providers	Private providers	Union provided consistent voice for systemic framing; kept focus on caseload and workforce.
Policy				
Administrative rules	Multiple efforts related to settlement of lawsuit	Several – for example, within 60 days supervisors must visit every child in foster care; foster parents/ children sign to confirm.	Local control; minor reform; new rules on foster parent/home licensing	End differential response; reviewing 911 call history; supervisory review of complex cases; new assessment, practice, and case closure models

Administrative organization	Major re-organization: Creation of the Office of the Child Advocate; New agency created: Department of Children and Families; formation of a children's cabinet to monitor reform.	Already undergoing large-scale privatization and devolution	Creation of monitoring team to oversee CPAs.	Re-open regional office
Legislative	Key areas of reform: reducing caseloads, adopting case practice model, establishing a training institute, developing community resources. Three pieces of legislation quickly introduced; one passed. Most significant, creating Office of Child Advocate	Resurrected previously considered legislation: 1) felony to falsify records 2) expand guardian ad litem. Passed Rilya Wilson Act (unexcused absences in child day care must be reported); development of core training curriculum.	Required training; recertification requirements of foster homes and child placement agencies (CPA); created prevention fund; performance audits, required studies, and comparisons between private and public providers	Limited legislative response; conducted hearings, requested report from OCA
Additional spending	Additional spending	Additional spending mostly for worker salaries and retention strategies.	Very little; budget process constrained by State Constitution	Governor proposed 5.1% increase primarily for caseworkers and administration/

Beyond public exposure, the problem of child tragedies in care needs to be framed in order to gain attention in the policy environment. There appears to be a consistent initial inclination to view these incidents as isolated tragedies and to propose solutions that are focused on individuals (a specific worker, supervisor, or agency head). It becomes increasingly difficult to pin the blame on individuals when the fatalities continue. Only through multiple deaths (which occurred in each state over time), was a systemic frame able to take hold, and even then, it could be contested. Maintaining a systemic frame required the support of stakeholders (particularly unions in Massachusetts and New Jersey) and media (in Massachusetts and Colorado) that used this frame.

In Massachusetts, the shift toward a systemic frame was facilitated by political stakeholders, namely the union representing agency workers, which continually framed the problem as caseload size. Elected officials, primarily the governor, also reframed repeatedly with a focus on caseload size (inadequate staffing) and outdated policies. This frame led to easily articulated and implementable policies—hire more and update or eliminate policies, including the policy of differential response discussed earlier.

Framing as a public sector agency problem also tends to fit with public sentiment that is less supportive of governmental action. In Massachusetts, the Pioneer Institute report that targeted the "dysfunction" of DCF can be seen as "softening up" (Kingdon 1984) the policy environment to consider greater privatization of services. Privatization was also a prominent theme in the Florida and Colorado cases (Gainsborough 2010). In Florida, the child welfare system was already engaged in large scale privatization and the child tragedies were used to suggest that privatization would be a partial solution (that is, it was already floating around as a

policy response). In Colorado, a highly decentralized, privatized system led to some problem framing that the privatized system was partially the problem because there was lack of adequate oversight of providers. Each of these suggests the critical relevance of framing to fit within political context; privatization is neither the problem nor the solution but child deaths in care can be used to make the case in either direction.

Even in the states (Colorado, New Jersey, Massachusetts) where systemic problem framing partially succeeded, systemic policy responses did not necessarily follow. The cross-state comparative analysis revealed several types of actions commonly adopted in response to child deaths in care: firing the worker and/or supervisor responsible for the case, replacing agency leaders (after an initial period of support), and forming commissions to make recommendations. In all four states emergency measures were primarily focused on orders that the agency review every open case and/or contact every child currently in the system. Such measures were noted by the union in Massachusetts to lack "commonsense". Changes to administrative policies and practices, rather than system-level approaches, were dominant, particularly in the near-term, and initial policy solutions were largely procedural and targeted toward the particular types of circumstances observed. Similar to Massachusetts' decision to screen foster homes for 911 calls based on a single case, Colorado decided, based on a single, high-profile case to require teen mothers of medically fragile infants to demonstrate adequate parenting skills or the presence of an additional caregiver before the baby is released from the hospital (Gainsborough 2010).

Because policy-making most often occurs incrementally it is not surprising that these very small, targeted policy changes are a primary response. Yet, they do not fit an overall

definition of the problem as long-term, wide-ranging, deep-seated, and fundamental. If a more systemic problem definition is advanced and gains a foothold, then reforms that solely tinker with the current system appear to be mismatched, from a policy perspective. Within the politics stream, however, they are favored because they require few financial or political resources.

Perhaps this tension between the streams is resolved by Kingdon's (1984) image of pre-set policy solutions "floating around" waiting to be attached to a well-defined problem. In all four states, the early actions and policy measures adopted were drawn from a familiar playbook of incremental, visible, reasonably non-controversial, and presumably feasible solutions. Alternatively, perhaps the tension between systemic problem-framing and reactive policy responses is better explained through the theoretical lens of social construction. Kingdon identifies a significant role for constituencies in determining policy agendas, but if vulnerable children and families are considered the key constituency in child welfare, there is no evidence that they have input into problem definition or policy development processes. As dependents and deviants in Schneider and Ingram's typology, and as involuntary clients of a system that is ostensibly designed to be helpful but that has substantial state power (investigation, child removal, termination of parental rights), vulnerable children and families by definition have very little power or standing to make claims on resources or public attention.

It is also important to note that children and families involved in child welfare services are often poor and are disproportionately racial minorities. A vast literature has documented this problem (for example, Harris 2014) and the consequent negative effects of both societal and systemic racism that further disenfranchises these families from receiving adequate supports and services. Some efforts have been made toward parental advocacy in child welfare

systems (Rauber 2009), but these are highly limited. The most egregious cases of child maltreatment can paint all families receiving services in a callous and unsympathetic light. This reinforces a negative social construction that disadvantages families at all stages of the policy process and makes systemic reforms politically difficult.

Would data indicators of the child fatalities problem----another factor of Kingdon's problem-framing schema----be sufficient to overcome the negative social construction of client families and support system-wide reform of child welfare services? The available data are limited and generally of poor quality. For example, the most recent national data on child fatalities (US DHHS 2017) lacked data from Massachusetts and two other states. Moreover, there appeared to be little interest during agenda setting and policy making processes to examine data to inform decision making. Here also an intersection with social construction may be relevant. If these families were more highly valued perhaps better systems of data collection would be built to guide policy processes.

Implications for Theory

Problem recognition stems from forces such as focusing events, data, and constituent feedback. In these cases, the influence of the focusing events (child tragedies) dominates the problem definition and the resulting policymaking processes. This many not be the case in other policy areas that rarely have high profile focusing events or that have access to high quality data indicators. In addition, social construction appears to play an important role when parents, as a constituent group, are widely recognized to be "deviants", and have no standing to garner more supports for vulnerable families. There is no indication that greater resources

for troubled families were ever seriously considered in any of the four states. In the states where additional spending occurred it was largely for hiring more workers and reducing caseload size—both important agenda items for unions. Overall, this analysis suggests that social construction of the population may play a powerful role in policymaking processes through all three of Kingdon's streams.

When cases occur frequently and interested stakeholders can link the cases as a pattern, early actions and simplistic solutions seem less convincing. But policymakers inclined to tack toward more substantive changes face serious obstacles to the adoption of policies tied to family support. These obstacles include the social construction of agency-involved families as "deviants," alongside the apparent dominance of short-term, incremental, case-specific policy options in the child welfare policy soup. Genetic mutations and recombinations of policy ideas, as per Kingdon's analogy to evolution, can occur in the child welfare space (for example, multiple forms of family group conferencing originally developed in New Zealand can be found in many child welfare systems). But newer, more cutting-edge policy ideas apparently do not fill the niches created by focusing events when policymakers under heavy public pressure may be expected to display risk aversive decision making. Transferable learning, discussed further below, is likely to suffer under these conditions.

At the intersection of the problem and politics streams, child tragedies in public care are best understood as part of a longer historical trajectory, rather than as discrete, isolated incidents. Even when tragedies occur in rapid succession and the memory of them is clear in the public mind, excuses can be made based on a perceived need to wait for further action until the impacts of newly instituted policies and procedures can be assessed. Too often, the public

memory of previous tragedies and the policy responses to them quickly fade. Maintaining public memory can be an important role for the advocacy community.

Gainsborough (2010) concluded that of the three states she studied, New Jersey initiated the most comprehensive reforms. That process focused on broader systemic problems rather than narrow, specific case failures. Although the scholarly literature offers mixed perspectives on the impact of reforms brought about through class action litigation (Center for the Study of Social Policy 2012), the New Jersey lawsuit appears to have played a vital role. Determining the impact of litigation on lasting change is difficult in the absence of counterfactuals, and it cannot be inferred that class action lawsuits in other states would lead to improvements in policy and practice. Nonetheless, it seems plausible that only a powerful institution, such as the courts, would be capable of overcoming the obstacles to systemic reform posed by negative social construction of client populations.

Implications for Transferable Learning

The four states compared in this article offer clear similarities in responses to child tragedies in public care, but no obvious evidence of transferable learning for systemic improvement. Further research is needed to explain the apparent institutional resistance to learning at times of crisis in child welfare.

Kingdon's original study examined policy making in transportation, where airplane disasters offer not only an example of focusing events, but also an example of systematic learning from past incidents to improve safety. A similar model might be used to examine root causes of failure in child welfare to continually improve the system (Rzepnicki and Johnson

2005). Although child fatality review teams exist in many jurisdictions, there has been little research to examine whether these reviews are used to provide effective policy feedback. More concerning, McKim (2015) concluded that dozens of cases of Massachusetts children who may have died of abuse and neglect remain unresolved for years because investigators are delayed in obtaining death reports. This suggests that while child deaths may be successful at garnering attention, the ability to learn from them to improve systems is greatly compromised when the systems designed to provide dispassionate review are lacking.

Organizational entities, such as the National Governors' Association and the Child Welfare League of America, facilitate shared learning among state actors in child welfare policy. Because child welfare is organized at the state, county, and tribal (Native American) levels, there are structural opportunities for transfer that may not be available for policy sectors more national in scope (for example, Veterans' care) or more diffuse at the community level (for example, public education). Intermediary organization such as the Annie E. Casey Foundation (AECF) also can, and do, play an important role. In addition to funding research AECF provides consulting and technical assistance to child welfare agencies to improve child and family outcomes.

Transferable learning also might occur through personnel changes, as when actors leave one state for another (Zhu, this volume), or when successful individuals from one jurisdiction are recruited to help "clean up" problems in another. Training provides another mechanism for the transfer of learning. Although frequently identified as a vehicle for staff development, training approaches are also a key element of policy implementation (Collins, Amodeo, and Clay

2007). In this way, training, which is a popular remedy for child welfare system problems (as it was in the four cases studied) also can serve as a mechanism to facilitate policy learning.

Further research is needed to examine the relative effectiveness of these and other strategies for enabling learning, while also recognizing that systemic reforms need to be adopted and evaluated before lessons about them can be drawn and transferred.

The process of choosing among pre-existing policies is hampered by an inadequate supply of evaluative research to assess the effectiveness of current and past policies. The example provided in this analysis in regard to differential response is a case in point. Here the role of organizations such as the AECF is particularly important. But far more expanded public and private infrastructure is necessary to develop, communicate, and implement potential policy solutions.

It is also possible that the lack of sufficient commitment to research in this policy area is related to the dependent status of children and the social construction of their parents as deviant. If these populations were more advantaged in the policy process, we might expect greater investments in research on their behalf. Where policy responses to child deaths in state care are concerned, transferable learning thus may both contribute to, and depend on, expanding capacity for evidence-based policy making.

One final observation suggests that the transferable learning that is occurring may be focusing far more in learning to manage these crises in child welfare systems rather than learning the lessons from tragedies that can be used to improve systems. Both advocates and researchers have a role in advancing learning for systems improvement rather than solely diffusing political crises.

Conclusion

Unfortunately it is likely that many additional cases can be added to future analysis. The societal response to child maltreatment remains imperfect both in the US and internationally. A firmer commitment is needed to learn from tragedies and act upon the lessons. Additional cases will further hone theoretical propositions about the impact of child tragedies on state policy-making and the obstacles to system reform. Given the high profile role of governors on this issue, further analysis might examine the attention paid by both campaigns and administrations to child welfare issues that are not reactive to child tragedies. Further analysis might also purposively search for states that exhibit more robust commitment to evidence-based policy making to include in future comparative analysis.

This is an area of practice that resonates across the globe; consequently international comparisons are also appropriate. As yet, there has not been much attempt to compare child welfare systems cross-nationally regarding their policy-making response in reaction to child deaths. In one exception, Lonne and Parton (2014) compared Australia and England. They noted the particular power of the media to bring problems to light, but in a way that distorts the realities of maltreatment and as a result "undermine[s] trust, reputation, and legitimacy of professionals working in the field" (p.822).

Multiple avenues of comparative inquiry – both within the US and internationally – are suggested by the analysis presented. The evidence from this reported analysis clearly suggests that problem definitions and political responses may be transferred across jurisdictions where child tragedies are concerned, but the transfer of substantive policy solutions appears to be

lacking. The social construction of the relevant populations limits both the availability of policy options to be considered and societal investment in determining the best policy options. Additional cases that examine these processes are needed to add to the possibilities for positive and consequential transferable learning.

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